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Australian pharmacists' experiences with assisted-dying: a qualitative study

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Abstract

Background: **Australia's assisted-dying legislation includes pharmacists as essential service providers. Their lived experiences, potentially inclusive of ethical, emotional and other challenges, remain underexplored in Australia.**

Objectives: **This study aimed to explore the experiences of Australian pharmacists involved in assisted-dying practice.**

Methods: **A qualitative study design was utilised, involving semi-structured interviews with 10 assisted-dying pharmacists from multiple Australian jurisdictions. Data was analysed thematically using a reflexive, inductive approach to identify recurring patterns, meanings and shared experiences.**

Key findings: **Four overarching themes were developed: (i) working within restrictive legislation; (ii) cultivating a unique skill set; (iii) lived experiences personally transformative; and (iv) professional challenges. Participants highlighted challenges such as inconsistent legislation, communication restrictions and limited education. Pharmacists described their work as emotionally demanding but rewarding, reshaping their views on death, autonomy, and patient care. Conversely, peer mentorship, teamwork and reflective practice enhanced resilience and professional fulfilment.**

Conclusion: **Pharmacists reported ethical and emotional burdens through exposure to legislative inconsistency, poor preparation and education, and lack of sustainable support systems. Pharmacist wellbeing was being maintained through professional comradery and sense of role purpose.**

Keywords Professional pharmacy practice, assisted dying, delivery of care, pharmacists' role

Introduction

In Australia, assisted-dying is legislatively referred to as Voluntary Assisted Dying (VAD) denoting a regulated medical process through which an eligible adult with decision-making capacity and a terminal illness may receive assistance to end their life for the purpose of alleviating intolerable suffering [1]. This paper will use VAD as an umbrella term encompassing equivalent practices referred to internationally as 'Assisted Dying', 'Medical Assistance in Dying (MAID)', 'Aid in Dying', 'euthanasia' or 'Physician-Assisted Dying', as outlined in Isaac *et al.* [2]. The practice remains controversial due to ethical implications of healthcare professionals facilitating patients' deaths [3]. There is growing VAD research, however it has largely focused on doctors and nurses [3, 4]. Factors influencing the debate on VAD include issues of self-determination, the patient-professional relationship, and the complexity of requests (including protecting vulnerable groups) [5, 6].

VAD is legal in several jurisdictions across Europe, the Americas and Oceania [5]. Many other jurisdictions, including the UK, are considering or have recently considered legalisation [7], reflecting a gradual shift in social norms [5]. For example, the 1990s saw pharmacists strongly critical of VAD legalisation, concerned about undermining palliative care and exploitation of vulnerable groups [8, 9]. Growing acceptance of VAD has been attributed to aging populations, rising chronic illnesses, increasing secularism and a stronger emphasis on autonomy [5, 6, 10].

Australia is a federation in which each state and territory has responsibility for its own VAD legislation and service delivery models. Australia has legalised a hospital-led service model of VAD in all jurisdictions except the Northern Territory [1, 11]. Across the Australian jurisdictions legislation requires: that the decision is voluntary and informed; assessment by more than one practitioner; applicants must be over 18, terminally ill with a life-expectancy of 6–12 months; and maintained decision-making capacity [12]. Eligible individuals may access either

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self-administered or practitioner-administered VAD, with the death occurring at a time and place of their choosing [12]. Limitations to this model have been identified in academic and policy literature, including lengthy processing, limited access to trained doctors, and bans on electronic/telehealth communication regarding VAD, leading to low awareness and access equity [11, 13, 14].

Globally, pharmacists' roles vary across jurisdictions including, dispensing and delivering VAD medications, patient education, reviews with physicians and nurses, documentation procedures and secure storage and disposal of unused drugs [10, 15, 16]. In the Australian model, pharmacists deliver the medications to patients' residences via a central-statewide pharmacy service. In this model, a single designated hospital pharmacy service coordinates the procurement, storage, dispensing, distribution and accountability of VAD substances for the entire jurisdiction, with dedicated pharmacists travelling throughout the state, including to rural and remote communities, to ensure equitable access in accordance with jurisdictional legislation [1, 11]. Literature shows pharmacists' attitudes towards VAD are shaped by broader perspectives regarding patient autonomy, professional duties, end-of-life care and religion [10]. Earlier studies from Canada and the US, reveal both support for patient autonomy and concern about moral distress, lack of training and insufficient legal protection for pharmacists [16–18]. Other studies also highlight a need for education, clear protocols and explicit professional guidance [19–21]. In Australia, pharmacists generally supported VAD but expressed concerns over transparency, physician authorisation and inadequate protocols [22]. Similar uncertainty exists internationally including in the Netherlands, where unclear legislation around pharmacists' roles contributes to professional uncertainty [23].

Studies show healthcare providers experience complex responses with focus on ethical debates, and attitudes to VAD more generally, rather than professional experiences [19, 24]. To date, none have focused on Australian contexts and models of delivery. There remains a clear need for further research exploring pharmacists' experiences in VAD. This study therefore aimed to explore the experiences of Australian pharmacists involved in the provision of VAD.

Methods

Study design

This qualitative study sought to understand pharmacists' experiences with VAD. Semi-structured interviews were undertaken with pharmacists who had direct experience with VAD, focusing on their perspectives and experiences of involvement in VAD-related care, enabling participants to describe and reflect on their direct experiences with VAD [25, 26].

Ethical considerations

Methods adhered to the 32 consolidated criteria for reporting qualitative research (Supplementary Material 1: COREQ checklist) [27]. The study was approved 16 September 2025, by the Sydney University Human Research Ethics Committee (Protocol No.2025/HE000846). All participants provided written consent prior to participation and received no financial compensation.

Participant recruitment

Eligible participants were required to have professional experience in the delivery or establishment of VAD services within their state. This included pharmacists who had dispensed VAD medications, supported patients undergoing the VAD process, or contributed to the development of VAD-related pharmacy procedures. There were no restrictions placed on length of professional practice or current practice. The population of pharmacists in Australia meeting these criteria is estimated to be less than 100.

A convenience and passive snowball sampling strategy was implemented [28]. Participants were recruited through email invitations distributed by researchers to pharmacists whose professional contact details were publicly available on organisational, health service, or professional association websites. Recruitment also involved an advertisement posted to the national professional body representing Australian hospital pharmacists and their Special Interest Group for VAD.

Data collection

Interviews were conducted October 2025 to April 2026, by author SV, using an interview guide developed by four researchers experienced in qualitative health research (Supplementary Material 2) [26]. They were conducted via Zoom Video Communications Inc. (San Jose, USA), video recorded and automatically transcribed using Zoom's transcription feature.

Transcripts were anonymised by removing identifying information, then assigned a participant code and checked against audio recordings for accuracy. Visual recordings were deleted after the interview and not used in analysis. Data was stored securely in password-protected files.

Data analysis

Analysis was thematic, using an inductive approach informed by the Naeem *et al* (2023) model [29]. In the first stage, authors SV and BC independently read the interview transcripts and compared notes to develop a coding framework. Quotes were manually categorised in Microsoft Excel tables. The coding framework was refined iteratively as additional interviews were analysed. Both investigators then coded the interviews individually and reconciled differences. The full research team collaboratively reviewed the coded data to coalesce codes presenting conceptually similar notions to generate meaningful themes. These themes were further compared across categories to identify a smaller set of overarching themes.

Reflexivity

The research team comprised experienced pharmacist-academics with extensive qualitative researcher experience (BC, SH, JP, and IM), a Medical Physician-academic (SI) and a pharmacist honours student (SV). Throughout analysis, researchers reflected on their

Table 1 Participant characteristics by gender, state of practice, duration of VAD practice, and current practice status.

Category	Breakdown	Count
Total		10
Gender	Female	5
	Male	5
State	State of Western Australia	1
	State of Queensland	1
	State of South Australia	1
	State of Victoria	5
	State of New South Wales	0
	State of Tasmania	0
	Australian Capital Territory	2
	Northern Territory	Not yet legal at time of data collection
Years of VAD practice	Under 1 year	4
	1–3 years	1
	4–6 years	5

professional backgrounds and experiences to situate their positionality during the process.

Results

Ten participants were interviewed from five (of seven) Australian states or Territories (Table 1). Interviews ranged from 40–88 min (mean = 59 min). All participants were practicing pharmacists.

Four themes were developed that captured key aspects of participants' experiences: (1) working within restrictive legislation, (2) cultivating a unique skill set for VAD services, (3) experience in VAD is transformative, (4) professional challenges.

Theme 1: working within restrictive legislation

Although laws governing VAD were seen to be designed to ensure safety and oversight, participants described the legislation that governed their VAD work as restrictive and inconsistent. Several aspects were identified as follows.

Commonwealth carriage service Laws

Participants expressed frustration at broad legislative prohibitions they believed limited pharmacists' communication about VAD. They reported significant disruptions of this on their coordination and delivery of care. One specific example is the prohibition on discussing VAD-related matters via phone, email or telehealth, (section 474.29A of the Criminal Code 1995 (Cth)). This prohibition resulted in participants not being able to use electronic prescriptions and patients being unable to talk to practitioners by phone. Participants said that this impeded timely, equitable access to care.

> 'Normally you ring the doctor. Now, they can't even fax prescriptions to you. It makes it much more difficult. That Commonwealth legislation is ridiculous.' (P2)

> 'Patients can't ring and ask follow-up questions. The lack of ability to use telehealth has limited how we run services.' (P6)

Institutional obstruction

Participants reported resistance from hospital services to incorporating access to VAD services or refusing entry to VAD practitioners. The following quote shows pharmacists forming alliances with willing individuals to overcome institutional resistance.

> 'You have health services that won't let you in, blocking patient care. Nurses will contact us and say 'I'm ashamed they're stopping this patient seeing you. When I'm on shift, I'll let you in.' (P4)

Some participants spoke of their advocacy efforts for legal reforms to prevent institutions from obstructing access:

> 'We've been continuing to work with getting legislation changed, not allowing institutions to block VAD services.' (P4)

Limits on discussing assisted-dying

Participants described the imperative to work within 'gag clauses' in state legislation, and how these restricted them from initiating VAD-related conversations with patients. They described delays, bureaucratic burdens, rushed decision-making and distress. Examples were provided of patients being unable to complete the required steps to access VAD, that challenged the participants' notions of professional responsibilities and care.

> 'Allowing us to initiate conversations would be so beneficial . . . ' (P4)

> 'People find out about it so late . . . spending precious time at the end of their life filling out forms . . . that's not patient-centred care!' (P6).

Eligibility requirements

Participants spoke of the emotional challenge of rigid legislative eligibility criteria, they believed negatively impacted patients. This included the requirement for a prognosis of six months or less to live (12 months for neurodegenerative conditions).

> 'Prognosis is an art, not a science . . . It's saying to some people, you've had a diagnosis, but you haven't suffered long enough. Suffer some more.' (P6)

They stated one of the most difficult aspects of VAD practice was managing situations in which patients experience a decline in capacity or physical ability between the time their permit is approved and the day they intend to self-administer. They described the impact of ethically fraught positions when patients become too unwell to take the medication and taxing judgments, especially when families plead for exceptions:

> 'I've seen the ability to self-administer on the day become a challenge for the patient, and then also, the effects it has on the family . . . patients vomiting, patients not drinking at all.' (P5).

Participants experienced other ethical challenges, such as potential misuse of the eligibility framework, which they considered to be *'reverse coercion',* (P8) where a clinician's personal

opposition to VAD can subtly limit access, introducing inconsistency into decision-making:

> 'If a clinician doesn't believe in VAD, they're not actively saying no. They're saying, "I think you've got more than six months in you.' (P8)

Participants described feeling powerless knowing that some patients who may wish to access VAD were nevertheless ineligible within the current criteria.

> 'You must have something like cancer. But if it's COPD and frailty and early onset dementia etc . . . . We don't have a mechanism to enable these people to access VAD.' (P9)

Ambiguity in legislative design

Participants expressed frustration with the technical wording of VAD legislation, noting that linguistic choices have created significant clinical and operational challenges, due to ambiguous interpretations/applications. As one South Australian pharmacist described:

> 'Our legislation says if you can digest the medicine, you have to have oral administration. But you don't digest medicines, you absorb medicines. That little six-letter word has been quite a barrier!' (P5)

Inconsistency between states

Participants highlighted the perceived patchwork nature of VAD legislation across Australia. Each state/territory has a different framework, creating inequities in access and confusion for practitioners. Participants advocated for national consistency in a unified framework.

> 'I'd be more comfortable if it was national legislation, without state barriers involved.' (P6)

Challenges of the centralised service design

Under the centralised statewide service model, delivering VAD medications was described as physically demanding, with pharmacists reporting long travel covering large rural areas and unpredictable workloads.

> 'You're in the car all the time, like 6 hours driving, that's a bit crazy . . . The physical side of this role hasn't been considered enough.' (P3)

Participants were challenged by the lack of equity and timely access to care from a centralised service. They spoke of the disadvantage to patients living outside metropolitan areas, e.g. in Western Australia where providing the service meant pharmacists covering vast physical distance causing major delays and logistical challenges.

Theme 2: cultivating a unique skill set for VAD services

VAD pharmacists reflected on the need for training that encompasses interpersonal, emotional and reflective skills, including the value they believed had been gained from ongoing professional development, peer mentorship and cultivation of soft skills essential to navigating emotionally complex situations. This suggested a multi-layered approach to education and training including formal courses, on-the-job training, honing of personal skills and resilience.

Formal training

Most participants reflected that their own training was heavily focused on procedural and pharmacological aspects. Skills that enhanced patient conversations were largely acquired through experience.

> 'Trial by fire. There wasn't an educational training day about how to talk to a dying person and their family . . . it was just experience and see what happens.' (P3)

> 'There is no training package that tells you how to start a conversation, what to do if a patient is crying, or tools to show empathy.' (P5)

Mentorship

Many highlighted the informal mentorship that naturally developed through paired visits, where new pharmacists would learn by observing how experienced colleagues functioned.

> 'We work in pairs. You're never doing it in isolation, you are getting mentorship from someone you know and your team.' (P4)

Importance of soft skills

Pharmacists emphasised that expertise in VAD extends beyond clinical knowledge and requires 'soft skills' including empathy, communication, patience and emotional regulation.

> 'Many pharmacists can tell you about drugs, but are disconnected when talking to patients and the confronting parts of the role, like using de-escalation techniques when tensions arise.' (P2)

Pharmacists routinely faced unpredictable, emotionally intense interactions with patients, requiring sensitivity and adaptability.

> 'Some interactions were living wakes. The family was there, kitchen full of food. Others might be alone and want you to stay with them while they take the substance. There were lots of tears.' (P4)

The ability to remain composed, compassionate and responsive under emotional strain was viewed as a skill.

> 'Your eyes have to be wide open, not full of tears, because you are there to help patients.' (P4)

Burnout

Participants described the emotional toll of their work and the necessity of support mechanisms, as well as a work-life balance, highlighting the challenge of balancing support with operational demands in a resource-constrained environment.

> 'There is undoubtedly an emotional burden being involved in VAD, you leave a little bit of yourself, and you take a little bit of them with you. You need to do other things as well.' (P4)

Debriefing, journaling, exercise and informal peer conversations were cited as essential support strategies. Routine debriefs were described as serving both educational and therapeutic purposes.

> 'We try to keep peer conversations ... part of it is touching base on the other person, making sure they are alright.' (P3)

However, pharmacists also acknowledged that debriefs were not always possible within the pressures of service delivery.

> 'We try to have a debrief at the end of the day but some days, it's not possible.' (P5).

Pharmacy education

Pharmacists reported the perceived uncertainty, both within the profession and wider community, about what the VAD pharmacist role entails. Many stated they had entered the field without a clear understanding of its demands. Participants believed that demystifying VAD practice for the pharmacy profession was important.

> 'The role was not what I was expecting it to be. It would be beneficial to actually tell pharmacists what the role involves...' (P1).

Beyond technical knowledge, participants felt that education should also focus on normalising conversations about death, dying and end-of-life medication use.

> 'That broader understanding of death and dying... What does it mean for someone who chooses VAD? Those are things pharmacists need more education on.' (P6)

Theme 3: experience in VAD is transformative

Pharmacists described the adjustment they experienced since beginning to work in VAD roles as being transformative. This included the shift in thinking about their professional entities from being about preservation of life to supporting death, and the accompanying emotional shift that comes from learning to rationalise and humanise their involvement in a space that challenged traditional medical norms.

They spoke of their understanding of death being reshaped from previous associations solely related to sadness or loss, to seeing a *'different side'* to dying, learning to appreciate it as an act of autonomy, love and even celebration.

> 'I thought the consultations would be sombre. But we've been in situations where they'll have a cake on the table, it's literally a party. It opens your eyes to the way people interpret death and dying in different ways.' (P3)

Pharmacists also described how proximity to death deepened their empathy and appreciation for life. Being witness to profound suffering helped rationalise VAD as compassionate relief rather than loss.

> 'Witnessing patients' resilience and humanity makes you a better listener and you learn life's short and you should value it.' (P4)

> 'The thought of them not suffering anymore overrides everything.' (P5)

Beyond emotional fulfilment, participants described their 'professional transformation', to become more confident communicators, better listeners and more compassionate practitioners.

> 'I watched my colleague's growth as a person, seeing how his communication and rapport-building skills improved remarkably.' (P5)

Theme 4: professional challenges

Participants described challenges of having to undertake complex clinical risk management, intensive teamwork and the navigation of others' conscientious objection in sensitive environments. In addition, pharmacists reflected on issues related to career sustainability and remuneration.

The evolving nature of risk management

VAD pharmacists reported challenging patient scenarios where even after following protocols precisely, outcomes were not always predictable.

> 'There have been cases where the patient died (naturally) ... and their partner took it! Or where they haven't died straight away, or they fell asleep while taking it.' (P4)

Other situations involved patients wanting to take medications in unconventional or public locations, increasing both logistical and ethical challenges.

> 'For example, some people ask to do it in public. Another was young, hadn't experienced life, and he wanted to use heroin.' (P5)

Teamwork and collaboration

Pharmacists spoke of the benefits and challenges of close work within multidisciplinary teams, including doctors, nurses, psychologists and interstate pharmacy colleagues, to support risk management, continuity of care and the delivery of patient-centred service. It was noted as important to support each other. Pharmacists noted that working in pairs for extended periods and sharing high-stakes responsibilities built a strong connection, yet has the potential to magnify interpersonal tensions.

> 'This tight-knit environment could go both ways ... you can get strong connections, but there are days where you get bothered by someone else.' (P5)

> 'Unfortunately, I didn't have a very supportive team. It is the reason I left.' (P7)

Conscientious objection

Conscientious objection is when a health professional declines to perform a legally and professionally accepted action that would be in violation of their core moral beliefs [30]. This introduces

operational and ethical complexities that require careful management for VAD pharmacists, who spoke of the imperative to manage unstated moral positions of other healthcare professionals, sometimes leading to their own moral distress. For example, one pharmacist described a scenario:

> 'I asked a colleague a general question about stability of a particular drug. Later, he asked whether my questions were related to VAD. I didn't realise that he felt as though he was involved in the process. The colleague felt very upset and ended up in tears. I felt terrible and ignorant.' (P2)

Ensuring conscientious objection does not impede patient access is a critical principle that underpins VAD service delivery.

> 'One of the saddest things you hear is when someone tells you how hard it is for them to access VAD, because someone's been a barrier...' (P3).

Career aspects

Pharmacists overwhelmingly described their VAD roles as deeply rewarding in enabling patients achieve a dignified death. However, career progression and remuneration can be limited, contributing to decisions to leave the role. Pharmacists may experience uncertainty about long-term pathways:

> 'You become a VAD pharmacist . . . where do you go from there? People feel lost . . . Do I want to do this for the rest of my life?' (P5).

Remuneration is another key concern, with one pharmacist noting:

> 'I don't think we are remunerated fairly . . . For pharmacists, I would like for all VAD services to be paid on a different tier. It's a completely different role.' (P5)

Discussion

This study provides the first in-depth qualitative exploration of Australian pharmacists' experiences and perspectives in delivering VAD in Australia, an area also underexplored in the international literature. Pharmacists revealed the requirements of their roles to navigate complex legislative frameworks, uphold ethical integrity and provide compassionate support to patients at end-of-life.

The strength of this study is the use of in-depth qualitative interviews, which enabled a rich and nuanced understanding of the ethical, emotional and practical dimensions of Australian pharmacists' work in assisted-dying.

A possible limitation is the relatively small sample size (n = 10). However, this was an exploratory study of the very limited number of VAD pharmacists currently practicing in Australia, and although geographically dispersed, there were sufficient aspects of commonality in the lived experiences of differing Australian jurisdictions, to consider theoretical sufficiency was attained. Theoretical sufficiency refers to data adequacy rather than data saturation [31]. Additionally, one state-based service provider declined involvement despite the study focusing on personal and professional experiences of individual pharmacists rather than patient-level data or health-service outcomes.

Findings aligned broadly with international literature regarding the emotional intensity, ethical complexity and patient-centred nature of VAD practice [24], while also exposing unique contextual strengths and tensions within the Australian model. For example, pharmacists described numerous facilitators that enhanced their professional functioning and wellbeing in VAD practice, including mentorship, peer support, teamwork and self-care. This mirrors international findings of Schindel *et al.* in Canada, where collaborative relationships amongst VAD pharmacists were perceived as buffers against burnout and moral distress [32].

Pharmacists also identified major challenges including perceived restrictive and inconsistent legislation. Commonwealth carriage laws, gag clauses and rigid eligibility criteria obstructed communication, delayed patient access and compromised patient autonomy. These issues echo Lau *et al.* and Peters *et al.* who described confusion, policy gaps and inconsistent implementation of VAD across jurisdictions [33, 34]. In the Australian context, VAD pharmacists reported experiencing emotional distress at being less able to care for people seeking their expertise.

Interestingly, some points of divergence from international literature included Bilsen *et al.* and Lau *et al.* who described poor physician-pharmacist communication, 'suspicious prescriptions', and breaches of protocol [33, 35]. Comparatively Australian pharmacists reported strong interdisciplinary relationships, open communication with other healthcare providers, and consistent adherence to guidelines likely reflecting the benefits and distinctive structure of Australian VAD services, where statewide centralisation and multidisciplinary coordination foster trust, peer mentorship, and consistent practice standards.

Conscientious objection, both individual and institutional, was identified as a source of occasional workflow disruption and interprofessional friction within multidisciplinary teams. This is consistent with Schindel *et al.* acknowledging the delicate balance between respecting individual choice and ensuring patient access [32]. While Australian legislation permits individual conscientious objection, institutional refusal raises distinct ethical and access concerns [36]. Such actions underscore the need for clearer guidance on institutional responsibilities regarding VAD frameworks. Pharmacists also highlighted the physical and emotional toll of the role, particularly in rural contexts where travel and unpredictable workloads compounded emotional fatigue. This concurs with Peters *et al.* in Oregon (USA) and Crumley *et al.* in Nova Scotia (Canada) who described significant workload pressures, time-intensive counselling and complexities of remuneration for VAD pharmacists [34, 37]. Career progression and remuneration represented notable challenges highlighted in this study, with pharmacists feeling their specialised work was not appropriately recognised within existing employment structures. Participants' describing the need for constant vigilance in risk management, particularly ensuring safe medication storage and self-administration, mirrors findings in Schindel *et al.* which emphasised the high cognitive and emotional demands carried by pharmacists navigating VAD provision [32].

Participants also described entering the VAD service without clearly understanding what the role entailed, with education largely occurring 'on the job.' This lack of transparency suggests that enhancing professional awareness about VAD and including it in pre-registration curricula and work-integrated learning could be beneficial. Reliance on experiential learning highlighted vulnerability to inconsistency, and the need for more

structured professional development. This aligns with Selby *et al.* documenting pharmacists' uncertainty about their professional responsibilities, limited access to VAD-specific guidance and increased need for education [38].

Implications and future research

Future research can be expanded to focus on practical areas and strategies to strengthen pharmacist engagement and wellbeing in VAD. This includes examining the effectiveness of structured emotional and organisational support systems, such as peer mentoring, reflective practice and mental health programs in mitigating burnout and sustaining long-term wellbeing among pharmacists. Research should also investigate the feasibility of a national standardisation of VAD laws to address jurisdiction inconsistencies, lack of transparency and communication barriers that reportedly impede practice nationally. Further studies are also needed to understand education and professional development and support needs that might best prepare pharmacists for the multidisciplinary, ethical, emotional and interpersonal complexities of VAD, beyond technical training alone. Furthermore, improving rural access requires research on the effectiveness of decentralised or hybrid service models.

Conclusion

This study aimed to explore the experiences of Australian pharmacists involved in the provision of VAD, and has demonstrated how Australian VAD pharmacists navigate complex ethical, legal and emotional dimensions of care and restrictive legislative frameworks, often in the absence of formal training or institutional guidance. Nonetheless, pharmacists exhibited empathy and a strong commitment to safe practices. Future strengthening of formal support systems, including career prospects and reimbursement, harmonising legislation, enhancing service design and investing in targeted education may ensure pharmacists remain both emotionally resilient and professionally sustainable.

Author contributions

Sonja Vujanic (Data curation, Formal analysis, Investigation, Writing—original draft), Stephen Hughes (Conceptualization, Formal analysis, Validation, Writing—review & editing), Sami Isaac (Conceptualization, Formal analysis, Investigation, Methodology, Writing—review & editing), Isaac Moore (Formal analysis, Validation, Writing—review & editing), Jessica Pace (Conceptualization, Methodology, Supervision, Validation, Visualization), Betty B Chaar (Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Supervision, Writing—review & editing).

All authors contributed to formulating the research question, BC, SH, JP, SI designed the study, SJ & BC conducted the interviews, analysis and first draft of the manuscript, all five researchers BC, SH, JP, SI & IM participated in continuous discussions in analysing the data, writing the article and editing to meet IJPP requirements.

The corresponding author has access to all the data, which is securely maintained in her portfolio, with enduring access. Data may be made available upon request.

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Supplementary material

Supplementary material is available at *Journal of Pharmacy Practice* online.

Conflict of interest

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