

The Pharmacy Counter as a Site of Public Health Advocacy: Reconciling Commercial Obligations, Professional Independence, and Claims from Underserved Communities

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Abstract

Community pharmacies occupy an unusual position in health systems: they are commercial enterprises, sites of regulated professional practice, and highly accessible points of contact for communities whose health needs may not be adequately met elsewhere. This combination raises a normative question that cannot be resolved by evidence of accessibility or unmet need alone: when should a community pharmacist move beyond individual service provision and undertake public-health advocacy? This conceptual article develops an Advocacy-Obligation Framework for distinguishing ethically permissible advocacy from individual professional obligation, collective professional responsibility, organizational escalation, and policy-level action. The framework separates descriptive evidence about need, access, discrimination, professional autonomy, organizational capacity, and community preferences from the ethical principles required to convert those facts into obligations. Justice, harm prevention, respect for persons and communities, professional responsibility, proportionality, legitimacy, competence, and feasible efficacy are treated as distinct considerations. Commercial obligations and organizational constraints are recognized as morally relevant without being allowed automatically to defeat professional duties. Conversely, professional accessibility is not treated as sufficient to create unlimited responsibility for social or public-health problems. The resulting account places the allocation of responsibility at the center of pharmacy advocacy: stronger community claims may justify stronger action, but the appropriate actor and level of action depend on practical independence, capacity, authority, community legitimacy, available alternatives, and the likely consequences of intervention. Advocacy becomes a professional obligation only under bounded and defensible conditions.

Keywords: Community pharmacy, Public health advocacy, Professional ethics, Professional independence, Health equity, Underserved communities

Introduction

Community pharmacy is simultaneously a health-care setting, a retail environment, and an increasingly visible point of public-health contact. Ethnographic work has shown that public-health activity in community pharmacies is shaped by the interaction of professional

aspirations, commercial pressures, policy targets, the physical environment of the pharmacy, and the expectations of people seeking care [1]. That hybridity matters ethically. A pharmacist may be asked to supply a product, advise an individual, identify a broader pattern of unmet need, or respond to circumstances in which the health problem cannot be corrected through an isolated transaction. The pharmacy counter can therefore become a point at which clinical service, commercial exchange, and questions of public responsibility converge. Community pharmacies also possess characteristics that make broader engagement with social and public-health problems plausible. Practice models have increasingly considered pharmacists as potential links between patients and community resources, particularly when

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medication-related needs are inseparable from transportation, food insecurity, housing, affordability, or other social conditions [2]. Yet the possibility of acting beyond dispensing does not establish that pharmacists are professionally required to do so. A profession can possess an opportunity without possessing an unlimited obligation to use it.

Accessibility further complicates the argument. National geographical analysis in the United States demonstrates that community pharmacies are widely distributed and often physically closer to residents than many other health services [3]. This proximity can make pharmacists unusually likely to encounter medication-related problems, barriers to care, or patterns of disadvantage. However, geographic proximity is not the same as equitable access. Analyses of pharmacy deserts show that transport mode, travel time, neighborhood conditions, and racialized patterns of urban access can substantially change who can realistically reach pharmacy services [4]. Accessibility is therefore a morally relevant circumstance, but it cannot function as a complete ethical premise.

The central problem is consequently not whether community pharmacists can contribute to public health. They already do. The harder question is when such contribution should become advocacy and when advocacy should become an obligation. Advocacy is used here to mean purposeful professional action intended to represent, contest, communicate, or alter conditions that affect the health interests of patients or communities beyond the immediate completion of an individual pharmacy transaction. This can include raising concerns within an organization, seeking changes in service design, mobilizing professional bodies, challenging policies that produce preventable barriers, or supporting community claims before institutions with greater decision authority.

This article develops an explicitly normative account of that transition. It does not infer obligation from unmet need, accessibility, expanded scope of practice, or professional goodwill. Instead, it asks which facts generate morally relevant reasons, which ethical principles connect those reasons to professional duties, what conditions strengthen or weaken those duties, and how responsibility should be allocated when an individual pharmacist lacks the authority or capacity to produce the required change.

Why advocacy at the pharmacy counter is a distinct professional problem

Community pharmacists already participate in activities that extend beyond the supply of medicines. Pharmacists surveyed across several regions reported contributions across the essential services of public health, including health education, linkage to services, prevention, and community-oriented activities [5]. These activities establish that public-health engagement is not conceptually alien to pharmacy practice. They do not, however, resolve where ordinary professional service ends and advocacy begins.

That boundary becomes important when the problem identified at the counter cannot be corrected solely by advising or treating the person currently present. Health disparities associated with pharmacy access, service design, vaccination, treatment availability, or broader social disadvantage have generated calls for pharmacists to participate more actively in equity-oriented work [6]. At that point, the pharmacist may confront a mismatch between what can be achieved through individual care and what would require changes in organizational policy, resource allocation, referral infrastructure, community engagement, or regulation.

A second distinction concerns who defines the problem. A professional may recognize a disparity but misunderstand the form of response that affected communities consider useful, acceptable, or legitimate. A scoping review of pharmacist-led services designed for minoritized populations found only a limited body of tailored interventions and incomplete involvement of intended communities in service design and evaluation [7]. This matters ethically because advocacy conducted for a population can become paternalistic when professional interpretation substitutes for the population's own account of the problem.

Codesign research provides a more demanding picture. People from ethnic-minority communities identified cultural competence, trust, communication, awareness, and practical accessibility as important conditions for obtaining useful medicines advice from pharmacies [8]. These concerns show why advocacy cannot be defined simply as “doing more.” A professionally enthusiastic intervention that ignores mistrust, language, cultural expectations, affordability, or previous exclusion may reproduce the problem it is intended to solve.

The distinct professional problem at the pharmacy counter therefore arises when three conditions coincide. First, the pharmacist encounters a health-related claim

that extends beyond an isolated dispensing episode. Second, the pharmacist occupies a professional position sufficiently connected to that claim to possess relevant knowledge, access, or influence. Third, meaningful improvement may require action directed toward an organization, institution, policy, or collective arrangement rather than only toward the individual patient.

These conditions identify a problem of responsibility, not its answer. They explain why the pharmacist cannot be understood solely as a retailer or as an unconstrained public-health agent. The next question concerns the commercial obligations that accompany the same institutional position.

Commercial obligations

Community pharmacy operates through organizations that must remain financially viable, meet contractual obligations, manage staffing and workflow, comply with regulation, and maintain reliable medicine supply. Qualitative research indicates that community-pharmacy practice is shaped by interacting influences at micro, meso, and macro levels, including economic incentives, policy arrangements, organizational expectations, and professional relationships [9]. Commercial considerations are therefore not external contaminants imposed on an otherwise purely clinical profession. They are part of the institutional conditions under which professional work is performed.

That observation matters because advocacy consumes resources. Time spent documenting inequity, communicating with external agencies, participating in community coalitions, challenging internal policies, or pursuing policy change is time that cannot simultaneously be spent on dispensing, clinical services, management, or other contractual work. A scoping review of community-pharmacist work identified multiple forms of role stress and strain arising from expectations that exceed or conflict with available resources and established roles [10]. Ethical analysis that ignores these constraints risks creating duties that can be stated rhetorically but cannot be discharged sustainably. Commercial considerations can also enter directly into ethical decisions. In research on community-pharmacist responses to medicine shortages, professional-ethical reasoning generally remained prominent, but business considerations became more salient under some scenarios, including those involving cost and perceived patient impact [11]. This finding is important because it

demonstrates that commercial and professional reasons can coexist within a single decision rather than belonging to entirely separate domains.

The ethical error would be to resolve this tension in advance. Treating every commercial consideration as morally suspect would ignore responsibilities to maintain a viable service, remunerate staff, protect continuity of supply, and sustain access for other patients. Treating commercial viability as automatically decisive would allow any inconvenient professional responsibility to be displaced by cost. The relevant question is instead whether the commercial burden is proportionate to the professional importance of the claim and whether the burden should properly be borne by the individual pharmacist, the employing organization, a commissioner, a professional association, or another institution.

Conflict becomes especially visible under disruption. Qualitative research conducted during the COVID-19 pandemic described multiple sources of conflict in community pharmacy, including changing demands, workplace pressures, uncertainty, and interactions with the public [12]. Although those findings are context-specific, they demonstrate why an advocacy obligation cannot be specified without attention to operational circumstances.

Commercial obligations should therefore be treated as legitimate but defeasible reasons within an advocacy decision. They can reduce what is reasonably expected from an individual, strengthen the case for collective or organizational action, or occasionally make a proposed intervention disproportionate. They do not, by themselves, determine whether the underlying community claim is morally valid.

Professional independence

Commercial pressure becomes ethically significant in a different way when it affects professional independence. Formal scope of practice specifies what a pharmacist is legally permitted to do, but permission is not equivalent to practical control over professional judgment. Research examining expanded pharmacy scope has shown that increasing formal responsibility can coexist with uncertainty about professional boundaries, expectations, and relationships with other health professionals [13]. Expansion of scope therefore does not automatically produce autonomous action.

This distinction is particularly important in employed community pharmacy. Qualitative research on pharmacist professionalism and autonomy has described

circumstances in which employment dependence, managerial arrangements, market control, and the internal politics of retail organizations constrain the pharmacist's ability to exercise professional judgment [14]. A pharmacist may possess the knowledge and legal authority required for an action while lacking control over staffing, workflow, communication channels, external representation, or organizational policy.

Professional independence in the present framework consequently refers to the practically usable capacity to exercise defensible professional judgment within lawful scope. It does not mean isolation from organizational accountability, freedom from evidence, or unilateral authority over community interests. Independence matters because an obligation directed at a person who lacks practical authority to discharge it may be misallocated.

Ethical dilemmas are already recognized as a recurring feature of community-pharmacy practice. Survey evidence indicates that pharmacists encounter conflicts in which professional codes, patient interests, organizational expectations, and other values require judgment rather than mechanical rule application [15]. Advocacy can intensify this form of conflict because the pharmacist may need to decide whether professional responsibility extends beyond an immediate service request.

Moral distress provides a further distinction. Community pharmacists have reported situations in which they believe one course of action is ethically preferable but experience constraints that impede acting accordingly [16]. Moral distress cannot prove that the preferred action was ethically correct. It does show, however, that moral judgment and practical permission are separable.

That separation has direct consequences for advocacy. If a pharmacist has strong ethical reasons to support a community claim but lacks authority to alter the relevant organizational condition, the appropriate obligation may be to document, communicate, refer, escalate, or participate in collective action. Requiring unilateral action would confuse professional responsibility with organizational power. Conversely, the existence of managerial constraints cannot erase every duty; some constraints may themselves become the object of legitimate professional challenge.

Claims of underserved communities

An advocacy obligation requires more than a capable professional and an available intervention. It also

requires a morally relevant claim. In community pharmacy, such claims may concern medication access, discrimination, affordability, culturally unsafe services, barriers to preventive care, social conditions that undermine treatment, or institutional arrangements that repeatedly disadvantage particular groups.

Pharmacists have been proposed as potential contributors to social-determinants-of-health work at patient, practice, and community levels [17]. That multilevel formulation is useful because it prevents all social problems from being assigned to the individual encounter. Some problems can be addressed through immediate assistance; others require practice redesign, referral networks, organizational resources, community partnership, or policy intervention.

Legitimacy becomes central when pharmacists seek information about social conditions. Interviews with Black adults living in medically underserved areas found that willingness to discuss social determinants with community pharmacists depended on the rationale for asking, the relationship with the pharmacist, and the availability of useful resources [18]. A professional interest in social need is therefore insufficient. Asking about vulnerability without a credible purpose, trusted relationship, or practical response may impose burdens without producing benefit.

The pharmacy itself can also be a site of inequity. A national survey found that some adults perceived discrimination in community-pharmacy encounters and that reported racial discrimination was associated with delayed prescription pickup [19]. Because the design was cross-sectional, this evidence does not establish that discrimination caused the delay. It nevertheless demonstrates that the pharmacy cannot be assumed to occupy a neutral position outside the inequalities it might seek to address.

Community-defined expectations also matter for service design. Research with Māori participants concerning pharmacist-led minor-ailment care emphasized the importance of culturally and clinically safe, strengths-based, community-responsive services [20]. These findings should not be transferred uncritically to populations with different histories and institutions. Their normative importance lies in demonstrating that equity-oriented action gains legitimacy when the affected community participates in defining what safe and useful care entails.

A community claim is therefore stronger when the harm or disadvantage is credible, consequential, connected to

pharmacy practice, and articulated or supported by those affected. Its strength is reduced when the professional interpretation is speculative, when the proposed action lacks community legitimacy, or when pharmacy has no meaningful competence or influence over the problem. This distinction prevents “underserved” from becoming a label that automatically authorizes intervention.

Normative foundations of pharmacy advocacy

The empirical evidence reviewed above identifies conditions that may matter ethically, but none of those conditions independently establishes an obligation. A descriptive statement—patients experience unequal access, pharmacists are nearby, or organizational policy constrains a service—cannot produce a professional duty without an ethical premise explaining why that fact creates responsibility.

A useful pharmacy-specific precedent is principle-based analysis of pharmacists' responsibilities in the sale of complementary medicines. That work explicitly derives conditional responsibilities from ethical principles while considering evidence, possible harm, consumer autonomy, and professional obligations [21]. The substantive issue differs from public-health advocacy, but the methodological lesson is transferable: professional obligations require a transparent ethical bridge rather than an intuitive leap from observed need to required action.

Five normative grounds are particularly relevant here. Justice supplies a reason to respond when avoidable institutional arrangements systematically disadvantage groups in access to medicines or pharmacy-related care. Beneficence and prevention of harm provide reasons to act when foreseeable and preventable health consequences are within the pharmacist's sphere of relevant knowledge or influence. Respect for persons and communities requires attention to autonomy, voice, culture, and the legitimacy of acting in another population's name. Professional responsibility recognizes that specialized knowledge and socially granted authority can create obligations that do not apply equally to every citizen. Proportionality limits those obligations by asking whether the expected value and legitimacy of action justify its burdens, risks, opportunity costs, and intrusion.

Justice may also operate at the level of the profession. Critical pharmacy scholarship has argued that pharmacy institutions, education, and professional structures can participate in reproducing racial inequity and therefore

cannot treat structural disadvantage as entirely external to professional responsibility [22]. Such an argument strengthens the possibility of collective responsibility where the relevant problem is institutional. It does not imply that every pharmacist individually bears the same duty or possesses the same means to discharge it.

Context remains indispensable. Ethical challenges in community pharmacy vary with law, culture, professional expectations, health-system organization, and local practice conditions [23]. The same action may be permissible in one jurisdiction, impossible in another, and obligatory in a third where professional authority and available resources differ substantially.

The resulting normative structure is deliberately conditional. Serious and credible harm can strengthen the reason to act. Direct pharmacy involvement can increase professional relevance. Community legitimacy can strengthen authority to advocate. Feasibility and likely efficacy can strengthen an expectation of action. Conversely, weak evidence, lack of competence, community objection, disproportionate burden, legal conflict, foreseeable harm, or the presence of a clearly better-positioned actor can narrow or defeat an individual obligation.

Proposed advocacy-obligation framework

The central contribution of the Advocacy-Obligation Framework is an allocation rule rather than a declaration that pharmacists should advocate more. The framework asks two linked questions: Is there a sufficiently strong professional reason for advocacy? and, if so, where should responsibility for that advocacy be located?

The first question concerns the grounds of the claim. A community need carries greater professional relevance when it involves medication access, safe use, preventable medicine-related harm, discriminatory pharmacy practice, public-health functions already connected to pharmacy, or institutional conditions over which pharmacy actors possess relevant expertise or influence. The ethical strength of the claim then depends on justice, foreseeable harm, respect for affected people, and the legitimacy of the proposed response.

The second question concerns allocation. Community-pharmacy integration with primary care has been described as requiring more than individual willingness: consensus, connectivity, communication, trust, and wider political, economic, social, and practice-level change may be necessary [24]. A pharmacist may therefore

correctly identify a serious problem while being the wrong level of actor to solve it alone.

A broader analysis of community-pharmacy integration similarly distinguishes multiple forms and levels of integration and shows that micro-level activity can depend on meso- and macro-level structures, policy, incentives, and institutional relationships [25]. Applied normatively, this supports a principle of responsibility allocation by effective authority. Responsibility should remain with the individual when the pharmacist has sufficient competence, practical independence, legitimate access to the affected person or community, and a proportionate opportunity to act. It should shift toward collective, organizational, or policy-level action when the relevant change requires powers that individuals do not possess.

Commercial obligations enter this reasoning as constraints on feasibility and proportionality, not as automatic exclusions. Evidence that pharmacists weigh business as well as professional considerations under some ethically difficult conditions [11] demonstrates why the framework cannot pretend that commercial reasons disappear once a public-health claim is recognized. The ethical question is whether the burden is a legitimate constraint, a responsibility that should be redistributed, or an organizational arrangement that itself warrants challenge.

Professional independence performs a related function. Where employment arrangements or market control restrict practical autonomy [14], assigning responsibility exclusively to the individual pharmacist can convert an organizational problem into personal moral failure. An ethically defensible framework must therefore distinguish having a professional reason to act from having sufficient authority to discharge that reason directly.

Community claims introduce another condition: advocacy must possess legitimate direction. The availability of multilevel SDOH strategies [17] does not authorize pharmacists to decide unilaterally what communities require. Patient willingness to discuss

social risks depends on relationships, reasons, and available resources [18], while discrimination within pharmacy settings can itself undermine trust [19]. Community-informed evidence further shows that cultural and clinical safety may need to be defined with, rather than merely for, the affected population [20].

The Framework therefore treats advocacy responsibility as configurational. A strong moral claim combined with professional relevance, community legitimacy, practical independence, feasible efficacy, and proportionate burden can support an individual obligation. A strong claim combined with low individual authority but meaningful collective leverage can instead generate a responsibility to escalate, coordinate, or act through professional organizations. A serious structural problem that requires regulatory or financing change may primarily justify organizational or policy-level action. When evidence is weak, pharmacy relevance is marginal, legitimacy is absent, or intervention is likely to cause greater harm than benefit, no pharmacy-specific advocacy duty may be established even though the underlying social problem remains important.

This allocation logic also prevents accessibility from becoming an unlimited-duty principle. The pharmacist's proximity to a problem strengthens responsibility only when proximity is joined to relevant competence, a defensible ethical ground, practical capacity, and a plausible route to beneficial action. Likewise, underserved status strengthens the moral seriousness of a claim but does not erase autonomy, professional boundaries, competing duties, or the need for community participation.

Taken together, these dimensions mean that the ethically important question is not whether advocacy is generally desirable. It is where responsibility should sit when community claims, professional reasons, commercial obligations, practical independence, and organizational authority do not align. **Figure 1** represents this allocation problem while preserving the distinction between evidence-supported considerations and the proposed normative synthesis.

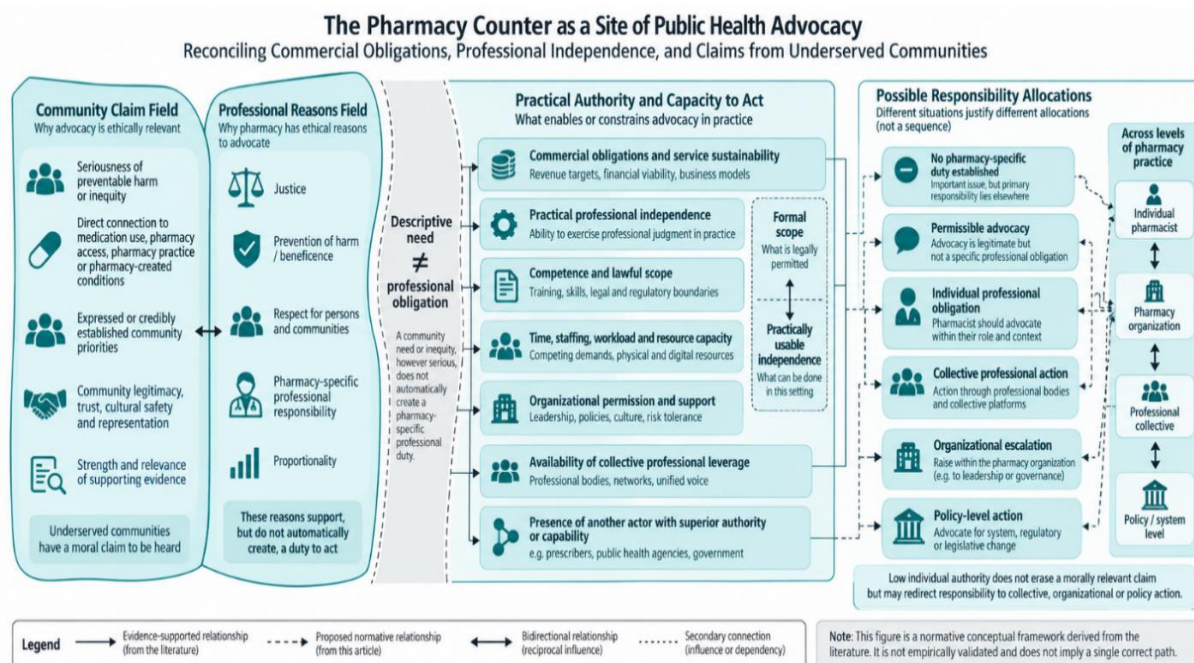


Figure 1. Allocating advocacy responsibility when community claims, professional independence, and organizational capacity do not align

Thresholds for individual and collective action

The Advocacy-Obligation Framework becomes useful only if it can distinguish a morally important problem from a pharmacy-specific obligation. That distinction requires thresholds, but not numerical scoring. The relevant question is whether a sufficiently strong combination of ethical seriousness, pharmacy relevance, community legitimacy, feasible efficacy, and practical authority exists to justify a particular form of action.

Moral seriousness concerns the severity, persistence, preventability, and distribution of the harm. A minor inconvenience does not generate the same claim as repeated inability to obtain essential treatment, discriminatory treatment, or a service arrangement that predictably excludes a vulnerable population. Seriousness alone, however, does not establish a pharmacy duty.

Pharmacy relevance asks whether the problem is materially connected to medication access, medicine use, pharmacy service design, pharmacy-created barriers, or an area in which pharmacists possess distinctive knowledge or institutional access. Geographic accessibility can strengthen this connection when pharmacies provide an otherwise scarce point of contact. For example, analysis of addiction-treatment availability found that pharmacies were present in many rural

counties lacking formal substance-use treatment facilities [26]. Such findings identify potential proximity and infrastructure; they do not prove that every pharmacy must assume treatment or advocacy functions beyond its competence.

Community legitimacy asks whether affected people have identified the problem, support the proposed direction of action, or have been meaningfully included in defining an acceptable response. The more advocacy purports to represent a population rather than a single patient's expressed interests, the stronger this legitimacy requirement becomes.

Competence and practical authority determine whether the pharmacist can act responsibly. A professional may have reason to raise a concern without possessing authority to redesign reimbursement, staffing, formulary rules, organizational policy, or public services. In those cases, the obligation may take the form of escalation or collective representation rather than unilateral intervention.

Feasible efficacy requires a plausible pathway between advocacy and benefit. Pharmacy-based public-health services can achieve substantial uptake when authority, infrastructure, and commissioning are aligned. In Wales, community-pharmacy influenza vaccination expanded considerably over successive seasons once the service

was formally established and supported [27]. The example shows that pharmacy can become an effective public-health platform under enabling conditions; it does not imply equivalent effectiveness for every advocacy objective.

Proportional burden concerns time, workload, commercial sustainability, risks to other patients, legal exposure, and opportunity costs. A burden can weaken an individual duty while simultaneously strengthening a

claim that employers, commissioners, or professional bodies should provide the resources needed for action.

Finally, alternative actors and collective leverage determine where responsibility should be placed. When a regulator, public-health agency, commissioner, employer, or professional association possesses substantially greater authority and capability, the pharmacist's responsibility may be to transmit evidence, support affected communities, or participate in collective action rather than attempt to substitute for that actor.

Table 1. Normative thresholds for allocating pharmacy advocacy responsibility

Advocacy situation	What strengthens the claim	What limits individual obligation	Appropriate responsibility allocation
Recurrent medication-access barrier encountered at the pharmacy counter	Serious or repeated harm; direct medication relevance; credible pattern rather than isolated inconvenience	Pharmacist cannot alter pricing, reimbursement, eligibility, or supply rules	Individual assistance where possible plus organizational or collective escalation
Pharmacy practice itself creates or reinforces inequitable treatment	Strong evidence of discriminatory or systematically exclusionary practice; affected community identifies the problem	Weak evidence, unresolved factual dispute, or proposed response risks additional harm	Individual corrective action within authority; organizational accountability when the practice is structurally produced
Underserved community requests a change in pharmacy service design	Community-defined priority; cultural and clinical safety concerns; feasible redesign	Request lies outside pharmacy competence or conflicts with overriding legal/safety duties	Codesigned practice change when feasible; escalation when resources or authority are organizational
Pharmacist identifies a social problem not clearly linked to pharmacy	High social importance but weak connection to medication use, pharmacy access, or pharmacy-created conditions	Limited professional competence, leverage, or legitimacy	Referral, support for better-positioned actors, or no pharmacy-specific advocacy duty
Serious pharmacy-related harm is visible but individual practical independence is low	Clear professional reason to act; preventable harm; pharmacist has relevant knowledge	Employer controls staffing, workflow, external communication, or service policy	Documentation, internal escalation, collective professional action, and organizational responsibility
Proposed advocacy would impose substantial commercial or workload burden	Strong expected benefit; no less burdensome alternative; burden can be shared or resourced	Threat to safe service delivery, disproportionate opportunity cost, or major uncompensated resource demand	Organizational or commissioner-level enablement rather than unrestricted individual sacrifice
Structural problem requires regulatory, financing, or system change	Broad population impact; repeated local manifestations; professional evidence can inform policy	Individual pharmacist lacks decision authority and local action cannot remedy the cause	Professional-association, organizational, commissioner, or policy-level advocacy
Community legitimacy, evidence, or foreseeable benefit is insufficient	—	Speculative need, community opposition, weak evidence, high risk of paternalism, or better-positioned actor exists	Permissible restraint, referral, further engagement, or no pharmacy-specific duty

The table makes an important distinction: failure to cross the threshold for an individual obligation does not necessarily mean that no responsibility exists. It may mean that responsibility properly shifts to a collective or institutional level.

Organizational conditions that enable ethical advocacy
Advocacy duties cannot be separated from the organizations in which pharmacists work. Evidence from community pharmacies in England links organizational characteristics with safety climate and patient

experience, including staffing arrangements, workplace culture, continuity, working patterns, and the availability of supporting personnel [28]. Because the evidence is observational, it cannot establish that modifying any single organizational variable will cause better advocacy. It does demonstrate that professional performance occurs within organizational conditions that can either expand or restrict practical capacity.

An organization that expects pharmacists to identify social or public-health problems while providing no protected time, escalation channel, referral infrastructure, or decision authority effectively transfers institutional responsibility downward without transferring the means to discharge it. Ethical advocacy therefore requires more than exhorting individual pharmacists to be courageous. At minimum, enabling organizations should provide a recognizable route for raising recurring patient or community concerns; mechanisms for distinguishing individual complaints from patterned service failures; permission to engage appropriate external partners; and safeguards against retaliation when pharmacists raise professionally defensible concerns. Where advocacy activities are expected as part of commissioned or organizational services, workload, staffing, remuneration, and documentation systems should reflect that expectation.

Community participation should also be institutionalized rather than left to occasional individual initiative. Advisory relationships, codesign mechanisms, local partnerships, and channels for feedback can improve the legitimacy of advocacy claims while reducing the risk that pharmacists speak for communities that have not authorized the representation.

These conditions do not eliminate individual moral agency. They clarify its limits. Pharmacists remain responsible for recognizing ethically important problems and acting within their competence, but organizations acquire responsibilities when they control the resources, rules, and permissions required for meaningful action.

Objections and boundary conditions

The strongest objection is that advocacy of this kind exceeds the proper role of community pharmacy. Pharmacists possess specialized expertise in medicines, not a general mandate to intervene in every social injustice. This objection is substantially correct. The framework rejects a universal advocacy duty and requires pharmacy relevance, competence, legitimacy, and a

plausible route to benefit before stronger obligations arise.

A second objection concerns paternalism. Professionals who interpret disadvantage on behalf of communities may reproduce the very inequalities they seek to challenge. The framework therefore treats community legitimacy as a substantive condition, not a procedural courtesy. Advocacy that bypasses affected people requires unusually strong justification, such as immediate serious harm or situations in which direct consultation is impossible.

A third objection is evidentiary. Many pharmacy-public-health activities are supported by descriptive, qualitative, implementation, or observational evidence rather than trials demonstrating downstream population-health effects. Ethical urgency cannot convert weak evidence into strong causal knowledge. Where effectiveness is uncertain, obligations should ordinarily favor reversible, proportionate actions, further engagement, documentation, referral, or collective inquiry rather than confident claims of benefit.

A fourth objection concerns commercial viability. Community pharmacies cannot sustain unlimited uncompensated public-health work. The appropriate response is not to deny commercial obligations but to allocate burdens fairly. If a health system expects pharmacies to perform advocacy-intensive public-health functions, commissioners and organizations may acquire corresponding obligations to finance, staff, and authorize them.

There are also clear boundary conditions. Advocacy may be inappropriate when it would breach confidentiality, conflict with a stronger legal or safety duty, expose a community to foreseeable harm, exceed professional competence, misrepresent community preferences, or duplicate the work of a substantially better-positioned actor. In some circumstances, ethically responsible non-intervention is the correct conclusion.

Policy and practice implications

For pharmacy organizations, the framework implies that professional independence should be assessed in practical rather than purely legal terms. Employers should examine whether pharmacists who are expected to respond to inequity actually possess time, staffing, escalation routes, and permission to exercise judgment. Professional associations have a different role. Problems that recur across pharmacies but cannot be resolved locally are candidates for collective advocacy.

Associations can aggregate evidence, represent common professional concerns, create ethical guidance, and engage regulators or commissioners without requiring individual pharmacists to carry system-level disputes alone.

Commissioners and policymakers should avoid treating pharmacy accessibility as a substitute for infrastructure. Assigning additional public-health responsibilities without sustainable remuneration, referral pathways, information access, or integration with other services risks converting professional commitment into hidden labor. Where pharmacy is deliberately used as an access point for underserved populations, enabling resources should be considered part of the intervention itself.

Education and professional development should likewise distinguish service delivery from advocacy. Pharmacists need skills in recognizing structural barriers, communicating concerns, understanding organizational authority, working with community partners, and deciding when escalation is preferable to individual action. Ethical training should include proportionality and responsibility allocation so that professional commitment does not become either role expansion without limits or premature withdrawal whenever commercial constraints appear.

For practice, the framework supports a simple discipline: identify the claim, establish its connection to pharmacy, seek the perspective of those affected, determine what action could plausibly help, and identify the actor with the authority and capacity to undertake it. That discipline is more defensible than assuming either that the pharmacist must solve the problem or that responsibility ends at the counter.

Conclusion

The pharmacy counter can reveal health needs that are simultaneously clinical, commercial, organizational, and social. Its accessibility gives community pharmacists opportunities to recognize problems that may remain invisible elsewhere, but accessibility alone does not create an unlimited duty to advocate.

A defensible advocacy obligation emerges only when the underlying harm is sufficiently serious, the issue is meaningfully connected to pharmacy practice, affected communities confer adequate legitimacy, the proposed response is ethically and evidentially supportable, and some feasible route to benefit exists. Even then, responsibility need not rest with the individual

pharmacist. Practical independence, organizational control, collective leverage, and policy authority determine where action should be located.

Commercial obligations therefore neither automatically defeat nor automatically yield to advocacy claims. They form part of the proportionality assessment and may reveal that responsibility has been assigned to the wrong level. The same is true of professional independence: limited individual authority can justify escalation without erasing the underlying ethical concern.

The resulting position is conditional but demanding. Community pharmacists should not be transformed into universal agents of social reform. Neither should a narrow account of dispensing allow preventable, pharmacy-relevant inequities to remain professionally invisible. Ethical advocacy begins where professional relevance, legitimate community claims, and feasible responsibility meet—and it becomes sustainable only when responsibility is allocated to actors who possess the authority and resources to act.

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