

Pharmacist's registration permanently cancelled

Ari Johannes (Harry) Toykkala, diploma 3170, guilty of professional misconduct

Between 2000 and 2006, Harry Toykkala had his pharmacist registration suspended four times due to addiction to drugs and/or alcohol. As a requirement to return to practice after each suspension, Mr. Toykkala voluntarily signed behavioural and aftercare agreements with his addictionologist and agreed to comply with the terms outlined in each agreement in order to maintain his registration to practise as a pharmacist.

On May 30, 2007, the College of Pharmacists of B.C. discipline committee panel conducted a hearing to inquire into the following allegations:

1. Between March 1, 2000 and November 30, 2006, Harry Toykkala failed to comply with limits and conditions on his registration as a pharmacist in that he breached the terms of various behavioural and aftercare agreements.
2. Harry Toykkala suffers from addiction to alcohol and/or drugs, affecting his practice as a pharmacist.

After reviewing all evidence, the panel found that Mr. Toykkala contravened terms of his behavioural and aftercare agreements after each return to practice by continuing to use drugs and/or alcohol. He was therefore found guilty of professional misconduct contrary to the *Pharmacists, Pharmacy Operations and Drug Scheduling Act* (the "Act") R.S.B.C. 1996 c. 363 s. 54(1)(f).

On October 20, 2007, the discipline committee panel conducted a hearing to determine penalty for Mr. Toykkala's professional misconduct. Pursuant to the Act, s. 54(2)(j), the panel decided to permanently cancel Mr. Toykkala's College of Pharmacists of British Columbia registration, based on his history of addiction to drugs and/or alcohol, failure to treat his addiction(s) despite having been given several opportunities, and risk to relapse.

Harry Toykkala has been removed from the College of Pharmacists of B.C.'s register of pharmacists.

what went wrong

The Institute for Safe Medication Practices Canada (ISMP Canada) published a safety alert earlier this year, following up on a comprehensive safety bulletin published in 2003, to help health care providers avoid errors in prescribing, dispensing and administering methadone.

Two case studies from the 2003 safety bulletin illustrate some of the potential problems.

Case study #1

A patient was taking 13 mg/day of methadone prepared by a community pharmacy using a methadone stock concentration of 1 mg/mL. The patient was hospitalized, and a telephone order for 12 mL methadone po daily was received by a nurse from a physician, who assumed the hospital's stock solution was the same strength as the community pharmacy's.

A technician using 10 mg/mL stock solution of methadone prepared the order. A pharmacist checked it against the pharmacy copy of the original order and the patient's in-patient medication profile. The methadone stock bottle was verified, and the technician had left the syringe used to measure the volume pulled back to 12 mL.

The patient received 120 mg methadone, but fortunately, vomited much of the dose. The patient recovered without any further medical intervention.

Case study #2

A patient receiving methadone for pain control from a community pharmacy reported that she felt unwell (pale, sweaty, clammy, shaky) two days after receiving her prescription for 8 mL of a 5 mg/mL stock solution (total dose 40 mg).

When the prescription was checked, the prescribed dose for the patient was 14 mL (total dose 70 mg). The significant under dose resulted in withdrawal symptoms, in addition to inadequate pain control.

Keeping patients safe

Methadone's dosing complexities and other contributing factors, such as dosing errors and errors associated with nomenclature, have resulted in multiple reports in Canada and the U.S. of medication errors resulting in serious patient harm.

ISMP Canada recommends that all health care providers involved in prescribing, dispensing and administering methadone have standardized policies and procedures for the management of the drug.

The following risk-reduction actions should be incorporated into practice if they are not already routine activities:

- All methadone orders must be written in mg, not mL.
- Prescribers should write the methadone dosage in words.

- Dates and times for administration should be specified (avoiding the use of the word "daily").
- Concomitant use of methadone with other narcotics, benzodiazepines and sedatives should be avoided.
- Pharmacies should stock only one concentration of methadone.
- If more than one concentration is required to manage patients appropriately, use prominent warning labels.
- When compounding methadone from powder, use a standard manufacturing formula, maintain a manufacturing log and clearly label the finished product.

