The emergency supply of prescription-only medicines: a survey of requests to community pharmacists and their views on the procedures

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Objectives — The provisions of the Medicines Act for the emergency supply of prescription-only medicines (POMs) represent circumstances in which pharmacists in the UK may lawfully supply a patient with a POM without having a prescription. The objectives of this research were to establish the frequency of requests for emergency supplies from doctors and patients, and the characteristics of the requests, to investigate the procedures for emergency supply from the perspective of community pharmacists and to survey their views on the subject.
Method — Data were gathered in a self-administered structured postal questionnaire. The sample comprised community pharmacists in three health authority areas in Greater London and the surrounding area.
Key findings — Over two-thirds of the 243 respondents reported receiving requests for emergency supplies of POMs from patients at least monthly. The most commonly requested items were inhalers for asthma, followed by medication for cardiovascular disease. Many pharmacists had refused to make supplies on the basis that the situation did not constitute an emergency and/or that a prescription could be obtained. They also experienced cases in which they doubted the suitability of the requested product. Over half of the respondents reported receiving at least monthly requests from doctors to dispense an emergency supply. Refusals to supply were most commonly because the requested product was a Controlled Drug and therefore disallowed. Most respondents believed that the emergency supply procedures provided an opportunity to exercise professional judgment and were an important "safety net" for patients.
Discussion — The provisions for the emergency supply of medicines are a common resort of both prescribers and patients and present pharmacists with an opportunity to exercise professional judgment. However, many pharmacists considered the procedures restrictive, believing that they should have more discretion in supplying POMs to regular patients and their representatives.
Conclusion — Professional developments as envisaged by the British government and the pharmacy profession will require greater flexibility regarding the arrangements for supply of POMs.

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THE emergency supply arrangements for prescription-only medicines (POMs), introduced in 1977 and revised in 1983 and 1997, under the Medicines Act 1968, allow a pharmacist to supply a limited quantity of medicines to a patient who is in immediate need of medication.[1] A request can be made by either the patient themself, or their medical practitioner. The provisions represent circumstances in which a patient may lawfully be supplied with a POM in the UK by a pharmacist without having a prescription.

The legislation includes provision for two types of emergency supply of POMs: those made at the request of a patient and those at the request of a doctor. For each, conditions that must be satisfied are specified. For example, regarding supplies at the request of a patient, the pharmacist must personally interview the patient and be satisfied that there is an immediate need, may supply only limited quantities and must maintain records detailing supplies. At the request of a doctor, the pharmacist must be satisfied that the

request comes from a doctor, the doctor must agree to furnish a prescription within 72 hours and records of supplies must be maintained.

The application of the provisions for emergency supply of POMs has been discussed. In considering "what constitutes an emergency?" Harrison[2,3] demonstrated how there is room for differences of opinion between pharmacists on an appropriate course of action following requests from patients for emergency supplies. Harrison[2] believed that many pharmacists equated "emergency" with "life-threatening", but argued that the provision in law for supply of such items as oral contraceptives and topical preparations indicated that this interpretation is not as intended. A similar view was expressed by Almond[4] who, in discussing new roles for pharmacists, claimed that many were reluctant to make emergency supplies at the request of a patient for fear of doing wrong. While recognising that the system was open to abuse, he cited an example in which a patient had to travel unnecessary distances to obtain an inhaler for asthma. Wingfield *et al*[5] have illustrated the difficulties of applying a systematic approach to professional decision making in pharmacy in the context of the law and professional responsibilities regarding responding to requests for emergency supplies. The Royal Pharmaceutical Society of Great Britain previously issued guidelines for pharmacists regarding the interpretation of, and their responsibilities within, legislation regarding emergency supplies.[6]

Although the provisions for the emergency supply of POMs are widely recognised, the extent to which supplies are made and the characteristics of requests have not been documented. The objectives of this research were to establish the frequency of requests to community pharmacists for emergency supplies by both doctors and patients, the characteristics of requests (eg, main drug groups and circumstances of requests), to investigate the operation of procedures for emergency supply from the perspective of community pharmacists and to survey their views regarding the provisions for, and their role in, emergency supplies of POMs.

Method

Data were collected in 1998 in a self-completion postal survey of community pharmacists in three health authority areas in Greater London and south east England. These areas included town/city, suburban and rural areas. The names and addresses of all community pharmacies in each of these areas were obtained from the health authorities. All pharmacy contractors in these areas were included in the sample.

The survey instrument was a structured questionnaire comprising open and closed questions. This was intended to enable the collection of data to provide information on the frequency and nature of events as well as providing respondents with an opportunity to express their opinions on relevant issues. The topics for questions were identified following a pilot project involving a sample (17) of community pharmacists drawn from a different health authority bordering London, using a semi-structured interview.

The questionnaire fell into four sections. The two main sections were designed to gather detailed data on emergency supplies made at the request of patients and doctors respectively. This included the extent to which requests were received and how requests were managed. To obtain information on pharmacists' views of the provisions for emergency supply and the operation of the procedures, pharmacists were asked to indicate their agreement or disagreement with a series of 34 statements on a five-point Likert scale. Information was also collected relating to the pharmacist themselves, the pharmacy and their clientele.

The final questionnaire was itself piloted among a small number of community pharmacists; it was estimated to take approximately 20 minutes to complete. The questionnaires were then mailed to a total of 476 pharmacies with prepaid reply envelopes. Reminders with a further copy of the questionnaire were mailed to non-responders between four and six weeks later.

Data were coded and analysed using SPSS. Analytical procedures included generation of frequency data and summary statistics. Statistical comparisons were undertaken using non-parametric procedures (chi square, Mann-Whitney U and Spearman's rank correlation) as indicated in the text. In all cases $P<0.05$ was taken as conferring statistical significance.

Follow-up of non-responders A random sample (10 per cent) of non-responders from each health authority area were followed up in a telephone survey. A short interview schedule was designed, comprising selected structured questions from the postal questionnaire, enabling comparison between responders and non-responders on variables important to the objectives of the survey.

Results

Response rates and characteristics of the sample Questionnaires were completed and returned by 243/476 pharmacists (response rate 51 per cent). Sixty-four per cent of respondents were male. The mean period of registration was 17 years (range three months to 53 years). The majority of pharmacists worked between 41-50 hours per week (mean 43.6 hours, maximum reported 79 hours).

To provide some indication of the size of the pharmacies, respondents were asked about the total number of staff employed in their work place (not only in the pharmacy department). The mean number of staff working in pharmacies

was 6.4. Thirty-eight per cent of pharmacies reported up to two staff members, a further 40 per cent of pharmacies employed between two and five staff members, 14 per cent employed six to 10 staff members and 8 per cent more than 10.

Forty-nine per cent of pharmacies were reported as being among a small group of local shops, and 36 per cent of pharmacists described the location of their pharmacy as in a town/city centre or on a main shopping street. The remaining 15 per cent were located in indoor shopping centres or supermarkets (8 per cent) or other locations, such as health centres (7 per cent).

The number of local general medical practices for which the pharmacy provided a regular dispensing service was used to provide some information on the extent to which the pharmacy clientele comprised local residents. A quarter of pharmacies reported that they served one or two local medical practices, with over three-quarters (77 per cent) serving five or fewer. Over half of the pharmacists believed that almost all of their clients used their pharmacy regularly; only 2.5 per cent of pharmacies believed that less than half of their clients used their pharmacy regularly.

Respondents were asked to indicate any "extra" services that they offered to their clients: 96 per cent maintained patient medication records (PMRs), 80 per cent offered a prescription collection and delivery service, 59 per cent participated in an out-of-hours rota system, 48 per cent provided services to residential and/or nursing homes, 36 per cent offered an emergency service for the dispensing of urgent prescriptions and 35 per cent reported undertaking home visits to their patients.

Emergency supply of POMs at the request of a doctor Pharmacists were asked to estimate, on average, how often they had received requests from doctors to dispense emergency supplies of POMs in the past 12 months. Over half (54 per cent) of respondents reported receiving requests, on average, at least once a month. Twenty-six per cent of pharmacists received such requests on at least a weekly basis. Approximately 10 per cent reported no requests in the previous 12 months (Table 1).

Following a request for an emergency supply, the prescriber is legally required to provide a prescription within 72 hours. Although nearly three-quarters of respondents reported that prescriptions were received within the permitted time limit most of the time, one-fifth of pharmacists claimed that this was uncommon (Table 2).

Over half (57 per cent) of the respondents reported having to remind prescribers to send prescriptions when they failed to arrive.

The regulations indicate those conditions which disallow the supply of POMs as an emergency supply. Among others, these include situations where a prescription could have been furnished by a doctor without undue delay, or if the requested product is a Controlled Drug listed in Schedules 2 or 3 of the Misuse of Drugs Regulations 1985[7] (with the exception of phenobarbitone for epilepsy). Respondents were asked if they had ever refused to dispense an emergency supply following a request from a doctor. Nine per cent (23) of respondents reported that they had refused to make such a supply. Reasons cited included the following: request for the emergency supply of a Schedule 2 or 3 Controlled Drug (15 cases), the need for an emergency supply was not established (four cases), the doctor was not known personally to the pharmacist (one case) and the doctor requesting the supply was not registered in the UK (one case).

Respondents were asked if they had ever contacted a doctor on behalf of a patient to initiate an emergency supply: 39 per cent of pharmacists reported that they had done so, but the majority (61 per cent) had not.

Emergency supply of POMs at the request of a patient The frequency with which pharmacists received requests from patients for the emergency supply of POMs is reported in Table 3. Over one-third of respondents reported receiving at least weekly requests and for a further third the frequency was at least monthly.

Categories of drugs requested by patients — Respondents were asked to indicate the categories

Table 1: Frequency of requests from doctors for the emergency supply of POMs (n=240)

Frequency	% of respondents	Cumulative %
Once a day or more	6	6
About twice a week	12	18
About once a week	8	26
About once or twice a month	28	54
Less than once a month	21	75
About twice a year	13	88
About once a year	2	90
No requests in last 12 months	10	100

Table 2: Frequency with which prescription is received within 72 hours (n=227)

Frequency	% of respondents	Cumulative %
Always	29	29
Most of the time	42	71
More than half of the time	9	80
Less than half of the time	12	92
Almost never	7	99
Never	1	100

Table 3: Frequency of requests from patients for the emergency supply of POMs (n=239)

Frequency	% of respondents	Cumulative %
Once a day or more	5	5
About twice a week	15	20
About once a week	16	36
About once or twice a month	31	67
Less than once a month	21	88
About twice a year	8	96
About once a year	1	97
No requests in last 12 months	3	100

Table 4: Percentage of respondents reporting that they had supplied a drug in each category as an emergency supply at the request of a patient in the previous 12 months (n=232)

Drug category	% of respondents reporting "yes"
Ulcer-healing drug	27
Diuretic	47
Anti-anginal drug	43
Antihypertensive	68
Anti-arrhythmic	19
Lipid-lowering drug	15
Anticoagulant	19
Asthma inhaler	83
Oral corticosteroid	17
Oral bronchodilator	18
Analgesic	35
Antiepileptic	38
Antidepressant	16
Hypnotic/anxiolytic	8
Oral contraceptives (except post-coital)	42
Post-coital contraceptive*	3
Antidiabetic	42
Other endocrine drug	12
Oral antibiotic	10
Ophthalmic preparation	13
Ear preparation	3
Nasal preparation	5
Anti-infective skin preparation	4
Other	5

*The study was undertaken prior to reclassification of post-coital contraception as a pharmacy medicine

of drugs (according to the classification used in the British National Formulary[8]) which they had supplied, as an emergency supply at the request of a patient, in the previous 12 month period (Table 4). The therapeutic categories of drug for which supplies were made most frequently were: respiratory, cardiovascular and central nervous system. Elderly patients, followed by other adults, were reported as the client groups from whom requests were received most frequently, requests for children being rare.

Patient identification — The Code of Ethics of the Royal Pharmaceutical Society of Great Britain in place at the time of the study stated, in relation to emergency supply, that the pharmacist should establish the identity of an unknown patient using appropriate documents.[6] Respondents were asked to indicate all methods which they had used in the identification of patients. Eight-two per cent of respondents reported requesting the old medicine bottle, and 58 per cent had asked for a medication card. Fifty-one per cent reported that they had accepted a document with the patient's name and address. In cases when identification was not sought, 87 per cent of respondents reported cases in which the person making the request was personally known, 79 per cent reported having used their PMRs, 37 per cent had used their professional judgment to analyse the situation, 9 per cent had taken the word of their staff, and 8 per cent had taken the word of the patient and trusted what they were told.

Contacting the prescriber — The Code of Ethics[6] notes that "there may be occasions when it is desirable to contact the prescriber." Respondents were asked how often they attempted to contact the prescriber. For the majority of respondents (60 per cent), this was described as "infrequent", "occasional" or "never".

Reasons for refusal of emergency supply requested by a patient — Respondents were presented with a list of possible reasons for refusal of an emergency supply. They were asked to indicate all which had been the basis of a refusal to make the supply (Table 5).

A majority of pharmacists reported having encountered patients requesting emergency supplies when the situation was not considered an actual emergency or when the pharmacist believed a prescription could be obtained. Also, many pharmacists had experienced a situation when they saw the need to refer the patient to a doctor for diagnosis and treatment.

"Loans" of POMs to patients — Pharmacists were also asked to comment on the extent to which they "loaned" prescription medication to patients on the promise of a prescription. This is a procedure for which there is no provision in legislation but anecdotally it is believed to be a fairly widespread practice. Loans enable the continuity of therapy for patients on long-term medication who come to the end of their current supply prior to receiving a repeat prescription. Data showed that many pharmacists do lend medication to patients. For 11 per cent of respondents this was done on a daily basis. Nearly half (47 per cent) of the respondents reported that, on average, they made loans at least once a week and nearly three-quarters (73 per cent) estimated the frequency as at least once a month. Only 2.5 per cent of respondents reported that they never made loans of POMs to patients.

Table 5: Reasons for refusal to provide an emergency supply of a POM on the request of a patient (n=243)

Reason for refusal	% of respondents reporting refusal to make a supply for this reason
Emergency/immediate need not established	73
Prescription could be obtained without undue delay	66
Patient referred to GP	56
Preparation not considered an "emergency product"	46
Medicine not prescribed on a previous occasion	44
Patient not registered with a UK doctor	43
Patient not available for interview	40
Medicine last prescribed more than 6 months previously	40
Patient requesting a Controlled Drug	37
Patient overusing emergency supply service	37
Patient referred to an accident and emergency department	35
Therapy considered inappropriate	25
Patient refused to pay	23
Unable to ascertain dose	20
Therapy stopped by doctor	16
Therapy inappropriate due to patient taking other medication	14
Other	4

Characteristics of the pharmacies and frequency of requests Associations between characteristics of the pharmacy (including location, size, proportion of regular clients and number of local medical practices for which the pharmacy provided a regular service) and the frequency of requests for emergency supplies and loans were investigated. There was no correlation between the size of the pharmacy (as indicated by the number of staff members) and the frequency of requests. Pharmacies described as being among a small group of local shops reported a higher frequency of requests from doctors (Mann-Whitney U, P=0.045) than those in town centres, main shopping areas or supermarkets. There was no significant difference in the frequency of requests from patients for either emergency supplies or loans.

In terms of the number of local medical practices served by the pharmacy, a higher frequency of requests from patients for both emergency supplies and loans was reported by pharmacies serving fewer local practices (Spearman's rank correlation, P=0.004 and P=0.015 respectively). There was no statistically significant association with the frequency of requests from doctors. The frequency of requests for loans was also greater for pharmacies with a higher proportion of regular clients (Spearman's rank correlation, P=0.021).

Comparison of responders and non-responders There was no statistically significant difference between the responders and non-responders in the proportion of male and female pharmacists, the type of location in which the pharmacy was situated or the frequency with which requests for emergency supplies were received from doctors or patients. However, responders were more likely to report frequently making loans of POMs to patients (Mann-Whitney U, P=0.015), 47 per cent of responders and 27 per cent of non-responders reporting that this occurred, on average, at least once a week.

Pharmacists' views of emergency supply procedures The final section of the questionnaire comprised a series of structured items to which respondents were asked to express their views on a 5-point Likert scale (strongly agree to strongly disagree). The items included issues relating to procedures for emergency supplies at the request of both patients and doctors (Table 6). The responses provide an overview of pharmacists' perceptions regarding the operation of current procedures, including potential benefits and problems, and their limitations. The first 25 items relate to supplies made at the request of a patient, the remaining ones concern requests made by doctors.

Regarding emergency supplies at the request of patients, most pharmacists reported that they were happy providing the service, although half believed pharmacists generally were reluctant to make emergency supplies to patients. Most respondents agreed that the facility was an important "safety net" for patients. Respondents expressed mixed views regarding whether or not patients should be able to "borrow" medicines on the promise of a prescription (for which there is currently no provision in the law). Only a minority of pharmacists were of the view that the service should be extended to patients not registered with UK doctors and broad agreement for availability of emergency supplies on the NHS was not expressed.

Three-quarters of respondents believed that in some cases patients making requests could quite easily see a doctor and a similar proportion believed that the service was abused by some patients. Over half of respondents agreed that most requests did not constitute genuine emergencies.

Over 90 per cent of respondents believed that the emergency supply procedures provided an opportunity for pharmacists to exercise professional judgment. The majority of respondents believed that pharmacists should have more discretion in supplying POMs to regular patients, and that they should be able to exercise discretion regarding supplies to a family member or representative of a patient. There was support from many pharmacists for a distinction between patients known to the pharmacist and those not.

Most pharmacists also reported that they were happy to provide an emergency supply service at the request of doctors, over 80 per cent seeing it as an illustration of inter-professional co-operation. However, many respondents believed that doctors were not fully aware of the legal requirements concerning provision or the associated administration on the part of the pharmacist.

Discussion

This is the first published study of community pharmacists' practices and views relating to emergency supplies of POMs. The response rate, at 51 per cent after one reminder, was lower than ideal. However, follow-up of non-responders showed that in most respects their answers were similar to responders.

The three health authority areas in which this study was conducted included diverse locations, town/city, urban, suburban and rural areas, and socio-economic characteristics. The follow-up of non-responders did not reveal significant differences in the extent to which pharmacists received requests from doctors or patients for emergency supplies, and thus the estimates of the frequencies of requests would be expected to be representative of pharmacists more widely.

On average, pharmacists reported receiving requests for emergency supplies from both doctors and patients between once a week and once or twice a month. A higher frequency of requests from patients was reported. Over half of the pharmacists reported receiving requests for

Table 6: Pharmacists' views of emergency supply procedures

	% of respondents				
	SA	A	N	D	SD
Emergency supply at the request of a patient					
1. Some patients who request an emergency supply could quite easily see their doctor	28	50	15	6	1
2. Patients who need supplies should be able to borrow some on the promise of a prescription	9	41	23	19	8
3. The existence of the emergency supply facility is sufficiently well known to patients	4	27	26	39	4
4. A patient should be able to request an emergency supply on the NHS	3	31	21	34	11
5. Charging patients for an emergency supply acts as a deterrent to them asking for one	10	43	24	22	1
6. I am happy providing an emergency supply service	14	61	18	6	1
7. The emergency supply facility should be extended to patients other than those with UK-registered doctors	3	16	14	37	30
8. Some patients abuse the emergency supply facility	28	52	13	6	1
9. The emergency supply procedure is an opportunity for the pharmacist to use his/her professional judgment	24.5	66	8	1	0.5
10. Pharmacists have a professional obligation to provide an emergency supply facility	18	57	17	7	1
11. The guidelines for the emergency supply procedure are unnecessarily bureaucratic	7	21	34	34	4
12. Pharmacists should have more discretion in supplying prescription-only medicines to regular patients	14	49	21	14	2
13. Pharmacists should be able to use their discretion in making an emergency supply to a patient's relative or representative	13	55	15	16	1
14. There should be a distinction between the emergency supply procedure to patients known to the pharmacist and those not known	20	46.5	19	14	0.5
15. Pharmacists should be able to provide more than 5 days' supply of medicine (eg, "patient packs")	13	39	11	32	5
16. Pharmacists are generally reluctant to make emergency supplies of prescription-only medicines to patients	9	43	29	18	1
17. The guidelines for the emergency supply procedure need to be more clearly defined	11	39	30	18	1
18. Most requests for emergency supply are merely for convenience and do not constitute genuine emergencies	12	40	22	24	2
19. It should not always be legally necessary to interview the actual patient before making an emergency supply	8	34	18	34	6
20. Records in the POM register should be unnecessary if records are kept on a PMR system	19	44	10	24	3
21. Promoting the emergency supply facility amongst patients will lead to an increase in abuse of the service	22	54	14	9	1
22. A higher patient charge should be levied for an emergency supply in order to deter abuse of the facility	13	30	29	26	2
23. The emergency supply procedure is an underused facility	5	30	41	23	1
24. Pharmacists should have more discretion in making emergency supplies to patients who need regular medication	11.5	57	21	10	0.5
25. The emergency supply facility is an important "safety net" for patients	17	68	12	3	0
Emergency supply at the request of a doctor					
26. Pharmacists should be paid an additional NHS fee for providing an emergency supply to an NHS patient	37	46	11	5	1
27. I am happy providing an emergency supply service to doctors	24	69	4	2.5	0.5
28. Doctors are fully aware of the legal requirements concerning the emergency supply procedure	1	21	28	41	9
29. The emergency supply procedure should be extended to practitioners other than doctors	5	27	25	34	9
30. Some doctors use the emergency supply procedure as a way of avoiding appointments/ call-outs	9	41	25	22	3
31. Most doctors do not appreciate the amount of work involved for the pharmacist when undertaking an emergency supply	18	58	19	5	0
32. Records in the POM register should be unnecessary if records are kept on a PMR system	17	57	19	5	2
33. The emergency supply procedure is a good illustration of inter-professional co-operation	13	68	15	3.5	0.5
34. The emergency supply procedure is an underused facility	4	22	42	30	2

SA = strongly agree; A = agree; N = neither agree nor disagree; D = disagree; SD = strongly disagree

emergency supplies from doctors at least once a month, and two-thirds received at least monthly requests from patients.

The frequency of requests from prescribers does not suggest that the facility is overused, and it is not perceived as such by pharmacists; most are happy to provide the service, seeing it as a good example of interprofessional co-operation. However, many pharmacists believed that doctors did not fully appreciate either the legal requirements or the extra work involved. This view is supported by the findings that prescriptions frequently did not arrive on time, necessitating reminders by pharmacists, and that refusals to supply were most commonly on the ground that a Controlled Drug was being requested.

The drug groups most commonly requested by patients were respiratory (especially inhalers for asthma, for which 83 per cent of pharmacists reported receiving requests) and cardiovascular products (often required on a continuous long-term basis, and more commonly by older people). However, requests had been received for products in all therapeutic categories, reflecting a diverse use of the emergency supply facility. The vast majority of pharmacists perceived the service to be an important facility for patients, although most of them had experienced situa-

tions in which they believed the immediate need for emergency supply was not apparent and/or that a prescription could realistically be obtained without undue delay. Thus, there may be reason to believe that emergency supply procedures are open to misuse, a view shared by over three-quarters of respondents. The findings also suggest that pharmacists and patients have different operating definitions of what constitutes an emergency.

The findings of this study confirm that making loans of POMs to patients is common practice; only 2.5 per cent of respondents reported not making loans and for nearly half this was at least a weekly event. This falls outside the regulations regarding the supply of POMs and, as such, is not lawful. Lending a regular patient a small supply which is typically reclaimed when their prescription is dispensed is a practice used as an alternative to making a formal emergency supply for which the patient would be charged. The willingness of pharmacists to make such loans is also believed to be valued by patients who experience difficulty in monitoring of supplies in the home and/or liaising with surgeries. A greater role for pharmacists in the management of patients taking medicines long-term has been proposed.[9] As well as making better use of pharmacists' expertise, this may also overcome problems patients experience which lead to the need for "loans" against future prescriptions.

The emergency supply procedure is perceived by most pharmacists as an opportunity to exercise their professional judgment. It is clear from this study, in particular in reports of reasons for refusals to supply, that pharmacists responding to requests for emergency supply endeavour to satisfy themselves that the need for the product constitutes an emergency. They are also mindful of the potential for abuse of the emergency supply provisions. The guidelines of the Royal Pharmaceutical Society[6,10] request pharmacists to consider the consequences for the patient if they refuse to supply in an emergency. Pharmacists clearly assume an active role in assessing the legal and therapeutic appropriateness of requests. The majority of pharmacists also believed that they should have more discretion in supplying POMs to regular patients and their representatives, although they expressed mixed views regarding the provision of emergency supplies on the NHS or extending it to persons not registered with UK medical practitioners.

Until recently, the provisions for the emergency supply under the Medicines Act have been the only situations in which pharmacists in Britain can make a lawful supply of POMs without a prescription. However, reforms in the National Health Service have included amendments to the Medicines Act which allow, under certain conditions, the supply and/or administration of POMs to patients under a patient-specific direction or under patient group direction by NHS bodies or designated individuals, which may include pharmacists. This introduces a greater flexibility in the arrangements that can be made for the supply and administration of POMs in the UK. The Royal Pharmaceutical Society guidelines regarding emergency supplies of POMs have also undergone substantial revision and provide less detailed guidance.[10] This illustrates a change in philosophy of the new Code of Ethics which is less prescriptive and attempts to encourage pharmacists to exercise their own judgment recognising their autonomy and accountability in their decisions.

Conclusion

In the future pharmacists can expect greater involvement in, and responsibility for, managing medication for their clients, especially those taking medicines long-term.[9] The British government is also encouraging people to take more responsibility for their own health and to expect services sensitive to their needs and wishes. This study has demonstrated that the present provisions for emergency supply of POMs are a common resort of both medical practitioners and patients, and also that in these circumstances pharmacists have, and take, the opportunity to exercise their professional judgment. However, professional developments as envisaged by both the British government and the pharmacy profession will require greater flexibility regarding the regulations relating to the supply of POMs.

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