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	Tom A. Hakemi
Counsel for the College of Pharmacists of British Columbia:	Alastair Wade
Counsel for the Disciplinary Panel:	Penny A. Washington
Dates of Second Penalty Hearing:	February 28, 2012
Place of Penalty Hearing:	200 - 1765 West 8th Avenue, Vancouver, BC
Second Penalty Decision:	July 16, 2012

PENALTY DECISION

1. On December 14, 2011 the Supreme Court of British Columbia set aside three counts in this matter as a result of the Appeal of the Panel's February 26, 2010 decision on liability (the "Liability Decision"). The Supreme Court confirmed the Panel's finding of guilt with respect to the remaining two counts. Those two counts are as follows:

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.

Count 5:

Between December 1, 2005 and March 31, 2009, you failed to comply with the 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.

2. The Panel had originally issued a decision on penalty on June 29, 2010 cancelling Ms. Farbeh's registration and imposing a $35,000 order of costs. In light of the Court's decision, the Panel reconvened to hear submissions on penalty in relation to counts 3 and 5 only on February 28, 2012. Ms. Farbeh's counsel at that time submitted that the appropriate penalty in this case would be:

(a) a reprimand;
(b) suspension from practice for the period of time that Ms. Farbeh has had her registration cancelled to date; and
(c) no costs to either party.

3. The College submitted that the previous penalty imposed by the Panel cancelling Ms. Farbeh's registration and subjecting her to an order for costs in the amount of $35,000 should not be varied.

4. Both counsel reviewed the case law setting out the factors the Panel should take into account as set out in the *Verma v. The College of Physicians and Surgeons of British Columbia,* [1994] B.C.J. No. 2701 (S.C.) and *Patel v. Ontario College of Pharmacists,* [2000] O.J. No. 256 (S.C.J.) decisions as follows:

(a) the protection of the public;
(b) the interests of the profession as a whole, including ensuring the public can have confidence in the integrity of the practice of pharmacy; and
(c) the particular circumstances of the individual member and the nature and gravity of the offending conduct.

5. The Panel notes that pursuant to s.39(2) of the *Health Professions Act*, the Panel 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 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).

6. The Panel has carefully considered afresh the entirety of the evidence it heard in relation to Counts 3 and 5. The Panel has endeavoured to set completely aside from its consideration the evidence relating only to the counts that are no longer before it.

7. The Panel also appreciates that the issue of rehabilitation is one which it must consider in sentencing Ms. Farbeh and it has carefully done so. The Panel notes that correspondence between the College and Ms. Farbeh concerning deficiencies in her practice began in late 2005 and continued throughout 2006, 2007 and 2008. She acknowledged the deficiencies and she had multiple opportunities throughout this period to improve her practice and did not do so. She was suspended as of December 1, 2008 and was reinstated by order of the Supreme Court on February 10, 2009 on certain conditions. Those conditions required her to review the applicable legislation, the Bylaws of the College, the Code of Ethics and the Professional Practice policies of the College, as well as, the Framework of Professional Practice which explains the professional standards in detail. These are essential documents all pharmacists should be very familiar with and they govern pharmacists in their daily practice. Ms. Farbeh signed a

declaration acknowledging that she had read and understood those documents before she was permitted to return to practice.

8. The evidence presented during the hearing on Count 3 established that Ms. Farbeh signed and dated several Summary reports as well as other documents acknowledging her commitment to take corrective action and remedy the deficiencies as noted in those respective documents. On subsequent visits, College inspectors found that the deficiencies previously noted had not been remedied and the corrective actions which Ms. Farbeh confirmed had been made had not been implemented. It should be noted that these examples date from August of 2006 to October of 2008 and the Panel is of the view there was ample opportunity for Ms. Farbeh to understand what was required and truly attempt to rectify the deficiencies noted. The Panel considers that it is also a very serious matter to mislead one's professional College.

9. Two members of the Panel are pharmacists with a total of over 60 years of retail pharmacy experience. Speaking in general terms, most pharmacists or pharmacy managers would take any documents or requests from the College as matters that require prompt attention. Pharmacists, in general, accept their professional responsibilities and try to improve their practice and remedy their deficiencies at all times. In the Panel's opinion, it would be reasonable to expect that corrective measures would be taken quickly and efficiently.

10. The Panel remains deeply concerned that despite several significant opportunities given to Ms. Farbeh in the past to improve her practice and to understand her professional responsibilities as a pharmacist, she failed to do so.

11. In sentencing, among other factors, the Panel has a responsibility to assess the nature and gravity of the proven allegations and the gravity of the risk to the public represented by Ms. Farbeh if she was permitted at this time to hold herself out as a licensed pharmacist. In the opinion of the Panel, that risk is grave in relation to public safety and the Panel considers that her registration should remain cancelled.

12. Ms. Farbeh's demonstrated lack of ability to improve her practice and to understand her professional responsibilities was very clear on the evidence and is a significant deficiency. While any professional can make a mistake from time to time, it is an important characteristic of a professional that they demonstrate an ability to learn from their mistakes and to rectify deficiencies in their practice. That is precisely what Ms. Farbeh has failed to accomplish. In

fact, in relation to Count 3, the Panel found that on several occasions she claimed to the College that she had rectified deficiencies when she had not. As a result, the Panel found that Ms. Farbeh deliberately misled the College. That is a significant factor in this decision on penalty. The evidence, in relation to the results of the practice audit she underwent on March 5 and March 10, 2009 while she was practicing under court-imposed conditions, is also very significant.

13. There were numerous examples in the evidence relating to Count 5 of the Citation of factors that contribute to public safety and the accurate practice of pharmacy. Deficiencies were found in that necessary quality assurance measures were lacking, there were errors in proper labelling of prescriptions and often a failure to attach a transaction tag to hardcopies to allow for proper record keeping, a failure to deal with expired stock and significant failures to properly record interactions with physicians, and a persistent failure to adhere to the professional guidelines for dispensing methadone. These were all areas in which deficiencies were identified through the evidence of the College inspectors who testified in this matter. The College inspector Mr. Budd, in particular, had raised many of these issues with Ms. Farbeh on multiple occasions. If Ms. Farbeh had truly taken seriously the information that had been provided to her time and again by the College inspectors, she should have been able to easily rectify these deficiencies. The responsibilities of the pharmacist and, in particular, the pharmacy manager, to have ensured that such tasks were promptly and regularly completed are set out in Bylaw 5 s.26(2):

> The community pharmacy manager must
>
> (a) actively participate in the day-to-day management of the community pharmacy,
> (b) as part of a quality management program under section 27, develop, maintain and enforce policies and procedures to comply with the standards of practice as stated within current community pharmacy legislation,
> (c) confirm that staff members who present themselves as pharmacists and who are employed to practise as pharmacists hold valid licences to practise,
> (d) notify the Registrar in writing of the appointments and resignations of registrants to the community pharmacy staff as they occur,
> (e) respond in writing to the Registrar's queries regarding community pharmacy practice and, where applicable identify the registrant(s) involved in any matter under review,
> (f) advise the Registrar in writing of the termination of a registrant's employment for cause including professional practice problems, theft, or drug or alcohol abuse,

(g) ensure that registrant and community pharmacy support person staffing levels are commensurate with the workload volume and patient care requirements at all times,
(h) ensure that new information directed to the community pharmacy pertaining to drugs, devices and drug diversion tactics is immediately accessible to registrants,
(i) establish policies and procedures to specify the duties to be performed by students, qualifying candidates, and support persons,
(j) be responsible for inventory management and procedures for proper destruction of unusable drugs and devices,
(k) ensure that purchase records for narcotic and controlled drugs are signed by a pharmacist,
(l) assume responsibility for the appropriate security and storage of all Schedule I, II, and III drugs,
(m) ensure that each individual working in the community pharmacy wears a badge that clearly identifies him or her as a registrant or community pharmacy support person,
(n) ensure that confidentiality is maintained with respect to all community pharmacy and patient records in accordance with section 35,
(o) in the event that he or she will be absent for more than eight weeks, notify the Registrar,
(p) notify the Registrar in writing at least thirty days before relinquishing an appointment as pharmacy manager,
(q) ensure the correct and consistent use of the community pharmacy operating name as it appears on the community pharmacy licence for all pharmacy identification on or in labels, directory listings, signage, packaging, advertising or stationery.

Ms. Farbeh's practice was deficient in many of these areas. She did not comply with s.26(2)(b), (g) and (j), of Bylaw 5 for example. These all have significant implications for patient safety. The policies and procedures relating to the dispensing of methadone, for example, have been designed to ensure patient safety in a situation in which abuse may occur. By way of another example, proper staffing levels are correlated to the ability to fulfill all professional responsibilities.

14. As part of Ms. Farbeh's court-ordered return to practice, she was required to document, on the back of a hardcopy of each prescription she dispensed, how she complied with the requirements of specific Bylaws including Bylaw 5, Section 43.4 and Section 44 which deal with the patient record and pharmacy/patient dialogue. She was then to submit those prescriptions to the Deputy Registrar of the College. The Deputy Registrar gave evidence that the information submitted by Ms. Farbeh was deficient. It was evident to the Panel that Ms. Farbeh had not appropriately reviewed the patient profile or otherwise engaged in appropriate dialogue with the patient to ensure adequate pharmaceutical care.

15. Ms. Farbeh was also made aware by the College as part of the court-ordered conditions on her return to practice that there was going to be an audit of her practice. This was a significant opportunity for Ms. Farbeh to demonstrate that she had learned from the suspension and was indeed able to practice in accordance with the requirements of the profession. Nonetheless, and despite her declaration that she had read and understood the documents that she was required to review as part of the conditions that allowed her to return to practice, she did not meet appropriate professional standards during the audit that took place in March of 2009. That is a very significant factor in this penalty decision.

16. The Panel heard evidence that in March of 2009, the auditor, Mr. Peter Cook, was able to observe Ms. Farbeh working at a small pharmacy in a suburban community that was not very busy and in which she had ample time with each patient to demonstrate her compliance with good practice standards. According to the evidence of Mr. Cook, 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". Mr. Cook found that Ms. Farbeh "does not meet the standard of practice in British Columbia in Role 1 and Role 3 Function E of the Framework of Professional Practice", the document she had indicated she had read and agreed to practice under.

17. The Framework of Professional Practice is a fundamental document that clearly explains the profession's standards as found in the Bylaws. Role 1 is to provide pharmaceutical care. Role 3 is to contribute to the effective operation of the pharmacy. Function E is to minimize practice errors and omissions, unsafe practices and professional misconduct. In a pharmacy that was not busy and where she had only 14 patient interactions over the two days that Mr. Cook was there to observe her, Ms. Farbeh was found to be so deficient in her practice that "this represents a high risk that the client could need further intervention by a health professional." It was as a result of that practice audit that she was suspended for a second time on April 3, 2009 (Exhibit 7). In the Panel's opinion, she had both the time and support on the court-ordered return to practice to easily practice within the standards set out in the Bylaws of the College. According to the examples given in Mr. Cook's evidence, however, she does not minimize errors and unsafe conduct and she does not take actions to minimize professional misconduct. The expert witness, Ms. Pollock cites the following random prescription from October 16, 2008:

> "A prescription was written for Dermovate but Betaderm was dispensed. No record of discussion with the physician regarding a change was noted. There is a significant difference in potency

> between clobetasol 17-propionate (Dermovate) and betamethasone valerate (Betaderm). The two corticosteroids are not interchangeable. This prescription was filled in error and could have led to the patient receiving inadequate therapy for her dermatological condition." (Exhibit 19 page 11)

There were other examples where Ms. Farbeh did not know the indication for the drug treatment either because of a lack of professional knowledge or because she did not appropriately discuss it with the patient. This is a significant problem and could lead to patient harm as she would not, for example, be able to properly inform patients of treatment risks and benefits or advise on side-effects in relation to the treatment objectives of the medication. Because of this unsafe practise, Ms. Farbeh represents a significant danger to the public in the Panel's view. Her willingness to contradict physician orders, for example, can clearly adversely impact the outcome of the patient's treatment.

18. This "second chance" opportunity distinguishes this case from many of the others cited by counsel for Ms. Farbeh in his thorough submissions on penalty in which he argued revocation is unusual for a first appearance before the College. It is true that the most serious penalties generally are for "repeat offenders". Although it is true she had no previous disciplinary history she was, however, given opportunities between inspections and, by court-order, a fresh opportunity after an initial suspension to demonstrate that she could improve her practice and comply with the Bylaws in a situation that should have been conducive to allowing her ample time to attend to all of her professional obligations and she failed to do so.

19. Although counsel for Ms. Farbeh suggested that this would be a different case and one deserving of greater censure if there was evidence before this Panel of actual harm to patients, the Panel's view is that it is not appropriate to say that one must await a case of actual harm before resorting to the most severe penalty if the deficiencies of the practice are such as to put the public at foreseeable risk.

20. The Panel has carefully considered anew whether there are practice restrictions and remedial options that could be imposed on the practice of Ms. Farbeh that would allow her to return to practice but would adequately protect the public in these circumstances. It was the determination of the Panel, however, that Ms. Farbeh had already had an opportunity to take advantage of remedial options which were designed to have her become familiar with and adhere to the Bylaws and other requirements of

the profession, and she had demonstrated an inability to incorporate those lessons into her practice.

21. Ms. Farbeh through her submissions on penalty and in her earlier evidence at the hearing appeared still to seek to be excused for some of her failure to comply with appropriate standards in the Bylaws while at AYC Pharmacy on the basis that it was a pharmacy in the downtown east-side of Vancouver. She stated she had been working very hard at the time, filling between 500 and 600 prescriptions a day. She also tended to deflect blame on others, such as the technicians for failing to keep up with filing or the owner for not hiring more pharmacists. Rather than valid excuses, the Panel sees this as evidence of her failure to meet her responsibilities as a pharmacy manager to manage her workload in a way that ensured patient safety and to ensure 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 timeliness. 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 in breach of her responsibilities under Bylaw 5, which ultimately put the public at risk.

22. Ms. Farbeh's counsel submitted that the fact Ms. Farbeh worked at a pharmacy in the downtown east side of Vancouver is a mitigating circumstance which argues in favour of a less severe sanction. The Panel is of the strong view that the residents of the downtown east side are entitled to the same standard of practice as the residents of other communities.

23. In fact, because of their complex health and socio-economic status, the patients likely require an increased vigilance on the part of pharmacists to ensure their well-being. Working in this area is not in any way a reason for a failure to practice within applicable standards. In addition, the Panel notes that the deficiencies continued to persist when she was working at a low-volume pharmacy in a different community, as noted in the March 2009 audit.

24. Also, of particular concern to the Panel were the complaints from physicians relating to her practice and procedures when she was the pharmacy manager at AYC

Pharmacy to the effect that she did not follow their directions and did not consult with them adequately or at all about changes she made to their prescriptions and there was no evidence the situation fell into the exceptions set out in Bylaw 5 (41)(Dispensing). There were complaints that prescriptions were daily dispensed by Ms. Farbeh without discussion with the physicians when it was clearly noted on the original prescription that the physician order was "Do Not Daily Dispense".

25. There was also an allegation that there was dispensing of Kadian (morphine) 50mg capsules by Ms. Farbeh without a prescription which is obviously very serious. The evidence was that the doctor stated that he did not prescribe morphine during the period in question (Tab 64 binder 1). PharmaNet records indicate that patient "SH" was dispensed 4 x Kadian (morphine) 50mg on a daily witnessed ingestion basis each day from November 25, 2007 – November 27, 2007. Yet a urinary drug screen taken on November 28, 2007 for this patient was negative for opiates. The period within which opiates can be detected on urinary screens is 1 to 3 days after ingestion. Witnessed ingestion is important to prevent diversion of such narcotics to illicit use. The pharmacist is responsible for witnessing the ingestion.

26. Ms. Farbeh's letter dated May 28, 2008 to the College stated the Kadian was for a fourteen day supply starting on November 10, 2007 with four capsules to be dispensed daily and ingestion to be witnessed. Ms. Farbeh claimed the November 26 and 27, 2007 doses (which were beyond the 14 day limit set out in the prescription) were given based on her professional discretion as the pharmacy was unable to contact the physician for refill authorization. The letter also stated the doses were always witnessed at the pharmacy.

27. According to the evidence led by the College, the physician subsequently indicated that the prescription for morphine for this patient was not renewed on October 17, 2007 and was not renewed again until November 29, 2007. The physician's chart also notes on November 28, 2007 that the patient "denies other opiate use".

28. The original triplicate hard copy prescription for the Kadian which Ms. Farbeh says she initially dispensed from starting November 10, 2007, which is required to be kept on file by the pharmacy, pursuant to Bylaw 5, s.39, has never been located. Ms. Farbeh's verbal reply to the College, from May 21, 2008 (Tab 66 of binder 1) and the letter (Tab 68 of binder 1) received by the College on June 9, 2008 indicated there was a management change in November 2007 and

she had been unable to find the prescription. The College inspectors were also unable to locate this prescription when they visited the pharmacy on October 16, 2008.

29. During the hearing, Ms. Farbeh provided the Panel with two copies of different prescriptions for Kadian in an initial attempt on her part to establish that she had found the prescription in question but the dates did not match the period in question and the patient birth date did not match that of the patient in question. The patient name and PHN were blacked out, therefore patient confirmation was not possible and when questioned about this, Ms. Farbeh claimed this was to protect patient confidentiality. Only after the discrepancies were pointed out to her, did Ms. Farbeh finally acknowledge to the Panel during the hearing that she still could not locate the original Kadian prescription for patient "SH".

30. The inability of Ms. Farbeh to find the original prescription for a narcotic, even to the date of the hearing, is of great concern given the potential for illegal diversion of such medications and potential harm to patients if they receive such medication when it has not been prescribed for them. This is at best another example of the serious consequences attendant upon her failure to maintain an appropriate filing system in place.

31. The Panel found that she did not respond appropriately to the complaints from physicians nor did she treat them seriously. In answer to a series of questions by a member of the Panel about the physician complaints about her, Ms. Farbeh agreed 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 yet those complaints related specifically to patient issues. When answering questions about why she would daily dispense medication without discussion with the physician when that had not been directed by the prescribing physician, she took the view that it was up to her to determine what was best for these patients, even despite the physicians' orders, because she "sees them [the patients] every single day" and more often than their physicians. This attitude is inconsistent with how pharmacists are expected to work within the healthcare team and is unprofessional. She also blamed her difficulties on 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 standard" but that she had been busy and there were "only" deficiencies in filing. She repeatedly demonstrated a complete lack of recognition of the importance of the issues raised by the College.

32. Finally, the expert who gave evidence on behalf of the College, Ms. Lynn Pollock, who has 33 years of experience as a pharmacist in community pharmacy including experience in a pharmacy which dispenses methadone, noted many significant breaches of acceptable and reasonable standards of pharmacy practice. She noted, and the Panel agrees, that Ms. Farbeh did not perform at the expected standard for a pharmacy manager and this could have significant concerns for a patient. There were serious discrepancies between the methadone doses received by patients 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 noted "that the actions of Ms. Farbeh with respect to the use and entry of PharmaNet information placed a number of patients at potential risk.

33. In general, the Panel was struck by the significant lack of compliance by Ms. Farbeh with the procedures set out in the Bylaws that define good pharmacy practice.

34. One of the concerns was her practice of frequently placing multiple medications in one vial without proper labelling. In regards to the concern for public safety that arises from that situation, Ms. Lynn Pollock stated the following with which the Panel agrees:

> "I believe that there are several issues to address regarding this situation. The fundamental concern with all of them however, is the issue of patient safety.
>
> It is considered good practice to label all medication containers to ensure that contents are clearly identifiable. Many medications look similar so errors can occur when visual tablet/capsule identification is the only means used to select a drug from stock. When medication is removed from the stock bottle and repackaged for stock in another container (e.g. vial for dispensing at a later time) the standard of practice would be to label the vial with the name, strength, DIN, lot and expiry date of the medication. This also ensures that if there is a product recall or a need to return a medication to stock that medications can be correctly identified. The standard of practice to ensure that the correct medication is selected when filling a prescription is to compare the prescription or label information with the drug name, strength and DIN on the stock bottle and also do a visual check. It would not be possible to perform these vital steps within the system that was used at AYC pharmacy. Even assuming that the pharmacist previously checked and verified the bag contents, the current standard of practice would not be met by the process used by Ms. Farbeh."

The relevant Bylaw provides as follows:

> **Bylaw 5 s.40**: All drugs dispensed under a prescription of a practitioner must be labelled with a typed or machine printed label that must contain the following
> (a) name, address and phone number of the community pharmacy,
> (b) prescription number and current dispensing date,
> (c) full name of the patient,
> (d) name of the practitioner,
> (e) unless the practitioner otherwise instructs,
> (i) for single-entity products, the generic name of drug followed by the brand name or the manufacturer name or the Drug Identification Number,
> (ii) for multiple-entity products, the brand name or all ingredients listed followed by the manufacturer name or the Drug Identification Number,
> (iii) for compounded preparations, all ingredients,
> (iv) quantity and strength of the drug,
> (f) practitioner's directions for use, and
> (g) any other information required by good community pharmacy practice.

35. The Panel found that Ms. Farbeh did not follow this Bylaw and considers that there are significant patient safety concerns that arise from failing to do so. The Panel also noted that Ms. Farbeh appeared to use several systems at the same time in relation to putting different medications into a single vial and inconsistencies in how vials were or were not labelled. There were many examples in the evidence that labelling that was on medication vials did not accord with what medications were in fact in the vials. Examples are set out in the Liability Decision on pages 15 and 16. This has obvious implications for patient safety as patients are entitled to assume that they are receiving the correct medication and they rely on the label being accurate. Ms. Farbeh's practice was neither reasonable nor safe. The Panel believes that Bylaw 5 s.40 is very clear and not difficult to follow in practice.

36. Ms. Farbeh made excuses that she "just could not come up with corrective actions" but she should have been fully aware of the bylaws that govern the profession of pharmacy in British Columbia and the Professional policies of the College that clearly outline the standards to be met.

37. The Panel finds it alarming that Ms. Farbeh would not recognize the problems and make a serious effort to promptly rectify the issues brought forth by the College inspectors. The issue of multiple medications being in one vial was raised repeatedly by the inspectors.

38. 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. The practices used by Ms. Farbeh seriously place patient safety at risk and are completely unacceptable. Yet, she continued to use them even after the problems with them were pointed out to her.

39. In her evidence, Ms. Pollock noted that:

> "Individual patients' medications for daily dispensing were pre-packaged in prescription vials and stored in white bags. Prescription labels were attached to the outside of the bag or alternatively instructions were handwritten on the outside. In some cases the labels on the bag did not indicate all of the bag's contents and many times the dates on the labels were not current. The vials containing the various medications were inconsistently labelled, many vials were not labelled and sometimes the vials contained medications that were different than the label. Some unlabeled or incompletely labelled vials contained more than one type of medication. Some vials contained a different number of tablets than was stated on the bag or from what was observed in other vials in the same bag. These bagged medications were used to dispense the daily medications handed to patients. Usually this was done by the pharmacy technician without the pharmacist checking the prescription product prior to dispensing. Ms. Farbeh stated that the medication is checked and verified by the pharmacist when first put into the bag but there was no consistently used log available or procedure observed to support that statement. Sometimes medication was removed from an unlabelled vial and returned to a stock bottle by Mr. Valencia, without Ms. Farbeh checking for accuracy"
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> Part of the problem was that the system used was also inconsistent. In some bags one vial contained numerous different medications that presumably were meant to correspond to a daily intake of medications for a patient. In other bags medications were packaged in separate vials each containing several day's worth of a specific medication. To that, add the fact that the contents did not necessarily correspond to the labels on the bags and the final product was not checked by the pharmacist and, it is clear, that the system is wrought with risk of error. In a community pharmacy with numerous demands and time constraints, an organized, clear, well thought out dispensing system can definitely help with the workload. It also usually contains safeguards or procedures that decrease the chance of medication error. The system used by Ms. Farbeh was not such a system and, in my opinion, did not meet a reasonable standard of practice.
>
> I understand why several different medications might be dispensed in one vial versus a compliance pack however there is no adequate reason to avoid labelling the medications. Labelling

> is for patient safety. If patients have been on the medications for a while they probably do not use the labels to confirm instructions for use. However, it is important for others, such as emergency medical personnel, to know details of the patient's medications if the need arises. From my experience it is common pharmacy practice to affix labels to the vial for all the medications contained within that vial. This can be done by providing the short version of a label as indicated in the by-laws or by attaching the complete labels as flags to the vial. At one point in the documentation it was noted that Ms Farbeh stated that putting 2 labels on a vial containing more than two medications was sufficient. At times she oversaw the dispensing of vials with no labels. In my opinion that is not a reasonable standard of practice."

40. The Panel agrees with the foregoing description of the concerns for public safety raised by Ms. Farbeh's style of practice.

41. Other examples of concern from Mr. Cook's audit report from his review in March of 2009 include:

> "While reviewing the prescriptions and notes Ms. Farbeh sent to Ms. Solven and also PharmaNet records of prescriptions filled under Ms. Farbeh's license number I noted the following issues which require comment. The instructions provided on prescription labels were sometimes incomplete. For example: Xalatan drops are to be instilled in the eye. Instructions simply indicated "Instil one drop daily". Complete instructions, would indicate that the drops were to be instilled in the eye and also which eye should receive the drops."
>
> "One patient received a new prescription for Betaderm three days after receiving a prescription for Hyderm from a different physician. Ms. Farbeh's notes indicated that she did not see any therapeutic duplication on the profile but it is apparent that there was one. There was no indication that the pharmacist had clarified the need for the second corticosteroid with the patient or provided guidance re: use of two similar medications for the same problem"
>
> "Tylenol #3 and Naproxen prescriptions were processed without clear instructions. The prescription was written with the sig: "as directed". These are not appropriate directions as they create the chance of the unintentional misuse of the medication. An appropriate approach would have been to clarify the instructions with the physician prior to dispensing. This was not done for the Tylenol #3. Naproxen instructions on PharmaNet indicated twice daily as directed. There was no record of how these directions were determined although they are reasonable instructions for the medication. It is important to record discussions with physician, process followed to determine dose etc in case there is a future

> problem that requires clarification. It could be a matter of patient safety or even, pharmacist safety. If a pharmacist's judgment or actions are ever questioned regarding a prescription it is important to have documentation to support what was done."
>
> "A prescription for CoActifed was filled with Cotridin Expectorant. An expectorant was not prescribed for the patient's dry cough. An expectorant is not recommended for a dry cough contrary to Ms. Farbeh's handwritten notes. If the plain syrup product was not in stock, an appropriate course of action would have been to discuss the switch to expectorant with the physician prior to dispensing the prescription."

42. The foregoing examples are again from a time in which Ms. Farbeh was working in a low-volume pharmacy situation and under court-ordered conditions, when she would be expected to work very hard to demonstrate the highest standards. Taken in conjunction with the other examples noted in the evidence above reviewed by the Panel, it is the unanimous conclusion of the Panel that Ms. Farbeh is not qualified to practice as a registered pharmacist in the Province of British Columbia.

43. It is also important to note that Ms. Farbeh did give evidence that she has taken many continuing education courses since becoming a pharmacist. However, 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 concern that she is either not sincere towards continuing education or simply is unable to apply the knowledge that she learns in such courses to her practice. As a result, the Panel has concluded that this situation continues to present a significant risk to public safety.

44. Ms. Farbeh 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 option.

45. Based on the evidence it heard from Ms. Farbeh, the Panel remains convinced that Ms. Farbeh's perception and understanding of the responsibilities of a retail pharmacist and the College's requirements and the standards of the profession are too far apart to ensure the public will be sufficiently protected. 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."

46. The Panel appreciates that in many of the penalty decisions cited by counsel for Ms. Farbeh 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 presented so many examples of substandard practice that it is the Panel's view that this takes it out of the category of simple incompetence in one or two areas which, when readily admitted, may also be easily remedied.

47. In the submission from the counsel for Ms. Farbeh, from paragraph 31, he stated by way of justification for a lesser penalty:

> "Here, the unique and particular circumstances of Ms. Farbeh before the Panel include that:
>
> a. She had no disciplinary record prior to late 2008 and the events described in the Liability Decision; and
> b. The pharmacies at which she worked are in the downtown east side of Vancouver (the DTES); and
> c. She relies on the practice of pharmacy to support herself and her family."

48. The Panel has considered Mrs. Farbeh's particular circumstances. The Panel is of the opinion that comment (c), however, is not particular or unique to Ms. Farbeh. In most cases, practicing pharmacists need to work to support their families or themselves. The Panel accepts part (a) of the submission from Ms. Farbeh's counsel and has addressed that issue at length in these reasons. In terms of b) the Panel has earlier rejected the idea that working in the downtown east-side somehow excuses the persistent and repeated failure to meet professional standards. This was not a case of a few isolated errors attributable to the pressure of a busy day or a difficult patient.

49. 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 practice his profession." In considering the appropriate penalty, while considering the situation and unique circumstances of the practitioner, there is a need to protect the public and ensure the safe and proper practice of pharmacy as well as to protect the public's confidence in the integrity of a self-regulated profession.

50. In terms of costs, the Panel notes that the original request for costs by the College was in the amount of $55,000 (1/2 of the $110,000 in costs incurred as established by the evidence and as permitted by the legislation and bylaws) and the Panel originally reduced that figure to $35,000. The Panel estimates that approximately one day of hearing time was devoted to evidence on the counts that were set aside by the Supreme Court or approximately 10% of the total hearing time and accordingly reduces the cost award by slightly more than that figure to $30,000. These costs must be paid before Ms. Farbeh is eligible to apply for any reinstatement of her registration.

51. Pursuant to s.30(3)(a) of the *Health Professions Act*, Ms. Farbeh has the right to appeal this order to the British Columbia Supreme Court.

52. 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 16th day of July, 2012.

Wayne Chen (Chair), Licensed Pharmacist

Jody Croft, Licensed Pharmacist

Michael MacDougall, Government Appointee

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