

Attitudes Towards Pharmacist Prescribing in Italy: A Cross-Sectional Survey of Pharmacists, Family Physicians, and Pharmacy Users

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Abstract

Globally and across various European nations, pharmacists possess the authority to initiate or adjust patient treatments. Conversely, within Italy, prescriptive authority remains strictly limited to medical practitioners and veterinarians. Expanding the scope of practice for Italian pharmacists to include prescribing could prove vital, particularly given the current workforce deficits that are straining the national healthcare infrastructure. This paper presents the results of a survey exploring the concept of the pharmacist prescriber, administered to pharmacists, general practitioners, and pharmacy patrons across North-Western Italy. Data collection involved structured interviews guided by questionnaires tailored to each participant group. A total of 234 pharmacists, 926 patrons, and 9 family physicians were interviewed. Most pharmacists and consumers supported implementing a pharmacist prescribing model. To offset this heightened professional accountability, pharmacists emphasized the necessity of formal legal recognition and specialized education. Pharmacists frequently cited rapid management of minor ailments or pathologies and the mitigation of unsafe patient self-treatment as primary justifications for this service. More than three-quarters of both pharmacists and general practitioners favored a prescribing framework structured around a clinical management plan. While family physicians generally expressed hesitancy toward pharmacist prescribers, they demonstrated genuine receptivity, particularly regarding prescription renewals. This investigation demonstrates a generally positive disposition among both pharmacists and pharmacy clients toward the establishment of prescribing pharmacists in Italy. Although considerable barriers persist, insights gained from established frameworks in other European and global jurisdictions suggest a viable pathway toward integrating prescriptive authority into Italian pharmacy practice.

Keywords: Pharmacist prescriber, Community pharmacy, Italy, Healthcare professionals

Introduction

Globally and within various European jurisdictions, prescriptive authority for medications has already been extended to pharmacists [1-9] Service-Public.fr, n.d. The operational structure of this practice varies

internationally but generally falls into two primary models: independent prescribing and supplemental prescribing. Under the independent model, the pharmacist bears autonomous accountability—carrying the same legal liabilities as a physician—for diagnosing the patient, initiating pharmacological treatment, and managing therapeutic outcomes without requiring external clinical oversight. Conversely, supplemental prescribing is conducted under a clinical management plan, enabling the pharmacist to oversee and adjust treatments initially ordered by an independent prescriber, such as a physician. Specifically, supplemental prescribing relies on a collaborative alliance between the primary medical practitioner and the pharmacist to

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execute a tailored care plan for managing chronic or non-acute disorders. This shared care plan delineates the specific medications involved and must be co-developed and approved by the doctor, the pharmacist, and the patient. This collaborative mechanism naturally mitigates the singular liability borne by the pharmacist [10]. A third hybrid approach involves protocol-based or collaborative prescribing, wherein pharmacists issue prescriptions autonomously because a physician formally devolves prescribing rights for designated medications intended for specified patient populations or classes of patients [11].

Regulatory frameworks often incorporate supplementary legal protections for pharmacists delivering these prescriptive services [12-14]; UK National Pharmacy Association, n.d.), though financial compensation for these duties is frequently absent in the majority of instances [15].

An expanding body of literature confirms that non-medical prescribing is both secure and clinically effective. Current evidence indicates that prescribing pharmacists, despite operating under diverse national regulatory frameworks and differing degrees of autonomy, deliver care that is equivalent in efficacy to that of traditional medical prescribers [16-19]. Furthermore, research has shown that integrating pharmacists into prescribing roles can optimize patient care by reducing morbidity and mortality, decreasing adverse drug events, and curbing overall healthcare expenditures [11]. Previous literature has also explored the perspectives of key healthcare stakeholders (including patients, pharmacists, physicians, and policymakers) regarding the implementation of this role [10, 16, 20, 21]. Key arguments favoring this expansion center on the professional competencies of pharmacists (such as their advanced training, communication skills, and expertise) alongside structural advantages (including a widespread community pharmacy network across the entire territory, extended operational hours, private consultation areas that ensure privacy, and potential integration with electronic medical records). Conversely, prominent hurdles include perceived deficits in pharmacists' clinical skills (necessitating rigorous educational programs in this field), the demand for expanded resources such as compensation models and staffing support, the necessity of shared electronic health record access, systemic resistance from the medical community, and logistical complexities (such as

establishing clear liabilities, managing potential conflicts of interest, and standardizing protocols) [16, 19].

Within the Italian context, the legal authority to issue medical prescriptions remains strictly confined to medical doctors and veterinary surgeons. Since 2009, however, Italian community pharmacies have been legally permitted to offer expanded clinical services utilizing specialized modalities. These include point-of-care testing (POCT) and telemedicine, as well as joint initiatives conducted alongside other allied healthcare practitioners, including registered nurses and physiotherapists [22].

As a direct consequence of the pandemic, the scope of pharmacy-based healthcare services expanded substantially. Pharmacists were authorized to perform rapid diagnostic screening for SARS-CoV-2 and Group A *Streptococcus* independently and to administer immunizations against SARS-CoV-2, seasonal influenza, and Herpes Zoster [22, 23].

From a legislative perspective, formalizing independent prescriptive authority for Italian pharmacists appears to be a distant objective. Nevertheless, establishing such a role is critically important when evaluating the previously detailed benefits alongside the profound challenges confronting the national healthcare architecture, particularly systemic workforce shortages among healthcare staff [24].

Given these considerations, this investigation seeks to explore the viewpoints of diverse stakeholders regarding the potential introduction of the pharmacist prescriber role in Italy.

Materials and Methods

Data collection was conducted through structured interviews with pharmacists, pharmacy patrons, and family practitioners across two distinct territories in the Piedmont region: the metropolitan area of Turin and the province of Cuneo. This fieldwork occurred between June and December 2021.

Participating pharmacies were purposely selected to encompass a highly diverse cross-section regarding geographic settings, daily customer volume, and commercial revenue. Regarding the study respondents, every consumer who entered a selected pharmacy and provided verbal consent was interviewed. Family practitioners were recruited via a telephone outreach strategy targeting physicians currently practicing within

the same geographic boundaries as the selected pharmacies.

Three separate questionnaires were developed for each participant cohort, consisting primarily of multiple-choice items in single- or multiple-answer formats (**Figure 1**). The pharmacist instrument was split into two thematic parts. The initial section gathered demographic and operational details about the pharmacy and the individual practitioner. The subsequent section assessed the respondent's endorsement of the pharmacist

prescriber model. Additionally, this portion evaluated the essential prerequisites for obtaining prescribing rights and the recognized benefits to the public. Respondents were further questioned regarding preferred prescribing models, clinical conditions, and the specific categories of medications they would feel confident managing. Finally, the survey examined pharmacists' willingness to partner with medical practitioners to establish collaborative clinical management team.

Pharmacy user version	
Pharmacy post code	-----
Sex	☐ Male ☐ Female
Age	--
Occupation	☐ Student ☐ In work ☐ unemployed ☐ Retired
Level of education	☐ Primary school ☐ Middle school ☐ Secondary school diploma ☐ Third level degree
How far is your doctor's surgery from your home?	☐ Less than 500 m ☐ 500 m - 1 km ☐ 1 km - 5 km ☐ More than 5 km
How do you usually travel to your family doctor's surgery?	☐ Alone by bicycle/on foot ☐ Accompanied on foot ☐ Alone by public transport ☐ Accompanied by public transport ☐ Alone by car ☐ Accompanied by car
How far is your home from the nearest pharmacy?	☐ Less than 500 m ☐ 500 m - 1 km ☐ 1 km - 5 km ☐ More than 5 km
How so you usually travel to your pharmacy?	☐ Alone by bicycle/on foot ☐ Accompanied on foot ☐ Alone by public transport ☐ Accompanied by public transport ☐ Alone by car ☐ Accompanied by car
Usually, to collect the prescription:	☐ I collect the paper copy from my doctor's surgery ☐ I receive it in electronic form on my computer or mobile phone ☐ Other
Have you ever asked your pharmacist for prescription medicines without getting a prescription from your family doctor?	☐ Yes ☐ No
Would you feel confident asking a pharmacist to prescribe medicine for you?	☐ Yes ☐ No

If you replied yes to the previous question, in which cases would you feel confident asking a pharmacist for a prescription? (More than one option is possible)	☐ Only to continue a therapy which my doctor prescribed before ☐ Only to prescribe medicine for minor pathologies or ailments (cystitis, toothache, ...) ☐ Only to modify the doctor's prescription ☐ In all cases
Would it be a benefit, in terms of convenience, if your pharmacist could prescribe medicine?	☐ Yes ☐ No

Pharmacist version	
Pharmacy post code	-----
Sex	☐ Male ☐ Female
Age	--
Pharmacist interviewed:	☐ Owner ☐ Manager ☐ Staff pharmacist
How often do you receive requests for prescription medicines from users without a prescription?	☐ More than once a day ☐ Once a day ☐ A few times a week ☐ Rarely
If pharmacists could prescribe medicines, would you agree?	☐ Yes ☐ No
If the pharmacist prescriber becomes a reality, what is the most important thing you would like in return for the added responsibility? (Please choose just one option)	☐ Nothing ☐ A fee ☐ Further training ☐ Legal safeguards ☐ Other: _____
Based on your experience, why should the pharmacist be allowed to prescribe medicine? (More than one option is possible)	☐ To help chronic patients ☐ To respond immediately to pathologies or minor ailments ☐ To prevent patients self-medicating inappropriately ☐ Pharmacists should not be allowed to prescribe medicines ☐ Other: _____
Based on your experience, how do you think the pharmacy prescriber could benefit the public? (More than one option is possible)	☐ Great access to treatment ☐ Better knowledge of medicine ☐ Lightening the workload on family doctors ☐ I disagree that the pharmacy prescriber could benefit the public ☐ Other: _____
Which prescription method do	☐ Independent prescribing

you feel would be most suitable and safest for the pharmacist?	- Prescribing after consulting the patient's doctor - Prescription in compliance with a strict procedure, based on protocols developed with the family doctor and/or other specialists
In which case(s) would you feel confident prescribing medicines? (More than one option is possible)	- In all cases - In all cases except for certain classes of medicines (e.g., narcotics, anti-cancer drugs, biotechnological treatments etc.) - Only to continue therapies/treatments underway previously prescribed by a doctor - Only to prescribe medicines for minor pathologies or ailments - Only to modify a doctor's prescription - Only for reimbursable medicines prescribed in hospital discharge forms - Only to prescribe medicines currently included in the list of repeat prescription medicines - None of the above: prescribing is a doctor's job
Which type of prescription do you think a pharmacist should be allowed to issue?	- Only private prescriptions - Both private and national health prescriptions - Neither: a pharmacist should not prescribe medicine
Do you think it would be useful for the pharmacy prescriber to have access to the patient's health records when prescribing?	- Yes, to the section concerning the patient's history of medicines prescribed and dispensed. - Yes, to the section concerning the clinical history of the patient. - Yes, to the sections above. - No
If pharmacists were allowed to prescribe medicines, would you be willing to collaborate with the family doctor to create a collaborative clinical management team?	- Yes - No - Other: _____
Family doctor version	
1. Surgery post code	-----
2. Sex	- Male - Female
3. Age	--
4. How many patients come to your surgery, or contact you for a consultation/prescription each week?	--
5. What percentage of your patients request only the renewal of a prescription?	10-30% 30-50% 50-70% 70-90% > 90%

6. After the COVID health emergency, what percentage of prescriptions are delivered in electronic format to a computer or phone?	10-30% 30-50% 50-70% 70-90% > 90%	Yes	No
7. In which case do you think a pharmacist should be allowed to prescribe medicines?	- In all cases and for all classes of medicines - In all cases except for certain classes of medicines (e.g., narcotics, biotechnological drugs etc.) - Only to continue therapies/treatments already underway and previously prescribed by a doctor - Only to prescribe medicines for minor pathologies or ailments - Only to modify the doctor's prescription - Only for reimbursable medicines prescribed in hospital discharge forms - Only for medicines currently subject to repeat prescriptions		
8. If you answered yes to any of the previous categories: Why should the pharmacist be allowed to prescribe medicine? (More than one option is possible)	- To facilitate chronic patients - To respond immediately to minor pathologies or ailments - To prevent patients self-medicating inappropriately - Other: _____		
9. Which prescription procedure do you feel is most appropriate and safest?	- Independent prescription with the task of diagnosis and therapy start-up - Prescription in consultation with the family doctor - Prescription in compliance with a strict procedure, based on protocols developed in collaboration with the patient's doctor and/or other specialists		
10. How do you think that the medical profession could benefit from the introduction of the role of pharmacy prescriber? (More than one option is possible)	- Reduce the doctor's workload, especially repetitive tasks - Reduce the number of non-essential examinations - Improve the quality of health care for the users		
11. How do you think the pharmacy prescriber could be beneficial for the public? (More than one option is possible)	- Increase accessibility - Better knowledge of medicine - Reduce the family doctor's workload - The pharmacy prescriber would be of no benefit to the public - Other: _____		
12. If the pharmacy prescriber becomes a reality, would you be willing to collaborate in the creation of a support team?	- Yes - No - Other: _____		
13. If there were to be a training course for pharmacy prescribers, which topics do you think are most important to deal with to obtain the qualification?	- Further training in the main chronic pathologies and the relevant management of the therapy - Further training in the main minor pathologies (e.g., urinary tract infections without temperature, rhino pharyngitis, traveller's diarrhoea, morning sickness, altitude sickness, acne, rashes and eczema, oral herpes, conjunctivitis and nasal allergies, menstrual cramps, ...) - Further training to acquire the skills to interpret data from laboratory tests and/or self-analysis - Other: _____		

Figure 1. Questionnaire prescribing pharmacist.

The consumer questionnaire gauged patrons' comfort levels regarding receiving prescriptions directly from a pharmacist, the specific medical contexts in which they would support this practice, and the perceived benefits regarding logistical convenience. For family practitioners, the survey asked them to identify specific clinical scenarios in which they would support pharmacist prescribing rights, the underlying rationale for their viewpoints, the safest operational frameworks, and the anticipated advantages for both physicians and patients. Furthermore, it assessed their willingness to cooperate with pharmacists within a combined clinical management structure.

A team of specifically trained investigators carried out data collection. All study respondents participated voluntarily and were verbally briefed on the scope and baseline objectives of the research. The survey instruments were completely anonymous. Because no personally identifiable information was gathered,

individual responses cannot be traced back to any specific participant. Respondents provided explicit verbal consent before participation; written consent was omitted to ensure absolute anonymity. The study involved no clinical or medical interventions on the participating patients. Consequently, in accordance with Italian legislation governing personal data protection, formal ethical approval was not legally required.

Descriptive statistical analyses were executed. Proportional distributions were compared utilizing Pearson's chi-squared test and Prevalence Ratios (PR). The PR values were derived via a modified Poisson regression model utilizing robust standard errors. The threshold for statistical significance was established at 0.05, with 95% confidence intervals (CI). Normality of the data distribution was verified using the Shapiro-Wilk test. All computational analyses were completed using Stata14 ® (Corp. 2015. Stata Statistical Software: Release 14. College Station, TX: StataCorp LP).

Results and Discussion

practitioners. The comprehensive data tabulations for this survey are presented in **Table 1**.

In aggregate, interviews were successfully executed with 234 pharmacists, 926 pharmacy patrons, and 9 family

Table 1. Complete results of the survey.

Results of questionnaire for pharmacists			
Survey focus	Specific response	Total sample	Count (%)
Gender	Male	234	76 (32.48%)
	Female		158 (67.52%)
Age Bracket	Under 30 years	234	45 (19.23%)
	31–65 years		182 (77.78%)
	Over 65 years		7 (2.99%)
Current Role	Pharmacy owner	201	77 (38.31%)
	Pharmacy manager		21 (10.45%)
	Employed pharmacist		103 (51.24%)
Frequency of unprescribed medication requests	Multiple times daily	234	215 (91.88%)
	Daily		9 (3.85%)
	Several times weekly		10 (4.27%)
	Seldom		0 (0%)
Supports pharmacist prescribing	Yes	234	195 (83.33%)
	No		39 (16.67%)
Prerequisites for taking on prescribing duties	None	234	2 (0.85%)
	Financial compensation		30 (12.82%)
	Additional education		91 (38.89%)
	Liability protection		106 (45.3%)
	Alternative requirement		2 (0.85%)
	All of the above		3 (1.28%)
Perceived professional advantages of prescribing (multiple choice)	Assisting chronic disease patients	234	112 (47.86%)
	Prompt treatment for minor illnesses		174 (74.36%)
	Preventing incorrect self-medication		160 (68.38%)
	Belief that pharmacists should never prescribe		13 (5.56%)
	Alternative advantage		3 (1.28%)
Perceived public advantages of prescribing (multiple choice)	Improved accessibility	234	187 (79.91%)
	Enhanced medication awareness		91 (38.89%)
	Lowering physician workload		69 (29.49%)
	No perceived advantages		9 (3.85%)
	Alternative advantage		4 (1.71%)
Preferred prescribing model	Autonomous	234	22 (9.4%)
	In consultation with physician		30 (12.82%)
	Guideline and protocol-driven		182 (77.78%)
Willingness to work with GPs in a care team	Yes	201	194 (96.52%)
	No		7 (3.48%)
Situations comfortable for prescribing (multiple choice)	Any situation	234	9 (3.85%)
	Any situation excluding restricted drugs (e.g., narcotics)		70 (29.91%)

	Continuing therapies initiated by a physician		170 (72.65%)
	Treating minor ailments		135 (57.69%)
	Adjusting a physician's order		66 (28.21%)
	Reimbursable post-hospital discharge drugs		118 (50.43%)
	Routine repeat medications		80 (34.19%)
	None (prescribing is strictly for physicians)		8 (3.42%)
Permitted prescription formats	Private only	234	82 (35.04%)
	Private and National Health System		139 (59.4%)
	Should not be allowed to prescribe		13 (5.56%)
Value of patient record access	Medication history only	234	65 (27.78%)
	Medical history only		19 (8.12%)
	Both histories		148 (63.25%)
	Unnecessary		2 (0.85%)
Patient/User questionnaire findings			
Survey focus	Specific response	Total sample	Count (%)
Gender	Male	926	373 (40.28%)
	Female		553 (59.72%)
Age bracket	Under 30 years	926	65 (7.02%)
	31–65 years		494 (53.39%)
	Over 65 years		367 (39.63%)
Employment status	Student	926	25 (2.7%)
	Employed		423 (45.68%)
	Jobless		100 (10.8%)
	Pensioner/Retired		378 (40.82%)
Highest education achieved	Primary education	926	117 (12.63%)
	Middle school		221 (23.87%)
	High school graduate		414 (44.71%)
	University degree or higher		174 (18.79%)
Proximity to GP clinic	Under 500m	926	267 (28.83%)
	500m to 1km		409 (44.17%)
	1km to 5km		201 (21.71%)
	Over 5km		49 (5.29%)
Travel method to GP clinic	Solo walk/bike	926	557 (60.15%)
	Escorted walk		0 (0%)
	Solo public transit		21 (2.27%)
	Escorted public transit		1 (0.11%)
	Solo drive		337 (36.39%)
	Escorted drive		10 (1.08%)
Proximity to pharmacy	Under 500m	926	517 (55.83%)
	500m to 1km		311 (33.59%)
	1km to 5km		86 (9.29%)
	Over 5km		12 (1.29%)
Travel method to pharmacy	Solo walk/bike	926	695 (75.05%)
	Escorted walk		1 (0.11%)
	Solo public transit		3 (0.32%)
	Escorted public transit		0 (0%)
	Solo drive		221 (23.87%)
	Escorted drive		6 (0.65%)
Prescription retrieval method	Physical paper pickup	926	393 (42.44%)
	Digital format		500 (54%)
	Alternative method		33 (3.56%)

Ever asked for medications without a prescription	Yes	926	702 (75.81%)
	No		224 (24.19%)
Trust in pharmacist prescribers	Yes	926	901 (97.3%)
	No		25 (2.7%)
Acceptable prescribing scenarios (multiple choice)	Continuing doctor-approved regimens	903	126 (13.95%)
	Minor ailment treatments		77 (8.53%)
	Adjusting current prescriptions		6 (0.66%)
	Any scenario		757 (83.83%)
Added convenience from pharmacist prescriber	Yes	926	
	No		844 (91.14%)
Family doctor questionnaire findings			
Survey focus	Specific response	Total sample	Count (%)
Gender	Male	9	4 (44.44%)
	Female		5 (55.56%)
Age bracket	Under 30 years	9	1 (11.11%)
	31–65 years		6 (66.67%)
	Over 65 years		2 (22.22%)
Practice volume dedicated to prescription renewals	10%–30%	9	1 (11.11%)
	30%–50%		4 (44.44%)
	50%–70%		4 (44.44%)
	70%–90%		0 (0%)
	Over 90%		0 (0%)
Electronic prescription rate post-pandemic	10%–30%	9	1 (11.11%)
	30%–50%		1 (11.11%)
	50%–70%		2 (22.22%)
	70%–90%		5 (55.56%)
	Over 90%		0 (0%)
Support pharmacist prescribing for:	Any medication category	9	0 (0%)
	Any category excluding restricted drugs		0 (0%)
	Ongoing doctor-prescribed therapies		8 (88.89%)
	Minor illnesses		5 (55.56%)
	Adjusting a GP's order		2 (22.22%)
	Reimbursable post-discharge drugs		8 (88.89%)
	Reimbursable drugs only		7 (77.78%)
Justifications for pharmacist prescribing (multiple choice)	Assisting chronic patients	9	8 (88.89%)
	Immediate care for minor ailments		2 (22.22%)
	Stopping unsafe self-care		5 (55.56%)
	Alternative justification		1 (11.11%)
Ideal prescribing workflow	Autonomous	9	0 (0%)
	Co-managed with patient's GP		1 (11.11%)
	Protocol/guideline-based		8 (88.89%)
Advantages for medical staff (multiple choice)	Lowering repetitive administrative workload	9	6 (66.67%)
	Cutting non-essential appointments		4 (44.44%)
	Elevating healthcare quality		6 (66.67%)

Public advantages of pharmacist prescribers (multiple choice)	Enhanced access	9	9 (100%)
	Better medication knowledge		3 (33.33%)
	Lowering GP workload		4 (44.44%)
	No perceived advantages		0 (0%)
	Alternative advantage		1 (11.11%)
Willingness to team with pharmacists	Yes	9	9 (100%)
	No		0 (0%)
Suggested pharmacist training topics (multiple choice)	Chronic disease and therapy management	9	6 (66.67%)
	Minor illness treatment		7 (77.78%)
	Reading lab results		1 (11.11%)
	Alternative training		0 (0%)

Among the cohort of 234 interviewed pharmacists, more than half (67.52%) identified as female, and the clear majority (77.78%) were between the ages of 31 and 65 years old (mean age: 43.15 years; IQR 68-25), with approximately half operating as staff pharmacists (51.24%). Managing requests for prescription-only pharmaceuticals from patients without a valid prescription is a frequent occurrence: 91.88% of respondents reported it occurring more than once per day, whereas roughly 4% reported it occurring only a few times a week. Most respondents (83.33%) agreed with introducing the pharmacist prescriber role in Italy. No statistically significant variations were identified between baseline pharmacist demographics (such as biological sex, age bracket, or professional rank) and their perspective on adopting the prescribing pharmacist model.

Furthermore, no statistically significant differences emerged when comparing distinct pharmacy settings (rural vs. urban) or geographic territories (Turin metropolitan area vs. the province of Cuneo) regarding respondents' attitudes toward integrating prescribing roles. To balance the heightened professional accountability inherent in prescribing, the primary prerequisites emphasized by the respondents were formal legal protections (45.3%) and specialized advanced training (38.89%). In comparison, a smaller segment argued that this clinical service warrants direct financial compensation (12.82%). Regarding the underlying justifications for granting pharmacists prescribing rights, a substantial majority (74.36%) indicated that providing immediate therapeutic interventions for minor pathologies or acute ailments is the foremost driver. Additionally, many respondents asserted that pharmacist prescribing rights could prevent unsafe or inappropriate

patient self-medication (68.38%) or deliver optimized clinical support for individuals with chronic illnesses (47.86%).

More than three-quarters of the surveyed pharmacists believe that introducing prescribing capabilities would markedly benefit the public sector by leveraging the superior accessibility of community pharmacies. Furthermore, approximately 40% suggested that this model could foster greater public literacy regarding pharmaceutical treatments, while roughly 30% anticipated it would alleviate the operational burdens placed on general practitioners and over three-quarters of the pharmacists indicated that the most appropriate prescribing framework should rely on clinical protocols and procedures co-developed alongside family physicians. Conversely, only about 10% believed that pharmacists should execute prescriptive duties entirely independently.

The vast majority of respondents indicated that, if the prescribing pharmacist role were implemented, they would be prepared to collaborate with primary care physicians within an integrated clinical management team. The surveyed pharmacists noted that they would feel comfortable managing ongoing treatments initiated by a physician (72.65%). A substantial proportion also reported confidence in prescribing medications for minor illnesses or symptoms (57.69%) and in facilitating hospital discharge transitions involving medicines subsidized by the public health system (50.43%).

Over half of the participants believe that pharmacists should hold prescriptive rights across both private and national healthcare systems. Additionally, a clear consensus emerged on the necessity of direct access to patient electronic health records when prescribing.

Within the pharmacy consumer cohort, approximately 60% of the interviewees were female, and slightly more than 50% fell within the 31 to 65 age bracket (mean age: 58.77 years; IQR 87-19). The major structural groups were employed individuals (45.68%) and retirees (40.82%). The study also assessed the spatial proximity from the respondents' residences to their primary care clinics versus their nearest pharmacies. The data revealed that, on average, physician offices were located further away than community pharmacies. Regarding transit to these locations, the majority of patrons commuted independently by walking or cycling to both destinations. Consumers obtained their prescriptions either as paper documents from the doctor's office (42.44%) or in digital format (54%).

Notably, 75% of the surveyed patrons confessed to having previously requested a prescription-only medicine at a pharmacy without presenting a valid prescription. Nearly all participants (97.3%) stated they would feel comfortable receiving medication prescriptions from a pharmacist, with the majority expressing confidence across all presented clinical scenarios. When examining the correlations between demographic traits and perspectives on pharmacist prescribing, age emerged as the sole statistically significant factor; older patrons showed a more favorable attitude toward pharmacist prescribing than younger patrons (< 30 years), though the strength of this association remained modest. Ultimately, more than nine out of ten consumers identified the pharmacist prescriber role as a distinct logistical convenience.

The participating cohort of family physicians was small (out of 30 doctors approached by the investigators, only 9 consented to participate) and does not represent a statistically generalizable sample of the broader medical community. The practitioners who declined to participate most frequently expressed categorical opposition to allowing pharmacists to prescribe medications, even for chronic disease states. Among the physicians who did participate, 4 indicated that approximately 30%–50% of their total patient encounters or consultations were driven solely by prescription renewals, while another 4 respondents estimated that this administrative burden accounted for 50%–70% of their patient volume. Furthermore, more than half of the interviewed doctors reported that 70%–90% of their prescriptions are electronically transmitted to patients.

All of the surveyed family practitioners rejected the proposal of allowing pharmacists to prescribe all classes

of medications. Conversely, only a single respondent opposed the concept of permitting pharmacists to manage ongoing maintenance therapies initially authorized by a physician. The majority of physicians noted that pharmacists should be granted prescribing rights to streamline care for patients with chronic conditions, thereby ensuring continuity of established treatments. The general medical consensus favored a structured framework where pharmacists operate strictly according to predefined clinical protocols. In line with the pharmacists' views, the family doctors recognized enhanced geographic and operational accessibility as the primary benefit of pharmacy-based prescribing. Every interviewed physician expressed a willingness to partner with pharmacists within a collaborative clinical management framework. According to these respondents, the primary pedagogical domains requiring targeted training for pharmacists are chronic disease states, long-term therapeutic management, and minor ailments.

This investigation provided an empirical framework for gauging stakeholder attitudes toward the prospective establishment of the pharmacist prescriber role in Italy. Structured interviews were conducted with the key groups affected by this potential systemic change: pharmacists, pharmacy patrons, and family practitioners. Pharmacy patrons demonstrated the highest level of enthusiasm for this initiative, with nearly all respondents approving the proposal.

A prominent finding from the survey is that pharmacists believe they would require stronger legal protections or specialized advanced training if prescriptive rights were enacted. In the United Kingdom, for instance, pharmacists can only transition to independent prescriber status after a minimum of 2 years of professional practice and completion of a dedicated educational curriculum (General Pharmaceutical Council, n.d.). This dual theoretical and practical training program must be delivered by an officially accredited training provider (General Pharmaceutical Council, n.d.). In contrast, the French framework allows a pharmacien correspondant to undergo optional specific training. Still, it mandates that they formally integrate into a coordinated care team centered on the patient's primary care physician [5].

Unquestionably, implementing and structuring the pharmacist prescriber role in Italy would necessitate extensive legislative overhauls, beginning with the "Consolidated Text of Health Laws" [25]. This foundational statutory framework dates back to the 1930s

and codifies the medical doctor as the sole professional authorized to prescribe pharmaceuticals.

Regarding legal protections, this remains a focal issue across many jurisdictions where pharmacist prescribing is already operational. Professional syndicates in those countries offer expanded professional liability insurance tailored to this role, which is frequently mandatory for practicing prescribers [26] UK National Pharmacy Association, n.d.). A segment of the pharmacists surveyed in this study also indicated a desire for a dedicated reimbursement structure for these services. The absence of structured financial compensation could function as a major impediment to the operational expansion of this role, a factor that must be carefully accounted for when planning the rollout of such services [16, 19, 27].

The primary advantages of the pharmacist prescriber role highlighted by this research include the capacity to deliver immediate interventions for minor ailments that do not warrant physician oversight, thereby deterring unsafe patient self-medication and improving overall healthcare accessibility. Comparable drivers have been documented in parallel international literature [10, 28].

The operational accessibility of community pharmacies—both in terms of geographic distribution and extended business hours—was identified by the surveyed pharmacists and physicians as the primary advantage. The finding further reinforced this structural benefit that nearly all interviewed patrons lived closer to a pharmacy than to their primary care clinic, with many able to reach it on foot.

In this study, both family physicians and pharmacists expressed a clear preference for a supplementary prescribing model governed by formalized protocols and procedures. This could be structured similarly to the French system, where pharmacists are permitted to prescribe from a designated formulary of authorized medications for specific, well-defined indications, such as cystitis and acute dysphagia [29]. The interviewed pharmacists predominantly felt comfortable managing prescriptions only following an initial medical diagnosis, thereby sustaining ongoing maintenance therapies. This aligns with the system deployed across multiple Canadian provinces [12]. Conversely, almost all surveyed pharmacy patrons supported pharmacist prescribing across all potential clinical scenarios. This finding diverges from other studies, in which patients reported greater comfort receiving a pharmacist-issued

prescription only after a medical doctor had established a primary diagnosis [19].

Introducing a non-physician healthcare provider authorized to handle prescription renewals under designated criteria would offer massive operational benefits to the national health system. Primary care physicians themselves emphasized that routine therapy renewals consume a major portion of their daily administrative workload. Furthermore, following the pandemic, these renewals are frequently processed digitally without requiring a physical examination of the patient.

Both family doctors and pharmacists agree on the critical need to implement an integrated, universally accessible electronic health records database to facilitate safe, evidence-based clinical decision-making. Moreover, both professional groups expressed strong support for developing interdisciplinary care teams, which are widely recognized as a cornerstone of optimized patient management in contemporary research [10, 22, 30].

Several limitations may influence the generalizability of these findings. Critically, only a small number of family physicians agreed to participate in this research, so the insights from this specific cohort cannot be considered statistically representative. A key directive for future investigations will be to increase the sample size of participating family practitioners significantly. Additionally, data collection for pharmacists, physicians, and pharmacy patrons was restricted to only two specific sub-regions within the Piedmont territory.

Conclusion

This study demonstrates that both pharmacists and pharmacy clients generally favor the introduction of the pharmacist prescriber role in Italy. The foundational prerequisites for pharmacist integration into such programs are, above all, clear legal protections and specialized post-graduate training. The most logistically viable short-term strategy, mirroring pathways taken in other nations, would involve the renewal or clinical review of maintenance therapies initially authorized by primary care physicians or hospital specialists. Based on models already tested across European and global jurisdictions, a definitive pathway toward integrating prescribing capabilities into Italian pharmacy practice can be conceptualized. Naturally, if this framework expands beyond basic prescription renewals, formal clinical guidelines must be established to rigorously

prevent conflicts of interest between prescribing and the financial dispensation of the pharmaceutical product. Finally, if the prescribing pharmacist model is to become a reality in Italy, it is vital to restructure undergraduate university curricula to reflect these clinical competencies, while simultaneously ensuring the availability of robust continuing professional education courses for active community pharmacists.

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