

Original Research

Factors associated with burnout and coping strategies among community pharmacists in Thailand: A Cross-sectional study

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Abstract

Objective: This study aimed to investigate the prevalence and factors associated with burnout among community pharmacists in Thailand and explore their coping strategies. **Methods:** This cross-sectional study investigated burnout among community pharmacists in Thailand. Data were collected using self-administered questionnaires on demographics, burnout levels and coping strategies. Statistical analysis included descriptive statistics, chi-square tests, and logistic regression to examine associations and predictors. **Results:** Of the 123 respondents, 29.3% reported high emotional exhaustion, while 9.8% reported high depersonalization. Burnout prevalence was 32.5%, with emotional exhaustion being the most common dimension. Significant predictors of burnout included marital status, with married individuals or those cohabiting without registration having lower odds (adjusted OR 0.26; 95% CI: 0.09–0.74; $p = 0.011$), and a history of suicidal thoughts or self-harm, which substantially increased odds (adjusted OR 6.91; 95% CI: 1.13–42.26; $p = 0.037$). Proactive coping strategies, such as identifying root causes of distress (86.2%) and maintaining a positive attitude (80.5%), were highly effective, whereas avoidant behaviors, such as reliance on substances, were overwhelmingly unhelpful. **Conclusion:** These findings underscore the need for interventions targeting both individual resilience and organizational support, including optimizing staffing levels and fostering a culture of well-being. Policymakers should prioritize these measures to enhance pharmacists' well-being and maintain patient safety. Future research should evaluate the long-term effectiveness of these interventions and explore additional strategies to sustain resilience among community pharmacists.

Keyword: Professional Burnout, Community Pharmacist, Coping strategies

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INTRODUCTION

Burnout is a condition characterized by physical and emotional exhaustion arising from prolonged and excessive workplace stress¹. According to Maslach and Jackson², burnout comprises three dimensions: emotional exhaustion, depersonalization, and reduced personal accomplishment. Burnout has emerged as a significant public health concern, yet its definition remains ambiguous, and no consensus exists regarding its diagnosis. Burnout in the medical field is widely acknowledged to harm professionals, institutions, and patients alike, underscoring the importance of early identification of risk factors and the implementation of preventive strategies³. The prevalence of burnout among healthcare workers during COVID-19 showed substantial variability, ranging from 4.3% to 90.4%⁴.

Burnout is a prevalent issue among pharmacists worldwide. A systematic review found that approximately 51% of pharmacists experience burnout⁵. The burnout rate

was reported to be higher among hospital and community pharmacists^{6,7}. Community pharmacists experienced high rates of burnout, low quality of life, and severe fatigue even before the COVID-19 pandemic, with these challenges likely exacerbated in recent years. Contributing factors include workload, pharmacy type, education or training level, and stress. Burnout among pharmacists is associated with increased mental health disorders, potential risks to patient safety and satisfaction, and adverse impacts on productivity, employer costs, and the overall healthcare system⁸.

Burnout among pharmacists not only compromises their personal well-being but also adversely affects their professional performance, potentially jeopardizing patient safety. A systematic review reported that over half of pharmacist's experience burnout, with contributing factors including excessive workload, high patient and prescription volumes, and poor work-life balance. These stressors can lead to increased rates of mental health disorders among pharmacists, which may, in turn, impact patient care quality and safety. Addressing burnout is therefore crucial to ensure both the well-being of pharmacists and the safety of their patients⁵.

Burnout among community pharmacists has been associated with multiple factors, including shorter years of professional experience, primary practice in chain pharmacies, and limited access to resources for managing burnout or building resilience^{5,7}. Other significant contributors include longer working hours, high patient and prescription volumes, excessive workload, and poor work-life balance. Additionally, working more than five days per week and operating in pharmacies staffed with only one or two pharmacists have been identified as key risk factors⁹.



Burnout can be prevented through various strategies, with self-care, mindfulness, and taking personal time or time off being among the most reported coping mechanisms¹⁰. Activities such as holidays, leisure pursuits, hobbies, sports, and relaxation play a vital role in mitigating burnout¹¹. Organizational interventions are equally important, including optimizing staffing levels and fostering a culture of well-being, to promote overall well-being and enhance resilience.

Burnout can be prevented with various strategies, such as self-care, mindfulness, and taking personal time or time off as the most reported. coping strategies with holidays, leisure, hobbies, sports activities, and relaxation¹¹. Additionally, organizational interventions, including improving staffing levels and fostering a culture of well-being, to enhance overall well-being and resilience¹⁰.

Although burnout is widely recognized as a significant issue among pharmacists, there are notable gaps in the existing research, particularly for community pharmacists. Existing evidence, largely based on cross-sectional studies, indicates a high prevalence of burnout among pharmacists, with community pharmacists exhibiting notably higher rates compared to their hospital counterparts.

This study aimed to investigate the prevalence and factors associated with burnout among community pharmacists in Thailand and explore their coping strategies.

METHODS

Study Design

This cross-sectional, exploratory study was designed to investigate patterns of job burnout among community pharmacists, identify factors associated with burnout, and explore coping strategies used to mitigate burnout.

Setting

The study was conducted across community pharmacies in Thailand. Data collection took place over a defined recruitment period, with questionnaires distributed to participants by mail.

Participants

The target population consisted of registered community pharmacists in Thailand, totaling 16,319 individuals, as reported in the 2020 Thai FDA statistics on pharmacy licenses. Eligibility criteria included active practice as a pharmacist in a community pharmacy. The study sample was determined using Taro Yamane's formula for sample size calculation, ensuring a 95% confidence level and a 5% margin of error. The calculated sample size was 390 participants. Systematic random sampling was employed to ensure geographical representativeness, with proportional

sampling from Thailand's northern, northeastern, central, eastern, and southern regions.

Ethics approval

This study was conducted in accordance with the Declaration of Helsinki. Ethical approval was obtained from the Ethics Committee of Ubon Ratchathani University (Approval No. UBU-REC-171/2564).

Variables

This study examined the dimensions to explore burnout among community pharmacists. First, burnout levels were evaluated as the primary outcome. These dimensions provided a comprehensive understanding of participants' experiences with burnout and its impact on their professional lives. Second, the study explored exposures and potential confounders. Exposures included demographic variables such as gender, age, and marital status, health-related factors like chronic illnesses, mental health history, and suicidal ideation, as well as work-related characteristics, including years of practice, type of pharmacy, daily working hours, and income sufficiency.

Data Sources and Measurements

Data collection was conducted using a self-administered questionnaire designed to capture comprehensive information in three key areas. The first section focused on personal information, gathering demographic details such as age, gender, and marital status, alongside health-related factors like chronic illnesses and mental health history. Work-related factors, including years of practice, type of pharmacy, daily working hours, and income sufficiency, were also included. The second section assessed burnout levels using the Thai-translated Maslach Burnout Inventory-General Survey (MBI-GS)¹², a tool validated for reliability and cultural appropriateness. The final section explored coping strategies, with questions aimed at understanding the approaches pharmacists used to manage job-related burnout.

Burnout levels were categorized based on the MBI-GS scoring thresholds across three dimensions. Emotional exhaustion scores were classified as low (0–16), moderate (17–26), or high (≥ 27). Depersonalization scores were categorized as low (0–6), moderate (7–12), or high (≥ 13). Conversely, personal accomplishment scores were reversed, with low burnout indicated by scores of 39 or higher, moderate burnout by scores of 32–38, and high burnout by scores of 0–31. These thresholds provided a robust framework for classifying participants' burnout levels and understanding their experiences. Burnout was defined as an emotional exhaustion score ≥ 27 and/or depersonalization score ≥ 10 ¹¹.

Efforts were made to minimize bias through systematic random sampling, ensuring equal representation across geographical regions. Data collection via a standardized questionnaire further reduced measurement bias.

Statistical analysis



Table 1. Baseline characteristics (N=124)		
Characteristic	Number (n)	Percentage (%)
Gender		
Female	84	68.3
Male	39	31.7
Age		
Less than 30 years	34	27.6
31–40 years	57	46.3
More than 40 years	32	26
Marital Status		
Single	67	54.5
Widowed/Divorced/ Separated	1	0.8
Married/Living together without registration	55	44.7
Chronic illness		
None	108	87.8
Present	15	12.2
History of Mental Health Issues		
None	115	93.5
Present	8	6.5
History of Suicidal Thoughts or Self- Harm		
None	115	93.5
Present	8	6.5
Smoking Status		
Non-smoker	121	98.4
Former smoker	2	1.6
Alcohol Consumption		
Never	53	43.1
Occasional/Social	70	56.9
Exercise Frequency		
Less than 1–2 times/ week	74	60.2
1–2 times/week	29	23.6
3–4 times/week	12	9.8
Daily	8	6.5
Years of Work Experience		
Less than 5 years	27	21.9
5–10 years	48	39.1
11–20 years	24	19.5

21–30 years	15	12.2
More than 30 years	9	7.3
Type of Pharmacy		
Chain drugstore	29	23.6
Private drugstore	94	76.4
Number of Pharmacies/ Workplaces		
One	114	92.7
More than one	9	7.3
Daily Working Hours		
Less than 5 hours	4	3.3
5–10 hours	64	52
11–15 hours	55	44.7
Income Sufficiency		
Insufficient (expenses exceed income)	10	8.1
Sufficient (expenses equal income)	35	28.5
Savings possible (expenses less than income)	78	63.4

Descriptive statistics, including frequencies, percentages, means, and standard deviations, were used to summarize participant characteristics and burnout levels. Chi-square tests were employed to examine associations between personal factors and burnout levels. Logistic regression analysis was conducted to identify predictors of burnout, adjusting for potential confounders, with odds ratios (OR) and 95% confidence intervals (CI) reported. Missing data were addressed through manual verification of questionnaire completeness.

RESULTS

Participant Characteristics

A total of 1,000 questionnaires were disseminated via email and online community platforms, resulting in 123 responses, yielding a response rate of 12.3%. Baseline characteristics of 123 community pharmacists participated in the study as shown in Table 1, with a majority being female (68.3%), while males accounted for 31.7%. The largest age group consisted of participants aged 31–40 years (46.3%), followed by those under 30 years (27.6%) and those over 40 years (26.0%). Regarding marital status, 54.5% of participants were single, 44.7% were married or living together without registration, and 0.8% were widowed, divorced, or separated. Most participants reported no chronic illnesses (87.8%) and no history of mental health issues (93.5%) or suicidal thoughts/self-harm (93.5%). Nearly all participants were non-smokers (98.4%), with 1.6% being

former smokers. Alcohol consumption was reported as occasional or social by 56.9%, while 43.1% reported never consuming alcohol, and no participants reported daily alcohol consumption. Exercise habits varied, with 60.2% exercising less than 1–2 times per week, 23.6% exercising 1–2 times per week, 9.8% exercising 3–4 times per week, and 6.5% exercising daily.

In terms of professional experience, 38.2% of participants had 5–10 years of work experience, followed by 22.8% with less than 5 years, 19.5% with 11–20 years, 12.2% with 21–30 years, and 7.3% with over 30 years. Regarding the type of pharmacy, 63.4% were owners, 23.6% worked in chain drugstores, and 13.0% were employees in privately owned pharmacies. Most participants worked at a single workplace (92.7%), with only 7.3% working at more than one location. Daily working hours varied, with 52.0% working 5–10 hours, 44.7% working 11–15 hours, and 3.3% working less than 5 hours. Income sufficiency was reported as sufficient with savings of 63.4%, sufficient without savings by 28.5%, and insufficient (expenses exceeding income) by 8.1%.

Level of job burnout

The levels of job burnout among community pharmacists were assessed across three dimensions: emotional exhaustion, depersonalization, and reduced personal accomplishment as shown in Table 2. Emotional exhaustion was reported at a high level by 29.3% of participants, while 25.2% experienced moderate levels, and 45.5% reported low levels. Depersonalization was predominantly low, with 78.9% of participants reporting low levels, 11.4% reporting moderate levels, and 9.8% reporting high levels. Reduced personal accomplishment was observed at high levels in 29.3% of participants, with 22.0% reporting moderate levels, and 48.78% experiencing low levels.

Factor associated with burnout

The analysis of factors associated with burnout is presented in Table 3. Burnout, defined as emotional exhaustion scores ≥ 27 and/or depersonalization scores ≥ 10 , was identified in 40 participants (32.52%). Male participants exhibited higher odds of burnout compared to females; however, this association was not statistically significant after adjustment (adjusted OR 1.78; 95% CI: 0.66–4.81; $p = 0.254$). Older age yielded mixed results: participants over 40 years demonstrated significantly lower crude odds of burnout (OR 0.14; 95% CI: 0.04–0.50; $p = 0.002$), though this association reversed in the adjusted model without reaching statistical significance (adjusted OR 6.19; 95% CI: 0.55–69.15; $p = 0.139$).

Marital status was a key factor, with married individuals or those cohabiting without registration having significantly lower odds of experiencing burnout compared to single participants (adjusted OR 0.26, 95% CI: 0.09–0.74, $p = 0.011$).

This suggests that social support may play a protective role in reducing burnout risk. Conversely, a history of suicidal thoughts or self-harm was associated with substantially increased odds of burnout (adjusted OR 6.91, 95% CI: 1.13–42.26, $p = 0.037$), indicating a strong link between mental health history and burnout vulnerability.

Work-related and lifestyle factors were less strongly associated with burnout. Participants with 5–10 years of work experience had significantly lower odds of burnout compared to those with less than 5 years (adjusted OR 0.26; 95% CI: 0.07–0.95; $p = 0.041$). However, factors such as chronic illness, smoking, alcohol consumption, exercise frequency, and type of pharmacy did not show significant associations. Similarly, income sufficiency was not significantly related to burnout.

Coping strategies for burnout

The results, summarized in Table 4, reveal that proactive strategies were predominantly rated as “helpful” by respondents. The most effective strategies included identifying root causes of mental distress and addressing them promptly (86.2%), adopting a positive attitude toward work (80.5%), and allocating time clearly and maintaining discipline (78.0%). Additionally, practicing relaxation techniques, such as yoga or exercise (74.8%) and suggesting systematic organizational management improvements (71.5%) were also highly regarded.

In contrast, avoidance or passive measures, such as relying on substances (96.8%) and displaying illness symptoms to avoid work (88.6%), were overwhelmingly rated as “not helpful.” Mixed responses were observed for strategies like spending excessively beyond usual habits and proposing more interaction-promoting activities, with lower “helpful” ratings of 32.5% and 57.7%, respectively.

DISCUSSION

This study highlights the significant prevalence of burnout among community pharmacists and the factors associated with its occurrence. Consistent with previous research⁹, burnout was found to be influenced by both personal and work-related factors. Notably, proactive coping strategies were identified as the most effective approaches to mitigating burnout, reinforcing the importance of addressing burnout at both individual and organizational levels.

The findings highlight the high levels of emotional exhaustion and reduced personal accomplishment among community pharmacists, as reflected in the Maslach Burnout Inventory-General Survey results. This aligns with a study conducted in Greece¹³, which also reported high levels of emotional exhaustion and moderate levels of depersonalization among community pharmacists. In terms of burnout, our findings indicate that 32.52% of community pharmacists in Thailand



Table 2. Levels of Job Burnout			
Dimension of Burnout	Level of Job Burnout N (%)		
	Low	Moderate	High
Emotional Exhaustion	56 (45.5)	31 (25.2)	36 (29.3)
Depersonalization	97 (78.9)	14 (11.4)	12 (9.8)
Reduced Personal Accomplishment	60 (48.8)	27 (22.0)	36 (29.3)

experience burnout. This prevalence is lower compared to previous studies. For instance, a study in the United States⁷ reported a high burnout rate of 74.9% among community pharmacists, while a study in Saudi Arabia⁹ found that the prevalence of personal burnout was 83.63%, work-related burnout was 83.19%, and client-related burnout was 76.11%. The lower prevalence observed in our study may be explained by differences in burnout assessment methods and variations in pharmacy practice across countries. Factors such as long working hours, high workloads, and limited resources, which were prevalent in this study, align with existing literature emphasizing the demanding nature of community pharmacy practice.

Demographic factors, particularly marital status and mental health history showed significant associations with burnout in this study. Married individuals or those cohabiting without registration had lower odds of experiencing burnout, suggesting that social support may serve as a protective factor. This finding is consistent with a study conducted among 1,035 healthcare professionals in Ecuador¹⁴, which also highlighted the protective role of social support in reducing burnout risk. Conversely, a history of suicidal thoughts or self-harm was strongly associated with higher burnout odds, underscoring the importance of mental health interventions in this population. These findings are consistent with previous research^{3,15}, which has identified psychosocial stressors or mental health problems as key contributors to burnout among pharmacists.

Interestingly, work-related variables, such as years of experience and type of pharmacy, showed limited significant associations with burnout. A study on Chinese hospital pharmacists¹⁶ found that work-related factors, including job demands, job control, and workload, significantly influenced burnout and job satisfaction. Job demands strongly predicted emotional exhaustion and burnout, while job control and workload mediated the relationship between personality, working environment, and emotional outcomes. Notably, job satisfaction emerged as a protective factor against burnout, highlighting the importance of fostering a balanced and supportive work environment. Our finding shows pharmacists with 5–10 years of experience exhibited significantly lower odds of burnout, potentially reflecting an adaptation period in their professional trajectory.

Income sufficiency and lifestyle factors, including smoking, alcohol consumption, and exercise frequency, did not show significant relationships with burnout, indicating the multifaceted nature of burnout and its interplay with psychological and environmental factors.

Proactive coping strategies, such as identifying root causes of distress, maintaining a positive attitude, and practicing relaxation techniques, were rated as highly effective by participants. These approaches align with established recommendations emphasizing self-care, mindfulness, and effective personal time management to address burnout. Organizational interventions, including systematic management improvements and enhancements to workplace environments, were also perceived as beneficial, reinforcing the importance of employer-level initiatives. Similarly, a related study¹⁰ found that the most reported coping mechanisms included self-care strategies, mindfulness, and taking personal time or time off. Respondents also highlighted the need for organizational changes, with many recommending improved staffing and fostering a culture of well-being to promote resilience and well-being.

In contrast, avoidant behaviors, such as reliance on substances and exaggerating symptoms to avoid work, were overwhelmingly perceived as unhelpful. These findings indicate that maladaptive coping mechanisms may worsen burnout rather than alleviate it. This aligns with a previous study on healthcare workers in Belize¹⁷, which demonstrated that burnout was significantly associated with maladaptive coping behaviors, presenting multiple physical symptoms, quitting jobs, deteriorating health, and other mental health challenges. Mixed perceptions of strategies like spending excessively and promoting personnel interaction activities indicate the need for tailored interventions that consider individual preferences and workplace dynamics.

Our study has several limitations that should be acknowledged. First, the response rate was lower than anticipated, which may have reduced the statistical power of the study and potentially limited the ability to detect significant associations. This could affect the generalizability of the findings. Second, the questionnaire used to assess burnout, while widely validated, was not specifically tailored to pharmacists. This lack of specificity may have influenced the accuracy of capturing the unique stressors and burnout dimensions experienced by community pharmacists. Third, the study was conducted during the early stages of the COVID-19 pandemic, a period characterized by rapidly changing circumstances. As a result, the findings may not fully reflect the long-term impact of the pandemic on burnout levels or coping mechanisms in this population. Additionally, while the study explored various coping strategies, these were not directly assessed for their effectiveness among participants who met the criteria for burnout. This limitation restricts the ability to draw conclusions about which strategies are most beneficial for mitigating burnout.

To mitigate burnout among community pharmacists, key policy recommendations include managing workload through duty



Table 3. Factors associated with Burnout				
Characteristic	Crude Odd ratio	P-value	Adjusted Odd ratio	P-value
Gender				
Female	Reference		Reference	
Male	1.95 (0.82-4.64)	0.131	1.78 (0.66-4.81)	0.254
Age				
Less than 30 years	Reference		Reference	
31–40 years	0.50 (0.21-1.19)	0.118	2.02 (0.58-7.02)	0.268
More than 40 years	0.14 (0.04-0.50)	0.002	6.19 (0.55-69.15)	0.139
Marital Status				
Single	Reference		Reference	
Widowed/Divorced/ Separated	N/A		N/A	
Married/Living together without registration	0.18 (0.08-0.45)	<0.001	0.26 (0.09-0.74)	0.011
Chronic illness				
None	Reference		Reference	
Present	1.04 (0.33-3.28)	0.943	2.15 (0.38-12.08)	0.384
History of Mental Health Issues				
None	Reference		Reference	
Present	2.19 (0.52-9.27)	0.285	2.06 (0.37-11.35)	0.406
History of Suicidal Thoughts or Self-Harm				
None	Reference		Reference	
Present	7.15 (1.37-37.20)	0.019	6.91 (1.13-42.26)	0.037
Smoking Status				
Non-smoker	Reference		Reference	
Former smoker	2.10 (0.13-34.50)	0.603	3.63 (0.09-140.17)	0.489
Alcohol Consumption				
Never	Reference		Reference	
Occasional/Social	1.41 (0.65-3.05)	0.386	0.85 (0.52-1.37)	0.498
Exercise Frequency				
Less than 1–2 times/week	Reference		Reference	
1–2 times/week	0.92 (0.37-2.25)	0.849	1.03 (0.37-2.86)	0.96
3–4 times/week	0.35 (0.71-1.71)	0.193	0.24 (0.31-1.90)	0.177
Daily	0.25 (0.03-2.13)	0.204	0.75 (0.07-8.08)	0.811
Years of Work Experience				
Less than 5 years	Reference		Reference	
5–10 years	0.44 (0.17-1.15)	0.093	0.26 (0.07-0.95)	0.041
11–20 years	0.40 (0.13-1.25)	0.115	0.25 (0.04-1.49)	0.128
Type of Pharmacy				
Chain drugstore	Reference		Reference	
Private drugstore	0.50 (0.21-1.70)	0.109	0.63 (0.23-1.72)	0.369
Number of Pharmacies/ Workplaces				

One	Reference		Reference	
More than one	0.24 (0.03-1.99)	0.186	0.28 (0.03-2.71)	0.272
Daily Working Hours				
Less than 5 hours	Reference		Reference	
5–10 hours	1.47 (0.14-14.95)	0.747	0.40 (0.31-5.14)	0.486
11–15 hours	1.46 (0.14-15.03)	0.751	0.69 (0.06-8.89)	0.776
Income Sufficiency				
Insufficient (expenses exceed income)	Reference		Reference	
Sufficient (expenses equal income)	0.75 (0.18-3.06)	0.689	0.66 (0.13-3.30)	0.618
Savings possible (expenses less than income)	0.34 (0.09-1.31)	0.119	0.27 (0.06-1.24)	0.092

Note: Values are presented as odds ratios with 95% confidence intervals (CI). N/A indicates data not available or not applicable.

Table 4. Categorization of Coping Strategies and Responders' Ratings

Coping strategies	Number of responders (%)		
	Helpful	Neutral	Not Helpful
Reliance on substances such as alcohol, cigarettes, drugs, or medications.	2 (1.6)	2 (1.6)	119 (96.8)
Displaying illness symptoms to avoid work or take leave.	5 (4.1)	9 (7.3)	109 (88.6)
Practicing relaxation techniques, such as yoga or exercise.	92 (74.8)	21 (17.1)	10 (8.1)
Spending excessively beyond usual habits.	40 (32.5)	17 (13.8)	66 (53.7)
Adopting a positive attitude toward work.	99 (80.5)	20 (16.3)	4 (3.2)
Allocating time clearly and maintaining discipline in following a schedule.	96 (78.0)	18 (14.6)	9 (7.3)
Identifying the root causes of mental distress and addressing those issues promptly.	106 (86.2)	10 (8.1)	7 (5.7)
Feeling entitled to special compensation or increased rewards.	80 (65.0)	27 (22.0)	16 (13.0)
Believing that the organization should improve the workplace environment and provide better facilities.	87 (70.7)	27 (22.0)	9 (7.3)
Suggesting the organization adopt more systematic management practices.	88 (71.5)	25 (20.3)	10 (8.1)
Proposing that the organization arrange more activities to promote interaction among personnel.	71 (57.7)	36 (29.3)	16 (13.0)

hour limits, adequate staffing, and flexible scheduling; providing access to mental health support such as counseling, mindfulness, and stress management; and promoting professional development to enhance confidence and engagement. Supportive leadership, peer mentoring, and a positive organizational culture that encourages work-life balance and psychological safety are essential. Policies

should prioritize systemic changes over reliance on individual resilience alone, emphasizing shared responsibility between healthcare systems and professionals to create sustainable, supportive work environments¹⁸.

Future research should focus on preventing and addressing burnout among community pharmacists. Longitudinal studies

are needed to assess the effectiveness of interventions like resilience training, workplace improvements, and workload optimization. Qualitative research could uncover nuanced stressors and coping challenges, while comparative studies across countries or healthcare settings may reveal the influence of cultural and systemic factors. Research on integrating mental health support in community pharmacies and its impact on pharmacists and patient care is also essential to guide policy and practice.

CONCLUSIONS

This study highlights the significant prevalence of burnout among community pharmacists in Thailand and the importance of proactive strategies to address its impact. Policymakers should prioritize the development and implementation of national guidelines to mitigate burnout, focusing on promoting mental health support systems and ensuring adequate staffing levels in community pharmacies. Pharmacy owners are encouraged to adopt organizational interventions, such as fostering a culture of well-being, reducing workloads, and providing access to resilience-building programs. Healthcare organizations should integrate regular mental health screenings and support services for pharmacists to address early signs of burnout. Additionally, tailored interventions, such as time management training and stress reduction techniques, should

be made readily available. By implementing these targeted actions, stakeholders can enhance pharmacists' well-being, improve job satisfaction, and ensure the sustainability of high-quality patient care in community pharmacy settings.

AUTHOR CONTRIBUTIONS

Somharutai Wattanakittisak: Conceptualization, Methodology, Supervision, Project Administration.

Anannit Weerapan: Conceptualization, Data Curation, Investigation, Formal Analysis.

Tuanthon Boonlue: Conceptualization, Writing – Original Draft, Data Curation, Investigation, Writing – Review & Editing.

Saksakon Paratsaphan: Data Curation, Formal Analysis, Writing – Review & Editing.

All authors contributed to the conception and design of the study. They have critically reviewed and approved the final manuscript.

CONFLICTS OF INTERESTS

The authors have no relevant financial or non-financial interests to disclose.

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