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"No one went into pharmacy … to sell a lot of Coca-Cola. It's just sort of a necessary evil" – Community pharmacists' perceptions of front-of-store sales and ethical tensions in the retail environment

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ABSTRACT

Background: Community pharmacists are expected to uphold ethical duties to patients and society while maintaining independent businesses or fulfilling expectations of corporate owners. Canadian pharmacy colleges provide only indirect guidance on the retail setting of the profession. Little is known about whether pharmacists identify ethical issues in retail pharmacy or around the sales of non-drug products.

Objective: This study sought to examine pharmacists' perceptions of their roles in health promotion, the factors that influence the selection of front-of-store products, and ethical issues relating to their dual roles as health care providers and retailers.

Methods: In 2020, 25 Canadian pharmacists participated in semi-structured phone interviews. Interviews were audio-recorded, anonymized, transcribed verbatim, and thematically analyzed using qualitative methods.

Results: Almost all participants described their role primarily as a health care provider, though some described themselves as 50–50 health care providers and retailers. Most staff pharmacists reported little control over front-of-store product selection. Where participants reported some control, external factors such as business viability and profitability impacted their choices, though some reported selecting products based on the needs of their patient community or their personal beliefs. The dominant tensions described stemmed from participants' dual roles as health care providers and retailers, though specific issues and situations were varied, ranging corporate targets, to service provision, to the sales of unproven or unhealthy products. Participants suggested solutions to the issues they described, ranging from a complete overhaul of the licensing structure of community pharmacies, down to one-on-one conversations with patients.

Conclusion: Our findings suggest that the retail setting of community pharmacy produces unique ethical tensions: the imposition of retail sales standards and targets are commonplace, and business viability is a primary driving force in front-of-store product selection. Clear guidance

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from Canadian pharmacy colleges and legislators to address these tensions and issues may be necessary.

1. Introduction

In September 2014, an independent community pharmacist in a small town in eastern Canada made news by removing all sweetened beverages from his pharmacy.[1] When questioned why, the pharmacist noted the health harms caused by excess sugar consumption and remarked, "[i]t made no sense to me. [I]n good conscience, we just couldn't continue selling."[1]

Studies on ethical dilemmas in pharmacy typically centre on pharmacists' professional roles[2,3] and are often presented as conflicts between pharmacists' freedom of conscience and pharmacists' professional duties to care for patients – for example, conflicts around providing emergency contraception in the United States (US),[4,5] or drugs used for assisted dying in Canada and Belgium.[6,7] Little is known about pharmacists' perspectives on other products sold within pharmacies.[8]

Legislation is sometimes used to address ethical tensions surrounding specific products. For example, the sale of tobacco is prohibited in most Canadian pharmacies. [9–12] Tobacco sales in pharmacies in the US and Canada introduced debates about potential conflicts between the sale of health-damaging products, and pharmacists' duty to protect patient health and prevent illness.[13–16] Some argue that selling tobacco in pharmacies directly violates pharmacists' codes of ethics.[17] Importantly, tobacco control legislation only regulates the sale of tobacco products, not pharmacists themselves.[18]

Community pharmacists are highly accessible, well-trusted sources of health information.[19–22] Thus, pharmacies that offer retail products may implicitly suggest approval by health care professionals. As health care providers, pharmacists have a fiduciary duty[1] to make professional decisions in their patients' best interests.[23,24] However, it is not clear how broadly this duty extends. For example, must pharmacists only sell products that are in the best interest of patients? Is every consumer who enters a pharmacy automatically a patient? Is the retail environment where a dispensary is located considered part of the pharmacy? Affirmative answers to these questions would require all pharmacies to be health-focused spaces that sell only high-quality, health-promoting products.

Many pharmacies sell front-of-store products that can have negative impacts on health or are not proven to support health outcomes, as front-of-store sales can make up a significant portion of pharmacies' revenues.[25] This study was conducted in Canada where there is little guidance from pharmacy regulators on front-of-store sales, though like many countries, Canadian pharmacists are governed by each region's code of ethics. Codes of ethics describe pharmacists and their role primarily as health care providers with a fiduciary duty to patients. However these codes only indirectly reference the profession's private funding model.[23,24] In contrast, physicians must only sell health-promoting items, and are provided with guidance around ethical issues that can arise from product sales in health care environments.[26] Little is known about the unique ethical issues facing community pharmacists in retail environments.[27]

This research is part of "Selling Health" – a project developed to examine issues around front-of-store product selection in the context of the ethical and legal frameworks that govern community pharmacists. Some research has explored the tensions relating to pharmacists' dual roles in connection with the sale of complementary medicines in Australia,[28] but there is limited research exploring pharmacists' perspectives on front-of-store products generally. This study was designed to address this gap and examine pharmacists' perceptions of the overlaps, tensions and/or ethical conflicts that arise in retail pharmacies. We sought to answer four questions through qualitative interviews with community pharmacists:

1. Roles: How do community pharmacists perceive their role(s) in health promotion or chronic disease prevention and as retailers or businesspeople?
2. Factors: What factors drive the selection of front-of-store retail products available in pharmacies?
3. Tensions: To what extent do pharmacists perceive ethical tensions between their roles as health care providers and retailers? How, if at all, do pharmacists describe these tensions?
4. Solutions: What policies can appropriately facilitate health-promoting retail environments in pharmacies, and better support pharmacists to make patient-centred choices in retail settings?

This research sheds light on pharmacists' perceptions of their roles, the factors that influence the selection of front-of-store products, and ethical tensions relating to pharmacists' dual roles as health care providers and retailers. The study also provides insights into participant-generated policy solutions to help pharmacists navigate difficulties arising from their dual roles, particularly around providing high-quality health care while ensuring business sustainability.

Throughout, "front-of-store" refers to all non-drug products that are sold in pharmacy settings, including food, medical equipment, gift items, and all herbs, supplements, or homeopathic remedies that are not scheduled drugs.[29] Over the counter or "OTC" products are not included in "front-of-store" products here. OTC describes drugs that are not federally regulated, but may be regulated at the local level. "Ethical tension" or "ethical issue" is used here to variously describe any dilemma, problem, situation, or concern expressed by participants that may compromise, or be perceived to compromise, their ability to provide high-quality health care to patients. This

[1] This project has another paper that examines the current legal framework and issues surrounding front-of-store sales in pharmacies, especially as it relates to this fiduciary duty.

definition is drawn from codes of ethics and the bioethical principles of benefiting others, doing no harm, respecting autonomy, and ensuring equitable treatment.[3]

2. Methods

Below are findings from qualitative interviews within a broader mixed-methods study. In the first phase, a survey was used to quantify and identify pharmacists working in various community pharmacy settings. Through e-mail lists and newsletters provided by pharmacy colleges and associations, survey participants were recruited from four Canadian provinces to gather pan-national insights.

The survey described the aims of the study, noting that we were seeking community pharmacists' perspectives on practice-related ethical issues.

Survey participants were asked questions about the ownership structure of the pharmacy they worked in (independent, banner, franchise/corporate), the setting (rural or urban, based on population),[30] their professional position (owner, management, or staff pharmacist), the length of time they had been in practice, their gender, and the province they worked in.

Of the 533 initial survey respondents, 286 participants consented to be contacted for an interview and provided their contact information, from which 56 participants were invited to participate in semi-structured interviews based on their responses to the demographic survey questions. Initially, we aimed to interview 12 participants per province based on balanced gender representation, varied levels of authority, balanced ownership structures, varied settings, and balanced length of time in practice. Of the 56 interview invitations sent, 25 pharmacists participated in interviews. Saturation was reached at 25 interviews when similar topic areas, ideas, and opinions were being repeatedly discussed by participants and no new thematic areas had emerged in the final three interviews.

Interviews were conducted by a single interviewer with an educational background in law, ethics, and journalism. The interviewer received training and was provided with guidance from members of the research team with experience in qualitative methods prior to the interviews.

Every interview participant consented and was given the opportunity to ask questions about the study prior to the interview. Interviews were conducted over the phone and were audio-recorded and transcribed verbatim with light cleaning for audio quality. Field notes were recorded. Identifying information was redacted from the transcripts by the interviewer prior to NVivo analysis. Interviews were completed between July and October of 2020.

Interviews ranged from 16 to 47 min in length, averaging 33 min. Interviews began with a scripted vignette based on a pharmacist removing all sugary products from their pharmacy. The vignette technique was used to elicit rich responses on participants' perceptions and beliefs, especially around ethical issues.[31] Participants were asked follow-up questions based on responses. Prompts of two specific products (cigarettes and homeopathic remedies) were used to probe perceptions further because these are controversial products without a direct benefit to health.[17,28] Open-ended questions were used to explore other ethical issues participants wished to discuss and identify possible solutions.

This study followed the six phases of thematic analysis outlined by Braun & Clarke (2006) to provide a thick, rich description of the

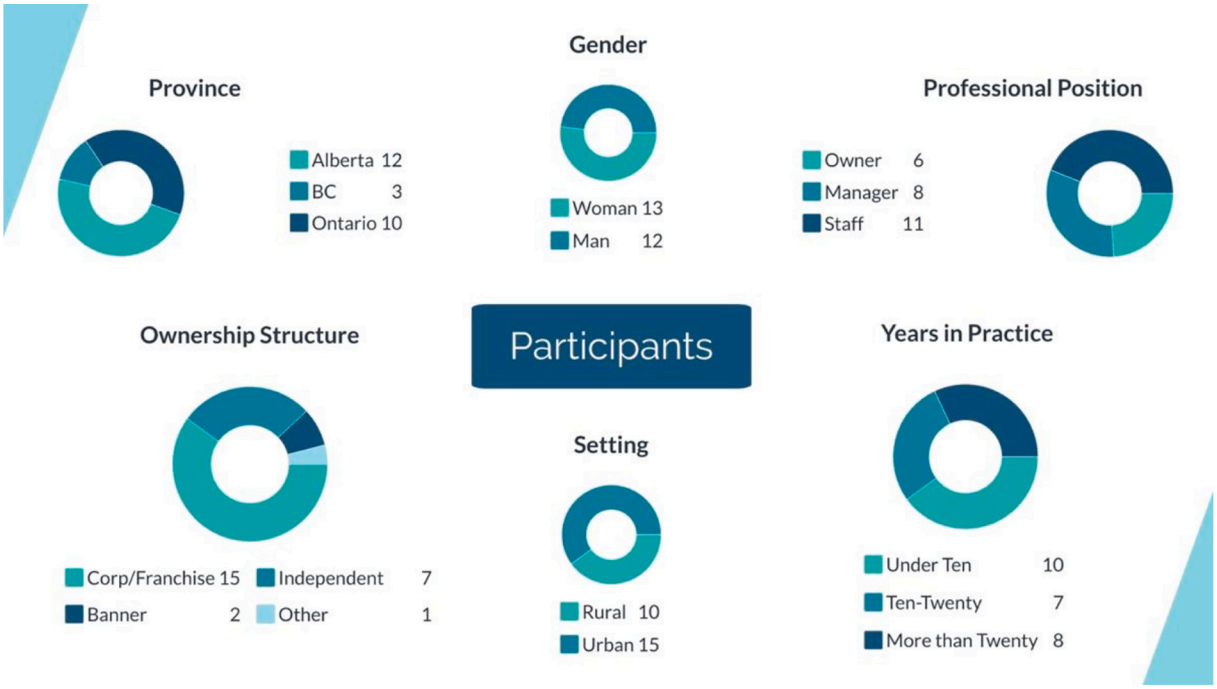

Image A. Participant demographics.

data.[32] First, interviews were transcribed and NVivo 12 was used to organize the data. Next, two researchers coded line-by-line, emphasizing breadth.[33] Third, semantic themes were identified inductively.[31,32] Several patterns significant to the research questions emerged from the codes.[31] For example, participants identified a lack of control in the selection of front-of-store retail products – this required a re-examination of our second research objective. Due to the reported level of control over the selection of front-of-store retail products, patterns in the description of tensions and subsequently described behaviours were of significance.

Candidate themes were then revised and refined to develop a thematic map. This iterative process included a second reading of the data while parallel coding was conducted to capture additional data that had been previously missed. In phase five, researchers defined and identified the themes. An interpretive analysis in phase six presented the rich description of themes that centred around the ethical tensions reported.

A variety of means, practices and methods were used to assess research quality,[34] such as measures to achieve sincerity through self-reflexivity and transparency about the research process by recognizing personal biases.[33] For example, the interviewer assumed that pharmacists would have issues with front-of-store products. Instead, the first two participants provided answers outside the scope of front-of-store product ethical concerns and related, instead, to working conditions and billing issues. Moving forward, follow-up questions were worded more broadly to allow for other issues to arise.

3. Results

Of the 25 interview participants — 13 women and 12 men — 12 practiced in Alberta, 10 in Ontario, and three in British Columbia (BC). Six participants were owners, eight were managers, and 11 were staff pharmacists. Ten practiced in small/rural communities, and 15 in urban areas. Fourteen practiced in corporate/franchise environments (many of these in large retail settings), seven in independent pharmacies, two in banner pharmacies, and one in a community pharmacy within a hospital. Corporate or franchise environment describes a pharmacy within a larger chain retail setting. Banner pharmacy describes retail banner or cooperative pharmacies.[35] Ten participants had been practicing for less than 10 years, seven between 10 and 20 years, and eight for more than 20 years (see Image A).

During de-identification, interviews were assigned an anonymized label representing their province (e.g., O1 for a participant in Ontario, A1 for Alberta, and B1 for BC).

Four areas framed by the research questions are discussed below: (i) descriptions of the role of a pharmacist within society and within communities, including participants' descriptions of their role as a pharmacist; (ii) factors that drive product selection in community pharmacies, and participant's level of decision-making control; (iii) ethical tensions relating to competing roles and influences that may impact pharmacists' ethical decision-making; and (iv) the solutions and processes participants described for tensions they face.

4. Role of the pharmacist

Three role categories were found using participants' own role definition: “Health Care Providers”, “50/50”, and “Health Care Plus”. “Health Care Providers” viewed their role as pharmacist as *primarily* that of a health care provider. Participants who identified as “50/50” were equally focused on both business and health care. “Health Care Plus” refers to pharmacists who identified themselves as not only interested in traditional dispensation and consultation, but also in active intervention, including additional care and patient advocacy. Fourteen participants self-identified primarily as “Health Care Providers,” nine as “Health Care Plus,” two as “50–50,” and none as solely “Businesspeople” or “Retailers” (see Image B).

Interview participants often directly provided normative descriptions of their role as a pharmacist: “*The primary role of a pharmacist is patient care*” (A7 – less than 10 years in practice, rural, banner, staff). This informed their ethical approach: “*My ethical prerogative is to promote the health and well-being of my patient-base*” (O10–10+ years in practice, rural, corporate, manager).

Role was also discussed indirectly through descriptions of prioritizing patient care above store or personal financial interests.

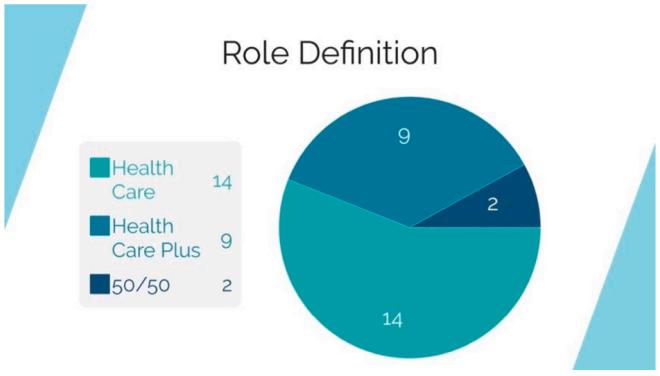

Image B. Categorization of Participants' Role Based on Self-Generated Role Definition.

Despite working in a busy pharmacy, one participant ensured that they maintained a patient-centric, holistic approach, but noted this was also "*in the interests of the store*" (A8 – less than 10 years in practice, urban, independent, manager).

Even when faced with the financial concerns of being a business owner one participant remarked: *"[T]he reason I became a pharmacist is… to help other people with their health… Money has never been something that I worry about a lot"* (A9–20+ years in practice, urban, independent, owner).

Regarding the impact of their role on product sales, one participant noted, "*People trust pharmacists. They will pretty much take what you recommend*" (A1–20+ years in practice, urban, corporate, staff). Others noted how the mere presence of a product located in or near a pharmacy may provide legitimacy: *"[T]here's an implicit acceptance of those* [homeopathic] *products as being valid… [T]here's almost like a halo effect from the fact that it's in a pharmacy"* (B3 – less than 10 years in practice, urban, various, staff).

Many participants recognized their influence on purchase decisions. For example, in the context of a patient looking for homeopathic products, one participant observed: "*[I]f I point at it* [the product requested] *is it showing my position on it? Or do I point at it because that's where it is, and people want the product?*" (O1–10+ years in practice, urban, franchise, owner).

5. Factors in front-of-store product selection

The participants who practiced in corporate/franchise environments described having little influence in their workplaces. Some expressed a desire to be able to influence product decisions, despite reporting little control over front-of-store product selection. Beyond a lack of control, other factors influencing product selection were more varied.

For those in a corporate/franchise environment, head-office or management were described as the product-related decision-makers – franchise agreements and planograms (diagrammatic merchandising layouts) also dictated product selection. For example, one participant said they had no control because of the pharmacy's location: "*My focus is on the pharmacy prescriptions and services. So, I can't remove sugar. It's part of the* [grocery] *store*" (A2–10+ years in practice, urban, corporate, manager).

Participants with agency to make product choices (mainly the 6 owner-pharmacists) described other external influences on selections. One noted: "*I'm not sure I would pull all my sugar products if my competitor didn't pull his sugar products too…People's shopping habits could perhaps change*" (B2–20+ years in practice, rural, corporate, manager). Another said the presence of nearby health care practitioners influenced their product selection decisions – "*We have a dentist in the building so we removed the candy. Not because it had been prescribed as unhealthy, but to respect the scope of practice of the dentist*" (O4 – less than 10 years in practice, urban, independent, owner). Conversely, one participant who worked nearby to a naturopath identified an ethical conflict in recommending patients speak to the naturopath about supplements – *"[W]hy am I recommending they talk to him? I know he's telling them things that I don't agree with, or I think could be potentially dangerous*" (A5 – less than 10 years in practice, urban, independent, staff). One owner-pharmacist discussed their perception that pharmacists' public image is impacted by the setting and products offered in the pharmacy: *"[W]here pharmacy becomes part of the grocery store, it diminishes what the pharmacist does"* (A11–10+ years in practice, urban, franchise, owner).

Some owners chose products based on clinical space needs, or the needs of their patients. One participant chose to carry expensive equipment that was otherwise unavailable locally as a "*service to their community*": "*I could have invested in something fast-moving that will turn over… and it would be higher return*" (A12–20+ years in practice, rural, banner, owner).

Several participants chose to work in environments where they were not required to sell products they did not ethically agree with, such as choosing to work in independent pharmacies to avoid "*corporate policy dictating that on Thursday you're going to sell Coke for $4.99*" (A4–20+ years in practice, rural, independent, staff). Cigarettes are still sold in some pharmacies in western Canada, and one participant noted, "*Intentionally, I've decided not to work in a pharmacy that sells cigarettes*" (B2–20+ years in practice, rural, corporate, manager).

6. Ethical tensions and decision-making

All participants described ethical tensions they face in daily practice. The main theme we found was tension stemming from the pharmacist's dual roles as both a health care provider and a retailer. These dual roles created varied issues, which can be broadly categorized as "service-related" (behind-the-counter issues), "sales-related" (front-of-store products) or "employment-related" (due to the work environment).

Ethical tensions stemming from dual roles were overtly described by several participants: "*There's a conflict, I think, within the industry of retail pharmacy… [Y]our primary job… is to provide health care to clients... However… in order to run a business effectively, you have to keep in mind that the bottom line is the dollar*" (A10–20+ years in practice, urban, corporate, staff). One participant noted the "*tricky situation*" that this dual role created within their decision-making: "*As a pharmacist… you are a health care professional… and then you have to think about your targets*" (A2–10+ years in practice, urban, corporate, manager). One explicitly recognized ethical conflicts as an owner-pharmacist: "*Am I just recommending this product to make more money or does the patient actually benefit from it?*" (A8 – less than 10 years in practice, urban, independent, manager). However, several noted that deciding to become a pharmacist is about helping to improve patients' health, even though "*balancing the business side is tough*" (A3–10+ years in practice, rural, independent, owner). As one participant observed, "*No one went into pharmacy because they wanted to sell a lot of Coca-Cola. It's just sort of a necessary evil of being able to have a viable business"* (B3 – less than 10 years in practice, urban, various, staff).

7. Decision-making influences

Decision-making influences were identified in the data. Participants even described their internal monologue or processes relating

to ethical decision-making. Situational examples were coded for both "material and economic" influences on decision-making, and "ideational and normative" influences. All 25 participants described "ideational and normative" influences, and 23 also described "material and economic" influences.

"Material and economic" influences were identified in scenarios impacted by employment circumstances, in concerns over business viability, or around financial considerations and incentives. One participant described the influence their retailer banner's flyer has on their product selection: "*I could…pick A* [or] *I could pick B, and B is going to be on sale, and people want to come into the store to buy it. So, I'll pick B"* (A3–10+ years in practice, rural, independent, owner).

"Ideational and normative" influences were coded in scenarios where participants described prioritizing patient care above any other influences. One participant noted: "*[I]f I'm concentrating on the money, I can't really concentrate on the patient care*" (O3 – less than 10 years in practice, rural, independent, staff). Another said sales-related bonuses did not impact their recommendations, and "*I discourage patients from using things that lack evidence*" (O10–10+ years in practice, rural, corporate, manager).

One participant noted, *"I have no financial incentive or at least very little financial incentive steering people away from* [items I disagree with selling]*"* (O8–20+ years in practice, urban, corporate, manager). Others were willing to accept potential financial consequences to their business by refusing to carry some products so they could prioritize patients' health. One refused to sell Tylenol with Codeine despite lost sales, "*because our interest is promoting the health of patients*" (A7 – less than 10 years in practice, rural, banner, staff).

Participants often described patterns of decision-making that required balancing both "material and economic" and "ideational and normative" influences. "*In every health care setting there is potential for that conflict* [between economic incentive and patient care]. *But at the same time, the expectation is that health care providers will be able to navigate that*" (B3 – less than 10 years in practice, urban, various, staff).

8. Solutions to address or avoid ethical tensions

Participants were asked to describe solutions that may address or resolve the ethical tensions they described. Participants produced a variety of creative ideas and policy interventions. These were coded for their impact and effect: "Major Policy Change" for industry-wide solutions, "Policy Layering" that addressed specific concerns, "Store-Level Decisions," and "Micro-Actions" that individual pharmacists could implement. Though not direct solutions, some participants discussed distancing themselves from or justifying inaction around ethical issues they described.

8.1. Major policy change

Eleven of the 25 participants identified that to have any impact on the tensions they experienced, industry-wide structural change to community pharmacies would be required. This is significant, as the responses on other prompts were more varied. Several focused on changes that would only allow pharmacists to be owners of pharmacies, rather than corporations. One participant shared "*pharmacists should never have been put in in grocery stores."* (A1–20+ years in practice, urban, corporate, staff).

Several participants desired changes to pharmacy's privatized model so pharmacists could better prioritize patient care and clinical services. "*I would be happy to see community pharmacies turned into health-centered places where they really only serve the purpose of providing medications, equipment, supplies… for necessary health interventions*" (B3 – less than 10 years in practice, urban, various, staff). Another noted that major regulatory change to the pharmacy licensing structure may be difficult to achieve, nevertheless, they stated, "*I am still for it – I wish we would"* (O10–10+ years in practice, rural, corporate, manager).

8.2. Policy layering

Several participant-generated solutions focused on addressing specific issues or tensions relating to their dual roles. These responses were grouped into six major categories: allowing pharmacists to generate revenue through the provision of clinical services; clear guidelines from regulatory colleges or policy makers; continuing education for pharmacists; mandated restrictions on front-of-store products; education and resources for patients and the public; and peer support groups or tools for pharmacists to work through and discuss ethical issues. *"If studies… can come up with tools to help pharmacists… navigate tricky situations… a framework… then that's an area that's certainly helpful"* (B3 – less than 10 years in practice, urban, various, staff).

As an alternative to front-of-store sales, revenue generation from clinical services was the dominant layered policy solution discussed by 14 participants. The discussion of clinical service provision with Alberta-based participants focused on public-payer health billing issues, because Alberta pharmacists have a broad scope of practice.[36,37] Respondents elsewhere indicated the desire to be able to provide and be paid a set rate for expanded clinical services.

Mandates from pharmacy regulators were also suggested for sugary products. One participant noted that "*colleges stood up…to say, 'no you're not allowed to sell tobacco'*", and proposed a similar ban on sugary products, but they were concerned that larger chains would find loopholes to gain "*a competitive advantage"* (B2–20+ years in practice, rural, corporate, manager).

8.3. Store-level decisions and micro-actions

Participants indicated that store-level support from owners and management would encourage pharmacists to make ethically sound, patient-focused decisions and reduce the influence of business viability or profit generation on their decision making: "*[G]etting some reassurance… that… there's not this underlying pressure of generating as much revenue as possible…[Y]ou practice ethically….* [with]

patients' best interests in mind" (A8 – less than 10 years in practice, urban, independent, manager).

Micro-actions focused on influencing patients' purchase decisions, or on making individual choices to address ethical tensions, such as discouraging patients from purchasing ineffective or unproven products and instead "*giving other advice*" (O7–20+ years in practice, urban, corporate, staff).

Many micro-action solutions were related to a pharmacist's choice of employment situation. Eleven participants, all working in pharmacies with different ownership structures, suggested that other types of environments might help them reduce or avoid ethical issues, but they also noted the nuances of other model's economic pressures. Those in corporate environments indicated that independent settings might allow for more autonomy and therefore less tension, but that the risk of financial instability could produce other issues. Those in independent settings indicated they were glad to not be pressured by corporate targets or sales policies, but they noted other business viability concerns: "*[T]he independent* [who] *has complete control is maybe the ideal world. But in the practical world, you sort of work with the parameters you're given"* (O9–20+ years in practice, urban, corporate, manager). One observed that their position helped them focus on patient care and reduce ethical tensions because they did not own the business: "*I get paid my salary anyways*" (A7 – less than 10 years in practice, rural, banner, staff). Another suggested that a non-profit model was ideal "*because that would give a… health-oriented front of store and that would exclude any debate about these challenges of having stuff with sugar for example – or non-scientific things – and also would have more… services for patients*" (O1–10+ years in practice, urban, franchise, owner).

One participant shared they declined to become a part-owner to avoid the ethical issues that economic responsibility could produce. They wanted to maintain their patient-centric focus: "*I've built a trusting practice and when I make a recommendation, often the patients will follow through with that recommendation… And I certainly wouldn't want to be in a position where I'm abusing that power*" (A8 – less than 10 years in practice, urban, independent, manager).

8.4. Justifying or distancing from ethical tensions

Several participants described strategies to distance themselves from identified ethical tensions or to justify their response. Conceptual distancing was sometimes represented as their lack of impact or agency within the regulation of retail pharmacy. For example, one participant noted, "*I think when you're an employee…the health position does not often trump the business position…[B]ut it's really probably next to impossible – unless you're an owner – to really influence the product selection in the store*" (O9–20+ years in practice, urban, corporate, manager).

Other participants did not consider their personal views on products relevant: "*If you asked me if there is too much sugar sold in pharmacy, I would say yes. Do I want to take out all sugar containing beverages? No, I don't*" (B2–20+ years in practice, rural, corporate, manager). Another recommended that pharmacists should be motivated to educate patients to take care of their health, but that should not necessarily dictate the types of products sold: "*[B]ecause pharmacy is a business, that is sort of a health place plus a store for people to buy other things, the one-stop shop kind of thing*" (B3 – less than 10 years in practice, urban, various, staff).

Some participants noted that the dispensary area is situated away from other retail products in larger grocery settings. Participants described this physical separation as a way to distance themselves from ethical issues: "*I operate a bit separately from areas that still sell unhealthy food products. So, I feel slightly sheltered from that*" (O10–10+ years in practice, rural, corporate, manager). Another noted that actively recommending products caused them more ethical tension than allowing patients to make their own selections: "*I could be out in the aisles of my store and say, 'oh, you've got these allergies – here, we've got all this really expensive allergy medication. We can hook you up with the nasal spray. We got four different tablets you can take.'… And at that point, it's kind of ethically questionable that I'm recommending all of these products. Whereas if it's just passively sitting there on the shelf and somebody wants to buy it, then it doesn't seem so bad*" (A5 – less than 10 years in practice, urban, independent, staff).

One participant supported removing cigarettes from pharmacies due to their negative health effects, but also supported stocking cigarettes in a controlled capacity. They justified this on the potential for intervention: "*[I]f someone comes in, you can do an assessment and say, 'OK, I can sell it* [the cigarettes] *to you, but do you really need it?' That's a different conversation*" (A11–10+ years in practice, urban, franchise, owner).

9. Discussion

We analyzed participants' role descriptions against behavioural descriptions to assess if expressed and performed roles align. We also analyzed factors in product selection and the implications of business influences on product selection. Tensions were also analyzed for insights into ethical decision-making in retail environments. Lastly, participant-provided solutions were analyzed to help inform future policy or regulatory changes.

Almost all participants described their role as a health care provider. Role description was identified and further analyzed based on descriptors participants used for patients (versus the use of "customers," "patrons," or "clients"), their responses to the vignette on sugary products, and the decision-making influences, processes, and behaviours described. The use of patient-centred language aligns with the pharmacist's fiduciary duty, as this language use suggests the pharmacist might view those they provide care to as "patients" rather than a transactional customer relationship, in accordance with their code of ethics.[23,24] Generally, participants' role description and their described behaviour aligned; however, our analysis indicates that not all participants were entirely focused on their described role. Some participants indicated material and economic decision-making behaviours and influences, despite providing a normative, health care-focused role description.

Most non-owner participants described having minimal influence in their workplaces and cited "head office" or "management" as the decision-makers relating to products. This aligns with the common industry practice of utilizing planograms, trade promotions, and

merchandising agreements to increase front-of-store sales and influence patient purchases.[38]

Those participants who described micro-influencing purchases at the patient level indicated that the products they did not agree with stocking were nonetheless still on pharmacy shelves. Discussions of the "halo effect" indicate that when pharmacies sell retail products with no health benefit, this may produce not only ethical tensions for pharmacists but could impact how patients view these products. While some research suggests consumer selection of non-prescription medicines is largely based on previous experience with the product,[39] concern over the relationship between product sales and patient trust is still salient. Although pharmacists are considered highly trusted,[40] recent research suggests that the retail environment of pharmacies may diminish patients' trust in community pharmacists, even though the retail environment is largely outside of the control of the individual pharmacists.[41]

Other health care practitioners may face ethical tensions related to products sales in health care settings, but the retail environment of community pharmacies produces unique issues. Our findings indicate that the major factors driving front-of-store product selection are unrelated to the pharmacists' roles or duties, sometimes unrelated to health promotion, and is largely out of pharmacists control. Owners who did control product selection were also influenced by external or economic factors, although some owner-pharmacists specifically make product selection decisions based on the needs of their patient community or their personal beliefs. This suggests business viability is an important force in front-of-store product selection. Consequently, this could further decrease trust within the pharmacist-patient relationship.[40]

Physicians are provided with specific ethical guidance on product sales.[26] Similarly clear guidance from pharmacy regulators on ethical issues relating to the retail environment and front-of-store product sales may be necessary.

The major theme of tensions stemming from pharmacists' dual roles manifested in a variety of examples. Participants described strategies to manage or to distance themselves from these issues/tensions, and justifications for their decisions. These could be seen as a pharmacist's attempt to maintain an ethical approach to practice while simultaneously selling products they see as a "necessary evil" for business viability.

The balance of described influences between "material and economic" and "ideational and normative" was almost even. This speaks to the dual roles and subsequent ethical tensions that pharmacists face in community practice. Some tensions were so significant for some participants that they described entirely avoiding employment situations or roles where their ability to promote patient health might be compromised.

It has been suggested that a framework grounded in principle-based ethics in health care provision should be applied to the sales of complementary medicines.[33] This study indicates that it may be necessary for such a framework to also be applied to front-of-store sales, issues stemming from billing for clinical services, or other ethical concerns in retail pharmacy environments.

There is limited regulatory guidance on front-of-store products or the retail pharmacy environment. Therefore, pharmacy owners have significant power to shape industry-wide standard practice and policies. Sales of non-health related products in pharmacies was seen as normal and somewhat inevitable and the retail model of pharmacy as too entrenched to change. That said, removing high-sugar products from pharmacy shelves would only minorly impact pharmacy revenues,[42] and many participants said they would support such a move. Many pharmacists are concerned about the tensions they face in the retail environment and have thought about policy solutions that could inform legislation, standards, or guidelines. Additionally, several participants expressed a desire to know how other pharmacists felt about the issues stemming from their dual roles. This indicates that a tool or support system drawing on an ethical framework, such as the one discussed by Popattia and La Caze,[28] could be helpful.

Based on the solutions provided, many participants thought major, industry-wide change or restrictive policies would be required to ensure that their ethical tensions could be addressed. Pharmacists were open to interventions, direct policy guidance from legislators and regulators on issues in community pharmacy, and would be open to receiving frameworks, tools, or resources to help navigate ethical concerns.

Ultimately, this study shows that pharmacists are a source of innovative policy solutions. Policy changes to improve patient care should be made in consultation and conjunction with community pharmacists, as they are vital sources of information on issues that impact patient care.

9.1. Limitations

Limitations may be seen in the narrow jurisdictional sampling. No interviews were conducted with pharmacists working in remote or Indigenous communities. Insights into the practice concerns in these communities may provide a richer understanding of other unique ethical issues. Participants may have already been interested in or concerned by such issues, so some form of self-selection bias may have occurred.

Future broader surveys on ethical tensions should be undertaken. Jurisdictional comparison may be helpful to understand if alternative licensing models – such as those where the licence-holder must be a pharmacist – have any impact on the ethical tensions pharmacists face. Additionally, ethnographic studies that observe ethical decision-making processes to achieve patient health promotion in community pharmacy may be warranted.

10. Conclusion

Almost all interview participants described their role as primarily a health care provider. Participants' reported behaviour and decision-making also largely aligned with their self-described roles. Reported ethical decision-making indicated a balancing of both "material and economic" and "ideational and normative" influences, speaking to pharmacists' dual roles.

Our findings suggest that because community pharmacies operate within retail settings, business viability and profitability are

primary factors in front-of-store product selection. Most participants reported little to no control over front-of-store product selection. Where participants did report a higher degree of control – as with independent owners – external factors such as retail viability and profitability, the interests of other types of practitioners working nearby, and the patient preferences impacted product selections. Some participants reported selecting products based on the needs of their community or on their personal beliefs.

Our results indicate that the imposition of retail sales standards and external influences on front-of-store product selection are commonplace in community pharmacy settings. Pharmacy regulators provide only indirect guidance on the profession's private funding model. Pharmacists are expected to uphold their fiduciary duty to patients and society while either maintaining the viability of independent businesses or fulfilling the business expectations of management. Our results suggest that there should be clearer guidance on the implementation of ethical and legal frameworks around the types of products that are appropriate and permissible to sell within community pharmacies. Additionally, pharmacists should ensure that they provide evidence-based recommendations to patients regarding front-of-store products, and they must be supported by their employers to do so. This research may also inform deeper consideration of the structure and private funding model of retail pharmacy itself, and whether this model best serves the interests of patients.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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