

Privacy Can Determine Whether Community Pharmacy Care Is Accessible at All: Connecting Consultation Space, Sensitive Disclosure, and Avoidance of Public Health Services

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Abstract

Community pharmacies are widely positioned as accessible sites for preventive, public-health, medication and increasingly sensitive clinical services. Physical proximity, opening hours and freedom from appointment requirements, however, do not ensure that a person experiences a pharmacy as a usable place for discussing a stigmatized, intimate or personally consequential concern. This article develops a Spatial-Relational Privacy-and-Access Model to explain how privacy can influence access before formal confidentiality obligations become relevant. The model distinguishes the objective affordances of pharmacy space from perceived visibility and audibility, anticipated social exposure, relational safety, disclosure sensitivity and the eventual decision to engage, delay, limit disclosure or avoid a service. Privacy is therefore treated as a configuration rather than a property of a consultation room. Physical separation can support access when it is usable, credibly signalled and embedded in workflows that allow discreet movement into private interaction; its value can be weakened when patients expect to be overheard, recognized, judged or publicly identified by the act of requesting privacy. Relational conditions further modify this process because trust, nonjudgmental conduct and confidence in the pharmacist can strengthen or weaken the protective value of the same physical environment. The model also identifies rival explanations, including cost, proximity, convenience, service awareness, professional capability and organizational readiness. Privacy should therefore be expected to matter most where anticipated social exposure is consequential and realistic alternatives are limited. The resulting account reframes community-pharmacy accessibility as partly spatial and relational, and generates testable distinctions between nominal privacy provision, experienced privacy and actual access.

Keywords: Community pharmacy privacy, Consultation rooms, Sensitive disclosure, Service access, Spatial design, Relational safety

Introduction

Community pharmacy is often described as one of the most accessible parts of the health system. Accessibility, however, is multidimensional. A pharmacy may be

geographically close, open for long hours and capable of providing a clinical or public-health service while still presenting conditions that make the service difficult to use. International work on community-pharmacy quality places access and features of the care environment within broader judgments of service quality [1]. As pharmacy roles expand, the practical conditions under which patients can enter into clinical interaction deserve the same analytical attention as the formal availability of the service itself.

Privacy is one such condition. Recent survey evidence indicates that consultation rooms are common in

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community pharmacies, yet their equipment, configuration and practical use are not uniform, and some sensitive interactions may still occur outside those spaces [2]. The difference is important because the presence of a room establishes only that privacy might be possible. It does not establish that patients can request it discreetly, reach it without signalling the nature of their concern, speak without expecting to be overheard, or experience the interaction as socially safe.

Public evaluations of community-pharmacy public-health roles reinforce this distinction. Privacy emerges alongside perceptions of pharmacy roles, relationships and service capacity rather than as an isolated architectural preference [3]. Its importance may therefore arise through the way physical and interpersonal conditions jointly shape whether an encounter feels usable. This question has become more consequential as community pharmacies have assumed broader clinical and public-health functions across health systems, with accessibility and acceptance among the factors associated with service development [4].

The theoretical problem is consequently narrower than whether pharmacies should offer confidential care. Professional confidentiality governs the handling of information once a person enters a professional relationship and reveals information. Access may be disrupted earlier. A person can decide that the setting is too exposed, that asking to use a private room would itself disclose something, or that the likely interaction does not feel sufficiently safe to justify raising a sensitive issue. The purpose of this article is to explain that earlier decision space and to identify the circumstances in which privacy becomes an access condition rather than a background feature of service quality.

Privacy beyond confidentiality

Confidentiality and privacy overlap in practice, but they operate at different points in the encounter. Confidentiality concerns what professionals do with information entrusted to them. Experienced privacy includes the conditions under which a person decides whether to entrust information at all. Qualitative research with people receiving opioid substitution treatment illustrates this broader meaning: participants linked privacy to both pharmacy layout and the quality of their relationship with pharmacy staff, and preferences for physical arrangements were not uniform [5]. A pharmacy could therefore satisfy formal confidentiality obligations

while still being experienced as an exposed place for requesting or discussing care.

This distinction is especially important when the act of seeking help carries social meaning. In research examining public acceptability of a pharmacy-based response to domestic abuse or suicidal ideation, participants recognized pharmacies as potentially accessible and discreet sites while also expressing concerns related to confidentiality and the conditions surrounding disclosure [6]. The access problem begins before the professional can protect disclosed information. A person must first judge whether initiating the conversation is worth the anticipated social and interpersonal risk.

Established pharmacy services show that this concern is not restricted to unusually complex interventions. A review of emergency hormonal contraception practice identified substantial variation in the use of private counselling environments and continuing privacy shortcomings across settings [7]. Likewise, research on pharmacist provision of sexually transmitted infection services shows that community pharmacies can support highly sensitive care, while acceptability and implementation depend on the characteristics of the service and local practice conditions [8].

Privacy should therefore be understood as a precondition that can vary in relevance by service, person and context. A minor over-the-counter inquiry may require little separation from surrounding activity. A request involving reproductive health, mental health, substance use, domestic abuse or stigmatized symptoms may carry a much greater perceived cost if other customers, acquaintances or staff can see, hear or infer what is occurring. The theoretical task is to explain how those differences become translated into access behavior without assuming that every patient requires maximal seclusion or that every sensitive service will be avoided when privacy is imperfect.

Spatial affordances of community pharmacy

The physical environment matters because it structures what forms of interaction are possible. Interviews examining information gathering during over-the-counter consultations found that consultation quality reflected interacting patient, professional and environmental determinants [9]. Space is therefore better treated as an affordance: it can make a private exchange easier, harder or practically unavailable depending on how the setting is organized and used.

A consultation room is the clearest example, but the relevant affordances extend beyond enclosure. They include acoustic separation, sight lines, proximity to queues, routes into and out of the space, interruptions, the ability to sit or remain at an appropriate distance, and the way private interaction is integrated into ordinary workflow. These features determine whether privacy can be enacted without unnecessary friction. Evidence from patients with long-term respiratory conditions indicates that private and clean consultation facilities can increase stated willingness to use community-pharmacy services, although preferences remained sensitive to service type and some respondents continued to favor general practice for more diagnostic or invasive care [10]. The finding supports a spatial contribution to access while also warning against infrastructure determinism.

The practical distinction is between nominal privacy and usable privacy. A pharmacy has nominal privacy when an appropriate room or private area exists. Usable privacy requires that the space be available at the relevant moment, function for the intended interaction and fit the workflow through which a patient seeks care. Contemporary survey evidence showing both high consultation-room availability and limitations in room facilities or use illustrates why the two states cannot be treated as equivalent [2].

The spatial component of access is therefore configurational. A room located beside a crowded waiting area, entered only after a conspicuous request at the counter, may provide excellent acoustic separation once occupied while offering weak privacy at the moment of access. Conversely, a modest physical space may perform better when the route to private consultation is normalised, clearly signalled and routinely offered. Objective spatial characteristics matter, but their influence depends on what patients believe those characteristics mean for exposure.

Perceived visibility and audibility

Patients respond to environments as they perceive them. Architectural separation may reduce actual audibility, but access behavior depends on whether the person expects the conversation to remain unheard and whether entering the interaction will reveal something they would prefer others not to infer. Perceived exposure therefore forms a conceptual bridge between spatial affordances and disclosure.

The distinction matters because patients cannot directly inspect many features of privacy. They may not know

how sound travels through a consultation-room wall, whether staff outside the room can hear, or whether people in the queue will recognize why the room was requested. They act on cues: door position, queue proximity, staff volume, prior encounters, signage, traffic through the pharmacy and the apparent normality or exceptional nature of entering a private area. The 2026 evidence on variation in consultation-room characteristics makes this gap between formal provision and experienced protection plausible [2].

Interpersonal history can modify the same appraisal. In the opioid-substitution study, positive relationships with pharmacists increased confidence in privacy for some participants [5]. A physical setting therefore does not carry a single privacy value independently of the relationship in which it is used. Familiarity may reassure one patient that information will be handled respectfully while making another more concerned about recognition or unwanted social knowledge.

This is also why privacy should not be separated from other evaluations of pharmacy care. Public comments about pharmacy public-health services place privacy alongside relationship and capacity concerns [3]. A patient can encounter a technically private environment and still anticipate an uncomfortable, rushed or judgmental interaction. Perceived privacy is consequently an appraisal of exposure embedded within a broader judgment of whether the interaction is safe enough to enter.

Sensitive disclosure

Disclosure becomes theoretically important when the information required for safe care carries embarrassment, stigma or feared social consequences. Research on the determinants of a community-pharmacy bladder and bowel service identifies embarrassment and stigma among the factors capable of obstructing engagement [11]. These concerns alter the meaning of ordinary environmental cues. A nearby queue or audible conversation may be inconsequential for a routine purchase yet become highly salient when the information could reveal continence problems, sexual-health needs, mental distress or another stigmatized concern.

Relational conditions can intensify or reduce this burden. Pharmacists participating in a harm-reduction intervention described changes in their attitudes and interactions while also reporting structural challenges that remained outside the interpersonal relationship [12]. The finding is useful precisely because it separates two

components of safety. A welcoming response can reduce anticipated judgment, but it cannot automatically correct an environment that exposes the patient. Improved spatial privacy can reduce exposure, but it cannot guarantee a non-stigmatizing encounter.

Mental-health services make the disclosure requirement particularly visible. The AMPLIPHY feasibility study demonstrated that community pharmacies can support consultations in which patients discuss mental-health concerns and personal experiences [13]. Such encounters involve more than transferring factual medication information. They can require patients to reveal states, experiences or worries whose disclosure depends on confidence in both the setting and the professional interaction.

Professional capability is therefore a necessary boundary on any privacy-based explanation. National work on community pharmacists' mental-health competencies shows that expansion into sensitive care requires appropriate education and training [14]. A private room cannot compensate for inadequate capability, poor communication or uncertainty about the pharmacist's role. In the Spatial-Relational Privacy-and-Access Model, provider competence is not folded into privacy. It is a separate condition that can determine whether a private encounter becomes clinically usable after access has occurred.

Sensitive disclosure should consequently be represented as a conditional decision. Greater exposure may lead one patient to abbreviate an answer, another to postpone the conversation, and another to proceed because trust in the pharmacist outweighs the environmental concern. The same individual may also respond differently across services. The theoretical significance of privacy lies in its capacity to alter the expected interpersonal cost of disclosure, not in a claim that imperfect privacy invariably suppresses communication.

Avoidance, delay and service non-use

The strongest version of the access argument concerns what happens when anticipated exposure changes whether a person seeks the service at all. Evidence from opioid-related pharmacy practice shows that stigma can inhibit engagement and that professional stigma-reduction interventions operate alongside structural constraints [15]. Stigma is not interchangeable with privacy, but it helps identify circumstances in which being recognized, overheard or judged could have unusually high perceived costs.

A privacy-based account must nevertheless compete with better-established determinants of pharmacy choice. A discrete-choice experiment found that cost and proximity materially influence community-pharmacy selection [16]. Other preference research demonstrates that members of the public trade convenience against cognitive pharmaceutical services rather than choosing pharmacies through a single attribute [17]. These findings prevent the theory from treating privacy as the default explanation for non-use. A patient may choose a pharmacy because it is near home, avoid another because of cost, prefer a physician because the service seems diagnostically complex, or remain unaware that a pharmacy offers the relevant service.

Privacy becomes theoretically consequential when it contributes information beyond these alternatives. Its role should therefore be tested as an incremental access condition: does perceived exposure explain disclosure, delay or service choice after proximity, cost, convenience, service awareness and provider readiness are considered? The question is also likely to be service-sensitive. Anticipated audibility may have little effect on use of a familiar low-sensitivity service but a much larger effect when requesting care could reveal a stigmatized condition before any consultation begins.

The possible outcomes should not be collapsed into a single category of avoidance. Privacy concerns may produce complete non-use, delayed help-seeking, choice of a more distant provider, a request for another channel, restricted disclosure within the encounter or completion of the service despite discomfort. Those outcomes impose different clinical and public-health consequences. A model of access therefore needs to preserve them as distinguishable responses rather than treating every privacy concern as a binary decision to attend or stay away.

Development of the spatial-relational model

The evidence reviewed so far supports a sequence of distinctions but does not establish a single causal chain. The model developed here therefore treats access as emerging from a field of interacting conditions. The first domain concerns objective spatial affordances: consultation space, acoustic and visual separation, workflow, routing and the practical possibility of moving into private interaction. The second concerns exposure appraisal: what a person expects others can see, hear or infer from the act of seeking care. The third concerns relational safety: confidence that the pharmacist and

surrounding staff will respond competently, respectfully and without avoidable judgment. These conditions shape, without determining, whether sensitive information is disclosed and whether a service is entered, delayed, limited or avoided.

Evidence from communication interventions helps clarify why workflow belongs within this field. A pilot randomized study of a digital health tool found that structured encounter support could change aspects of patient participation and concern expression during community-pharmacy interactions [18]. Qualitative work with a question prompt list similarly found that pharmacists perceived more active patient participation while identifying time and work pressure as barriers to sustained use [19]. Communication therefore depends partly on whether the encounter gives a person a practical route to formulate and voice a concern.

Relational preferences also differ. Research on patient-centered outpatient pharmacist practice identified distinct patterns in what patients value from pharmacist relationships [20]. The model should not assume a universal amount of familiarity, continuity or interpersonal distance that creates safety. For some

people, an established relationship may reduce uncertainty; for others, anonymity may be preferable when a concern is stigmatized or intimate.

The constructs are measurable in principle, although existing measures should not be treated as validation of the present model. A patient-reported measure of community-pharmacy service quality demonstrates that pharmacy experience can be assessed psychometrically [21]. Direct observation of self-medication consultations likewise shows that information exchange can be examined behaviorally and varies with characteristics of the encounter [22]. Future tests of the Spatial-Relational Model should combine these traditions while measuring objective privacy, perceived exposure, relational safety, disclosure behavior and actual service use separately.

The resulting visual field is shown in **Figure 1**. Its central distinction is between the pharmacy conditions that make privacy objectively possible and the patient's appraisal of whether entering the interaction will actually reduce exposure. Workflow and signalling cross that boundary because they can change the meaning of the same physical environment before any sensitive information has been disclosed.

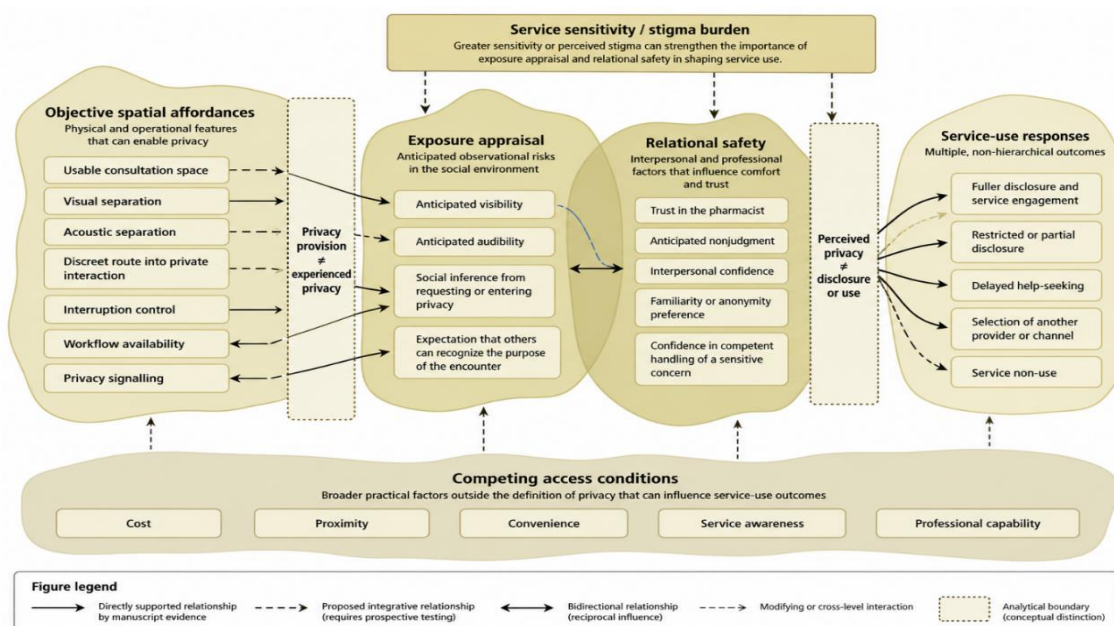


Figure 1. Usable privacy as a spatial-relational access condition in community pharmacy

From physical space to relational safety

The model becomes more informative when the same physical environment is allowed to produce different interpersonal experiences. Privacy infrastructure creates

opportunities for separation, but patients encounter those opportunities through people, routines and expectations. Research on implementation of pharmacist-led support for people living with severe and persistent mental illness

shows that sensitive services depend on internal pharmacy conditions as well as wider implementation context [23]. A private area therefore sits inside an organizational system that determines whether pharmacists have the time, role clarity and operating support to use it well.

Provider readiness is a separate dimension. Measures developed for pharmacist screening for perinatal depression demonstrate that professional acceptability, willingness and self-efficacy can be distinguished and assessed [24]. A pharmacy may offer excellent physical privacy while the pharmacist feels uncertain about initiating or managing a sensitive discussion. Conversely, a highly motivated and competent pharmacist may work in an environment that makes private interaction difficult. The two failures have different remedies and should not be merged into a single construct of “privacy quality.”

Theory-based research on naloxone provision provides a further reason to preserve the professional side of the interaction. Pharmacists’ beliefs and perceived control are associated with intentions to discuss or provide naloxone-related care [25]. These professional mechanisms operate before and during an encounter and can influence whether a patient receives an invitation to discuss a stigmatized concern. Relational safety is

therefore co-produced. It depends on what the patient anticipates and on how the professional actually structures the interaction.

This relational conversion explains why identical spatial arrangements can produce different access states. A consultation room offered routinely and without fanfare may signal that private discussion is an ordinary feature of care. The same room may carry a different meaning if access requires a whispered request at a crowded counter or if staff appear surprised when it is requested. An established pharmacist relationship may reassure one patient while increasing another patient’s concern about local recognition. A virtual encounter can remove the public queue yet introduce privacy problems in the patient’s home. The relevant theoretical unit is consequently the configuration connecting space, signals, relationship, service sensitivity and available alternatives.

Figure 2 develops this scenario-sensitive logic. It separates physical privacy from relational safety and then represents several routes through which patients may respond. Equity enters as a modifier because the consequence of a privacy failure depends partly on whether a person can afford to travel elsewhere, use a digital channel, delay care safely or tolerate the social exposure attached to the service.

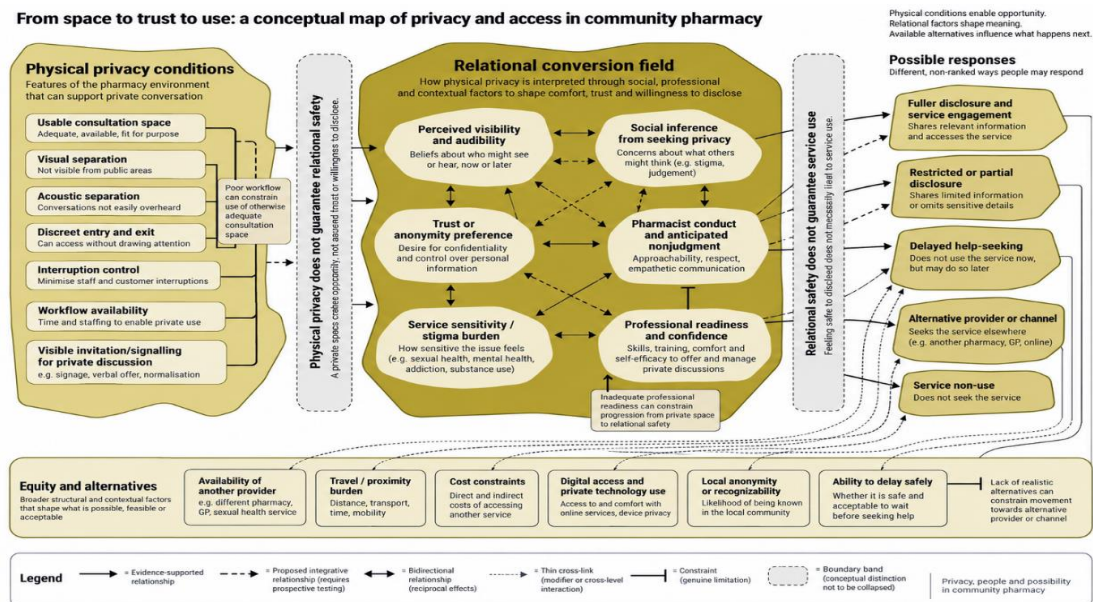


Figure 2. How physical privacy is converted into relational safety, disclosure and service-use states

Service scenarios with different privacy requirements

Privacy requirements are unlikely to be uniform across community-pharmacy services because the information

disclosed, the social meaning of requesting care, and the consequences of recognition differ. Continence care illustrates this problem. A systematic review found only a small and heterogeneous evidence base for community-pharmacy promotion of continence care, despite generally favorable indications that pharmacy could contribute [26]. The evidence does not establish a fixed privacy threshold, but embarrassment-sensitive care cannot reasonably be treated as equivalent to routine transactional encounters.

Virtual care further demonstrates that privacy can be reconfigured rather than simply increased. A scoping review found that virtual community-pharmacy services may expand access while introducing technical, operational and equity constraints [27]. Remote contact may remove exposure associated with queues or public counter conversations, yet shared devices, household audibility, poor connectivity or lack of private space can generate different privacy problems.

Service-specific evidence reinforces this configurational view. Pharmacy-based responses to domestic abuse or suicidal ideation raise discretion and confidentiality concerns [6]. Emergency hormonal contraception shows substantial variation in private counselling practice [7], while sexually transmitted infection services combine disclosure sensitivity with requirements for professional competence and acceptable delivery [8]. Bladder and bowel care adds embarrassment and stigma [11]; mental-health support may require comparatively deep personal disclosure [13]; and opioid-related care can be complicated by stigma [15]. These services should therefore not be assigned one generic standard of “adequate privacy.”

The contrast is represented in **Table 1** as differences in privacy configuration rather than a hierarchy of service importance.

Table 1. Service-specific privacy configurations for community-pharmacy access

Service scenario	Disclosure burden	Exposure most likely to matter	Relational requirement	Privacy configuration suggested by the model	Access failure requiring empirical testing
Emergency or reproductive-health request	Intimate and often time-sensitive	Being overheard or having the purpose of care inferred	Efficient, nonjudgmental normalization	Discreet transition from request to private discussion	Withholding information or selecting another provider
STI-related care	Intimate and potentially stigmatized	Recognition of the service being requested	Confidence in respectful and competent handling	Private route with sufficient consultation time	Partial disclosure despite attendance
Mental-health support	Personally consequential and relationally deep	Audibility, interruption or visible distress	Trust, continuity or preferred anonymity	Low-interruption private interaction with explicit invitation to talk	Superficial engagement
Harm-reduction or opioid-related care	Stigma-sensitive	Recognition, labeling or anticipated judgment	Explicitly non-stigmatizing conduct	Normalized access to private interaction	Delay, avoidance or constrained discussion
Bladder, bowel or continence care	Embarrassment-sensitive	Being heard or observed requesting help	Matter-of-fact professional response	Rapid, unobtrusive access to private discussion	Non-presentation or incomplete symptom disclosure
Domestic-abuse or suicidal-ideation response	Highly consequential and potentially unsafe	Exposure of help-seeking itself	Trust, discretion and competent escalation	Immediate private pathway with minimal public signalling	Failure to initiate disclosure
Virtual pharmacy encounter	Variable by service	Household audibility, shared-device visibility or digital exposure	Confidence in secure remote interaction	Private technology use with a viable fallback route	Apparent access but unusable privacy

Design requirements for consultation space, workflow and signalling

Design implications should follow the mechanism of privacy failure rather than default to a universal consultation-room specification. Realist evaluation of

extended pharmacist roles shows that community-pharmacy services emerge through context-dependent mechanisms rather than one implementation arrangement [28]. Privacy design should be treated similarly. The same room can function as a credible access resource in

one workflow and remain practically irrelevant in another.

Usable privacy begins with separation but extends to routing, timing and signalling. Environmental conditions influence information gathering [9], while communication-support work shows that participation can be constrained by time and work pressure [19]. Patients must therefore be able to reach private interaction without unnecessarily revealing why they

require it, and staff need sufficient operational capacity to use the space without avoidable delay or interruption. Signalling operates especially early in the access process. Patients should not need to disclose a sensitive concern merely to discover whether privacy is available. Neutral signage, routine offers of private discussion and normalized use can reduce the exceptional social meaning of requesting privacy. The resulting design configurations are specified in **Table 2**.

Table 2. Design configurations for usable privacy before and during community-pharmacy care

Design problem	What nominal provision misses	Spatial or workflow response	Likely patient interpretation	Relational requirement	Model-predicted risk if unresolved
Consultation room exists but is difficult to access	Presence without practical usability	Keep route clear, room available and workflow-compatible	Private care exists but is difficult to obtain	Staff normalize room use	Remaining at the public counter or abandoning the request
Acoustic privacy is uncertain	Closed door without confidence in sound separation	Reduce sound transmission and adjacent conversation traffic	Others may still hear	Appropriate staff voice and discretion	Restricted disclosure
Entering a private area publicly identifies the purpose of care	Privacy after entry but exposure during transition	Create routine, non-exceptional pathways	Requesting privacy itself reveals something	Staff offer privacy without demanding justification	Delay or provider switching
Workflow produces interruption or time pressure	Separation without protected interaction time	Protect consultation time and minimize interruption	The concern may be rushed	Attentive, nonjudgmental interaction	Superficial disclosure
Privacy is poorly signalled	Space exists but patients do not know how to use it	Neutral signage and routine verbal offers	Private discussion is normal and available	Consistent staff behavior	Non-use despite adequate infrastructure
Professional readiness is inadequate	Space cannot compensate for weak capability	Combine privacy design with training, role clarity and referral routes	The setting is private but the service may not be competent	Confidence and appropriate escalation	Private but clinically unusable encounter
Virtual care is treated as an automatic privacy substitute	Absence from the pharmacy does not guarantee privacy	Confirm surroundings, technology access and fallback options	Remote care may or may not be private here	Secure and competent remote conduct	Digital exclusion or constrained disclosure

Equity implications

Privacy failures are unlikely to impose equal consequences on all users. Their cost may be greater for people seeking stigmatized services, those living in communities where recognition is likely, or patients with few realistic alternatives. Privacy already appears among the considerations shaping public perceptions of pharmacy services [3], while opioid-related evidence demonstrates how stigma can inhibit engagement [15]. Opportunity sets therefore modify the model. Cost and proximity influence pharmacy choice [16]. A person able

to travel easily may respond to uncomfortable privacy conditions by changing providers; another may face delay or non-use. Virtual alternatives can widen choice but may introduce digital and household privacy constraints [27]. Equity assessment should consequently ask not only whether privacy infrastructure exists, but who can escape an unusable privacy configuration without additional cost, travel, delay or exposure.

Propositions and research agenda

The Spatial–Relational Privacy-and-Access Model generates propositions that are deliberately more discriminating than the claim that additional privacy necessarily increases service use.

Proposition 1. Objective privacy will influence disclosure and service willingness principally to the extent that it reduces perceived social exposure.

Proposition 2. The importance of reduced exposure will increase as the sensitivity, stigma or social consequences attached to the service increase.

Proposition 3. Relational safety will modify spatial effects, such that similar physical environments can produce different disclosure states depending on trust, anticipated judgment and preferences for familiarity or anonymity.

Proposition 4. Credible privacy signalling will affect access before disclosure by reducing the social cost of requesting private interaction.

Proposition 5. Nominal consultation-space availability will have limited value when workflow prevents timely, discreet or interruption-controlled use.

Proposition 6. Perceived privacy should explain incremental variation in disclosure or service use after accounting for cost, proximity, convenience, service awareness and provider readiness.

Testing these propositions requires separate measurement of objective spatial conditions, perceived exposure, relational safety, service sensitivity, disclosure and service use. Existing pharmacy patient-experience measures demonstrate that rigorous measurement is possible [21], and direct observation shows that information exchange can be assessed behaviorally [22]. Prospective and mixed-method studies should additionally test counterfactual configurations—for example, whether a trusted pharmacist can partly compensate for weak spatial privacy, or whether a technically private room provides little benefit when entering it is conspicuous.

Results and Discussion

This article positions privacy within the process of gaining access to community-pharmacy care rather than restricting it to the protection of information after disclosure. Its central distinction is between nominal privacy, experienced exposure, and relational safety. A consultation room establishes a physical possibility; it does not establish that patients can enter it discreetly,

expect not to be overheard, trust the interaction, or regard the service as socially safe to request.

The evidence does not support architectural determinism. Direct privacy studies remain limited, and parts of the Spatial–Relational Model integrate evidence from adjacent research on stigma, communication, service choice, professional readiness and implementation. Cost, proximity, convenience, awareness and professional capability are therefore genuine rival explanations. The model is useful only where perceived privacy adds explanatory value beyond those established determinants.

Nor does the synthesis identify a universally optimal consultation-room design. Privacy emerges from configurations of physical separation, workflow, signalling, interpersonal conduct and available alternatives. The small and heterogeneous evidence base for some pharmacy services, including continence care [26], makes strong cross-service generalization inappropriate. Context-sensitive implementation evidence similarly cautions against assuming one arrangement will work across pharmacies [28].

For practice, evaluation should begin with the patient's route into care. A pharmacy can ask whether people know private discussion is available, whether requesting it reveals unnecessary information, whether the space is realistically usable when required, whether conversations are plausibly protected from observation, and whether staff can conduct the interaction competently and without avoidable judgment. These questions shift privacy assessment from possession of infrastructure to the provision of usable access conditions.

The model also clarifies why seemingly contradictory observations can coexist. A patient may value a known pharmacist yet prefer anonymity for one service. A consultation room may improve confidence for one encounter but add little when access to it is conspicuous. Virtual care may eliminate exposure in a pharmacy while creating exposure at home. These are not exceptions to the model; they are the configurations through which its central mechanisms can be tested.

Conclusion

Community-pharmacy care can be geographically and formally available while remaining practically inaccessible to a person who expects sensitive help-seeking to be seen, heard, inferred or judged. Privacy becomes an access condition when spatial affordances,

workflow and signalling shape anticipated exposure strongly enough to influence disclosure or service-use behavior. That relationship is neither universal nor automatic. It depends on service sensitivity, relational safety, professional readiness and the availability of realistic alternatives. The evidence-bounded theoretical claim is therefore conditional: privacy can determine whether community-pharmacy care is accessible when the social cost of exposure is consequential and the setting does not provide a credible, usable route into safe private interaction.

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