

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

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

BETWEEN:

THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

AND:

MANIJEH FARBEH

PENALTY DECISION

Panel Members:	Wayne Chen, Chair Jody Croft Michael MacDougall
Appearing in person:	Manijeh Farbeh
Counsel for Manijeh Farbeh (on written submissions only)	Jeremy West
Counsel for the College of Pharmacists of British Columbia:	Alastair Wade
Counsel for the Disciplinary Panel:	Penny A. Washington
Dates of Penalty Hearing (Oral Submissions):	February 26, 2010
Date Written Submissions concluded:	April 19, 2010
Place of Penalty Hearing:	200 - 1765 West 8th Avenue, Vancouver, BC

PENALTY DECISION

1. The Panel found in its decision of February 24, 2010 (the "Decision") that Ms. Farbeh (the "Member") was guilty of incompetence and of a failure to manage two pharmacies for which she was responsible as manager in accordance with the Bylaws pursuant to the *Pharmacists, Pharmacy Operations and Drug Scheduling Act* [RSBC 1996] c.363 then in force. More specifically, she was found not to have complied with Bylaws 26, 27, 29, 30, 31, 35, 37 and 38.

2. She was also found guilty of professional misconduct in submitting responses to the College's quality outcome specialist following inspection on more than one occasion when she knew or ought to have known that the information she had provided in her responses was misleading and inaccurate. Of particular relevance to this Panel, when considering the appropriate penalty, was the fact that she had signed and verified that she had made a number of significant corrections to her practice as a result of the inspections by the quality outcome specialist. The Member had also promised in writing that those deficiencies would not be present at subsequent pharmacy site visits. In fact, she had not corrected the deficiencies and they were still present on subsequent visits. She therefore deliberately misled the College.

3. Pursuant to section 39(2) of the *Health Professions Act*, the Panel has a number of options available to it in terms of penalty. It may, by order, do one or more of the following:

- (a) reprimand the respondent;
- (b) impose limits or conditions on the respondent's practice of the designated health profession;
- (c) suspend the respondent's registration;
- (d) subject to the bylaws, impose limits or conditions on the management of the respondent's practice during the suspension;
- (e) cancel the respondent's registration;
- (f) fine the respondent in an amount not exceeding the maximum fine established under section 19 (1) (w).

4. Counsel for Ms. Farbeh advocates in his thorough submissions that the penalty in this matter should be:

- (a) a reprimand

- (b) the imposition of limits or conditions on her practice; and
- (c) costs, in the suggested amount of \$10,000 to \$15,000.

5. Counsel for the College advocates that the penalty should be:

- (a) cancellation of the registration of Ms. Farbeh; and
- (b) costs in the amount of \$55,904.87 which the College advises is 50% of the actual costs incurred by the College, pursuant to s.39 (6) of the *Health Professions Act*.

6. The Panel heard much evidence over a fairly lengthy discipline hearing. The Panel noted in its Decision that there were a number of issues with the Member's practice that had the potential to create an adverse effect on patient safety and patient outcomes. The Panel has enumerated examples of these concerns in its Decision. Yet the Member and her representative before the Panel (not her present counsel) who initially made oral submissions on penalty on February 26, 2010, argued that many of the concerns and findings of the Panel related only to what they characterized as "office" work or minor typographical errors. In particular, they identified prescription filing as such a task. The Panel notes that the keeping of accurate and properly filed prescription files which can be readily retrieved for the purposes of patient care and accountability is fundamentally related to patient safety and the Member's failure to fully appreciate this is of grave concern.

7. The Panel has also noted the decision presented to us, *Essa v. The Ontario College of Pharmacists* at page 2 which states "however, this case clearly demonstrated that proper administrative and record keeping duties and functions, though they may be mundane and time consuming, are integral to maintaining the standards of practice."

8. Indeed, in her written submission to the Panel which she presented on the first day of the Hearing (Exhibit 3), the Member had indicated that, among other improvements to her practice, she intended to set up a filing system and maintain it in an orderly fashion and recognized the importance of this, but her subsequent statements during the Hearing and at the Penalty Hearing have caused the Panel to doubt the sincerity of her earlier statement.

9. There were numerous examples in the evidence related to count 5 of the Citation of factors that contribute to public safety and the accurate practice of pharmacy. Necessary quality assurance measures, proper labelling of prescriptions and improvements to the

procedures for dealing with expired stock, the stocking of proper methadone measuring cylinders, and adherence to the guidelines for dispensing methadone, could all easily have been done if the Member had truly taken seriously the information that had been provided to her time and again by the College inspectors. While much of the actual work in these areas could have been completed by a pharmacy technician, this does not derogate from the responsibility of the pharmacist and, in particular, the pharmacy manager, to have ensured that such tasks were promptly and regularly completed.

10. The Panel appreciates that in many of the penalty decisions cited by counsel for the Member, issues that relate only to matters of incompetence often result in a lesser penalty than those that contain an element of malfeasance or fraud. In the estimation of the Panel, however, this is only a matter of degree. This case before it presented so many examples of such concern to the Panel that it is the Panel's view that this takes it out of the ordinary category of simple incompetence in one or two areas which, when readily admitted, may also be easily remedied. There were also several examples in the evidence that reflected poorly on the credibility of the Member, on her integrity and on her sincerity about remediation.

~~11. The Panel carefully considered whether there were practice restrictions and remedial~~ options that could be imposed on the practice of the Member that were short of cancellation of her licence but which would adequately protect the public. The Panel, for example, considered whether having the Member engage in two retail placements modelled after the University of British Columbia courses Pharmacy 469 and 479 taken by fourth year students under the Structure Practice Education Program would serve to ensure that the Member is safe to practice together with the successful completion of the OCSE and Jurisprudence examinations. This would essentially mean completely retraining the Member. It was the determination of the Panel, however, that the Member had already been given remedial options by the College which were designed to have her become familiar with and adhere to the Bylaws and other requirements of the profession, and she had demonstrated a complete inability to incorporate those lessons into her practice.

12. On December 1, 2008, she had been suspended by the College. This suspension was lifted by the Supreme Court on February 10, 2009 with specific conditions that included requirements for the Member to review the applicable Legislation, the Bylaws, the Code of Ethics and the Professional Practice Policies of the College, as well as, the Framework of Professional Practice. The Member signed a declaration acknowledging that she had read and

understood those materials before she was permitted to return to practice. She was also required to document on the back of the hard copy of each prescription she dispensed how she complied with the requirements of Bylaw 5 section 43.4 and section 44 and submit those to the Registrar. A practice audit was conducted on March 5 and March 10, 2009 and the auditor, Mr. Peter Cook, was able to observe the Member, who was then working at a small pharmacy, conduct 14 actual patient interactions over a period of 9.5 hours. Mr. Peter Cook has over 26 years of pharmaceutical experience and has formal training in practice audit assessment. He gave evidence before the Panel. The prescriptions that were processed by the Member and subsequently sent to the College had not been thoroughly completed, were lacking the required details (see Tab 85 of binder 1), and were not to the satisfaction of the Registrar.

The Member was aware of the requirements she was operating under, because she had signed the Order from the Supreme Court, and she was also aware that there was an impending practice audit. Nonetheless, she did not meet the appropriate standards during the audit. In fact, Mr. Cook stated that she "does not critically evaluate, assess and interpret signs, symptoms and health status. She frequently fails to identify, solve and give advice about drug-related problems". She "does not recognize and consistently intervene in potentially risky or unsafe situations. She does not implement changes and pre-emptively work to remove risk". This is a significant concern to the Panel.

13. The conclusion of the audit carried out by Mr. Cook was that "her lack of complete procedures and knowledge and checking prescriptions and patient profiles represents a high risk that an error will occur. This could result in a serious risk to the client". He also found the Member "does not consistently apply the foundation science skills to identify, solve and give advice about drug-related problems. This represents a high risk for the client needing further intervention by the health professional".

14. In the low activity pharmacy in which she was working at the time, there would have been ample time to perform at an elevated level, and it was an ideal opportunity to demonstrate her proficiency and skills to Mr. Cook and the College. The Member failed to meet the required level of competence. As a result of that practice audit, she was suspended for a second time on April 3, 2009 (Exhibit 7). Currently, she remains suspended.

15. In answer to this audit at the Hearing, the Member attacked the professionalism and objectivity of Mr. Cook, without success, and did not accept the veracity of his observations.

The Panel did accept the audit report and Mr. Cook's conclusions as valid, based on the evidence before it.

16. The Member in her oral submissions on penalty also appeared to seek to excuse some of her earlier failure to comply with appropriate standards and bylaws while at AYC Pharmacy on the basis that she had been working very hard at the time, filling between 500 and 600 prescriptions a day. Rather than an excuse, the Panel sees this as a complete abdication of her responsibilities as a pharmacy manager to manage her workload in a way that ensured patient safety and that the pharmacy was properly staffed. It appears instead, for example, that she blatantly disregarded proper procedures for methadone dispensing in favour of expediency and speed. While she stated during the Hearing that she should have stood up to the pharmacy owner and left the job under these conditions, the fact is that she had taken on the responsibility for being the pharmacy manager and she chose to continue to work in that system, which ultimately put the public at risk.

17. The other factors weighing in favour of cancellation of registration in the view of the Panel included the complaints from physicians relating to her practice and procedures when she was the pharmacy manager at AYC Pharmacy. These complaints included a concern that prescriptions were daily dispensed when it was clearly noted on the original "Do Not Daily Dispense". There was an allegation that there was fraudulent dispensing of Kadian (morphine) 50mg capsules by the Member. The evidence was that the doctor stated that he did not prescribe morphine during the period in question (Tab 64 binder 1). At an opiate screening, this patient tested negative for narcotics although PharmaNet records indicated that Kadian was daily dispensed by the Member for three days prior to the opiate screening. The Member claimed there had been a prescription for Kadian for this patient for the relevant dates. Neither the original triplicate prescription, which would have been required to authorize the Member to dispense this medication or any copy, was ever located by the Member. She did provide the Panel with two different prescriptions for Kadian but the dates did not match the period in question, the patient name and PHN were blacked out and the birth date did not match that of the patient in question. She finally acknowledged to the Panel that she could not locate the relevant prescription.

18. The Panel found that she did not respond appropriately to these complaints nor did she treat them seriously.

19. There was yet another audit of the practice of this Member during the relevant period which was conducted by First Canadian Health from October 20 to October 23, 2008 several days after the inspection by the College. At that point in time, she should have been well aware of the concerns of the College and should have been making some of the necessary improvements and changes. First Canadian Health observed similar areas of concern to those noted earlier by the College inspectors including unauthorized prescription splitting, the pharmacist rarely witnessing methadone ingestions, the signed methadone log not being maintained and unauthorized prescription refills, as well as poor filing methods and missing prescriptions.

20. Finally, the expert that gave evidence on behalf of the College, Ms. Lynn Pollock, who has 33 years experience as a pharmacist in community pharmacy including experience in a pharmacy which dispenses methadone, noted many breaches of acceptable and reasonable standards of pharmacy practice. She noted that the Member did not perform at the expected standard for a pharmacy manager. There were serious discrepancies between the methadone doses received and the doses recorded, for example, as great as a 10 fold difference. As stated in Ms. Pollock's expert report, these "could have been the cause of harm to the patients had the PharmaNet record been used for therapeutic decision making". She also found that the actions of the Member with respect to the use and entry of PharmaNet information placed a number of patients at potential risk". She also found that the Member "abdicated her professional role and did not provide adequate supervision of the pharmacy technician on a significant number of occasions".

21. Ms. Lynn Pollock also noted with respect to the physician complaints about the Member that she would consider any physician's formal complaint to the College about a pharmacist to be a very serious issue and she suspected that "most pharmacists never received such a complaint during their professional lives".

22. In general, Ms. Lynn Pollock was struck by the significant lack of compliance with the policies and procedures that define good pharmacy practice. "On many occasions I believe that she abdicated her professional role and handed it over to a support staff member. The possibility of error was greater than acceptable and patient safety was put at risk".

23. While the Member has indicated that she has subsequently taken many continuing education courses since becoming a pharmacist, she has not apparently been able to apply this information to her practice. For example, she took an Addiction Medicine and Methadone

Maintenance 101 workshop on June 21, 2008 (Exhibit 21) and yet on October 2008 during an inspector visit (Tab 16 binder 1) problems with her dispensing of methadone were noted. This has caused the Panel considerable concern that she is either not sincere towards continuing education or simply does not have the capacity to apply the knowledge that she learns in such courses. As a result, the Panel concluded that this situation presented a significant risk to public safety.

24. There were a number of other incidents that were unusual and which the Panel considered examples of a lack of integrity:

(a) While under suspension on April 8, 2009, the Member went to a pharmacy and requested PharmaNet access in relation to several methadone patients. The pharmacist in charge showed the Member the log book and thereafter the Member accessed PharmaNet without using her own pharmacist ID and password (Exhibit 8).

(b) On May 29, 2009 while under suspension, the Member requested that a College staff member "arrange a pharmacist position" at the College staff member's place of employment.

(c) While under suspension on or about June 15, 2009, she requested hard copies of prescriptions from a pharmacy. The pharmacist who received this request advised the College that the Member had claimed she was "working for head office" (Exhibit 13).

Pharmacists, like other professionals, are trusted by the public and their peers and are expected to exhibit the highest ethical standards. The Code of Ethics, is noted in the Framework of Professional Practice (Exhibit 16) is a cornerstone of pharmacy in British Columbia. The Member has not demonstrated that she is worthy of the public trust.

25. There was also throughout the Hearing a disturbing pattern on the part of the Member of deflecting responsibility and blame to others. She tended to blame her problems on someone else, such as the owner or the inspector, or indeed even the College for having failed to effectively make her appreciate how serious the matter was. She also claimed that one of the physician's complaints was due to a conflict of interest in that he referred his patients to different pharmacies allegedly because there was some sort of financial arrangement between the physician's office and the pharmacy. There is absolutely no evidence in fact that this occurred.

26. In answer to a series of questions by a member of the Panel about the physician complaints about her, the Member stated that she did not think they were legitimate complaints

as they did not speak to her ability as a pharmacist but more to the financial aspects of pharmacy practice. She stated it was her view that it was up to her to determine what was best for these patients in terms of whether medication was dispensed daily or not, even despite the physicians' orders. She blamed the owner of AYC Pharmacy and the volume of the work. She stated when asked if she had any shortcomings as a pharmacist that she had met the standards but that she had been busy and there were only deficiencies in filing.

27. The Member has been a licensed pharmacist in British Columbia since November of 2000. According to the evidence, she has worked in at least seven different pharmacies from that date to November 2008. The opportunity of working with different pharmacists and in different environments should have presented an ideal opportunity for her to learn a variety of methods of prescription checking, filing systems, the requirements for documentation and counselling techniques. Yet from the practice deficiencies identified in these proceedings, it does not appear that she has been able to take any effective measures to improve her skill level. In the Panel's view, remediation or practice subject to conditions is not a feasible or safe outcome.

28. Based on the evidence it heard from the Member, the Panel considers that there is a dangerous gulf between the Member's perception and understanding of the responsibilities of a retail pharmacist and the College's requirements and the standards of the profession. As noted in the *Verma* decision, "the emphasis must be upon the protection of the public interest, and to that end, an assessment of the degree of risk, if any, in permitting a practitioner to hold himself out as legally authorized to practise his profession." In addition, the Panel was urged by Ms. Farbeh's counsel to consider the test in *Patel* which includes a consideration of the interests of the profession as a whole and of the particular interests of the Member before us. The Panel did so in its deliberations.

29. The Panel concludes there should be a strong message to the profession that the misconduct demonstrated in this case should not be tolerated. The Panel appreciates that this Member, having been suspended since 2009, has been subject to a severe and significant penalty to date; however, the risk to the public is too great, in our view, to permit her to return to practice at this time.

30. The Panel has therefore determined that the Member's registration should be cancelled immediately. If she reapplies for registration in the future, the Registration Committee of the

College should carefully review the Panel's Decision and its Penalty Decision in considering what conditions should apply. At a minimum, the Panel thinks the courses set out in paragraph 11 should be required. She is also assessed costs in the amount of \$35,000.00 which must be paid before she is eligible to apply for any reinstatement of her registration.

31. Pursuant to section 30(3)(a) of the *Health Professions Act*, Ms. Farbeh has the right to appeal this order to the B.C. Supreme Court.

32. In making this decision, we have considered all of the submissions before us, whether or not they are specifically referred to in these reasons.

DATED this 29th day of June, 2010.



Wayne Chen (Chair), Licensed Pharmacist

Jody Croft, Licensed Pharmacist

Michael MacDougall, Government Appointee


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