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Original Research

Exploring discrimination towards pharmacists in practice settings

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Abstract

Background: Discrimination towards pharmacists, as a public-facing health professional group, is reported but not well-studied.
Objectives: The aims of this study were to identify accounts of discrimination in pharmacy practice and to explore the nature and impacts of and discrimination experienced by pharmacists.
Methods: A cross-sectional survey was emailed to practice-based preceptors associated with the School of Pharmacy at the University of Otago. The survey included demographic questions, in addition to questions asking about the frequency and sources of different types of discrimination and abuse encountered in practice. Survey respondents could also provide their contact information for follow-up interviews. Interviews occurred after completion of the survey to better understand the nature of discrimination in pharmacy practice. A thematic analysis of interview transcripts was conducted to identify pertinent themes.
Results: A total of 43 participants completed the survey. A total of 29 (67.4%) respondents reported experiencing discrimination in pharmacy practice. The most common types of discrimination experienced included discrimination based on gender, appearance, or past, present, or expected pregnancy. Verbal abuse and sexual harassment were also frequently reported. Most discrimination was sourced from patients, colleagues, or supervisors/leaders. Discrimination specific to pregnancy was largely sourced from supervisors/leaders. Verbal abuse was sources primarily from patients, patient's family, supervisors/leaders, and other healthcare professionals. Patients were the primary source of sexual harassment. Three themes were identified from the interview phase: Discrimination occurs for a variety of reasons from different sources with different behaviors, the impact on a person is individualized/personal, and preventative strategies can be broad and encompass multiple layers of society.
Conclusions: Findings of this study support the notion that training programs must adjust to adequately train pharmacists with effective coping strategies, prevention mechanisms, and resilience building strategies. Pharmacist employers should also be accountable to creating zero tolerance workplaces and providing route maps for how pharmacists report and navigate situations when faced with discrimination. Doing so may result in a better equipped workforce that is able to navigate the pressures encountered through discrimination in practice.

Keywords

Pharmacists; Pharmacies; Workforce; Workplace; Sexual Harassment; Social Discrimination; Education, Pharmacy; Resilience, Psychological; Surveys and Questionnaires; Qualitative Research; New Zealand

INTRODUCTION

Discrimination is defined as 'the unjust or prejudicial treatment of different categories of people, especially on the grounds of race, age, or sex'.[1] Discrimination towards health professionals may occur based on these factors but also others, including appearance, religion, sexuality, language, or disability.[2-5] It may also affect any professional group, even those that are not public facing. Pharmacists, as frontline care providers may be at increased risk, due to the unscheduled nature of interactions with patients and caregivers with whom they have no pre-existing relationship.[6,7] Student and training pharmacists may also be exposed during practice-based experiences from patients, other professionals, or even supervising evaluators.[8,9] Whether or not discrimination exists in pharmacy practice, any instance may have poor implications for pharmacist well-being and could consequently negatively impact patient care. Efforts must therefore be made to understand accounts of discrimination in pharmacy practice, in order to provide adequate training to promote development of practitioner resilience and well-being.

Despite the potential detrimental impacts of discrimination within the workplace, there is a paucity of literature attempting to describe the nature and extent of practice-based discrimination in pharmacy. There is also minimal literature describing discrimination within other health disciplines, such as medicine and nursing. Identified reports account for various aspects of discrimination, including told stories of racism, institutional racism, differences in employment opportunities based on cultural and ethnic factors, and discrimination against those actively or planning to become pregnant.[6,10] In pharmacy specifically, it appears that race may be a cause of discrimination that leads to unequal employment opportunities with respect to recruitment, retention, and progression in the UK.[6] There is also evidence of gender discrimination within the pharmacy profession, specifically for recruitment into leadership positions in Australia.[11] Although these are important considerations for the profession, there also needs to be exploration of practice-based discrimination that may occur on a day-to-day basis.

A recent study was published that reported discrimination, abuse, harassment, and burnout in surgical residency training.[12] This study surveyed 7,409 surgical residents in

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the United States and found high rates of discrimination directed towards this population. Greater than 30% reported discrimination based on self-identified gender, over 16% reported racial discrimination, 30% reported verbal and/or physical abuse, and 10% reported sexual harassment. Women reported all accounts at greater frequencies than men. The most common source of discrimination was patients and patients' families for gender and race. Attending physicians (e.g. supervising physician) were the greatest source of sexual harassment and abuse. The authors reported that burnout and resilience depletion was a major concern, with 38% of residents reporting burnout and 4.5% having suicidal thoughts within the past year. Authors call for the establishment of safer, more equitable, and more effective educational environments for these practitioners.[12]

Given the vulnerability of pharmacists as frontline care providers and the recent evidence of prejudice and discrimination within the medical profession, a study exploring instances of perceived discrimination in pharmacy practice is warranted. The aim of the study was therefore to identify accounts of perceived discrimination in pharmacy practice and if identified, to explore the nature and impacts of perceived discrimination experienced by pharmacists.

METHODS

This was an exploratory study that used mixed methods (survey and interviews). The study was based at the School of Pharmacy, University of Otago in Dunedin, New Zealand. In 2018, New Zealand had 3,787 registered practicing pharmacists.[13] The School of Pharmacy hosts a BPharm program that graduates approximately 130 students per year. Students complete a variety of on campus courses, as well as experiential training placements. During placements, students are matched to a practicing pharmacist preceptor who directs and monitors their experiential learning needs and outcomes. Using preceptors as the sampling frame, Phase 1 of this study sought to identify accounts of perceived discrimination experienced by practicing pharmacists and Phase 2 sought to better understand the nature, impact, and implications of these accounts.

Phase 1: Survey of practicing pharmacists

A survey was administered to practicing pharmacists in New Zealand to elicit reports of discrimination in practice. The survey consisted of a questionnaire that was adapted from Hu *et al*. (2019) reporting discrimination towards surgical residents.[11] In addition to the questions addressed from this study, we added questions (based on the literature review) relating to discrimination based on appearance, sexuality, religion, social skills, and English proficiency. We also adapted the sources of discrimination to reflect pharmacy practice. The questionnaire consisted of demographics and two matrices relating to discrimination and behaviors deemed to be associated with discrimination. Participants were informed that discrimination was defined as any perceived mistreatment due to gender, race, sexuality, religion, or other characteristics. The first matrix requested participants to state the frequency (never, a few times a year, a few times a month, a few times a week, every day, or other) of experiencing the type of discrimination or abusive behaviour listed directed towards themselves. Items to be considered included discrimination based on gender, race, sexuality, appearance, religion, English proficiency, social skills, or behaviours of physical abuse, verbal abuse, or sexual harassment. An item was also included for past, present, or expected pregnancy. The second matrix asked participants to select the source of discrimination or abuse for each item given above. Sources included none, patients, patient's family, colleague, other healthcare professional, supervisor/leader, or other. Participants were able to select multiple sources, if applicable. Participants were asked to optionally provide an email address if they were willing to participate in a follow-up interview to better understand their responses. The questionnaire was uploaded to Qualtrics for distribution to potential participants. It was piloted with two individuals who belonged to the target population but no changes were made. These responses were not included in the results.

The survey was administered to a sample of practicing pharmacists in New Zealand using a pharmacist preceptor database maintained by the School of Pharmacy. This database contained 247 email addresses of individuals and/or pharmacies in New Zealand. It was unknown, however, how many active emails were captured in the database. Pharmacists were encouraged to share with other colleagues that may be interested in completing the survey, via the introductory email. The purpose of the survey was to characterize discrimination but to also identify participants willing to be interviewed in Phase 2. The first page of the survey included information about the study, expectations, and informed participants that their participation was voluntary and they could withdraw from participating at any time. A reminder email was sent two weeks after sending the first email. The survey remained open for one month. No specific sample size was targeted due to the exploratory nature of the study (e.g. attempts to capture any report of discrimination in pharmacy practice). Survey responses were extracted to SPSS v. 25 and descriptive statistics were used to summarize results.

Phase 2: Respondent interviews

Participants who provided positive interest and contact information in Phase 1 for a follow-up interview were contacted via email. Interviews were conducted to better understand how participants experience the phenomenon of discrimination in practice. A discussion guide was developed to guide the interview and included questions intended to elicit the participant's narrative about the discrimination they had encountered in pharmacy practice. Investigators asked participants to recall any instance of discrimination they could remember experiencing in pharmacy practice. Then, questions were targeted to better understand the nature of such discrimination by asking questions related to the source of discrimination, how it was delivered (e.g., verbally, written), frequency, emotional impacts, and any actions or reactions provided by participants. All interviews were conducted by members of the investigator team. The lead researcher has extensive training and experience conducting interviews and trained

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the other two investigators himself. In addition to training, three pilot interviews were conducted with practicing pharmacists from the target sample and the full investigator team to receive feedback on the questions asked, as well as for feedback to be provided to all interviewers. Although no changes were made to the process or interview guide upon completion of the pilot, feedback was provided to interviewer with respect to question wording and probing for more information. All interviews (including pilots) were recorded.

Upon completion of the interviews, recordings were transcribed by one investigator and checked for errors by a second investigator. Full transcripts were provided to the full investigator team for coding. The senior researcher trained the other two investigators to code transcripts. Coding was conducted independently by all three investigators and was conducted via inductive, open-coding. This approach had investigators separate transcripts into words, sentences, or phrases that represented a single thought or idea. Each thought or idea was then given a unique identifying code. Once all coding was complete, investigators met to reconcile discrepancies and produce the final coding framework. Investigators then reviewed all codes collectively and began to categorize closely related codes based on similar meaning. After completion of this stage, investigators met to interpret themes from the categorized data.[14] Transcripts were then reviewed to search for confirming and disconfirming evidence in relation to each theme and representative quotes were extracted. All investigators agreed upon final themes and supporting data.

This study was approved by the University of Otago Human Ethics Committee on January 24, 2020 (D20/005).

Reflexivity

As this study was focused on a sensitive subject nature (e.g. discrimination), it is important to recognize the perspective of the authors interpreting the study results. Two authors are undergraduate pharmacy students and belong to ethnic minorities of Asian descent. Both have encountered discrimination in their respective life experiences, specific to race. One author self-identifies as a member of a sexual minority group and has also encountered discrimination in both work and life experiences, including as a practicing pharmacist. These past experiences may have influenced how investigators interacted with interview participants, the types of probing questions asked, and how results were analyzed. For any instance identified relating to race or sexuality, all investigators had an open discussion regarding the interpretation before coding and development as a theme.

RESULTS

Phase 1: Survey

A total of 43 participants completed the survey. Demographic characteristics of respondents are provided in Table 1. The majority of respondents were experienced (>10 years), worked in urban settings, female (72.1%), heterosexual (90.5%), and identified ethnically as 'New Zealander' (63.3%). A total of 29 (67.4%) respondents reported experiencing prejudice or discrimination in pharmacy practice.

Table 1. Demographics of survey respondents

Characteristic	Number (%)
Experience (n=43)	
Less than a year	0 (0)
1-5 years	7 (16.3)
6-10 years	6 (14.0)
>10 years	30 (70)
Location (n=43)	
Urban	25 (58.1)
Rural	16 (37.2)
Other	2 (4.7)
Age (n=43)	
<30 years	10 (23.3)
31-50 years	22 (51.2)
>50 years	11 (25.6)
Gender (n=43)	
Female	31 (72.1)
Male	12 (27.9)
Sexual Orientation (n=42)	
Heterosexual	38 (90.5)
Gay male	0 (0)
Lesbian female	2 (4.8)
Other	0 (0)
I'd prefer not to say	2 (4.8)
Ethnicity (n=43)	
New Zealand	28 (65.1)
Maori	3 (7.0)
Pasifika	1 (2.3)
European	4 (9.3)
Asian	2 (4.7)
Other	5 (11.6)
Religion (n=43)	
None (Atheism)	12 (27.9)
Christianity	15 (34.9)
Agnosticism	7 (16.3)
I'd prefer not to say	5 (11.6)
Other	2 (4.7)
Hindusim	1 (2.3)
Islam	1 (2.3)
Ever encountered discrimination in pharmacy practice?	
Yes	29 (67.4)
No	11 (25.6)
Unsure	3 (7.0)

Table 2 provides results about the types of discrimination experienced by pharmacists. The most common types of discrimination experienced included discrimination based on gender, appearance, or past, present, or expected pregnancy. The occurrences of these types of discrimination were notably higher than the other types listed. Verbal abuse and sexual harassment were also frequently reported, as compared to the other types of abuse. Table 3 provides results about the sources of discrimination experienced by pharmacists. Most discrimination was sourced from patients, at much greater rates than other potential sources. The exception to this finding was discrimination sourced from supervisors/leaders with respect to expected, actual, or recent pregnancy. Verbal abuse was sourced primarily from patients, patient's family, supervisors/leaders, and other healthcare professionals. Patients were the primary source of sexual harassment.

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Table 2. Frequency of discrimination based on classification or type reported by respondents

Question	Never	A few times a year	A few times a month	A few times a week	Everyday	Other	Total
Discrimination based on gender							
Total	11 (25.6)	19 (44.2)	4 (9.3)	3 (7.0)	0	6 (14.0)	43 total
Female	3 (9.7)	17 (54.8)	4 (12.9)	2 (6.5)	0	5 (16.1)	31 female
Male	8 (66.7)	2 (16.7)	0	1 (8.3)	0	1 (8.3)	12 male
Discrimination based on race							
Total	31 (73.8)	6 (14.3)	2 (4.5)	0	0	3 (7.1)	42 total
Female	21 (70.0)	5 (16.7)	2 (6.7)	0	0	2 (6.7)	30 female
Male	10 (83.3)	1 (8.3)	0	0	0	1 (8.3)	12 male
Discrimination based on sexuality							
Total	40 (95.2)	0	0	0	0	2 (4.8)	42 total
Female	29 (96.7)	0	0	0	0	1 (3.3)	30 female
Male	11 (91.7)	0	0	0	0	1 (8.3)	12 male
Discrimination based on appearance							
Total	18 (42.9)	21 (50.0)	0	0	0	3 (7.1)	42 total
Female	10 (33.3)	18 (60.0)	0	0	0	2 (6.7)	30 female
Male	8 (66.7)	3 (25.0)	0	0	0	1 (8.3)	12 male
Discrimination based on religion							
Total	41 (97.6)	0	1 (2.4)	0	0	0	42 total
Female	29 (96.7)	0	1 (3.3)	0	0	0	30 female
Male	12 (100)	0	0	0	0	0	12 male
Discrimination based on English language proficiency							
Total	40 (95.2)	2 (4.8)	0	0	0	0	42 total
Female	28 (93.3)	2 (6.7)	0	0	0	0	30 female
Male	12 (100)	0	0	0	0	0	12 male
Discrimination based on social skills							
Total	38 (90.5)	3 (7.1)	0	0	0	1 (2.4)	42 total
Female	26 (86.7)	3 (10.0)	0	0	0	1 (3.3)	30 female
Male	12 (100)	0	0	0	0	0	12 male
Physical abuse							
Total	38 (95.0)	1 (2.5)	0	0	0	1 (2.5)	40 total
Female	27 (93.1)	1 (3.4)	0	0	0	1 (3.4)	29 female
Male	11 (100)	0	0	0	0	0	11 male
Verbal or emotional abuse							
Total	12 (28.6)	20 (47.6)	6 (14.3)	2 (4.8)	0	3 (7.1)	42 total
Female	9 (30.0)	15 (50.0)	3 (10.0)	2 (6.7)	0	2 (6.7)	30 female
Male	3 (25.0)	5 (41.7)	3 (25.0)	0	0	1 (8.3)	12 male
Sexual harassment							
Total	33 (78.6)	6 (14.3)	0	0	0	3 (7.1)	42 total
Female	21 (70.0)	6 (20.0)	0	0	0	3 (10.0)	30 female
Male	12 (100)	0	0	0	0	0	12 male
Discrimination based on past, present, or expected pregnancy							
Total	32 (78.6)	8 (18.6)	1 (2.3)	1 (2.3)	0	1 (2.3)	43 total
Female	20 (64.5)	8 (25.8)	1 (3.2)	1 (3.2)	0	1 (3.2)	31 females
Male	12 (100)	0	0	0	0	0	12 males

Phase 2: Respondent interviews

A total of 13 interviews were included for this phase. Ten interviews were solicited from positive survey responses and three were included from the pilot as minimal changes were introduced after pilot completion. Eleven of the participants were female and two were male. Seven identified as European White, two as Indian, two as Chinese, 1 as New Zealand Maori, and 1 as Middle Eastern. Eleven had greater than five years of experience and two had less than five years of experience. Three themes were interpreted from the interview data: discrimination characteristics, impacts, and prevention.

Theme 1: Discrimination occurs for a variety of reasons from different sources with different behaviors

Participants' perceived reasons for the discrimination encountered were broad. These included a patient's own expectations, the participant's own gender (e.g. being female), ethnicity, age (e.g. young/new graduate), English language proficiency, or a lack or rapport with colleagues. With respect to patients' expectations, some expected a specific profile of a pharmacist, 'I would say there are pockets of society that will associate pharmacists with being a white, old man.' A female spoke of gender discrimination against a colleague who recently gave birth, 'She couldn't come back part-time, she could only come back full-time, so she needed to resign.' For ethnicity, an Asian respondent spoke of discrimination that occurred largely from elderly patients, 'And it was primarily with elderly patients, where I would come in and before I say a word, they would say immediately, "I don't want the Asian one."' Participants also revealed many different behaviours associated with discrimination, including racial slurs, bullying, dogmatism, and sexual harassment.

Theme 2: Impacts of discrimination are variable

The main message under the theme of impact was that impacts of discrimination on a person are highly individualized/personal. Affected individuals appear to have a wide range of emotional responses (e.g. no

Table 3. Sources of discrimination based on classification or type reported by respondents

Question	None	Patient	Patient's family	Colleague	Other HCP	Supervisor /Leader	Other	Total
Discrimination based on gender	10 (26.3)	27 (71.1)	3 (7.9)	5 (13.2)	6 (15.8)	6 (15.8)	0	38
Discrimination based on race	30 (78.9)	8 (21.1)	3 (7.9)	2 (5.3)	2 (5.3)	2 (5.3)	0	38
Discrimination based on sexuality	34 (89.5)	4 (10.5)	0	0	0	0	0	38
Discrimination based on appearance	28 (73.7)	17 (44.7)	2 (5.3)	6 (15.8)	3 (7.9)	3 (7.9)	0	38
Discrimination based on religion	36 (94.7)	0	0	2 (5.3)	0	0	0	38
Discrimination based on English language proficiency	36 (94.7)	1 (2.6)	0	1 (2.6)	0	0	0	38
Discrimination based on social skills	35 (92.1)	0	0	3 (7.9)	0	0	0	38
Physical abuse	36 (97.3)	1 (2.7)	0	0	0	0	0	37
Verbal or emotional abuse	8 (21.1)	28 (73.7)	7 (18.4)	4 (10.5)	6 (15.8)	8 (21.1)	0	38
Sexual harassment	31 (81.6)	8 21.5)	0	0	0	0	0	38
Discrimination based on past, present, or expected pregnancy	27 (71.1)	2 (5.3)	0	3 (7.9)	1 (2.6)	8 (21.5)	0	38

response, frustration, anger, sadness, disheartened). These responses appeared to vary in intensity between individuals but all were noted to reflect negativity and cause distress. Individuals also found discrimination negatively impacted their ability to perform at work (e.g. powerless, under-appreciated, stressful, lack of professional growth). For example, discrimination from patients caused one participant to question 'why they would continue to work so hard' if they were not being appreciated. Alternatively, one participant stated that 'the person who feels potentially discriminated against also has a role in the way they think or perceive discrimination – it could just be that the persons had a bad day.' Impact is therefore likely dependent on the nature of discrimination combined with how one perceives and reacts to it.

Participants discussed coping strategies that also appeared to be largely individualized or situational. Some participants expressed avoidance, 'my way of coping is to try to be as far from him as possible at work.' Others offered support in the context of a colleague experiencing discrimination, 'if anyone says anything even remotely hinting at anything like that [racism], you [the colleague] come to me straight away.' Others were self-assured, 'it is not a reflection of who I am' and this, at times, resulted in ignoring the discriminatory behaviors, 'I am an inclusive person, I don't think I see color, shape…I try to focus on the patient in front of me and focus on them and their needs.'

Theme 3: Preventative strategies can be broad and encompass multiple layers of society

The need to prevent discrimination from occurring in the workplace was addressed by many participants. Strategies discussed by participants ranged from individual efforts to workplace policies to promotion of tolerance and respect within local, national, and global societies. A common thread to participants' responses was that discrimination was not occurring due to being a pharmacist but rather being a pharmacist exposed them to discrimination by some individuals (patients, colleagues, supervisors, other healthcare professionals). As such, prevention efforts need to be addressed at levels higher than simply instituting zero tolerance policies within the workplace. That being said, participants suggested workplace policies are important, as in many cases, there was no clear 'route map' of who to approach or how to deal with discrimination when it occurred. Participants largely agreed that pharmacy curricula should include training on encountering discrimination in practice and coping with depletion of personal and professional resilience. One participant suggested 'revisiting' the topic throughout each year of the pharmacy program.

DISCUSSION

This study aimed to identify and explore perceived discrimination experienced by pharmacists in practice. Findings show discrimination occurs in pharmacy practice and in the sample assessed, primarily based on sexism and appearance. Verbal/emotional abuse was reported as the most common type of abuse encountered by respondents. Sources of discrimination and abuse were largely reported to come from patients, other healthcare professionals, and supervisors. The interviews conducted revealed detrimental impacts on participants but also provided guidance for development of prevention strategies and student training. These finding have numerous implications for education and practice that are discussed below.

A key finding from this study was simply that discrimination against pharmacists is perceived to occur in practice and for a variety of reasons. While some forms of discrimination may reflect greater societal viewpoints that are difficult to control (discrimination from patients, for example), others are specific to the profession and could be prevented (discrimination from supervisors, colleagues, or other healthcare professionals). The findings of this study align with those found with surgical residency training.[12] Both studies suggest that practitioners are facing numerous challenges that may deplete resilience and negatively impact overall well-being. Both studies found a wide range of discrimination and abuse to be reported by participants and from a variety of sources. Despite occurring in different professions and different contexts, the alignment of these results calls for a review of how well programs train graduates for encountering discrimination and abuse in practice.

Findings of this study aligned with other studies conducted in pharmacy and other health professions but also had some key differences. Similarities included the impacts of discrimination encountered by participants, as well as the sources (patients, other healthcare professionals) and type of abuse (verbal).[3,4,6,12] Despite these similarities, the previous literature identified largely focused on race and sexuality as perceived reasons for discrimination.[2-4,6,10] On the other hand, this study found that gender and

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appearance were the most commonly reasons reported by participants. While most respondents were female and this may have biased the sample (as most gender and appearance discrimination was reported by females), it is also possible that females are more likely to respond due to experiencing discrimination or abuse based on their gender or appearance. As pharmacy is a female dominated profession in many countries (including New Zealand), this finding deserves greater attention and further exploration to better understand the pressures female pharmacists face in the workplace and how these can be specifically prevented.

This study has implications for practice, education, and future research. For practice, employers could increase awareness of discrimination within the workplace and collaborate with staff to develop safer working environments. Specifically, developing a route map for reporting such events or promoting zero tolerance policies may be beneficial. For education, it may be beneficial to address coping skills and/or skills for resilience building within pharmacy programs. Pharmacy training programs, as well as continuing professional development, should include these concepts within the curriculum with a goal of better preparing the workforce for encountering and overcoming discrimination in practice. Although coping strategies should not need to be the first line of defense against discrimination encountered within pharmacy practice, it is important for pharmacists to develop these skills to avoid depletion of motivation and resilience, as well as professional accountability. Future research should be conducted to better understand the frequency of this problem in practice, as this study was exploratory in nature. Research should also focus on better understanding pharmacists' coping strategies and ways that professional associations and employers may better support their development. Finally, with the largest source of discrimination identified as being the patient, future studies should assess how occurrences of discrimination may be influenced by the pharmacist-patient relationship and if strengthening these relationships through person-centered care and communication could decrease discrimination encountered in practice.

The results of this study should be interpreted in consideration of some limitations. First, the survey sample size was small. Despite the desire to achieve a greater number of responses, the goal of the survey was largely to identify incidences of discrimination and attain a sample of respondents for the interview phase. Secondly, those responding to the survey may have responded due to interest in the subject or past experiences with discrimination. Results may not therefore be applicable for all practicing pharmacists in New Zealand. It is possible some eligible participants chose not to participate due to the sensitive subject nature or if they did not feel they had anything to contribute. Thirdly, some terms in the questionnaire were purposefully not defined (e.g. abuse, sexual harassment, appearance), in order to not limit responses by participants in the phase for identifying perceived accounts of discrimination. However, these terms may have consequently been interpreted differently across participants. Despite these limitations, the results from this exploratory study are important for design of future studies and education-based interventions targeting discrimination, coping, and resilience.

CONCLUSIONS

This study identified instances of perceived discrimination and abuse occurring towards pharmacists in practice. Findings support the notion that training programs must adjust to adequately train pharmacists with effective coping strategies, prevention mechanisms, and resilience building strategies. Pharmacist employers should also be accountable to creating zero tolerance workplaces and providing route maps for how pharmacists report and navigate situations when faced with discrimination. Doing so may result in a better equipped workforce that is able to navigate the pressures encountered through discrimination in practice.

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CONFLICT OF INTEREST

All authors report no conflicts of interest to declare.

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