Professor John Lawrenson reviews the current law regarding sale and supply of drugs by optometrists in the UK

In June 2008, optometrists were given the opportunity to obtain the necessary accreditation to prescribe any licensed medicine for ocular conditions affecting the eye and surrounding tissues. Since 2000, there have been several other important legislative changes relating to the use and supply of medicines that have impacted on all registered optometrists. The purpose of this article is to review these changes and highlight their significance for clinical practice. The article will also summarise recent legislation regulating medical devices, which is relevant to the licensing of contact lens care products and artificial tear preparations.

Medicines legislation
Changes to the GOC rules relating to injury or disease of the eye in 2000, formally allowed optometrists to use their professional judgement to decide not to refer a patient with an ocular abnormality to a medical practitioner and to render appropriate therapeutic treatment. However, at this time, restrictions to the availability of pharmaceutical agents severely limited the ability of the optometrist to manage common non sight-threatening conditions. Two main legislative changes occurred in 2005 that went some way to removing these barriers (Titcomb and Lawrenson 2006):
- Update to the list of POMs available to all registered optometrists
- Removal of the 'emergency' requirement for the sale and supply of Pharmacy (P) and General Sales List (GSL) medicines.

Prior to 2005, the list of POMs available to optometrists had only been updated sporadically and was in urgent need of a major review. Moreover, several included drugs were no longer commercially available in the UK. In the case of antimicrobial preparations, chloramphenicol was the only POM available to optometrists for treating superficial infections of the eye or as prophylaxis following ocular surface injury. Although framycetin sulphate was listed, it was of little clinical value as its use was restricted to administration only. The 2005 changes consolidated the list of POMs available to optometrists and at the same time added the antibacterial agent fusidic acid to the POMs available for sale and supply (Table 1).

The POMs that are available to optometrists for supply can be sold or supplied directly to patients in emergency situations only. Routinely, these drugs should be supplied via an order written by the optometrist, which can be presented by the patient to a registered pharmacist (signed order). An order for POMs should include:
- The optometrist’s name and address
- The date
- The name and address of the patient (if applicable)
- The name of the drug
- Quantity, pharmaceutical form and strength of the POM (eg 0.5 per cent eye drops 10ml)
- Labelling directions (where applicable)
- The original signature of the optometrist

The signed order must be written in indelible ink; this includes typewritten and computer-generated orders. The College of Optometrists’ guidance recommends that the optometrist’s GOC number should also be included (College of Optometrists 2012).

The 2005 legislation also removed atropine sulphate and the miotic pilocarpine from the list of exemptions available to all optometrists. These drugs were transferred to the ‘additional supply’ list, which meant that further training and accreditation was required to use and supply these drugs.
Another important legislative change in 2005 was a relaxation of the law governing the supply of P and GSL medicines by optometrists. It was recognised that the restriction on supply of these agents to ‘in an emergency’ was unnecessarily restrictive. The removal of the emergency restriction allows the direct supply to patients of any P medicine that is used in the course of their professional practice, which is available in their practice. Although the drugs can be sold or supplied from the College website, although when it comes to ophthalmic devices and a medicine is fairly clear cut, usually the distinction between a medical device and a medicine is not clear cut, even though it doesn’t act in this way, it now considered to be medical device eg artificial tears. However, since each application is assessed on a case by case basis there are some apparent anomalies. Although the action of a medicinal product is typically achieved by pharmacological means, a substance administered for diagnostic purposes, even though it doesn’t act in this way, is also considered to be a medicinal product rather than a medical device. This explains why diagnostic stains eg fluorescein paper strips and rose bengal are classed as P medicines and are therefore regulated by the Medicines Act. This was clarified in a recent bulletin from the Medicines and Healthcare Products Regulatory Agency (MHRA 2011). The discontinuation of rose bengal in minims has promoted the increased use of lissamine green as an alternative. Although lissamine green can be imported into the UK or purchased online it does not have a UK licence. However, should an application be made, its similarity to the other staining agents would suggest that it will also classified as a P medicine.

A further reading list is available from william.harvey@rbi.co.uk

John Lawrenson is professor of clinical visual science, Division of Optometry and Visual Science, City University London