IN THE MATTER OF THE
HEALTH PROFESSIONS ACT, R.S.B.C. 1996

AND IN THE MATTER OF A HEARING BEFORE
THE DISCIPLINARY PANEL OF
THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

BETWEEN:

THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

AND:

MANIJEH FARBEH

DECISION

Panel Members:	Wayne Chen, Chair Jody Croft Michael MacDougall
Appearing in person:	Manijeh Farbeh
Counsel for the College of Pharmacists of British Columbia:	Alastair Wade
Counsel for the Disciplinary Panel:	Penny A. Washington
Dates of Hearing:	October 13, 14, 15, November 30, December 1,7, 8, 10 ,11 and 16, 2009
Place of Hearing:	200 - 1765 West 8th Avenue, Vancouver, BC

DECISION

Throughout 2007 and 2008, a Quality Outcome Specialist employed by the College of Pharmacists of British Columbia (the "College") identified a number of concerns and deficiencies in respect of the pharmacy practice of a registrant, Ms. Manijeh Farbeh ("Ms. Farbeh"). The College also received a number of complaints from physicians in late 2007 and early 2008 concerning the pharmacy practice of Ms. Farbeh.

The investigation relating to these various concerns resulted in site visits on September 5 and October 16, 2008 by several College inspectors to AYC Pharmacy, the pharmacy where Ms. Farbeh was the manager. The reports of the inspectors were provided to the Inquiry Committee of the College, which suspended both AYC's pharmacy license and Ms. Farbeh's license as a pharmacist by letter on November 20, 2008.

A Citation was issued against Ms. Farbeh by the Inquiry Committee and was amended and delivered to her on September 25, 2009 (Exhibit 1) setting out the following counts:

1. Between September 1, 2008 and March 31, 2009 you practiced incompetently as a pharmacist at AYC Pharmacy.

2. Between December 1, 2005 and March 31, 2009 you failed to manage Abbott (Renuka) Pharmacy and AYC Pharmacy in accordance with the bylaws pursuant to the *Pharmacists, Pharmacy Operations and Drug Scheduling Act* [RSBC 1996] c. 363 then in force; and more specifically, bylaws 26, 27, 29, 30, 31, 35, 37 and 38.

3. As manager and pharmacist of Abbott (Renuka) Pharmacy and AYC Pharmacy you engaged in professional misconduct by submitting responses dated August 4, 2006, April 27, 2007, October 1, 2007 and October 8, 2008 to the College's Quality Outcome Specialist when you knew or ought to have known that the information provided therein was misleading and inaccurate.

4. On or about November 21, 2008 while acting as a registrant and manager of AYC Pharmacy you engaged in professional misconduct and breached Values 1 and 7 of the Code of Ethics by making threatening remarks to the Deputy Registrar, Suzanne Solven and to the Quality Outcome Specialist, George Budd.

5. Between December 1, 2005 and March 31, 2009, you failed to comply with standards of practice set out in the bylaws pursuant to the *Pharmacists, Pharmacy Operations and Drug Scheduling Act* [RSBC 1996] c.363 then in force.

6. In the alternative, between December 1, 2005 and March 31, 2009, you engaged in [sic] professional misconduct.

At the outset of the hearing the Amended Citation was further amended by consent to substitute the date of November 30, 2008 for March 31, 2009 in Counts 1 and 2.

Another Citation (Exhibit 2) was issued September 25, 2009 setting out the following count:

> 1. On or about April 22, 2009, you represented to the Bank of Montreal that you were a registered pharmacist and the pharmacy manager of AYC Pharmacy when at the time your registration was suspended, contrary to section 59 of the Bylaws of the College of Pharmacists.

The College led evidence to confirm that the foregoing Citations were personally served on Ms. Farbeh on September 25, 2009.

Ms. Farbeh, through counsel, applied to the Supreme Court of British Columbia to lift her suspension and the College and Ms. Farbeh ultimately entered into a Consent Order with respect to the reinstatement of her licence, subject to certain conditions, on February 10, 2009. One of the conditions was a Practice Audit which took place on March 20, 2009, as a result of which the Inquiry Committee again suspended Mr. Farbeh's licence as of April 3, 2009. Ms. Farbeh again applied to court to lift the suspension on June 9, 2009 but that application was denied.

The hearing before this Panel of the Disciplinary Committee into the foregoing Citations commenced on October 13, 2009 and proceeded on October 14, 15, November 30, December 1, 7, 8, 10, 11 and 16, 2009. At the commencement of the hearing the Chair read the Citations into the record.

After being asked by the Chair if she admitted to the charges, Ms. Farbeh presented a typed statement to the Panel signed by herself and dated October 12, 2009. This was marked as

Exhibit 3. In her statement, she indicated that "the attached documents represent my acknowledgement of my deficiencies that the College of Pharmacists has demonstrated...."

The Chair asked Ms. Farbeh to clarify which charges in the Citations she admitted. She admitted to **Count 1**:

> Between September 1, 2008 and November 30, 2008 you practiced incompetently as a pharmacist at AYC Pharmacy.

and **Count 2**:

> Between December 1, 2005 and November 30, 2008 you failed to manage Abbott (Renuka) Pharmacy and AYC Pharmacy in accordance with the bylaws pursuant to the *Pharmacists, Pharmacy Operations and Drug Scheduling Act* [RSBC 1996] c. 363 then in force; and more specifically, bylaws 26, 27, 29, 30, 31, 35, 37 and 38.

Ms. Farbeh specifically admitted she was responsible for her:

- Lack of attention to hiring adequate staff, pharmacists and technicians to ensure that patient care was not compromised
- Lack of proper security for narcotic medications and procedures to prevent the loss thereof
- Lack of proper filing procedures and maintenance of day to day filing
- Lack of accountability in terms of record keeping for checking of prescriptions
- Lack of proper supervision of technicians

The Panel therefore finds Ms. Farbeh guilty of Counts 1 and 2. Even in the absence of her admissions, the Panel heard ample evidence to support the charges in Count 1 and Count 2. Some of this evidence is reviewed below in relation to other charges but applies equally to these charges.

On Count 3, Ms. Farbeh indicated she did not agree with all of the charges although she agreed with the majority. She denied Count 4. She gave the same answers to Counts 5 and 6 as she gave to Count 3.

She denied the charge on the second Citation (Exhibit 2). The Panel determined that in the circumstances it would treat her responses to Counts 3, 4, 5 and 6 as a denial of those charges.

The Panel, having carefully considered all of the evidence presented by the parties, makes the following findings on the balance of the counts in the Citations:

Count 3:

> As manager and pharmacist of Abbott (Renuka) Pharmacy and AYC Pharmacy you engaged in professional misconduct by submitting responses dated August 4, 2006, April 27, 2007, October 1, 2007 and October 8, 2008 to the College's Quality Outcome Specialist when you knew or ought to have known that the information provided therein was misleading and inaccurate.

The Panel finds Ms. Farbeh guilty of Count 3. The Panel has carefully reviewed the correspondence between the College and Ms. Farbeh. The College Quality Outcome Specialist set out a number of specific deficiencies that required remedy in his site inspection report of August 4, 2006, which Ms. Farbeh signed. Ms. Farbeh did not dispute any of her signatures on any of the documents entered into evidence by the College. In so signing, she confirmed as follows:

> "I hereby confirm that the above-noted corrections have been made as of this date and that the deficiencies will not be present at subsequent pharmacy site visits."

The document also contained the warning:

> "Failure to maintain these corrective actions could result in referral to the Inquiry Committee. Returning the signed document when the above-noted HAVE NOT been corrected may constitute professional misconduct, and could result in disciplinary action."

Mr. Budd gave evidence that he observed the same deficiencies in place during his subsequent site inspection on April 12, 2007 which he had noted in his inspection report of August 4, 2006. The Panel finds that Ms. Farbeh therefore had not corrected the deficiencies and her response dated August 4, 2006 was not true and was misleading.

Mr. Budd wrote to Ms. Farbeh on April 18, 2007 bringing the deficiencies, particularly about dispensing multiple daily doses of multiple medications in one vial, to Ms. Farbeh's attention yet again. On April 27, 2007, Ms. Farbeh signed the letter of April 18, 2007 acknowledging she had read it but stated in relation to dispensing multiple medications in one vial:

> "I have gone through this matter since I started in this field, however, I really could not come into suitable solution so far. I will try my best to help the patient with their daily meds."

On April 26, 2007, Mr. Budd sent a more detailed letter to Ms. Farbeh setting out the deficiencies and violations he had observed on his site visit of April 12, 2007. The deficiencies with respect to dispensing of multiple medications in a vial and handing out doses of methadone prior to processing the doses on Pharmanet were the same as he had noted on his August 4, 2006 visit. Ms. Farbeh had therefore failed to implement any corrective action in respect of the August 4, 2006 site visit.

The Panel is unable to accept Ms. Farbeh's response to the April 18, 2007 letter as sent out above. The practice standard is clear (Bylaw 40).

Ms. Farbeh made excuses that she just could not come up with corrective actions but she should have been fully aware of and understood the bylaws that govern the profession of pharmacy in British Columbia. There are many information sources that Ms. Farbeh could have used to help her find remedies: the bylaws of the College, brain-storming with other pharmacists that work in the same area and with the same clientele, speaking to other pharmacy managers working in the area, networking with more experienced pharmacists, communicating with the owner to request help and guidance, or asking the College for suggested alternatives or options. There is even a hot-line for pharmacists to call the College with practice questions.

The Panel finds it very disconcerting that a pharmacist would not recognize the problems and seriously make an effort to promptly rectify the issues brought forth by the College inspectors.

The Panel also finds it very disturbing that Ms. Farbeh seemed to take the matter of inspections, corrective action and replies to the College very lightly. She chose to sign the inspection notices and letters but did not in fact in good conscience attempt to remedy the majority of issues brought to her attention.

Ms. Farbeh suggested that the College could have been more conciliatory and offered more guidance and help with her problems. The Panel considers there was ample opportunity and time for Ms. Farbeh to make the necessary changes to her pharmacy practice and procedures to accord with the College's requests.

The evidence led before the Panel demonstrated a pattern of Ms. Farbeh acknowledging deficiencies and indicating they are or will be corrected but subsequent inspections demonstrating that no corrections have been made. The Panel noted that, for example, on August 29, 2007, Mr. Budd made a site visit to Abbot (Renuka) Pharmacy and sent a letter to

Ms. Farbeh dated September 18, 2007. In that letter he observed a number of practices which were contrary to the Pharmacy Methadone Maintenance Guide. In particular he noted:

> "Pharmanet was not checked nor entries made at the time of the patient's methadone ingestion."

This was the same deficiency as noted in the August 4, 2006 and April 12, 2007 site visits. In response, Ms. Farbeh on October 1, 2007, responded to the letter of deficiencies and confirmed:

> "We will make sure that we work under the framework of the professional practice."

On October 1, 2007, Ms. Farbeh acknowledged receipt of the deficiency letter dated September 18, 2007. (Exhibit 28) Ms. Farbeh nonetheless failed to implement any correction action in respect of the August 29, 2007 site visit.

On September 5, 2008, Mr. Budd conducted a site visit to AYC Pharmacy, where Ms. Farbeh was the new pharmacy manager. He observed the same infractions at AYC Pharmacy as he had observed on the previous site visits to the Abbott (Renuka) Pharmacy. His notes were signed by Ms. Farbeh. By signing the notes Ms. Farbeh confirmed that his observations were accurate.

Mr. Budd also prepared a Summary Report dated September 5, 2008. On October 8, 2008, Ms. Farbeh signed and returned the Summary Report and stated:

> "I hereby certify that the above corrections have been made as of this date and that the deficiencies will not be present at subsequent pharmacy site visits."

The Summary Report also contained the following statement acknowledged by Ms. Farbeh:

> "Failure to maintain these corrective actions could result in referral to the Inquiry Committee. Returning a signed document where the above-noted conditions HAVE NOT been corrected may constitute professional misconduct and could result in disciplinary action."

On October 16, 2008, Mr. Budd re-attended at AYC Pharmacy. On this occasion it was a comprehensive site visit in which Ashifa Keshavji, Doreen Leong and Valerie Tsui also participated as inspectors from the College. The same deficiencies that were noted in Mr. Budd's report of September 5, 2008, were noted to be present on this subsequent site visit by the representatives of the College.

Ms. Farbeh failed to implement the corrective actions that she stated she would implement in respect of the September 5, 2008 site visit.

The Panel notes that while some of the noted deficiencies are minor, many are serious, particularly those relating to methadone dispensing procedures and the dispensing of multiple daily medications in single vials.

Putting multiple daily doses of multiple medications in one vial creates a real possibility of filling errors or patient harm through overdosing or otherwise making an error with multiple medications. Failure to scrupulously follow the methadone dispensing procedures exposes the patients to serious risks of requiring either too much or too little medication, which puts the patients at risk. The Panel notes that Ms. Farbeh pointed out in her evidence that no patient had complained of coming to actual harm as a result of her procedures. This is irrelevant to the issue of risk. In addition, there is no way to know if in fact harm occurred but was simply not reported or recognized. The Pharmacy Methadone Dispensing Guide is designed to try to prevent patient harm as far as is possible and every pharmacist needs to adhere to those procedures in order to ensure patient safety.

Count 4:

> On or about November 21, 2008 while acting as a registrant and manager of AYC Pharmacy you engaged in professional misconduct and breached Values 1 and 7 of the Code of Ethics by making threatening remarks to the Deputy Registrar, Suzanne Solven and to the Quality Outcome Specialist, George Budd.

The Panel has considered carefully the evidence of the Deputy Registrar, Suzanne Solven, and Mr. Budd, the Quality Outcome Specialist. It has reviewed Exhibit 31 which is a copy of Ms. Solven's notes made for the Vancouver Police Department. This charge arises out of a visit made to AYC Pharmacy by Ms. Solven and Mr. Budd on November 21, 2008 to ensure compliance with the conditions placed on the Pharmacy during the suspension. During the site visit, Ms. Farbeh indicated that the patients were not happy about the closure and said "they are going to come after you for this" and she "hoped the College knew what it was doing". Shortly thereafter, a patient in the pharmacy became aware of the impending pharmacy closure and said this was "bullshit" and "this is a pharmacy, man" and "she does a good job, why do you fucking want to do this". Ms. Farbeh at this time said "see, they are going to come after you for this." After a closure notice was put up, the patients became agitated and again Ms. Farbeh stated "they are going to come after you for this". At this point both the Deputy Registrar and the Quality Outcome Specialist testified they felt uncomfortable and left the pharmacy.

During her evidence, Ms. Farbeh stated she had no intention of threatening either the Deputy Registrar or the Quality Outcome Specialist. She stated she was just informing them of what may happen if the pharmacy is closed. Ms. Farbeh further stated that she was not herself on that occasion and was upset with the suspension.

The Panel recognizes that this was a difficult situation in a working environment not normally seen in a regular retail pharmacy. There are a high number of methadone patients and more than the normal number of street drug addicted patients. These factors can create a tense working environment. The Panel also recognizes the fact that a suspension would create

anxiety, apprehension and angst for a registrant and that unfortunate remarks can be made in the heat of the moment. There is no evidence of any physical action from Ms. Farbeh or any threatening gestures on her behalf. The Panel finds insufficient evidence to establish Count 4 of the Amended Citation and finds Ms. Farbeh not guilty of that charge.

Count 5:

Between Dec 1,2005 and Mar 21/09 you failed to comply with standards of practice set out in the Bylaws pursuant to the Pharmacists, Pharmacy Operations and Drug Scheduling Act (RSB1996) c.363 then in force.

The Panel heard considerable evidence dealing with the situation found during the inspection at AYC Pharmacy and reviewed photographs taken by the inspectors on October 16, 2008. The Panel particularly notes and accepts the evidence about the following aspects of Ms. Farbeh's practice which the Panel finds do not accord with the Bylaws:

Filing System

The Panel notes that there appears to be no filing system in place. The photographs entered into evidence clearly show an array of cardboard boxes and plastic baskets with loose prescriptions plus a cabinet with more prescription files (Exhibit 28 tab 24). There appears to be no order and both boxes and baskets do not appear to be labelled in any manner. The prescription bundles in the cabinet also do not appear to be marked or labelled.

The expected standard seen in most pharmacies is folders, bundles or books of 100 prescriptions collected together and marked for ease of reference with the number or date sequence. Usually regular prescriptions and narcotic/control prescriptions are separated. If there are bundles of prescription files they should be in order and marked in some manner with notes indicating the date. There are different methods of filing but the necessary endpoint is a filing system that is easy to use and maintain and facilitates the retrieval of hard copies in an efficient manner. Prescriptions must be filed promptly: the common practice in slower stores is the filing is being done throughout the day. In busy stores, the filing is done at the end of the

day and should be a priority rather than an after thought. There will always be unusual circumstances such as sick staff or extremely busy days when filing cannot be done on a regular basis but it is reasonable to expect that the filing will be kept in an orderly and accessible fashion and that generally it will be up to date within a day or two.

Ms. Farbeh stated that she did have a system in place but that the staff were behind in filing. If there was a filing system, it firstly was not being kept up to date and secondly did not seem to be very efficient. Finally, Ms. Farbeh as the manager should have ensured the staff made filing a priority. Ms. Farbeh also stated that there is no legal time frame within which to file prescriptions. Any conscientious or reasonably competent pharmacist or manager would make a reasonable attempt to get the files in order as soon as possible. The retrieval of hard copies is a professional necessity if there are any questions regarding instructions, quantities, forgeries, illegal attempted drug procurement or quantity changes and documentation of consultation with another health care provider. In fact there was such disorder that as part of a College inspection on October 16, 2008, Valerie Tsui focused solely on the filing system to find prescriptions related to specific complaints. She was charged with finding 15 prescriptions and by the end of the day could locate only four. As of the date of this submission, the four outstanding prescriptions are still missing.

The Panel also notes that Ms. Farbeh has had experience in other stores (methadone and non methadone) and should have learned from these work environments and recognized the need for keeping an efficient and orderly filing system.

The Panel finds the disorganized boxes of files and the demonstrated inability of both inspectors and Ms. Farbeh to quickly locate hard copies of prescriptions deplorable and evidence that she was not complying with the standards of practice set out in the Bylaws as pharmacy manager. It was her responsibility to ensure record-keeping procedures are set and maintained (Bylaw 27, and 35: Framework of Professional Practice ("FFP") Role 1 and 2).

Documentation on Hard Copy Prescriptions

The Panel is appalled by the lack of proper procedure in terms of attaching computer generated transaction tags to hard copies of prescriptions. A tag must be applied to all hard copies and serves not only as a guide to check details of the prescription and patient but also should bear the initials of the pharmacist that did the final check (Bylaw 38(6). The Panel understands that different software programs present different information on the "transaction tag" but even if the information is minimal it must be affixed to the hard copy for identification purposes. The Panel cannot understand why this would not be routine in Ms. Farbeh's practice since it is an easy and simple task to peel and attach the tag to the hard copy. Exhibit 28 Tabs 34,37,38,45, 47 are example of prescriptions with no computer generated label or tag. Ms. Farbeh claims that this was due to a printer problem and the lack of co-operation from the owner/head office. This may have contributed to the filing problem, if hard copies did not have a transaction or prescription number. It was nonetheless her responsibility as manager to ensure any problem was promptly fixed (Bylaw 27(1). There appear to be too many examples to be the result of a temporary printer problem.

The Panel also notes that comments related to the prescription are rarely or poorly documented. Verbal consultations with physicians must be noted with date and time and details of the conversation. Noting with just the pharmacist's initials or "confirmed or verified by Dr" is not sufficient. Simple concise notes will suffice such as "was taking 20 mg daily and patient not aware of decrease to 10mg daily. Dr confirms 10mg daily SAB". This verbal contact must be initialled. Drug changes i.e., betamethasone for Dermovate must be confirmed with the physician (see Exhibit 12/schedule 14). The fact that the patient had previously been dispensed betamethasone is not sufficient to warrant a change without checking with the physician.

Witnessed Ingestion of Methadone

The purpose of witnessing the ingestion of methadone is to ensure the patient receives their dose and that the methadone is not stored in the patient's mouth to be spit out at a later time. It also provides the pharmacist an opportunity to assess the patient prior to ingesting the methadone. With the large number of methadone patients and the local environment of drug

abuse and illegal diversion of prescription medications, it would be expected that there would be patient attempts to not ingest their methadone. Ms. Farbeh should have clearly understood this and been more vigilant in terms of monitoring the ingestion.

With the volume of methadone prescriptions (500 – 600) processed daily at AYC (Exhibit 28, tab 75) it is not conceivable that the adjudicating/processing of prescriptions, volume checking and witnessing the ingestion could be properly done with one or two pharmacists. The Panel also accepts the expert evidence of Ms. Pollock that it would be impossible for one pharmacist and a technician to process that volume of prescriptions and provide an accepted minimum level of care. Ms. Pollock determined the rate for processing 500 – 600 prescriptions in the time the AYC Pharmacy was open was one every 60 seconds. The normal appropriate range for processing time is between 3 – 7 minutes based on previous studies referred to by Ms. Pollock. The Panel notes that there is a significant financial incentive for processing the maximum number of methadone prescriptions. Pharmacists, however, are required to put their professional obligations ahead of any financial considerations. The other possibilities could be that Ms. Farbeh chose to ignore or did not fully understand the guidelines as noted in the Pharmacy Methadone Maintenance Guide. The Panel takes a very dim view of this non-adherence to methadone witnessed ingestion because of its implications for patient care.

The Panel also notes that the audit by First Canadian Health which followed the College inspections some days later also reached the same conclusion that many methadone doses were not witnessed by the pharmacist, including Ms. Farbeh.

Documentation of Methadone Part-Fills

The Panel notes there is a large clientele requiring methadone at AYC pharmacy. With this environment, it would be incumbent that the manager/pharmacist recognize the need to thoroughly document part-fills. With the large volume of methadone dispensed, all doses must be logged and initialled by the patient and pharmacist. Missed or partial doses must be reported to the physician. As stated in the Pharmacy Methadone Maintenance Guide professional practice section, if a patient has not picked up their daily dose or refuses all or a

portion of their daily dose this should be communicated to their physician and properly documented. The guide offers Appendix F which is a form to record such communication.

The Pharmacy Methadone Maintenance Guide clearly states that every part-fill must be accounted for. Also, the amount dispensed, pharmacist's initials and date must be recorded. There are several methods to log or document this; typically the back of the prescription, or a pre-printed log sheet or a copy of Appendix D can be used.

The Panel also notes Exhibit 28 tab 10 that a patient only received a portion of the daily dose (split dose) and was to come back later in the day for the remainder of her dose. There is no documentation whether this patient received the remainder, or if the physician was called or why the patient only requested a portion of her daily dose.

Labelling of vials for other Medications

The photographs presented by the College show vials with numerous different drugs, some labelled and some not, sometimes the vials contained medications that were different from the label. Paper bags with labels or hand written notes were used to prepare daily dispense group medications for patients. Also labels on the bags sometimes were not current, and sometimes did not indicate all the contents.

For example:

Exhibit 28 tab 24 page 6 shows more than 7 ramipril and no Valtrex
Exhibit 28 tab 24 page 8 shows labels dated Jul8/08 yet a note shows the Rx ends Sept 2/08
Exhibit 28 tab 24 page 11 shows M-Eslon labelled at tablet instead of capsule
Exhibit 28 tab 24 page 14 shows a vial with what appears to be 5 tablets for daily dispense when it should be 1 tablet
Exhibit 28 tab 24 page 17 shows a vial with 3 large tabs which do not correspond to any label on the bag

Exhibit 28 tab 24 page 18 shows an extra unknown capsule in a vial that does not correspond to a label
Exhibit 28 tab 24 page 19 shows only 1 x cimetidine 300 mg when the label indicates 2 tablets
Exhibit 28 tab 24 page 21 shows a bag with either a surname or first name, not both

Ms. Farbeh has stated that these bags or vials were not the final preparations for dispensing. Ms. Farbeh stated that sometime the blisters were prepared ahead of time. It does not matter what stage they were in, they were an error waiting to happen. The accepted or usual standard is separate individually labelled vials or blister packs with each drug individually labelled. This should all be gathered together for the pharmacist to check prior to dispensing. The use of one vial for several medications is not common practice and if done all medications within the vial must be labelled with a corresponding label (Bylaw 40).

These practices seriously place patient safety at risk and are completely unacceptable.

Review of PharmaNet Prior to Dispensing

From Exhibit 27 tab 75, from Oct 21 – 23/08, PharmaNet records show that Ms. Farbeh had over 500 entries per day attached to her license number. Bearing in mind there may be a small number of reversals, the calculations (during the opening hours) indicate putting through about 45-50 prescriptions per hour. For a pharmacist to process this many transactions, it would require the fast repetitive motion of hitting the enter key. In the Panel's opinion, this would not allow any review of the patient's PharmaNet profile.

The Panel also notes during the October 16, 2008 site visit by Mr. Budd, the Quality Outcome Specialist, the computer froze during Ms. Farbeh's attempt at processing the prescriptions, apparently due to the speed of processing.

The review of a patient's PharmaNet profile is an integral part of prescription filling. The purpose is to check for duplication of drug therapy, multi-doctoring, previous dosage and compliance to name a few. This is important in all retail settings but is even more critical in an environment such as AYC pharmacy. The possibility of multi-doctoring or requesting and obtaining emergency prescriptions is a much higher risk than in other retail settings. The Panel is of the opinion that this is completely unacceptable (Bylaw 43).

Expired Medications

The presence of expired drugs in a pharmacy is not overly unusual. A common practice in many pharmacies is a regular check of different sections of pharmacy stock. A log is kept of the expiration dates of the drugs in each section. Expired stock is removed from the shelf and stored separately from dispensing stock. Drugs that expire shortly within 1 to 3 months are flagged in a distinctive way and other drugs that expire within 6 months are also tagged. Subsequent checks would quickly remove drugs that are nearing their expiry date or are expired. Other methods include noting the expiry date on the back of the Rx, pharmacist and/or technician checking the expiry date on the stock bottle and writing the expiry date on the prescription label. The disturbing aspect in this case is there appears to have been no system for checking for expiry dates at the time of filling the prescription or with expired inventory checks.

As a pharmacy manager, it was Ms. Farbeh's responsibility to ensure these procedures were instituted and carried out on a continual basis (Bylaw 26(2).

Methadone Measuring

The accurate measuring of any liquid in a pharmacy is very important. This is more critical with methadone, as a variation in the dose can have an adverse effect. It is well known that patients find the final phases of discontinuation of methadone very difficult. As the doses become smaller, uniformity of dosing is essential.

Methadone should be measured in a graduated cylinder that is as close to the measured volume as possible. Dose uniformity is compromised by not using the correct size cylinder.

The simple stocking of all the usual sized cylinders would help resolve this issue. Small doses could be measured in 10 or 20 ml syringes. The proper training of the technicians to use the correct size cylinder is the responsibility of the pharmacist and/or manager (Bylaw 27).

Prescriptions Accepted Contrary to Conditions Placed

The College received complaints from physicians that prescriptions at AYC Pharmacy were being dispensed daily despite their written indication to the contrary. Exhibit 28 tab 51 is a copy of a prescription initially indicating "do not dispense daily" but the "do not" has been written over. Any reasonable pharmacist would immediately question why this was done and by whom. Some effort should have been made to call the physician to clarify this and any conversation with the patient/agent or doctor should have been documented. The medications for this patient were subsequently filled on a daily basis. Under tab 53 it is clearly written "do not dispense daily" yet the 4 medications on this prescription were dispensed daily. Again there is no noted reason or documentation for the need for daily dispensing, contrary to the physician's instructions. Exhibit 27 Tab 50 is a complaint from Dr. G. Horvath stating that his instructions "not to daily dispense" were being disregarded. Exhibit 27 Tab 55 Dr. H. Weiss makes a complaint that the "ALL D-D" appearing on a prescription written by Dr. M. Tyndall was not written by him. Tab 57 is Dr. Tyndall's statement that he did not write this.

This is not standard pharmacy practice and the Panel finds this type of activity intolerable. It serves to undermine the working relationship between a physician and a pharmacist.

During the practice audit at Chemist Pharmacy, the auditor noted that Ms. Farbeh did not appear to have a thorough checking procedure or routine when performing the final check of prescriptions. The Panel realizes this review is not a specific requirement but any caring and competent pharmacist would consider this as second nature to decrease errors and help ensure patient safety. In busy stores with more than one pharmacist it is essential to check each other's

work. In slow stores with one pharmacist, this routine must be used to prevent "prescription bias".

Further correspondence under tabs 85 and 86 between Ms. Farbeh and the College indicates that she did not have a full understanding of the Framework of Professional, although she had been required to review the FFP, as well as the Act, Bylaws, Code of Ethics and the College's professional policies as a condition of the lifting of her suspension.

The Panel also notes on one prescription a patient was prescribed prednisone but had previously received 60 diclofenac 25 mg five days earlier as per PharmaNet records. The Panel recognizes there was a language problem in this case but some attempt should have been made to check with the physician concerning this possible duplication of therapy.

The audit was done at Chemist Pharmacy which is a "slow" pharmacy. Ms. Farbeh processed 14 prescriptions during the 2 days while the auditor was present. This presented ample time and opportunity to thoroughly review the patient's profile and counsel appropriately to ensure patient safety and the correct therapeutic outcome. The Panel finds her lack of initiative and attention to detail as described in the audit very disturbing.

Based on the above noted evidence the Panel finds Ms. Farbeh guilty of Count 5 of the Citation.

Count 6:

> In the alternative, between December 1, 2005 and March 31, 2009, you engaged in [sic] professional misconduct.

As the Panel has found Ms. Farbeh guilty of Counts 1, 2, 3 and 5, and as it received no specific submissions on Count 6, which is framed as an alternative charge, it makes no finding on Count 6.

In Count 1 of the second Citation (Exhibit 2) the College has claimed that Ms. Farbeh represented herself as a registered pharmacist and manager of AYC Pharmacy when in fact she was suspended. It is alleged that Ms. Farbeh used her daughter to telephone and represent to the Bank of Montreal (BMO) that she was a registered pharmacist working at AYC Pharmacy in order to procure a business loan on April 22, 2009, when she was suspended. A recording of a telephone conversation on April 22, 2009 on a CD was obtained from BMO via subpoena and played during the hearing by the College.

The voice heard on the CD definitely does not belong to Ms. Farbeh, but the person identified herself as Ms. Farbeh and said she was a pharmacist. At that time Ms. Farbeh was in fact suspended. On parts of the CD the Panel could hear a conversation with another person in the background. Unfortunately the background conversation is not clear. It appears the conversation with the second person was generally in response to the Bank's representative asking for details of financial information about Ms. Farbeh's affairs. The person on the CD talking to the Bank's representative said she was calling from her branch of the Bank of Montreal. During the playing of the CD, Ms. Farbeh was observed to be smiling and seemed to be amused by the CD.

A copy of the CD had been given to Ms. Farbeh at the same time that it was given to the Panel by the BMO representative on October 13, 2009. It was not played for the Panel until December 10, 2009. During the Hearing, Ms. Farbeh stated that December 10 was the first time she had listened to the CD and recognized her daughter's voice. The Panel finds it unlikely that Ms. Farbeh would not have listened to the CD before it was presented to the Panel given the allegations in the Citation.

On December 11, 2009 Ms. Farbeh requested that her daughter take the stand to give evidence on her behalf. Her daughter testified that she in fact was the person on the CD calling the bank. The daughter gave evidence that she wanted the loan to help her mother with the family expenses while her mother was suspended but that she did not tell her mother what she was doing. She was going to tell her if the loan came through as she would have had to sign documents. She claimed she knew all the necessary financial details about her mother's affairs.

The Panel notes that the daughter was falsely representing herself as her mother to BMO to obtain the line of credit and clearly would say whatever it took to support her mother. The Panel considers it much more likely that Ms. Farbeh was aware of her daughter's call at the time, had gone into the branch with her and supplied the necessary information during the call than that she did not.

The Panel therefore finds Ms. Farbeh guilty of Count 1 of the second Citation (Exhibit 2).

Signed in counterparts.

DATED this ______ day of ▼, 2010.

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Wayne Chen (Chair), Licensed Pharmacist

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Jody Croft, Licensed Pharmacist

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Michael MacDougall, Government Appointee