

Pharmacy Connection



Official Publication of the Ontario College of Pharmacists



PRIVACY

Personal Health Information Protection Act

September/October 2004

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- Executive
- Accreditation
- Complaints
- Discipline
- Fitness to Practice
- Patient Relations
- Quality Assurance
- Registration

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- Finance
- Professional Practice

Special Committees

- Communications
- Standards of Practice Working Group
- Structured Practical Training
- Task Force on Optimizing the Pharmacist's Role
- Working Group on Certification Examination for Pharmacy Technicians
- Working Group on Pharmacy Technicians



ONTARIO COLLEGE OF PHARMACISTS

MISSION STATEMENT

The mission of the Ontario College of Pharmacists is to regulate the practice of pharmacy, through the participation of the public and the profession, in accordance with standards of practice which ensure that pharmacists provide the public with quality pharmaceutical service and care.



WE'RE BACK ON TV!

Airing across Ontario this fall
on CBC and CTV
from October 27 to December 5, 2004



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registered with the Ontario College of Pharmacists.

Pharmacy Connection

The objectives of *Pharmacy Connection* are to communicate information on College activities and policies; encourage dialogue and to discuss issues of interest with pharmacists; and to promote the pharmacist's role among our members, allied health professions and the public.

We publish six times a year, in January, March, May, July, September and November. We welcome original manuscripts (that promote the objectives of the journal) for consideration. The Ontario College of Pharmacists reserves the right to modify contributions as appropriate. Please contact the Associate Editor for publishing requirements. We also invite you to share your comments, topics suggestions, or journal criticisms by letter to the Editor. Letters considered for reprinting must include the author's name, address and telephone number. The opinions expressed in this publication do not necessarily represent the views or official position of the Ontario College of Pharmacists.

Council Elections

- District 2 Elaine Akers
- District 5 George Phillips
- District 8 Iris Krawchenko
- District 11 David Malian
- District 14 James Delsaut
- District 17 Shelley McKinney (Acclaimed)

Congratulations to All!

Call for SPT Preceptors

ORIENTATION WORKSHOPS

Pharmacists wishing to become preceptors (and have never attended a preceptor workshop) can register at an upcoming Toronto session.

The **Orientation Workshop** teaches and/or reinforces preceptors' feedback and assessment skills; outlines the role of the *Activities* as tools for the student or intern to demonstrate their competence during their training; and explains the degree to which the *Activities* are to be reviewed and assessed prior to being submitted to the College.

ADVANCED WORKSHOP

An **Advanced Workshop** will be held for pharmacists who attended an Orientation Workshop more than two years ago and wish to continue building their preceptor skills.

The **Advanced Workshop** provides preceptors an opportunity to review and learn how to assess the clinical and communication skills that are being taught to students in the U of T Pharmacy undergraduate program and in the International Pharmacy Graduate Program.

Please Note: Pharmacists who last attended an Orientation Workshop more than two years ago and have taken an SPT student or intern must attend one of the two workshops.

Pharmacists outside Toronto who need to attend a workshop can have their travel expenses reimbursed by the College. For details, please contact Vicky Gardner, SPT Administrative Assistant at x 297.

2005

Preceptor Workshops will be held monthly in Toronto and, from March to June 2005, workshops will be held in other major cities throughout Ontario. Upcoming dates and locations will be published both here and on our website.

Workshop Date	Workshop Type
Wednesday, September 22, 2004	Orientation
Wednesday, October 6, 2004	Advanced
Wednesday, October 13, 2004	Orientation
Wednesday, November 17, 2004	Orientation



Professional Opportunity:

INVESTIGATOR

We are currently seeking an Investigator who will apply practical pharmacy knowledge, analytical, problem solving and communication skills to conduct investigations of pharmacists (as it relates to professional misconduct, incompetence or incapacity) and of pharmacies (as it relates to operational breaches and non-compliance with relevant legislation).

THE PERSON

You have sound knowledge of the standards of practice and the legal framework that govern pharmacy in Ontario. You have a degree in pharmacy or in a relevant health discipline as well as a minimum of 3-5 years practice experience. You possess excellent oral communications skills; experience in detailed report-writing; demonstrated knowledge of investigative interviewing techniques; and proficient computer skills including pharmacy related software and billing programs. You remain objective, consistent and fair in all interactions. You have a passion for learning; creatively look for new ways of achieving your goals; and are able to work either independently or within a team environment. You possess a valid driver's license.

THE POSITION

Reporting to the Manager, Investigations and Resolutions Programs, you will: conduct investigations including onsite visits to pharmacies throughout the province; gather information/evidence; liaise and follow up with law enforcement and other agencies; provide assistance in preparing cases for discipline hearings and testify as required; and attend various committee meetings/hearings to provide clarification on cases.

If you are interested in becoming a member of this team, please forward your resume with salary expectations by October 15th to:

Lisa Baker, HR & Administrative Services Coordinator
Ontario College of Pharmacists
483 Huron Street
Toronto, ON M5R 2R4
fax: (416) 847-8279
lbaker@ocpinfo.com

We wish to thank all applicants for their interest in this position. Only those candidates chosen for an interview will be contacted.

Personal Health Information Protection Act, 2004

Ann Cavoukian, Ph.D.
Information and Privacy Commissioner of Ontario

PHIPA WILL COME INTO EFFECT ON NOVEMBER 1ST, 2004.

The Ontario government has enacted the Personal Health Information Protection Act, 2004 (PHIPA) — a new provincial law that will govern the collection, use and disclosure of personal health information within the health care sector. This new privacy law was designed to provide a set of comprehensive and consistent rules for the health care sector to ensure that personal health information is kept confidential and secure.

VISIT www.ipc.on.ca

PHIPA is based on the ten privacy principles set out in the Canadian Standards Association (CSA) Model Privacy Code. PHIPA builds upon many of the existing high standards and protections enshrined in various statutes, the common law and professional codes of conduct. **It also establishes some new duties and responsibilities for health care professionals and for those organizations that receive personal health information from health care providers covered under PHIPA. It is therefore important that stakeholders understand and are prepared to comply with the provisions of this Act.**

PHIPA will apply to all individuals and organizations involved in the delivery of health care services under the umbrella term “health information custodian,” including pharmacists and other health care practitioners listed as health information custodians under PHIPA.

The legislation will also apply to an agent of a health information custodian who authorizes the collection, use and disclosure of personal health information on behalf of that custodian.

One of the unique features of PHIPA is the implied consent model. PHIPA provides health care professionals with a flexible framework to obtain disclosure and use health information as necessary in order to deliver adequate and timely health care. **As such, pharmacists are considered to be within the “circle of care” when providing direct health care and are permitted to rely on an individual’s implied consent for the collection, use and disclosure of personal health information.**

Custodians may rely on implied consent if they post a wall notice or make pamphlets or brochures readily available to the public so that individuals can understand the purpose of the collection, use or disclosure of his/her personal health information. Disclosures outside the circle of care or to another custodian unrelated to the provision of health care will require express consent.

A companion to the implied consent model is the right of an individual to restrict a custodian from sharing personal health information with another custodian, as long as the custodian informs the recipient custodian that part of the medical record has been “locked” by an individual.

In keeping with a flexible legislated framework under PHIPA, custodians are permitted to collect, use and disclose personal health information without consent in certain limited circumstances. For example, custodians

are permitted to use personal health information for the purpose of health planning and management, risk assessment, education and reimbursement and/or verification of claims. Custodians are also permitted to disclose personal health information without consent in circumstances related to a significant risk or to control and contain specific diseases. These permissible uses and disclosures derive from existing common law and statutory requirements.

Under PHIPA, custodians will be required to implement information practices that are PHIPA compliant. For example, custodians must take reasonable steps to safeguard and protect personal health information and ensure that medical records are retained, stored, transferred and disposed of in a safe and secure manner. PHIPA sets out a formal procedure that must be followed for individuals who make access and correction requests. Custodians will also be required to notify an individual if personal information is lost, stolen, or accessed by an unauthorized individual or organization. In addition, a contact person must be designated who is responsible for responding to access and correction requests, inquiries and complaints.

PHIPA should have minimal impact on the daily functions of pharmacists who continue to maintain the confidentiality and security of personal health information and ensure that the highest protective privacy standards continue to be in place.

Complaints regarding privacy breaches by any custodian covered under PHIPA can be made to my office - the Office of the Information and Privacy Commissioner/Ontario (IPC). The IPC is an independent oversight body charged with broad investigation, mediation and order-making powers. In addition to launching a complaint with my office, an individual will also have the right to pursue a remedy in court for any harm or mental anguish suffered.

Our philosophy is exemplified by the 3 C’s: consultation, co-ordination and co-operation. This is the also approach we intend to take with pharmacists in addressing their privacy issues.

As the Information and Privacy Commissioner, I look forward to working with pharmacists and other health care stakeholders to ensure that the implementation of PHIPA complements the invaluable work that you perform on a daily basis.

Frequently Asked Questions

These and other FAQs are available at www.ipc.on.ca

Q What is the purpose of PHIPA?

PHIPA establishes a set of uniform rules about the manner in which personal health information may be collected, used or disclosed, and includes provisions that:

- Require patient consent for the collection, use and disclosure of personal health information, with necessary but limited exceptions that would allow health care providers to provide efficient care;
- Require that health information custodians treat all personal health information as confidential and keep it secure;
- Strengthen an individual's right to access his/her personal health records, as well as the right to correct errors;
- Give a patient the right to instruct health information custodians not to share any part of his/her personal health information with other health care providers;
- Establish clear rules for the use of personal health information for fundraising or marketing purposes;
- Set guidelines for the use and disclosure of personal health information for research purposes;
- Ensure accountability by granting an individual the right to complain to the IPC about the practices of a health care organization; and
- Establish remedies for breaches of the legislation

Q What is the relationship between PHIPA and the federal Personal Information Protection and Electronic Documents Act (PIPEDA)?

The collection, use and disclosure of personal information within the commercial sector is regulated by federal privacy legislation under the *Personal Information Protection and Electronic Documents Act*. PIPEDA was enacted to regulate the collection, use or disclosure of personal information in the hands of private sector organizations. As of January 1, 2004, PIPEDA has applied to all private sector organizations including pharmacies, laboratories, and health care providers with operating practices that

qualify as "commercial activities." PIPEDA will not apply to personal information in provinces and territories that have "substantially similar" privacy legislation in place.

The application of PIPEDA to personal health information has raised a number of concerns. The requirements under PIPEDA were designed to regulate direct marketing, electronic commerce and other analogous activities and do not specifically address the unique circumstances encountered within the health care system. The federal government is expected to deem the provisions of Ontario's PHIPA to be substantially similar to PIPEDA in order to exempt health care providers that will be covered under PHIPA from also having to comply with the provisions of PIPEDA.

However, even if such an exemption is made, PIPEDA will continue to apply to all commercial activities relating to the exchange of personal health information between provinces and territories and to information transfers outside of Canada.

Q What is personal health information?

Personal health information is "identifying information" collected about an individual. It is information about an individual's health or health care history in relation to:

- The individual's physical or mental condition, including family medical history
- The provision of health care to the individual
- Long-term health care services
- The individual's health card number
- Blood or body-part donations
- Payment or eligibility for health care
- The identity of a health care provider or a substitute decision maker for the individual

Personal health information does not include identifying information about an employee or agent of the custodian that is not maintained for the provision of health care. For example, a doctor's note to support an absence from work in the personnel file of a secretary employed by a health information custodian is not considered personal health information.

Q What does the "provision of health care" mean?

The provision of health care means any observation, examination, assessment, care, service or procedure provided for health care purposes. This includes the following:

- The treatment or maintenance of an individual's physical or mental condition
- The prevention of disease or injury or the promotion of health care
- The compounding, dispensing, or selling of a drug, device or equipment pursuant to a prescription
- A community service that is described in the *Long-Term Care Act, 1994*

Q What is a health information custodian?

A health information custodian is a listed individual or organization under PHIPA that, as a result of their power or duties, has custody or control of personal health information.

Examples of health information custodians include:

- Health care practitioners, including doctors, nurses, pharmacists, psychologists and dentists
- Hospitals
- Psychiatric facilities
- Pharmacies
- Laboratories
- Nursing homes and long-term care facilities
- Retirement homes and homes for special care
- Community care access centres
- Ambulance services
- Boards of health
- The Minister of Health and Long-Term Care
- Entities prescribed by regulations that are not defined as health information custodians but are permitted to collect personal health information from health information custodians for the purpose of health planning and management

Q What is an agent?

PHIPA defines an agent to include any person who is authorized by a health information custodian to perform services or activities on the custodian's behalf and for the purposes of that custodian.

An agent may include an individual or company that contracts with, is employed by or volunteers for a health

information custodian and, as a result, may have access to personal health information. PHIPA permits custodians to provide personal health information to their agents only if the custodian is permitted to collect, use, disclose, retain or dispose of the information.

For example, an agency relationship under PHIPA includes a nurse who is employed by, or a medical student who volunteers at, a hospital. An agency relationship may also include a physician who is not employed by a hospital but has admitting privileges to use the hospital's equipment or facilities.

In such cases, the custodian hospital is permitted to authorize the agent to handle or deal with personal health information on its behalf so long as the agent complies with PHIPA and adopts the information practices of the custodian.


Q What is the "circle of care?"

The "circle of care" is not a defined term under PHIPA. It is a term of reference used to describe health information custodians and its authorized agents who are permitted to rely on an individual's implied consent when collecting, using, disclosing or handling personal health information for the purpose of providing direct health care

For example,

- In a physician's office, the circle of care includes: the physician, the nurse, a specialist or other health care provider referred by the physician and any other health care professional selected by the patient, such as a pharmacist or physiotherapist;
- In a hospital, the circle of care includes: the attending physician and the health care team (e.g., residents, nurses, technicians, clinical clerks and employees assigned to the patient) who have direct responsibilities of providing care to the individual;

The circle of care does not include:

- A physician who is not part of the direct or follow-up treatment of an individual;
- A medical officer of health or a board of health;
- An evaluator under the *Health Care Consent Act, 1996*;
- An assessor under the *Substitute Decisions Act, 1992*;
- The Minister, together with the Ministry of Health and Long-Term Care; and
- Any other person prescribed in the proposed Regulations. 

district meetings

2004

OPTIMIZING THE PHARMACIST'S ROLE

2004 DISTRICT MEETING PHARMACIST SURVEY AND BREAK-OUT GROUP RESULTS

The College's Task Force on Optimizing the Pharmacist's Role used the 2004 District Meetings as an opportunity to seek pharmacists' opinions on how best to advance the profession's role and scope of practice.

The results, presented below, are being closely scrutinized by the Task Force and will significantly help the Task Force set its areas of focus for the coming months. We will continue to inform you of the Task Force's activities as they progress.

I. INDIVIDUAL SURVEY RESULTS

Pharmacists attending the district meetings were asked to complete self-surveys indicating their current knowledge of, and comfort levels with, various roles.

The following chart presents areas of practice that 485 individual pharmacists ranked from highest to lowest in priority for areas of possible practice advancement.

Clearly, being able to conduct *medication reviews*, *monitor chronic therapy* and having authority to *refill medica-*

TABLE A:

A. Priority Levels 1: High, 13: Low	Area of Practice	B. Comfort Levels		
		1: Comfortable	2: Need Training	3: Not at All
3.6	Medication Reviews	68%	29%	3%
4.2	Monitoring Chronic Therapy	47%	49%	4%
4.2	Refill Authority for Chronic Therapy	49%	46%	5%
5.1	Pharmacist as Resource to Physicians for Drug Information	75%	23%	2%
5.1	Adjusting Doses for Chronic Therapy	18%	70%	12%
5.2	Collaborative Practices: with Physicians in Specific Care Areas	18%	71%	11%
5.4	Trial Prescription Programs	69%	28%	3%
6.9	Screening Clinics	26%	60%	14%
7.2	Documentation of Recommendations: Schedule II Drugs	73%	23%	4%
7.2	Independent Prescribing: Physician Diagnoses/Pharmacist Prescribes	8%	65%	27%
7.7	Lab Tests: Ordering and Accessing Results	8%	63%	29%
8.0	Documentation of Recommendations: Schedule III Drugs	70%	24%	6%

tions for chronic therapy are priorities to pharmacists. At the same time 68% are comfortable at present in conducting medication reviews, and pharmacists are equally split in being comfortable at present versus needing training before actively *monitoring* and *refilling* for chronic therapies. Very few (3, 4, and 5%) expressed the view that they will never be comfortable undertaking these practices.

Three-quarters of pharmacists are comfortable serving as a *drug resource for physicians*.

Being able to *adjust doses for chronic therapy* and participating in *collaborative practices* are relatively high priorities for pharmacists to pursue, 70 and 71% of respondents stated that they would need training first.

Ten percent of members stated they would never be comfortable in these areas.

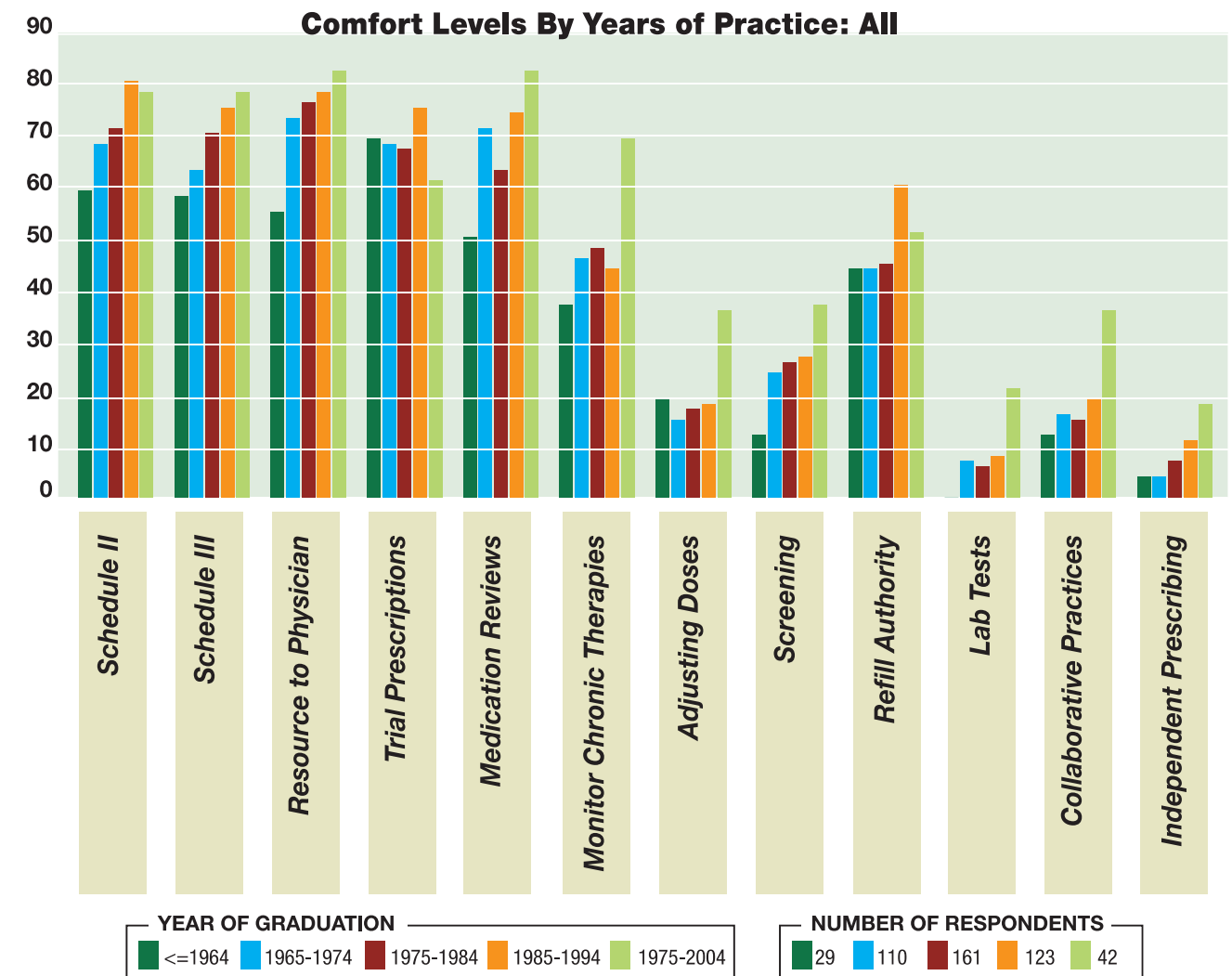
More than two-thirds (69%) of pharmacists are now comfortable in participating in *trial prescriptions* and nearly a third (28%) would first need training.

Pharmacists placed lower priority on *documentation of recommendations for Schedules II and III* (7.2, 8.0) while most (73 and 70%) are comfortable with this skill.

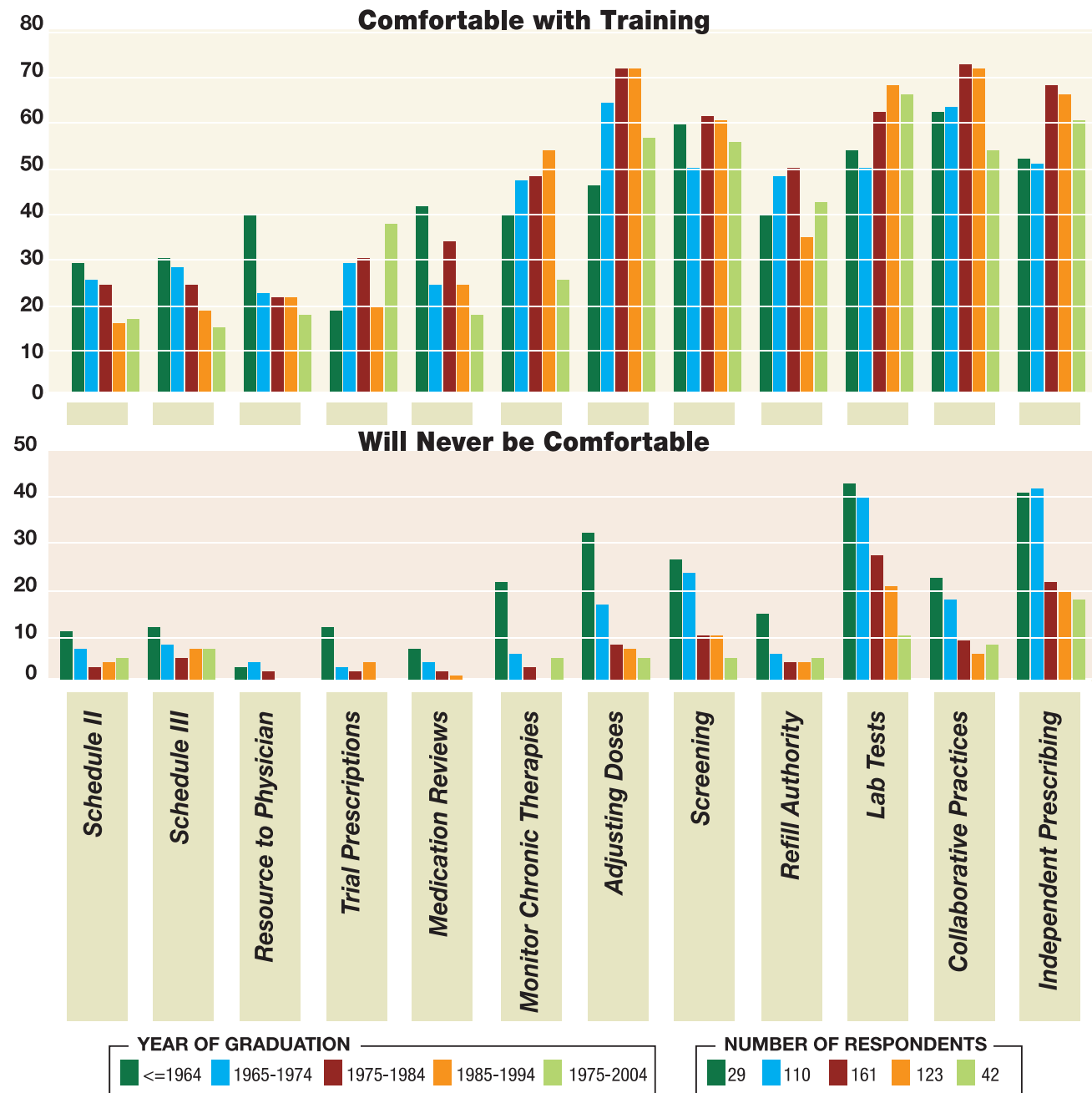
Interestingly, in their individual surveys, pharmacists expressed low interest in pursuing *independent prescribing* and *lab tests*, yet later in their breakout groups, these pharmacists placed much higher priority on these areas of practice (see page 12).

TABLE B: RESULTS BY YEARS OF PRACTICE

Following are charts summarizing pharmacist interests by their years of practice.



TABLES C, D:



II. BREAKOUT GROUP RESULTS

The attending pharmacists were asked to gather into break-out groups to collectively discuss and recommend areas of focus for the Task Force. The break-out groups were asked to consider what the pharmacist’s role as professional could be, providing the following three working assumptions were in place: remuneration is not an issue; appropriate legislation

is in place; and no staff shortages or time constraints exist in the workplace.

In all, 163 breakout groups provided up to five recommendations each. Their suggested roles, as presented in the chart on the following page, are summarized as closely as possible from the notes that were recorded.

TABLE E: BRAKEOUT GROUP PRIORITIES

% of Groups Suggesting This Role	Total for Category	# of Groups Suggesting Role	Suggested Role (As proposed by Break-out Groups)
61%	99	36 31 15 13 4	Refill Authority: Chronic, Maintenance Drugs Refill Authority Refill Authority: 30 days Refill Authority: Emergency Medication Supply Refill Authority: 3-7-14 days
42%	69	76	Medication Reviews
39%	64	31 17 12 3 1	Lab Tests: Order, Review, Monitor, Adjust Lab Tests: Order & View Results (screening) Lab Tests: Access to Results Lab Tests: Ordering Lab Tests: Order, Review and then Recommend to Physician
34%	57	28 16 4 4 2 1 1 1 1	Prescribing: Limited Prescribing: Independent (some say w/ physician partnership) Prescribing: After Physician Diagnosis Prescribing: For Some Topical Conditions Prescribing: Schedule II and III Prescribing: for Pharm Ds Limited Diagnosing and Prescribing Make Schedule II as a Pharmacist-Prescribing Category
28%	46	31 9 4 1 1	Collaborative Practices Collaborate with Physician (on certain diseases) Collaborative Prescribing Increased Communication with Physician Follow up with Physician on Patient Case by Case
27%	44	41 3	Monitor Chronic Therapy Monitor: Follow up with each Patient after Starting a New Prescription
6%	9	9	Monitor: Compliance
7%	7	7 4	INR: Warfarin INR: Monitoring
24%	39	19 18 2	Dosing Adjustments: for Chronic, Long Term Drugs Dosing Adjustments Dosing Form Adjustment
23%	38	15 11 5 4 2 1	Records Access: Electronic Patient Records (universal) Access: Patient Diagnosis Access: Patient Medical History Access: Patient Medical History (i.e. Smart Card) Access: Patient Discharge Records Access: Coded Diagnosis on Prescription
15%	29	24 5	Home Visits Onsite Consulting (one example included LTC facilities)
14%	23	14 7 2	Screening Clinics Screening Screening: For Known Risk Factors (i.e. hereditary risks)

% of Groups Suggesting This Role	Total for Category	# of Groups Suggesting Role	Suggested Role (As proposed by Break-out Groups)
13%	21	20 1	Prescribing ECP Getting paid for ECP
10%	17	17	Pharmacist as Drug Resource (to Physician and/or Patient)
10%	16	16	Trial Prescriptions
10%	17	7 3 2 2 1 1 1 1	Disease Management : Diabetes Specialty monitor/adjust Asthma monitoring Smoking Cessation Diet Control - sugar, cholesterol, counselling Thyroid Cholesterol Monitoring Age-Related Disease Management Anticoagulation Clinic
7%	12	4 3 2 1 1 1	Documentation: Mandatory Documentation: Schedule 2 Counselling Documentation: Better Documentation: Monitoring Devices Documentation: of Recommendations Documentation: Refills
7%	11	3 2 2 1 1 1 1	Professional Judgment: Substitution Authority (with physician agreement) Professional Judgment: Lipitor® /Biaxin® Professional Judgment: Drug substitution of non ODB generic drugs Professional judgment: To change salts, dosage Professional Judgment: Make therapeutically equivalent choices Professional Judgment: Reduce drug supply if patient travelling Professional Judgment: Ability to update and re-label previously dispensed medications to reflect change in dosage
6%	9	3 3 3	Part of Health Care Teams Group Practices Part of Home Care team
6%	9	7 2	Seamless Care: Hospital to and from Community (may include health units) hospital discharge follow-up
6%	9	5 2 1 1	First Contact or Triage, recommend course of action Pharmacist at Front Line - i.e. ER Ability to Refer Patient to Other Health Care Professional Pharmacist as gatekeeper
4%	7	7	Patient Education on Medical Conditions
4%	7	2 2 3	Specialty Clinics Wellness Clinics Clinic Days
4%	6	6	Limited Use and/or other Forms
3%	5	2 2 1	Counselling: 100% Counselling by Pharmacist on Refill, New Prescriptions and Document Counselling: Medical State, General Counselling: Devices

REGISTRATION



Chris Schillemore, R.Ph., B.Sc.Pharm. M.Ed.
Manager, Registration Programs

Recently, we have received a number of queries from both applicants and members about the disclosure of criminal charges and convictions. As a member or a potential member of the College, you have an obligation to report any charges or findings of guilt under any Act regulating the practice of pharmacists or relating to the sale of drugs, or of any criminal offence. The specific provision which requires applicants to do so may be found in subsection 28(1) of Ontario Regulation 202/94, as amended, made under the *Pharmacy Act*, 1991 ("Regulation"). That Regulation, frequently referred to as Part IV of the College's General Regulation, is in your OCP Manual.

QI am an undergraduate student in pharmacy and I am in the process of applying for a *Certificate of Registration* as a (non-credit) student with the College. On the "Affidavit of Good Character" that must accompany my application it states that I must declare that "I have not been found guilty of an offence under any Act regulating the practice of pharmacists or relating to the sale of drugs or of any criminal offence." I got a speeding ticket last summer; does this mean I can't sign the affidavit?

A speeding ticket is not a criminal offence nor is it an offence under any act regulating drugs or the practice of pharmacists, so you may sign the "Affidavit of Good Character". It is important to note that if you are *charged* or *found guilty* of a criminal offence or an offence under any act regulating drugs or the practice of pharmacists, you cannot sign the Affidavit. Examples of criminal offences would include

vehicular homicide, impaired driving, theft or any offence that could lead to incarceration.

QI notice on the "Affidavit of Good Character" the wording refers to "found guilty" rather than "convicted". What's the difference?

The first part of a criminal proceeding deals with guilt or innocence. If you were found guilty but received an absolute or conditional discharge, you would still be required to disclose that finding. The same holds true for a conviction for which you have received a pardon.

QWhat happens if I was found guilty of a criminal offence in the past and couldn't sign the affidavit? How would this affect my ability to get licensed as a pharmacist?

If you are unable to sign the affidavit, your application would be referred to a panel of the Registration Committee. The panel would decide whether you would be allowed to be registered, and if so, what terms and conditions (if any) should be put on your *Certificate of Registration*.

QA friend of mine was convicted of shoplifting as a young teenager. What would happen if she signed the affidavit anyway?

Any finding of guilt in a criminal matter, even as a young offender, would prevent your friend from signing the Affidavit. She must disclose this fact when she is applying for any level of registration. It is likely that the panel would

Continued on page 17

PRACTICE



Greg Ujiye, R.Ph., B.Sc.Pharm.
Manager, Pharmacy Practice Programs

QA physician in my area has passed away. It is difficult for his former patients to find a new physician with the doctor shortage in my area. I understand that refills on the current prescriptions are no longer valid. Can I continue to fill prescriptions for these patients?

You are correct to state that a prescription and all of its refills are no longer valid once the physician has passed away (or has moved or has had his/her privileges revoked). This is because your patient is no longer under the care of the physician and the patient's conditions are not being properly monitored. This is similar to those situations where patients present themselves at your pharmacy after their refills have been exhausted and their physician cannot be contacted.

You have a responsibility to ensure continuity of care for all patients. How you choose to provide this is left to your professional judgement and discretion. To automatically continue to dispense the refills would not be considered good professional judgement. In using your professional judgement you must assess the patient and the situation before taking any course of action. You must also be aware of the demands on the health care system and the availability of other health care providers. Depending on the patient, it may be more appropriate for you to refer the patient, if their condition warrants, to the hospital or a walk-in clinic. You should also act in the best interests of your patient where, in your professional judgement, the patient requires the medication. Whatever the decision you make you should document your decisions and actions.

In all situations, you must remind and encourage your patient to find a new physician as you no longer have "legal" authority to fill these prescriptions.

QSome physicians have fax programs on their computers or are using palm devices to send faxes using a digital or electronic signature. Can I accept these faxes?

There are two issues identified in this question.

One issue is digital or electronic signatures. At this time, the College does not recognize digitized or electronic signatures of physicians as acceptable for signing prescriptions. Where you are unsure, you should call the physician to verify. All narcotic or controlled drug prescriptions must be signed in the physician's own handwriting.

With respect to faxes, please refer to the College's *Policy on Faxed Prescriptions* (June 1999). This policy allows you to accept any type of prescription from a prescriber by fax, including straight narcotics or controlled drugs. In accepting a fax, you are reminded to:

- Take reasonable steps to determine the authenticity of the prescription by knowing the doctor's signature and the telephone number on the prescription letterhead. You are expected to verify the authenticity of a prescription whenever there is doubt about the signature or the identity of the prescriber
- Keep in mind that the fax number that appears on the top of the faxed page is programmed by the sender and, as such, does not provide any security. All faxes should have a programmed number and identification at the top of the faxed sheet. Faxed prescriptions should not be cut or trimmed as these may be considered photo copies
- Know what the prescriber does with the original after it is faxed. If the prescriber places the prescription in the patient's chart after faxing it, the faxed prescription conveys authority to fill. When clarifying this with the

prescriber, you might ask if the original could be marked "faxed to pharmacy" to ensure it is not given to the patient at a later date

QI have received a prescription from a physician on which the quantity is referred to as "trade size" (some cases 1 box, bottle, tube, etc). Can I accept this as a quantity?

Although quantity is not referred to in the definition of a prescription in the DPRA, the *Food and Drugs Act* and Narcotic Regulations define that a "stated amount" of drug be dispensed. It may be argued that "trade size" refers to a

quantity; however it may not be clear if several sizes of the product exist. An exact or stated quantity provides clear direction to a pharmacist as to the physician's intent in all situations.

In this situation, as with any prescription, you should look to the *Standards of Practice* and act in the best interest of the patient. You should contact the physician for clarification/verification whenever you have doubts about a prescription's validity.

REGISTRATION



Continued from page 15

consider her circumstances and grant her a *Certificate of Registration*, given that the offence was not too serious and that it occurred many years ago when your friend was quite young.

However, if the College discovers your friend has lied on her Affidavit the repercussions would be far more serious, as this dishonesty would put into question her right to have a *Certificate of Registration* as well as her ability to practice her profession with honesty and integrity. Contact College staff if you or anyone has any doubts about his or her ability to sign the Affidavit.

QAs a pharmacist member of the College, what is my obligation to report a legal proceeding to the College?

The answer to this query can be directly quoted from the Regulation [see subsection 28(3)]:

"Every certificate of registration is subject to the condition that the member shall provide the Registrar with the details of any of the following that relate to the member and that occur

or arise after the registration of the member:

1. A charge relating to an offence under any Act regulating the practice of pharmacists or relating to the sale of drugs, or in relation to any criminal offence.
2. A finding of guilt in relation to an offence under any Act regulating the practice of pharmacists or relating to the sale of drugs or in relation to any criminal offence.
3. A finding of professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession.
4. A proceeding for professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession."

A failure to report such details would constitute professional misconduct and, therefore, could result in the member's referral to the Discipline Committee.

Thank You...

... to our Regional CE Coordinators/Associates

Since 1995, the College and the Ontario Pharmacists' Association have used the services of pharmacist volunteers who taken on the task of bringing continuing education (CE) events to their respective regions. A number of members began volunteering in 1995 and many more have volunteered for a number of years.

In an effort to reduce their workload we continue to look for more volunteers to help.

Although we can periodically thank these volunteers in their quarterly *Regional CE Coordinators' Newsletter*, we do not often get this opportunity to do so on a larger scale.

On your behalf, we extend sincere thanks to:

Coordinators/Associates	Region	Vicinity
Christa Vallier	1	Ottawa-Carleton area
Joanne Labelle, Hilary Blackburn	2	Stormont/Dundas/Glengarry counties
Carolyn Burpee	3	Brockville and area
Kelli Ouimet	4	Petawawa and area
Shanthi Raval, Shannon Hinton, Michelle Cain	5	Peterborough and area
Cindy Londry	6	Kingston and area
Debbie Moffatt	7	Quinte area
Karen Matwijec, Heather Philpot, Dijana Micanovic	8	Durham region
Barbara Minshall	9	Lindsay and area
Rupert Muggoo	10	North Bay and area
Janet Shore, Carolyn Bornstein, Danielle Caron	11	York North region
Reza Farmand, Henry Halapy, Goretti Nguyen	12	Toronto
Aldo Anzil	13	Mississauga/Oakville
Dan Caswell	14	Barrie and area
Antonietta Forrester, Susan Nuttall	15	Hamilton and area
Lee Ann Chan, Susan Nuttall	17	Brant county
Judy Cimino, Lisa MacEachern	19	Guelph and area
Ravinder Banait, Shailesh Desai	20	Halton region
Sherry Peister	21	Kitchener/Waterloo area
Adele Kaminski, Dinesh Shah, Mauri Kuyper, Martin Keeping	22	Owen Sound and area
Mary Ann Hornick	23	Kent County
Jan Groulx	24	Essex County
Maria Coccimiglio, Jane Jennings, Marie Paluzzi	25	Sault Ste. Marie and area
Vinay Kapoor, Tim Slack	26	Thunder Bay and NW Ontario
Kalvin Brown	27	Porcupine and NE Ontario
Stella Rupert, Wilf Steer	28	Sudbury and area
Karen Riley, Kelly Haggerty	29	Lambton County

We would also like to recognize Beth Gallagher, formerly the Coordinator for Region 3, and Anil Patel, formerly an Associate for Region 13, both volunteers from 1995 until June of this year, for their many contributions.

We would also like to welcome the following pharmacists who have recently volunteered to represent their CE Regions:

- Johnny Wong, Coordinator for Region 14
- Priti Luhadia, Coordinator and Akash Luhadia, Associate for Region 3

We rely on volunteers to help meet our profession's CE needs, particularly through the organization of live programs throughout the province. A number of volunteers also review home study resources to determine their applicability to pharmacy practice in Ontario. These individuals are all deserving of your recognition for their dedication and commitment in bringing CE opportunities to you.

VOLUNTEERS NEEDED

We strive to have regions represented by at least one coordinator and one associate. If you would like to consider being a part of bringing CE to your area, we are seeking volunteers for Regions:

- 1, 4, 6, 7, 9, 10, 13, 14, 16, 17, 18, 21, 22, 23, 24, 27, 29

If you wish to find out what region you are in, check our website: www.ocpinfo.com: Continuing Education/CE Region Assignments/What CE Region am I in?, or call Celia Powell at the College.

ROLE OF THE REGIONAL CE COORDINATOR

The Regional CE Coordinator works with the College and the OPA and, where feasible, with the local pharmacists' association to:

- Identify CE needs of pharmacists in your region
- Identify topics and speakers for presentations in your region
- Organize CE presentations in your region

TIME COMMITMENT

We cannot specify the amount of time that you will need/wish to devote to your responsibilities as a coordinator. By and large this will depend on the number of presentations you are able or willing to organize in your region. You need not work alone; you may find it advantageous to recruit colleagues to work with you.

For more information on the role of the CE Coordinator and/or to volunteer, contact Celia Powell at the College, tel: 416-962-4861, x 251, fax: 416-847-8281, or cpowell@ocpinfo.com.

CONGRATULATIONS TO THE ONTARIO PHARMACISTS' ASSOCIATION!

We take this opportunity to also recognize the great strides the Ontario Pharmacists' Association has made over the last few years in CE.

Under the directorship of Sandra Winkelbauer (and Karen Cameron who replaced Sandra during her maternity leave), we have seen numerous workshops created and held throughout the province. Terry Cunningham has also arranged several facilitating workshops to train our coordinators/associates on how to bring more effective CE to their regions. Sherrie Hertz at the OPA's Drug Information and Research Center has also been involved with the *Guide your Patients to a Smoke Free Future* program over the last three years and has brought this CE event to many cities throughout the province.

Through the efforts of the OPA, we have seen a substantial increase in the availability of CE for Ontario pharmacists in the form of live, distance learning, and online programs. We have come a long way since 1995!





Serving as a Bridging Education Tool

The International Pharmacy Graduate Program was created in 2001 to serve as a “bridging” education model for pharmacists educated outside North America seeking to further develop their skills to meet Ontario’s entry-to-practice requirements.

Since 2001, over 300 licensure candidates have participated in the first eight-week block of academic modules — Canadian Pharmacy Skills I (CPS I). This number includes 33 international pharmacy graduates who participated in a pilot project this past summer in British Columbia. By the time this article goes to press it is anticipated that 73 international pharmacy graduates will have attended the CPS II course in Toronto and Vancouver. (The IPG Program also has plans to offer the program in other cities in Ontario. This initiative will be discussed in a future article.)

In addition to assisting international pharmacy graduates meet Ontario’s entry-to-practice requirements, the IPG Program has been instrumental in preparing candidates for the rigors of the Pharmacy Examining Board of Canada (PEBC) Qualifying Examination — the national entry-to-practice examination. As members are aware, this exam is comprised of two parts: Part I which assesses candidate’s understanding and application of knowledge to problems relevant to the practice of pharmacy and Part II which assesses candidates ability to problem-solve, communicate information, and exercise judgment through the Objective Structured Clinical Examination (OSCE).

Program statistics indicate that the success rate of IPG program participants is greater than 95% on both parts of the *Qualifying Examination*. These superior results are encouraging and serve as a testament to the determination and enthusiasm of the Program’s students, as well as the commitment and focus of the IPG Program staff, lecturers and teaching assistants. Furthermore, many pharmacists have acted as mentors and preceptors for the Program’s students and have guided their professional development by assessing and coaching.

Currently, the training model preferred by most international pharmacy graduates is the “continuous” model (CPS I followed immediately by CPS II), rather than the “intermittent” model (SPT Studentship taken *between* CPS I and II).

It should be noted that the phenomenal success rate of the IPG Program occurs most when IPGs are exposed to pharmacy practice. This is no surprise, given the Canadian context required for workplace and professional success. At this time over 200 international pharmacy graduates who participated in the IPG Program have been licensed as pharmacists in Ontario. Others, still in the licensing process, eagerly anticipate joining their peers in practice.

FOCUS ON GRADUATES – NELIA NGO

Nelia arrived from the Philippines in October 2003, attended the CPS I and II continuously, and completed the program in May 2004. Subsequently, Nelia was successful on both parts of the *Qualifying Exam*. Nelia shared these feelings after receiving her results:

“I would like to say again, thanks for everything. CPS I and CPS II not only helped me with my chosen profession, but I feel that it has helped me to become a much better person, especially in communicating and interacting with other people.

“The communication classes really opened my eyes, and even now I try to apply them in my daily life. I just hope that I can internalize them as well as my mentors. Oh, how I envy them. They make everything look so easy and natural.

“As for the technical part, it has expanded my appreciation of the practice of pharmacy. Despite all my years of helping my mother in her drugstore (I’m a second generation pharmacist), I never fully realized the extent of the care and assistance we could provide to patients. Over there, I was just a glorified sales clerk, never knowing, nor inquiring, about the patient. (A common joke is that we were “legalized drug pushers.”)

“The program opened my eyes and made me realize that these customers are not simply “sources of sales revenues” but are actual, living, breathing people who need care and help. And wonder of wonders, I am in a position to help them. My world has suddenly become bigger and brighter.”

FOCUS ON STAFF: DORIS KALAMUT

A perennial favourite course in the program is *Communication Skills in Pharmacy Practice*, taught by Doris Kalamut, a 1978 graduate of the University of Toronto’s Faculty of Pharmacy. This course, a series of 15 interactive seminars, successfully blends relevant communication theory with pharmacy practice scenarios and role-playing. Doris states that her greatest achievement is the appreciation and realization of the impact the course has on international pharmacy graduates in their personal and professional lives:

“Communication skills are my passion” said Kalamut, “...and the international pharmacy graduates never cease to amaze me. Another reward for me, personally, is their success – I admire them so much!”

Bernie Des Roches, Ph.D.
Manager, Continuing Education and
Pharmacy Technician Programs

learning needs. By completing, reviewing and reflecting on your completed Survey before submitting it to the College, you can identify those competencies, clinical knowledge topics, and professional and business skills where you have indicated interest and/or need to access learning resources. It is your first step in a process that has been designed to encourage you to reflect on your personal learning needs and take responsibility in addressing them.

Through the use of the College's *Professional Profile and Learning Portfolio*, you can also translate your learning needs into an action plan to address your needs and to monitor your progress.

On a larger scale, your response when combined with data from approximately 1,400 colleagues, serves as a valuable resource to help creators and organizers of learning resources/events to focus on topics that have been identified with the greatest interest and need.

2003 RANKING OF COMFORT LEVEL WITH STANDARDS OF PRACTICE

Data was gathered on the six standards of practice* approved by the College:

- Practice pharmaceutical care
- Assume ethical, legal and professional responsibilities
- Access, retrieve, evaluate and disseminate relevant information
- Communicate and educate effectively
- Manage drug distribution
- Apply practice management knowledge and skills
- Clinical knowledge, professional & business skills

*These titles are as they appear in the Self-Assessment Survey form; some of the terminology differs from that used in the *Standards of Practice* published in the November/December 2002 issue of *Pharmacy Connection*. For conciseness, clinical knowledge and professional & business skills are presented as an additional category for assessment purposes only.

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Self-perceived Learning Needs and Experiences

OVERVIEW OF 2003 RESPONSES

The *Self-Assessment Survey and Summary of Continuing Education Activities* (Survey) has been a part of the College's Quality Assurance Program since the program's creation in 1996. The Survey has been revised over the years; in 2002 questions were added and others

refined to provide a better opportunity for pharmacists to self-identify their learning needs while enhancing the value of sharing data with others.

The following data is reported from the 2003 Survey responses. As this is the seventh year of self-assessing, pharmacists should now be familiar with the process.

It is important to keep reminding ourselves of the philosophy that guides the College's QA program. From its outset, the program has been based on an educational approach. Its objective is to ensure that all pharmacists continue to meet our profession's standards of practice.

You are responsible for your continuing education and accessing learning resources to maintain the required knowledge and skills levels. This begins by assessing your

Your response, when combined with data from 1,400 colleagues, serves to help creators and organizers of learning resources/events to focus on topics that have been identified with the greatest interest and need.

Survey Respondent Profile

In 2003, 1415 pharmacists submitted completed surveys. Having been randomly selected, their demographic profiles accurately reflect those of the total pharmacist population in Part A of the Register.

Type of Practice

76% - Community pharmacies
18% - Hospital or long-term care facilities
6% - Other settings, e.g., government, association or unemployed

Qualifying Degree

51% - Ontario
16% - Another province
26% - Another country
7% - U.S.

Employment Status

18% - Owners or directors
17% - Designated managers
57% - Staff pharmacists
7% - Other
1% - Unemployed

Graduation/Registration

59% - Graduated more than 15 years ago
46% - Registered with College more than 15 years ago

HEALTH CANADA

Advisories & Notices

DATE	TYPE
August 16, 2004	Health Canada - URGENT RECALL NOTICE - Immediate Action Required TAXUSTM Express2™ Paclitaxel-Eluting Coronary Stent Systems and Express2™ Coronary Stent Systems - Boston Scientific
August 09, 2004	PUBLIC ADVISORY - Health Canada advises of potential adverse effects of SSRIs and other anti-depressants on newborns
July 30, 2004	Health Canada Endorsed Important Safety Information & PUBLIC ADVISORY on the Possible Association of RITUXAN (rituximab) with Hepatitis B Reactivation - Hoffmann-La Roche Limited
July 27, 2004	WARNING - Health Canada advises consumers not to use the products containing ARISTOLOCHIC ACID
July 27, 2004	WARNING - Health Canada Warns Canadians Not to Use "SESA HAIR SUPPLEMENT" capsules – a product designed to treat hair loss.
July 8, 2004	Health Canada Endorsed Important Safety Information - Association of DESYREL® (trazodone) with drug interactions with medications that alter CYP 3A4 metabolism. - Bristol-Myers Squibb Canada PUBLIC ADVISORY - Health Canada is advising Canadians that antidepressant trazodone may interact with certain medications.
June 29, 2004	Health Canada Advises Consumers Not to Ingest Teas or Health Products Containing STAR ANISE Unless it Is Identified as Chinese Star Anise
June 25, 2004	Health Canada Endorsed Important Safety Information on the Possibility of sensitization to CIDEX® OPA Solution with repeated exposure - Johnson & Johnson Inc.
June 25, 2004	Health Canada Endorsed Important Safety Information on ARAVA® (leflunomide) and interstitial lung disease (lung inflammation causing difficulty breathing) – Aventis Pharma Inc.
June 24, 2004	Health Canada releases important information on the dispensation of CLOZAPINE products in Canada. Communications to Health Professionals, Public & Notice to Hospitals
June 22, 2004	Important Safety Information regarding the association between CRESTOR® (rosuvastatin) and rhabdomyolysis - AstraZeneca Canada Inc. Health Canada is advising Canadians about a possible association between CRESTOR and rhabdomyolysis
June 18, 2004	Health Canada advises health professionals and consumers about penicillin allergy test recall. Health Canada Endorsed Important Safety Information on PRE-PEN® (benzylpenicilloyl polylysine injection USP) DIN: 00328693 - Omega Laboratories, Ltd
June 10, 2004	Important Safety Information on Hemodialysis Units and Blood Tubing Sets Incorporating a Transducer Protector - Notice to Hospitals
June 10, 2004	Health Canada Endorsed Important Drug Safety Information on WELLBUTRIN® SR and ZYBAN® (bupropion HCl) - Warning for SSRIs and other newer anti-depressants regarding the potential for behavioural and emotional changes, including risk of self-harm. Bupropion is marketed in Canada as both the anti-depressant WELLBUTRIN® SR and the smoking cessation drug ZYBAN®.

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DATE	TYPE
June 4, 2004	Product Recall - Health Canada is advising health professionals and patients regarding the recall of specific batches of PROGLYCEM® (diazoxide) suspension by Schering Canada Inc. The affected lots are: 2-GJAB-02, 3-GJAB-01, 3-GJAB-02A.
June 3, 2004	ADVISORY - Health Canada advises Canadians of stronger warnings for SSRIs and other newer anti-depressants.
June 2, 2004	Health Canada Endorsed Important Safety Information on CELEXA® (citalopram hydrobromide)- Stronger WARNING for SSRIs and other newer anti-depressants regarding the potential for behavioural and emotional changes, including risk of self-harm.
June 2, 2004	Health Canada Endorsed Important Safety Information on EFFEXOR® and EFFEXOR XR® (venlafaxine) - Stronger WARNING for SSRIs and other newer anti-depressants regarding the potential for behavioural and emotional changes, including risk of self-harm.
June 2, 2004	Health Canada Endorsed Important Safety Information on PROZAC® (fluoxetine hydrochloride) - Stronger WARNING for SSRIs and other newer anti-depressants regarding the potential for behavioural and emotional changes, including risk of self-harm.
June 2, 2004	Health Canada Endorsed Important Safety Information on REMERON RDTM / REMERON® (mirtazapine) - Stronger WARNING for SSRIs and other newer anti-depressants regarding the potential for behavioural and emotional changes, including risk of self-harm.
June 2, 2004	Health Canada Endorsed Important Safety Information on ZOLOFT® (sertraline hydrochloride) - Stronger WARNING for SSRIs and other newer anti-depressants regarding the potential for behavioural and emotional changes, including risk of self-harm.
June 2, 2004	Health Canada Endorsed Important Safety Information on PAXIL® (paroxetine) - Stronger WARNING for SSRIs and other newer anti-depressants regarding the potential for behavioural and emotional changes, including risk of self-harm. For paroxetine, this replaces the previous interim contraindication.
June 2, 2004	Health Canada Endorsed Important Safety Information on LUVOX® (fluvoxamine maleate) - Stronger WARNING for SSRIs and other newer anti-depressants regarding the potential for behavioural and emotional changes, including risk of self-harm.

For complete information and electronic mailing of the Health Canada Advisories / Warnings / Notices, subscribe online at: <http://www.hc-sc.gc.ca/hpfb-dgpsa/tpd-dpt/>

For each standard, pharmacists were asked to indicate their level of comfort from the perspective of their own practice (using a four-point scale). The first three choices allow pharmacists to self-identify their comfort level on each standard. A fourth option was given for *clinical knowledge and professional & business skills* (clinical knowledge) where the respondents could indicate those areas which they do not encounter in their practice.

ACCORDING TO ALL RESPONDENTS

For the seven standards, the mean of the comfort levels reported by the group as a whole ranked as follows (3.00 being the highest comfort level possible, 1.00 the lowest):

1. Manage drug distribution	2.45
2. Ethical, legal, professional responsibilities	2.38
3. Practice management	2.37
4. Pharmaceutical care	2.32
5. Communicate and educate effectively	2.25
6. Access, retrieve, evaluate, disseminate information	2.19
7. Clinical knowledge, professional & business skills	2.11

For each standard, there were several associated competencies listed in the Survey. On several of these competencies, a considerable number of pharmacists (arbitrarily selected as a response rate greater than 10%) indicated that they would benefit from assistance. These competencies (abbreviated here due to space) are as follows:

PHARMACEUTICAL CARE:

- Identify, document, report an adverse drug reaction (12%)
- Evaluate and modify a plan of care (18%)
- Document and follow up on interventions (11%)

ETHICAL, LEGAL & PROFESSIONAL RESPONSIBILITIES

- Knowledge of labour legislation (23%)
- Legal responsibilities in cases of suspected child abuse (13%)
- Legal responsibilities in cases of suspected abuse by health professional (15%)
- Maintaining record of continuous learning activities (13%)

ACCESS, RETRIEVE, EVALUATE AND DISSEMINATE INFORMATION

- Document responses to drug information requests (28%)

COMMUNICATE AND EDUCATE

- Assist groups/individuals with development/implementation of plans to overcome wellness barriers (26%)
- Seek opportunities to develop partnerships with stakeholders in health care (38%)
- Identify educational needs of individuals or groups (18%)
- Select appropriate educational methods, resources etc., to meet learner's needs (18%)
- Apply time management principles in development/delivery of a presentation (17%)
- Assess whether learner's needs were met (16%)

PRACTICE MANAGEMENT KNOWLEDGE AND SKILLS

- Conduct performance appraisals of auxiliary personnel (14%)
- Explain and put into practice principles of inventory management (13%)

These results are very similar to those gathered since 1996. It is encouraging that respondents generally report an increasing comfort level on all standards as the years progress.

In 1997 and 1998, means were as low as 1.81; compared to a lowest mean of 2.11 reported in 2003. This may be reflective of pharmacists' growth in confidence and ability to meet the standards as they gain experience in addressing them.

This trend has been particularly strong for *clinical knowledge*. It is interesting to observe that *clinical knowledge* is now the *standard* "clinical knowledge" and it is noted with the greatest indication by pharmacists for assistance. This has not generally been the case in previous reports. Indeed, this finding may not be surprising, given the rapid rate at which new products and drug information are being made available. It also reinforces the fact that we must continue to address clinical knowledge as a learning need.

ACCORDING TO YEARS IN PRACTICE AND PLACE OF GRADUATION

Generally, those who have been in practice for 25 or fewer years expressed a higher comfort level on the standards than did their senior colleagues. For some, this represents a statistically significant difference.

These differences follow some logic. Those who graduated *more* than 25 years ago are more comfortable than their younger colleagues on standards which come with experience: *drug distribution; ethics; and practice management*. Those who graduated less than 25 years ago are more comfortable on the other standards which are strong elements of the current North American education model: *pharmaceutical care; communicate and educate; access, retrieve and disseminate information; clinical knowledge*. Furthermore, these differences are statistically significant on several standards**, but are overall not surprising and remain consistent with previous survey results.

Analysis of the data based on place of graduation indicates that graduates of non-North American universities rate themselves as more comfortable on all standards than do these who graduated from North American universities. The differences are statistically significant for all standards and this pattern is similar to previous surveys.

ACCORDING TO PRACTICE SETTING

For pharmacists in a community pharmacy or a hospital practice (including long-term care facilities), past surveys have revealed both predictable and surprising variations in reported comfort levels.

The 2003 Survey yielded one

change from previous survey results in that those in community pharmacy indicated, overall, a higher comfort level than hospital pharmacists on all standards except for one: *accessing, retrieving and disseminating information*. Hospital pharmacists previously reported higher comfortable levels on their ability to *communicate and educate effectively*. (These differences are statistically significant for all standards *except pharmaceutical care and ability to communicate and educate effectively*.)

COMFORT WITH CLINICAL KNOWLEDGE

In that clinical knowledge is the foundation of our professional role, we focused on respondents' self-assessment of learning needs on clinical topics to help in the development and access to relevant resources. The Survey lists 82 topics for comment.

While only the most frequently rated topics are presented here, the complete results (by the 29 CE regions) have been shared with provincial and national agencies involved in developing and disseminating educational resources. For example, we provide our regional CE coordinators with data by OCP region so they can target programs to meet local pharmacists' needs. Please visit our website for a list of all CE Coordinators and regions.

We also provide province-wide trends to provincial program developers and providers such as the Leslie Dan Faculty of Pharmacy, Ontario Pharmacists' Association, Canadian Society of Hospital Pharmacists (Ontario Branch) and drug manufacturers. Data covering *topics of least interest/need* is also shared so that CE providers can avoid

spending valuable resources on less necessary topics.

Table A on the following page highlights the topics of greatest interest (respondents' indication of top ten topics they would like to first address) and need (determined from response "benefit from assistance").

These results are consistent with those of our previous surveys in many respects. This consistency gives us confidence that the *survey* is a valid and trustworthy instrument that is being completed in a reflective and honest way.

Topics added to the 2002 Survey allow for more specific identification of those areas of greatest interest/need. Some continue to top the list year after year, e.g., AIDS, cancer chemotherapy, while others drop off to be replaced by new topics that merit our attention.

Why the changes? One could speculate that resources on some topics e.g., diabetes, are now sufficient and readily accessible to meet pharmacists' needs. Conversely, new developments on the health care scene may give rise to a need for information on topics not previously considered "high priority". Nonetheless, the data from these surveys help direct resources to specific needs.

COMFORT WITH PROFESSIONAL & BUSINESS SKILLS

We added a new section in the 2002 Survey to determine comfort levels in the following areas of professional and business skills: *communication skills; compounding/sterile preparation; documentation; identifying drug-related problems; jurisprudence; management; patient interview skills; presentation skills; and sales and marketing skills*. As with the

** Data was analyzed at a significance level of p<0.05 to adjust for sample size and reduce error of finding a difference where none exists.

TABLE A: TOP TEN THERAPEUTIC TOPICS OF GREATEST INTEREST AND NEED - 2003

Want to Address First	Benefit from Assistance	
√	√	Adrenocortical dysfunction
√	√	AIDS
√		Alzheimer's Disease
√	√	Cancer chemotherapy
	√	CPR
√		Epilepsy/seizures
√		Herbal remedies
		Home health care products
√		Infectious diseases/vaccines
√	√	Infertility in women
	√	Intermittent claudication
	√	Pancreatitis
√		Parkinson's Disease
	√	Poisoning and overdose
√	√	Renal diseases
	√	Total parenteral nutrition

2002 Survey, this survey yielded significant indication that respondents felt they would benefit from assistance in two topics – *presentation skills* (15%) and *sales & marketing* (26%).

SUMMARY OF CONTINUING EDUCATION ACTIVITIES

As stated previously, data collected from continuing education activities records from such a large number of pharmacists provides us with the ability to assess the ways in which you learn, the possible frustrations you encounter in locating suitable resources, and the focus of your learning needs. Here, we provide you with insight into the content and experiences of your colleagues' records of learning activities over the previous year. In requesting input, we used the College's Professional Profile and Learning Portfolio (portfolio) as the basis for entering data from the Survey.

LEARNING OBJECTIVES

Respondents were asked to indicate the total number of learning objectives they had listed in their portfolio and the percentage of objectives that they were able to achieve. Approximately 82% had listed three or more learning objectives they hoped to achieve (approximately 45% had listed 3-6 objectives). The significant majority (75%) achieved at least half of the objectives that they set for themselves and 37% achieved 75-100% of their goals. These figures are slightly higher than those reported in previous surveys — reversing the gradual decrease seen over previous years. We will watch for any changes in future surveys to determine whether or not a new trend is emerging.

LEARNING ACTIVITIES

The *portfolio* provides space for you to record individual learning activities; those for which you have identified

your learning needs and the resources you will to address them. Typically, learning needs arise over the course of daily practice, in response to a challenging patient profile or complex request for information from a medical practitioner.

The *portfolio* also has a section to record structured CE activities, e.g., seminars, workshops, conferences, and home study programs where learning needs have been identified by someone else, such as a conference planning committee or lesson author.

INDIVIDUAL LEARNING ACTIVITIES

Approximately 64% of respondents identified six or more individual learning activities they had addressed in the previous year. The most common number of individual learning activities has decreased from 37% in 2002 reporting one-five individual learning activities to 33% in 2003.

About 54% of respondents spent 16 or more hours in the past year pursuing individual learning activities, while 23% spent more than 30 hours. This is comparable to the 2002 results.

One of the most significant outcomes that can arise from engaging in learning activities is a decision to change one's practice. In 2003, 82% found at least one learning activity in the previous year that caused them to make such a change (80% in 2002).

At the portfolio sharing sessions held as part of the Practice Review, we encourage pharmacists to be selective in what they record as learning activities. You learn, with experience, to record only those activities which are significant, to which you may wish to refer at a later date, or to document as part of building your learning portfolio. This is a maturation process and the statistics indicate that this appears to be taking place.

STRUCTURED CE ACTIVITIES

As in the past, over 95% of the respondents report participation in at least one structured CE activity over the previous year, with 44% reporting one to five of such activities. The proportion of pharmacists spending 21 or more hours in structured CE activities (39%) is identical to last year's. The proportion who found that these activities prompted them to consider making a change to their practice (81%) is also identical.

The most popular structured CE activity continues to be the live program formats, with 91% indicating they attended at least one seminar, workshop or conference. The proportion who attended five or more such events continues to decline: 40% in 2000, 37% in 2002 and 35% in 2003. No other differences to past surveys were noted.

Participation in correspondence courses is down slightly to 46% in 2003 from 50% in 2002. The proportion of pharmacists completing five or more courses remains nearly the same (16% in 2003 compared to 15% in 2002). Just as in 2002, pharmacists comment on how much busier they are in the work setting; this likely continues to impact on the personal time available to pursue learning endeavours.

CHALLENGES TO LEARNING: ACCESSING RESOURCES

Respondents were asked to identify which of the six standards challenged them most in terms of finding suitable resources to address their learning needs. There was no provision for respondents to indicate whether or not they were even interested in finding resources, in any learning format, related to a particular standard. Thus, if a pharmacist did not fill in a circle beside a standard, it is possible that it was not a topic in which the respondent even had an interest. For our analysis, we assume that any indication was generated by an inability to find resources to meet their needs on the particular standard.

	2002	2003
Documentation	18%	19%
Technical competencies	18	18
Jurisprudence	10	12
Communication skills	9	9
Pharmaceutical care	10	10
Disease conditions	13	14
Drug therapy	7	7

LEARNING RESOURCE PREFERENCES


How do pharmacists prefer to learn?

	2002	2003
Live	80%	79%
Home study	63	62
Internet	61	64
CD-ROM	57	58
Audio/videotapes	45	43
Videoconferencing	23	22

Further analysis of the most popular format indicates that pharmacists prefer short live programs, i.e. two-hour evening presentations (88%) with progressively decreased interest as programs get longer. For example, 70% prefer a one-day program on varied topics, 27% prefer a two/three-day program on varied topics, and only 13% prefer a program which is longer than three days.

In this age of technology, a growing number of pharmacists are interested in Internet-based learning but may be frustrated by the dearth of such programs in areas specific to their learning needs. Those who develop and market such programs will likely respond only when they see a large enough potential market; in Ontario, it appears that market is growing quite rapidly. Approximately 95% of pharmacists surveyed in 2003 indicated that they have Internet access (41% from home, 8% from work and 46% from both). Almost 60% have high speed access and 85% have sound output capability on their computers.

SUMMARY

The value of data from the *Self-Assessment Survey and Summary of Continuing Education Activities* has been enhanced as pharmacists like you accept that you will not be judged on your responses and that you can be open and honest in your self-evaluation. As you recognize and accept responsibility for taking charge of your personal learning, you come to appreciate the value of the *survey* and the *portfolio* as tools to help you identify and address these needs and reflect on your progress. As an added benefit, you gain access to learning resources which will be developed to address the needs you and your colleagues have identified as a priority. 

CASE 1

Lack of Appropriate Follow-up Following a Dispensing Error

Member: Fadhil Al-Sarraj, Peterborough
Hearing Date: November 20, 2003

Mr. Al-Sarraj was found to have failed to maintain a standard of practice of the profession.

The Panel accepted Mr. Al-Sarraj's plea of professional misconduct and was provided with an Agreed Statement of Facts which formed the basis of his plea.

Facts

In a complaint filed with the College, the patient explained that after having obtained a third repeat of a prescription for a three-month supply of Synthroid® 125mg dispensed to her by Mr. Al-Sarraj, she experienced a deterioration of her health. She also noticed that the pills were a slightly different shade of yellow than the Synthroid® pills that had been dispensed to her on prior previous occasions. As a result, she contacted the pharmacy at which time a pharmacy technician invited her to exchange the pills and return the medication that was dispensed. As well, a locum pharmacist later provided the patient with new Synthroid® and destroyed the old batch of medication. Mr. Al-Sarraj, the Designated Manager, was not on duty at the pharmacy at this time.

Upon his return to the pharmacy the next day, Mr. Al-Sarraj was advised of the exchange of medication and the

surrounding circumstances. Mr. Al-Sarraj was satisfied that in his absence, the locum pharmacist had dispensed the correct medication to the patient. Mr. Al Sarraj took no further action to ascertain the nature of the medication originally dispensed to the patient, or to follow-up on the health of the patient.

The patient had retained one of the pills originally dispensed to her and had her physician identify the pill; it was Digoxin (Lanoxin®). It was when the patient returned to the pharmacy again to report her findings that Mr. Al-Sarraj learned that the original drug dispensed was not that which had been prescribed, and that he had been the dispensing pharmacist. Mr. Al-Sarraj then contacted the physician and verified with the physician's nurse that the medication that had been originally dispensed was Digoxin (Lanoxin®).

Mr. Al-Sarraj acknowledged that he:

- Dispensed Digoxin (Lanoxin®) instead of the Synthroid® that was prescribed by the physician
- Failed to thoroughly check to ensure that the drug being dispensed was the drug that had been prescribed

Mr. Al-Sarraj further acknowledged that, as designated manager, he failed to:

- Ensure that appropriate protocols were in place to deal with dispensing errors
- Ascertain clearly that an appropriate review of the transaction had been conducted at the time that the medication exchange was originally reported to him

Reasons for Accepting the Joint Submission on Penalty

In accepting the *Joint Submission on Penalty*, the Panel considered the appropriateness of the proposed penalty in light of the facts and findings in this case.

The inappropriateness of the dispensing error was further compounded by Mr. Al-Sarraj's lack of adequate response and subsequent follow-up with both the patient and the physician. Specifically, having learned of the dispensing discrepancy, Mr. Al-Sarraj failed to check to ensure that the drug originally dispensed was indeed the drug that had been prescribed. It was the responsibility of Mr. Al-Sarraj, as designated manager of the pharmacy, to ensure that protocols and procedures for error management were in place and followed by all pharmacy staff.

Order

1. A reprimand
2. Specified terms, conditions and limitations on Mr. Al-Sarraj's *Certificate of Registration*, and, in particular, that he complete successfully, at his own expense, within 12 months of the date of this order, the education program "Confronting Medication Errors", offered by the Ontario Pharmacists' Association, including Workshop #1, "Understanding the Issues and Dealing with Incidents", and Workshop #2, "Taking Action to Improve Patient Safety"
3. A suspension of Mr. Al-Sarraj's *Certificate of Registration* for a period of one month; the suspension to be remitted on the condition that he complete the remedial training exercises specified in paragraph 2 above
4. Costs to the College in the amount of \$1,000

CASE 2

Billing Irregularities

Member: Trevor Wrightman, Toronto
Hearing Date: April 21, 2004

Mr. Wrightman was found to have:

- Failed to maintain a standard of practice of the profession
- Failed to keep records, as required, respecting his patients
- Falsified a record relating to his practice
- Signed or issued, in his professional capacity, a document that he knew to contain a false or misleading statement
- Submitted an account or charge for services that he knew to be false or misleading
- Charged a fee that is excessive in relation to the service provided
- Breached the *Drug and Pharmacies Regulation Act* and regulations thereunder

The Committee accepted Mr. Wrightman's plea of professional misconduct and was provided with an *Agreed Statement of Facts* which formed the basis of his plea.

Facts

Mr. Wrightman has been the sole director and majority shareholder of a company that owns The Medicine Shoppe ("the pharmacy") on Yonge Street in Toronto, Ontario, since 1999. Mr. Wrightman has also been the designated manager of the pharmacy and a dispensing pharmacist.

The College received a complaint from the Drug Program Branch of the Ministry of Health and Long-Term Care in January 2003, following an audit that revealed that a number of claims for seven-day supplies of medications were being submitted at intervals of five to six days.

The result was substantial over-billing of the ODB Plan, for, in particular, medications dispensed to, and claims submitted for, 12 patients for the period between April, 2001 and September 2001.

The details provided by the ODB audit of the dispensing transactions and claims to ODB for the 12 patients during this period revealed that all of the medications for these patients were dispensed in seven-day pill packages and that Mr. Wrightman had submitted 2,978 claims for these patients. Had the medications been dispensed properly at seven-day intervals, the number of proper claims would have totaled 2,295 claims. Therefore, during this period, Mr. Wrightman submitted 683 improper claims for these patients.

At ODB's request, Mr. Wrightman reimbursed ODB the full value of all of the excess claims identified in the complaint.

Mr. Wrightman acknowledged that there had been discrepancies in his practices with respect to his billing to ODB during the relevant time period. He also advised the College that he had changed his ODB billing practices to bring them into full compliance with all regulations and guidelines.

Mr. Wrightman also acknowledged that he failed to ensure that all written and verbal authorizations were documented.

Joint Submission on Penalty

Having considered all the material facts in this case, the panel accepted the joint submission on penalty and made the following Order:

Order

1. A reprimand
2. Specified terms, conditions and limitations on Mr. Wrightman's *Certificate of Registration* that, at his own

expense and within 12 months, he successfully complete the "Basic Professional Practice Laboratories" course and evaluations in the Canadian Pharmacy Skills Program offered through the Leslie Dan Faculty of Pharmacy at the University of Toronto, and attend the "Jurisprudence Seminar" offered by the College

3. A suspension of Mr. Wrightman's *Certificate of Registration* for a period of two months, with one month of the suspension to be remitted on the condition that the Member complete the remedial training exercise as specified above
4. Costs to the College in the amount of \$3,000

CASE 3

Theft, Billing for Drugs not Dispensed, Misuse of Drug Samples, Dispensing Without Authorization, Failure to Keep Records

Member: Subhash Parekh, Sarnia

Hearing Date: May 19, 2004

Mr. Parekh was found to have:

- Failed to maintain a standard of practice of the profession
- Dispensed or sold drugs for an improper purpose
- Failed to keep records as required respecting his patients
- Falsified a record relating to his practice
- Signed or issued, in his professional capacity, a document that he knew to contain a false or misleading statement
- Submitted an account or charge for services that he knew to be false or misleading
- Contravened the *Drug and Pharmacies Regulation Act* and regulations thereunder
- Contravened, while engaged in the practice of pharmacy, the *Food and Drug Act* regulations and the *Narcotic Control Regulations*
- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional

The Panel accepted Mr. Parekh's plea of guilty to several allegations of professional misconduct; the facts of which were set out in an Agreed Statement of Facts as follows:

Facts

Mr. Parekh was employed at all relevant times as the designated manager and was a narcotic signer and dispensing pharmacist at the pharmacy at which the misconduct took place until his employment was terminated.

Mr. Parekh misappropriated approximately \$25,000 from the pharmacy, over the period of approximately one year. In order to cover the misappropriations of cash, Mr. Parekh used drug samples received from a physician and other persons, over a period of approximately three years, to augment the pharmacy's drug inventory. Mr. Parekh subsequently made restitution for the misappropriated monies.

Mr. Parekh admitted that, for approximately two years, every two to three months, he dispensed eight tablets of Viagra®, to a patient, for which he charged the patient \$80 cash each time, without authorization, without issuing a receipt, and without keeping records. He also admitted that, on one occasion, he sold Oxycodone to a person, without prescriber authorization and without keeping a record, for approximately \$150 cash, which he kept for himself.

Mr. Parekh further admitted that, over a period of approximately nine years, he defrauded insurance drug companies regarding drug claims. According to Mr. Parekh, he and a physician had an arrangement to submit claims to insurance companies for drugs that were more expensive than the drugs actually dispensed to the patients or for drugs that were covered by the insurance plans although the drugs *actually* dispensed were not.

Mr. Parekh also admitted that, as designated manager of the pharmacy, he failed to monitor the purchase of narcotics and the narcotics inventory of the pharmacy — thereby effectively admitting responsibility for the purchase and sale or other disposition of narcotics and controlled drugs for an improper purpose and/or without authorization, over a period of approximately one year.

Joint Submission on Penalty

In arriving at its decision, the Panel considered a joint submission on penalty as well as a number of aggravating and mitigating factors.

Weighing most in the panel's deliberations determining the appropriate penalty was the seriousness of Mr. Parekh's misconduct which involved fraud, breaches of trust and deceit. The offences were not singular in nature but occurred over a protracted period of time, and in collaboration with others. As well, this was Mr. Parekh's second appearance before a disciplinary panel of the College regarding allegations of professional misconduct for which he was found guilty.

The member accepted responsibility for his actions and plead guilty, sparing the College the expense of a lengthy hearing. He paid restitution to his employer for the full amount of funds misappropriated and was prohibited from practicing, by the College, by way of an interim suspension of his *Certificate of Registration*, for a period of two years preceding this disciplinary proceeding.

The Panel accepted the Joint Submission on Penalty and made the following Order.

Order

1. A reprimand
2. Specified terms, conditions and limitations on Mr. Parekh's *Certificate of Registration* and in particular, that the Member complete successfully at his own expense within 12 months of the date of this order the "Jurisprudence Seminar" (with examination) provided by the College
3. A suspension of Mr. Parekh's *Certificate of Registration* for a period of 12 months, with 6 months of the suspension to be remitted in light of the lengthy interim suspension served, and on the condition that he complete the remedial training as specified in paragraph 2 above
4. Costs to the College in the total amount of \$10,000

CASE 4**Billing Discrepancies****Member:** Abraham Kucyi, Toronto**Hearing Date:** June 10, 2004

Mr. Kucyi was found to have:

- Signed or issued, in his professional capacity, a document that he knew to contain a false or misleading statements
- Submitted an account or charge for services that he knew to be false or misleading
- Contravened the *Drug and Pharmacies Regulation Act*, the *Regulated Health Professions Act, 1991* or regulations thereunder
- Engaged in conduct or performed an act relevant to the practice of pharmacy that, having regard to all circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional

The Panel accepted Mr. Kucyi's plea of professional misconduct, the facts of which were set out in an Agreed Statement of Facts as follows:

Facts

The College received a complaint from Manulife Financial resulting from an audit of Mr. Kucyi's practice that revealed that Manulife Financial had been billed for drugs that had not been dispensed. The false claims involved 153 transactions totaling \$7,830.01 over a period of one to two years. Mr. Kucyi agreed to reimburse Manulife Financial for the total amount of the claims plus the cost of its investigation.

During the College's investigation of the complaint, Mr. Kucyi acknowledged and apologized for his misconduct. He explained that he had experienced emotional and psychological problems during the period within which the misconduct occurred. He provided a psychiatrist's report which outlined a history suggesting that, because of ongoing emotional distress related to financial concerns,

the professional misconduct had occurred in the past. The psychiatrist opined that, with continued psychological counselling, the possibility of similar misconduct in the future would be reduced and, as such, Mr. Kucyi will not present an obvious risk to the public.

Mr. Kucyi has two prior findings of professional misconduct against him. Both cases involved improper billing practices.

Joint Submission on Penalty

The parties agreed to a penalty which was presented to the Panel by way of a Joint Submission on Penalty.

In considering the appropriateness of the agreed upon penalty, the Panel considered a number of issues. Most troubling was Mr. Kucyi's two previous findings of professional misconduct before a Discipline panel of this College. These cases also involved improper billing practices, occurring over a four year period and one year period respectively.

Juxtaposed against Mr. Kucyi's prior disciplinary record were several mitigating factors which were also taken into account:

- Mr. Kucyi cooperated fully with the audit conducted by Manulife Financial and voluntarily paid restitution, plus the cost of its investigation, to Manulife Financial
- In the College's investigation, Mr. Kucyi acknowledged and apologized for his misconduct
- Mr. Kucyi has experienced significant personal difficulty in the past, including emotional distress, during the relevant period to this complaint related to financial concerns, marital conflict and his prior disciplinary record. However, Mr. Kucyi provided assurances that he has received appropriate medical treatment, has changed his life in those areas that led to his prior and current disciplinary offences, and that he will continue with recommended psychological counselling such that he should not present a risk to the public at this time

Taking into account all of the above considerations the Panel accepted the Joint Submission on Penalty.

Order:

1. A reprimand
2. Specified terms, conditions and limitations on Mr. Kucyi's *Certificate of Registration*, and in particular:
 - a. Psychological counselling by Mr. Kucyi's psychiatrist, or a qualified mental health professional recommended by the psychiatrist, for as long as the responsible professional recommends, with confirmation to the College, in writing by the responsible professional, regarding his compliance at four-month intervals for as long as the counselling continues
 - b. Three unannounced monitoring inspections by the College over a three-year period, with the inspections to be paid by Mr. Kucyi
3. A suspension of Mr. Kucyi's *Certificate of Registration* for a period of 6 months
4. Costs to the College in the amount of \$1,500

CASE 5**Theft, Fraud and Possession of Drugs for the Purpose of Trafficking****Member:** Tom Dong, Toronto**Hearing Date:** July 7, 2004

Mr. Dong was found to have committed an act of professional misconduct in that he:

- Was found guilty of an offence relevant to his suitability to practice pharmacy contrary to the *Criminal Code of Canada*
- Failed to maintain a standard of practice of the profession
- Dispensed or sold drugs for an improper purpose
- Signed or issued, in his professional capacity, a document that he knew contained a false or misleading statement
- Contravened the *Drug and Pharmacies Regulation Act*
- Contravened, while engaging in the practice of pharmacy, the *Controlled Drugs and Substances Act* and the *Narcotic Control Regulations*
- Engaged in conduct or performed an act, relevant to the

practice of pharmacy that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional

The Discipline Committee accepted Mr. Dong's plea of professional misconduct and was provided with an Agreed Statement of Facts which formed the basis of his plea.

Facts

Mr. Dong was found guilty on three separate occasions of criminal charges. These included theft under \$5,000; fraud under \$5,000; and possession of controlled substances for the purpose of trafficking.

The first charge arose from misconduct committed when, while employed by Brant Pharmacy, Mr. Dong misappropriated cash from a cash box and cash received as payment for a prescription in an amount totalling approximately \$1,030. The second charge was laid when Mr. Dong was caught switching price tags on items at a Winner's store. The third conviction related to possession of Oxycodone, Diazepam and Clonazepam and anabolic steroids for the purpose of trafficking.

When information about the criminal charges was brought to the attention of the College, Mr. Dong voluntarily surrendered his *Certificate of Registration* pending the disposition of the criminal charges and the allegations of professional misconduct.

A report, provided by a physician specializing in psychotherapy and behaviour disorders, identified emotional and behavioural disorders compounded by business and relationship problems as having contributed to Mr. Dong's misconduct. According to this physician, Mr. Dong has demonstrated a better understanding of his emotional circumstances and appropriate mechanisms for dealing with business and relationship stresses.

Reasons

The Panel was presented with a Joint Submission on Penalty. In assessing its appropriateness, the Panel considered several aggravating and mitigating factors involved in this case:

The criminal offences involved matters of dishonesty and lack of integrity. Moreover, possession for the purpose of trafficking controlled substances is a particularly serious criminal offense for a practising pharmacist who has responsibility for, and access to, these types of drugs.

However, Mr. Dong accepted responsibility for his criminal acts by not contesting the charges; conceded that they are relevant to his suitability to practice; admitted to his professional misconduct which saved the College the time and expense of a protracted hearing; and voluntarily surrendered his *Certificate of Registration* pending dispositions of both the criminal and disciplinary proceedings. Mr. Dong had no previous disciplinary history with the College and had been restricted from practising for a period of 14 months at the time of the hearing.

The expert report assisted the Panel in understanding the background emotional and behavioural disorders which existed during the time period that contributed to the professional and criminal misconduct. Also, the specialist's opinion that Mr. Dong is not likely to re-offend provided the Panel with the reassurance that, in the future, and in his capacity as a pharmacist, he will not be a danger to the community.

The Panel, therefore, accepted the Joint Submission on Penalty and made the following Order.

Order

1. A reprimand
2. Specified terms, conditions and limitations on Mr. Dong's *Certificate of Registration* that he complete successfully, at his own expense, within 12 months of the date of the Order, the "Advanced Professional Practice Laboratories", including evaluations, in the Canadian Pharmacy Skills Program offered through the Leslie Dan Faculty of Pharmacy at the University of Toronto
3. Further specified terms, conditions and limitations on Mr. Dong's *Certificate of Registration* that he will not own a pharmacy in any capacity, or be designated as the manager or a narcotic signer at any pharmacy, for a period of five years from the date of the order
4. A suspension of Mr. Dong's *Certificate of Registration* for

a period of 12 months, with three months of the suspension to be remitted on condition that he complete the remedial training program specified in paragraph 2 above

CASE 6

Loyalty Programs

Members: Virginia Cirocco, Brian Relph, Toronto

Hearing Date: July 8, 2004

Ms. Cirocco and Mr. Relph were found to have:

- Offered or distributed, directly or indirectly, a gift, rebate, bonus or other inducement with respect to prescription or prescription services

The Panel of the Discipline Committee accepted Ms. Cirocco and Mr. Relph's plea of professional misconduct and was provided with an Agreed Statement of Facts which formed the basis of their pleas.

Facts

The Members, Ms. Cirocco and Mr. Relph, both senior executives of Shoppers Drug Mart Inc. ("SDM") and Directors of TDM Drugs Inc. ("TDM"), the corporate owner of several SDM pharmacies, admitted that they engaged in an act or acts of professional misconduct by authorizing and offering a bonus or other inducement, with respect to prescription services in connection with the offering of *Optimum Points* for prescriptions filled at SDM pharmacies between November and December 2002.

In particular, in October 2002, Ms. Cirocco approved the launch of an *Optimum Points* direct mail promotion by SDM. Coupons were mailed to target customers including senior Optimum cardholders (65+), select female Optimum cardholders (45-65), and customers in ten designated geographical locations that awarded *Optimum Points* to customers who brought a prescription and an *Optimum Points* coupon to a SDM pharmacy during November and December, 2002.

A SDM memorandum addressed to associates and pharmacy teams, dated November 7, 2002, outlined the details of the promotion, including the following salient paragraph describing the operation of the promotion:

"*Optimum Points* are provided to customers who bring a prescription and direct mail coupon offer to us, between now and December 31, 2002. Points are awarded to customers for the portion that they pay on their prescription. Points are not to be awarded if a patient pays nothing on their prescription. Terms and conditions associated with this initiative are in accordance with provincial regulations."

The College became aware of the promotion and advised Ms. Cirocco both verbally and in writing, prior to the promotion start date, that it violated the College's *Policy on Loyalty Programs* (as published in *Pharmacy Connection* July/August 1999) and notified Ms. Cirocco of the College's intention to inform SDM pharmacists that participation in the program exposed the pharmacists to disciplinary action.

In her capacity as Senior Vice President, Pharmacy, Shoppers Drug Mart Inc., Ms. Cirocco circulated a memorandum to Ontario SDM associates confirming SDM's position regarding the program and offering the "full resources of the corporate office" should the College receive a complaint.

The College subsequently notified all SDM associates, designated managers and pharmacists of the College's position that offering points for having a prescription filled violates subsection 1 (29) of O. Reg 681/93 and participation in this *Optimum Points* promotion exposed the pharmacist to disciplinary proceedings by the College.

Ms. Cirocco and Mr. Relph, in their capacity as directors of TDM, acknowledged that the *Optimum Points* promotion under issue constituted a bonus or other inducement contrary to the Regulation and amounted to professional misconduct. Specifically, they acknowledged that, as directors of TDM, they are (a) accountable for their conduct in relation to all policies and practices relating to pharmacy practice; and (b) must make their best efforts to ensure that

all applicable laws and regulations take precedence over any competing proposed corporate decision that may impact upon the operation of pharmacies and the standards of practice for SDM pharmacists. Moreover, they acknowledged that it is their individual responsibilities not to create a conflict between SDM promotions and the professional obligations and standards of practice of pharmacists who work at SDM pharmacies.

Joint Submission on Penalty


The Panel was presented with a Joint Submission on Penalty and, in assessing its appropriateness, weighed both aggravating and mitigating factors.

The primary aggravating factor was the members' disregard for the College's *Policy on Loyalty Programs* and their ongoing defiance in continuing to advocate that SDM associates proceed with the promotion even after having received the College's written position on the issue. Moreover, the members encouraged SDM associates to proceed with the promotion with their assurances that they would support any associate in any disciplinary matter before the College.

The mitigating factor was that the members have given strong acknowledgements, recognizing their misconduct in potentially placing SDM associates in conflict with their regulatory body.

Having considered these factors, the Committee accepted the Joint Submission on Penalty and made the following Order, the results of which are to be recorded on the public register.

Order

1. A reprimand
2. A fine in the amount of \$10,000 (to be paid jointly by the members)
3. Costs the College in the amount of \$15,000 (to be paid jointly by the members) 

Recommendations on Drug Use in the Elderly

The following recommendations were taken from the Thirteenth Annual Report of the Geriatric and Long-Term Care Review Committee to the Chief Coroner for the Province of Ontario.

During 2003, 17 cases were reviewed with eight cases giving rise to recommendations that should be reviewed by pharmacists in the categories of *medical/nursing management, communication and documentation and drug use in the elderly*.

The recommendations are presented here (verbatim) for you to consider when caring for the elderly.

MEDICAL/NURSING MANAGEMENT

1. Health care professionals should be reminded that constipation and obstipation are common, preventable and treatable medical conditions that affect the elderly. Untreated, these conditions can be devastating and may even result in death. Once obstipation is suspected, aggressive investigation and treatment should be considered on a case by case basis.

As with many geriatric syndromes, obstipation may present either typically (abdominal pain, fecal incontinence) or atypically (confusion, delirium). Health care professionals should be especially wary of elderly patients who present with constipation/obsti-

pation who have associated systemic symptoms (tachycardia).

In these cases, the ordering of laboratory investigations and an EKG should be considered on a case by case basis. Elderly patients receiving medications known to decrease bowel motility such as narcotics or other proconstipatory drugs such as calcium channel blockers should be put on a prophylactic bowel regimen. The bowel regimen should include the addition of fibre to their diet, the provision of stool softeners, and prn laxatives such as Milk of Magnesia or Lactulose every night that there isn't a bowel movement. If there is no

bowel movement for three days, consideration should be given to the administration of an enema. In addition, health care professionals should be aware that initiating treatment with natural fibre and/or bulk forming laxatives in the presence of obstipation/fecal impaction can potentially worsen the situation especially if the patient's fluid intake is inadequate and/or mobility is impaired.

Health care professionals should also be reminded that, in the perioperative period, the presence of bowel movements does not always eliminate the possibility that obstipation/fecal impaction is present and/or developing. The development of postoperative abdominal pain in the elderly should alert the treating health professionals to the possibility that obstipation/fecal impaction is present.

The occurrence of overflow incontinence should alert the treating health care professionals to the possibility that the patient has developed fecal impaction with overflow incontinence. Fecal impaction can be difficult to treat and should be treated vigorously when present. Careful abdominal and rectal examinations should be performed. The finding of soft stool or no stool in the rectum does not absolutely rule out the presence of fecal impaction.

In these cases, an abdominal flat plate x-ray should be ordered to rule out the possibility of a higher impaction that cannot be detected on rectal examination and/or a developing acute/sub acute bowel obstruction (dilated loops of bowel with air/fluid levels). While manual disimpaction should be the first intervention attempted, the presence of obstipation with a higher impaction should be primarily be managed with enemas to clear the bowel from below. In some cases, the addition of oral osmotic laxatives such as Lactulose can be used to clear the bowel from above. Gastrointestinal lavage solutions have also been proven to be very effective in treating fecal impaction.

Reference: Constipation can be Deadly – Canadian Family Physician, Volume 38, October 1992; Goldlist B., Nagalie G., Gordon M.

Comment: This recommendation was made in two reviews in 2003.

2. Health care professionals should be reminded that the presence of a persistent fever following the institution of antibiotic therapy may be indicative of the presence of an unrecognized medical condition.
3. Health care professionals should be reminded that treatment with oral antibiotics is a reasonable first line of defence in the management of elderly patients with a suspected infectious process. The development of systemic symptoms such as nausea, vomiting, decreased bowel function, and abdominal

It is evident from the recommendations that this committee sees pharmacists as an integral part of the health care team in providing optimal services to geriatric and long-term care patients.

pain should result in consideration being given to changing the route of antibiotic administration from oral to parenteral.

4. Health care professionals caring for the elderly in the long-term care setting should be knowledgeable about the causes, complications, and management of urinary incontinence and retention. Long-term care facilities should develop policies and procedures to assist health care professionals in the management of these conditions.
5. Health care professionals should be reminded that, although decubitus ulcers are commonly seen in the immobilized, ill elderly, they are **never** a normal consequence of disability and immobility. The potential for the development of serious infection, septicemia, and death must always be remembered.
6. All health care institutions in the Province of Ontario should develop a policy and procedure to ensure that resuscitation carts contain all necessary equipment to conduct resuscitation.


COMMUNICATION AND DOCUMENTATION

1. Health care professionals should be reminded of the importance of keeping complete, comprehensive, and accurate progress notes regarding treatment decisions and assessments including capacity assessments. Frequently, the Committee finds these notes to be absent, scanty, incomplete, irrelevant, inaccurate, and/or illegible. These notes should meaningfully reflect issues identified by all members of the health care team (including the family) and include the reasons why certain treatments are/are not being done in relation to these issues.
2. Health care professionals should be reminded of the importance of good communication amongst **all** members of the health care team including family members in situations where a patient's clinical condition suddenly, unexpectedly, and unexplainably changes, and/or when family members have expressed concerns regarding the patient's clinical course. The importance of documenting the information communicated and with who the communication has occurred cannot be overemphasized.

THE USE OF DRUGS IN THE ELDERLY

1. When using psychoactive drugs in the ill elderly, the lowest dose possible should be the initial dose and further doses titrated upwards depending on the response unless there is convincing evidence that a higher dose is necessary because of compelling clinical considerations (i.e. acute delirium) which puts the patient at extreme risk and requires rapid intervention to eliminate the associated agitation which might interfere with medical care.
2. Health care professionals should be reminded that the prescribing of psychotropic medications can be a valuable management tool to control aggressive behaviour in the demented elderly. When indicated, the importance of documenting behavioural responses to the prescribed medications cannot be overemphasized. If the use of validated behavioural scales does not support the efficacy of the prescribed interventions, consideration should be given to discontinuing pharmacologic treatment interven-

tions. The importance of monitoring for the development of untoward side effects such as decreased mobility and the development of pressure ulcers cannot be overemphasized. In addition, health care professionals should be cautioned about the dangers of prescribing large "prn" doses of psychoactive medications which can cause excessive sedation with rebound agitation.

3. Health care professionals prescribing "prn" psychoactive medications for the agitated, immobilized elderly should be reminded of the importance of specifying what the "prn" medication is to be given for.
4. Health care professionals should be reminded that Meperidine Hydrochloride is a narcotic that should rarely, if ever, be prescribed for the elderly because of its prolonged half life, penchant for causing and/or exacerbating a delirium, and tendency to mask other symptoms. If narcotic analgesia is required, consideration should be given to using a narcotic such as Morphine Sulfate which has a shorter half life and less anticholinergic effects.
5. Health care professionals should be reminded that the regular administration of non-narcotic analgesics such as Acetaminophen may significantly reduce the need for narcotic analgesics.
6. Health care professionals should be reminded that medications such as narcotics and antihistamines may exacerbate behavioural problems in the demented elderly.
7. Health care professionals should be reminded of the proconstipatory effects of medications such as calcium channel blockers.
8. Health care professionals should be reminded that Benzotropine Mesylate is not a recommended treatment for restlessness and agitation in the demented elderly. In the absence of documented neuroleptic side effects, this medication should not be routinely prescribed. 

Letter to Editor

Dear Editor –

My name is Henry Halapy and I am a pharmacist specializing in diabetes care at St. Michael's Hospital. I would like to address the College's position on the sale of food items loosely termed "junk food" in pharmacies. Often, when one walks into a retail pharmacy outlet, there are several aisles devoted to pop, chips, chocolates, candies, cookies and other related foods. True, that many pharmacies are located within grocery stores or other department stores and may not have any say in what is sold in other areas of the store; however many pharmacies are not.

My concern with the sale of these items lives with the fact that both obesity and resultant diabetes are growing at increasing rates in the Ontario and Canadian populations according to the StatsCan and ICES surveys. In fact, diabetes is now present in 6% of the population, in particular type 2 diabetes and is predicted to grow significantly over the coming decades, according to these surveys. As the pharmacy profession strives to better serve the Ontario population's health care needs and enhance its role as primary health care providers, it seems paradoxical to me that the high-calorie and fat-dense foods that are seen as one of the factors contributing to the nation's and the province's obesity epidemic are so liberally sold in pharmacies. I see this situation much akin to the sale of tobacco products in pharmacies debate which gripped the profession approximately ten or so years ago. In the end, the government, quite justifiably, banned the sale of cigarettes form pharmacies to resolve the issue for once and for all.

While I hope that this situation can be discussed more earnestly by the profession than the cessation of tobacco sales perhaps were, I would like to ask the College's thoughts on the sale of such food items in pharmacies. I surely believe that the College would be serving its mandate to ultimately protect the health and welfare of the public (with respect to the pharmacy profession and its regulation) by looking into this matter. Thank you for your anticipated response.

Henry Halapy, R.Ph.

Editor's Note:

I am printing Mr. Halapy's letter to stimulate discussion amongst our profession. Many pharmacists are certified diabetes educators. What do you believe is the responsible role for pharmacists on foods and promoting a healthy lifestyle?

FOCUS ON Error Prevention

Ian Stewart, B.Sc.Pharm.

Health Canada's Therapeutic Products Directorate assigns a single *Drug Identification Number (DIN)* for products with varying sizes, provided that all other product characteristics including product name, manufacturer's name, dosage form, route of administration, medicinal ingredient(s), and corresponding strength(s) are identical. As a result, different product packages have been assigned identical DINs.

Since pharmacists use the DIN as a key check to confirm that the correct drug has been dispensed, this system of assigning DINs can contribute to dispensing errors.

CASE

A pharmacy technician was presented with a prescription for Engerix B® for a six-year-old child for filling. The prescription was entered into the computer correctly as Engerix B® Pediatric dose. However, in error, a second technician selected the Engerix B® Adult dose to be dispensed. The pharmacist checked the prescription including the DIN, but did not detect the error. Fortunately, the error was detected by the physician prior to administration.

Contributing Factors:

- The DIN for both Engerix B® Adult and Engerix B® Pediatric is identical

- Both products have identical package size, shape and appearance (vial volume difference)
- Due to the small package size of Engerix B®, the prescription label affixed to the product by the pharmacy technician obscured key product information

Recommendations:

- Become familiar with products that are assigned identical DINs. These include:

Product	Strength	DIN
Engerix B® Pediatric Dose (5mL)	20 mcg / mL	01919431
Engerix B® Adult Dose (1mL)		
Lovenox® 40mg / 0.4mL		
Lovenox® 60mg / 0.6mL	10mg / 0.1mL	02236883
Lovenox® 80mg / 0.8mL		
Lovenox® 100mg / 1mL		
Fragmin® 5000 IU / 0.2mL		
Fragmin® 10,000 IU / 0.4mL		
Fragmin® 12,500 IU / 0.5mL	5000 unit / 0.2mL	02132648
Fragmin® 15,000 IU / 0.6mL		
Fragmin® 18,000 IU / 0.72mL		
ratio-lpratropium UDV 20 vials x 1 mL	250 mcg / mL	02097168
ratio-lpratropium UDV 10 vials x 2 mL		

*Please note this is not an exhaustive list.

- When dispensing these products, double-check the dose being dispensed
- Though the DIN may be identical, the bar code assigned to each product is unique. Therefore, if possible use the bar code as a double check to confirm that the correct product is being dispensed
- Educate pharmacy technicians of the potential problems associated with covering key information on the product that is being dispensed *before* the prescription is checked by the pharmacist

Use the [OCPinfo.com](http://www.ocpinfo.com) site to stay up-to-date on College Notices and to learn about upcoming CE Events/Resources

If you cannot find a particular event, search by keyword using the website's search engine

CE Section Contains CE Events, Resources and Links for Pharmacists. Items are organized by type and location

CE for Technicians: Look for technician events here

Click on the "OCP CONNECTS" banner to pay your fees with a credit card or to update information

Notices to Pharmacists: Displays OCP and Health Canada Notices

Click on title bar for full listing

CE Listings: Lists next three upcoming CE events

OCP
info
.com

Visit the College's website: www.ocpinfo.com for a complete listing of upcoming events and/or available resources. A number of the programs listed below are also suitable for pharmacy technicians.

Sep - Oct
Health Information Protection Act, 2004 Educational Sessions Ministry of Health and Long-Term Care. Check the OCP website for more detailed location information and registration page.

Sep 14: Kingston
 Sep 16: London
 Sep 21: Toronto
 Sep 23: Ottawa
 Sep 28: Windsor
 Oct 5: Hamilton
 Oct 12: Sudbury
 Oct 14: Sault Ste. Marie
 Oct 19: Timmins
 Oct 21: Thunder Bay
 Oct 26: North Bay
 Oct 28: Toronto

Sep - Nov: Toronto
Implementing Effective Communication Strategies: A Workshop for Health Care Professionals
 Sep 22, 29, Oct 1: Module A
 Oct 20, 29, Nov 6: Module B
 tel (416) 498-1700; 1-866-800-0020
reception@mediatedsolutions.ca

Sep 22: Newmarket
Pharmacotherapy in Pregnancy & Lactation, York North Pharmacists' Association; Pharmacy Technicians are welcome
 Janet Shore
 tel (905) 853-0855
 fax (905) 853-0571
jshore@pathcom.com

Sep 22: Bayfield
Common Oral Conditions and Therapies: The Dentist/Pharmacist Interface, Huron County

Pharmacists' Association
 Dan Stringer
 tel (519) 524-2145
 fax (519) 524-8213
danstringer@hurontel.on.ca

Emergency Contraception, Ontario Pharmacists' Association
Sep 22: Ottawa, Christa Vallier
christa.vallier@sympatico.ca
Sep 27: Sudbury, Wilf Steer
wsteer@sympatico.ca
Sep 28: Pembroke, Kelli Ouimet
lkouimet@nrtco.net
Oct 12: Walkerton, Adele Kaminski
adele.kaminski@utoronto.ca
 Sandra Winkelbauer
 tel (416) 441-0788 x 4235
 fax (416) 441-0791
swinkelbauer@opatoday.com
www.opatoday.com

Sep 23: Markham
Living Well: An Integrated Approach to Respiratory Health, Ontario Respiratory Care Society
 Sheila Gordon-Dillane
 tel (416) 864-9911 x 236
 fax (416) 864-9916
orcs@on.lung.ca

Sep 30: London & Oct 1: Richmond Hill
The Virus, Biomed
 tel (925) 602-6140 or
 1-877-246-6336
 fax (925) 363-7798

Oct 2-6: Ottawa
12th Cochrane Colloquium: Bridging the Gaps
 tel (604) 681-2153
cochrane@meet-ics.com
www.colloquium.info

Oct 5: Windsor
It's All About Lungs! A Respiratory Care Update, Ontario Respiratory Care Society
 Sheila Gordon-Dillane
 tel (416) 864-9911 x 236
 fax (416) 864-9916
orcs@on.lung.ca

Oct 6: Newmarket
Physician-Pharmacist Collaboration Workshop, York North Pharmacists' Association and Pfizer Canada
 Janet Shore, jshore@pathcom.com
 Carolyn Bornstein, bornstein@sympatico.ca
 For information on upcoming workshops in your area:
 tel 1-800-363-5634 x 24

Oct 20: Newmarket
Drug Interactions - Part II: Herbals, York North Pharmacists' Association
 Janet Shore
 tel (905) 853-0855
 fax (905) 853-0571
jshore@pathcom.com

Oct 21: Guelph
Respiratory Care in the Royal City, Ontario Respiratory Care Society
 Sheila Gordon-Dillane
 tel (416) 864-9911 x 236
 fax (416) 864-9916
orcs@on.lung.ca

Oct 22-23: Listowel
Current Topics for Pharmacy Technicians 2004, Listowel Memorial Hospital
 Christine Vanderspiegel
 tel (519) 291-3125 x 231
 fax (519) 291-5440

chris.vanderspiegel@lwha.ca
 Cathy Schuster
 tel (519) 271-2120 x 2412

Oct 22 -24: Toronto
POP at NOPS, National Oncology Pharmacy Symposium
www.capho.ca

Oct 29: Ottawa
Pharmacy Technician Conference: Pharmacy - Growing Pains The Ottawa Hospital
 Corleen Tighe
 tel (613) 737-8899 x 78807
CTIGHE@Ottawahospital.on.ca

Nov 3: London
Gasping for Air, Ontario Respiratory Care Society, Southwestern Ontario Region
 Sheila Gordon-Dillane
 tel (416) 864-9911 x 236
 fax (416) 864-9916
orcs@on.lung.ca

Nov 10: Toronto
Confronting Medication Errors 2 - Taking Action to Improve Patient Safety, Ontario Pharmacists' Association
 Penny Young
 tel 1-877-341-0788 x 2209
 Sandra Winkelbauer
 tel (416) 441-0788 x 4235
 fax (416) 441-0791
swinkelbauer@opatoday.com
www.opatoday.com

Nov 12: Toronto
Managing Severe Respiratory Disease, Ontario Respiratory Care Society, Greater Toronto Region
 Sheila Gordon-Dillane
 tel (416) 864-9911 x 236
 fax (416) 864-9916
orcs@on.lung.ca

Nov 13: Toronto
Annual General Meeting & Education Sessions, Canadian Society of Hospital Pharmacists - Ontario Branch
www.cshpontoario.ca

Nov 15-16: Toronto
Tuberculosis Management, Lung Association's Tuberculosis Committee
 Sheila Gordon-Dillane
 tel (416) 864-9911 x 236
 fax (416) 864-9916
orcs@on.lung.ca
www.on.lung.ca

Nov 19-20: Toronto
2004 POGO Symposium: Difficult Beginnings - Cancer in Infancy, Pediatric Oncology Group of Ontario's (POGO)
 Gillian Lachance
 tel (416) 592-1232 x 237
 fax (416) 592-1285
glachance@pogo.ca
www.pogo.ca

Nov 23 or 24: Toronto
Neurodegenerative Diseases of the Elderly, Details Healthcare Conferences
 Randy Sorenson
 tel (416) 642-9717
 fax (416) 462-3460
Rand.sorenson@sympatico.ca

Nov 25: Newmarket
Glaucoma and its Treatment York North Pharmacists' Association
 Janet Shore
 tel (905) 853-0855
 fax (905) 853-0571
jshore@pathcom.com

Nov 27: Toronto
Anticoagulation Specialty Workshop, Ontario Pharmacists' Association
 Sandra Winkelbauer
 tel (416) 441-0788 x 4235
 fax (416) 441-0791
swinkelbauer@opatoday.com
www.opatoday.com

CANADA
Nov 26-28: Montreal QC
Raising the Standard of Care in COPD, Canadian COPD Alliance
cca@lung.ca

INTERNATIONAL
Compounding Certificate Programs - 2004, American College of Apothecaries Memphis TN
Oct 29-30; Nov 10-11: Contemporary Prescription Compounding
Oct 27-28; Nov 12-13: Aseptic Compounding Techniques
Oct 20-21: Compounding for Pain Management
Oct 22-23: Program in Compounding for Women's Health
 tel (901) 383-8119 or
 1-800-828-5933
 fax (901) 383-8882
www.acainfo.org

Oct 16-17: Naples FL
Cardiology Update 2004 Cleveland Clinic Florida
 tel 1-877-675-7223 x 4366
cme@ccf.org
www.clevelandclinicflorida.org

Nov 6-7: Naples FL
Essentials in Colorectal Diseases Cleveland Clinic Florida
 tel 1-877-675-7223 x 4366
cme@ccf.org
www.clevelandclinicflorida.org

BULLETIN BOARD

CLASS of 8T4 REUNION

The 20-year Reunion for the University of Toronto Pharmacy Class of 8T4 will be held this fall on Saturday, October 23, 2004 at the Hockley Valley Resort, Orangeville. The event will feature a dinner and dance. For more information, please email Beth Sproule at bethsproule@sympatico.ca.

The Canadian Diabetes Association is changing its meal planning system!

The introductions of new medications and new methods for the management of diabetes has prompted changes in diabetes education. To meet these new needs, the Canadian Diabetes Association has been working on revising its meal planning system to make it more compatible with *Canada's Food Guide to Healthy Eating* and with the systems used in Québec and the U.S. The biggest change will be in food groups containing carbohydrates

(e.g. grains and starches, vegetables, fruits, and milk), where one serving of a food in all of these groups will contain 15 grams of carbohydrates.

At present time, the feedback on the first draft of the proposed new system has been consolidated and a second draft of the system is being readied. An "almost final" version will be presented at the CDA/CSEM professional conference in late October, with the final basic version expected in January or February 2005. A larger, more detailed, manual will be ready about one year later.

Consumers may notice that the Association's Food Choice Values and Symbols will no longer appear on food packaging. New labelling regulations will provide more nutrition information that can be used to make good food choices.

For more information, please go to the Association website at www.diabetes.ca.



CORONER'S JURY REPORT

RE: E.J. SAUNDERS
KINGSTON ON, MARCH 3, 2004

CASE SYNOPSIS

Mr. Saunders was an inmate housed at Frontenac Institution, Kingston. He was known to suffer from diabetes mellitus and Hepatitis C. On April 17, 2003 he was found unresponsive in his unlocked cell and was subsequently pronounced dead by the on-duty coroner.

The Coroner's Jury found that Mr. Saunder's cause of death was accidental, due to an overdose of opiates (pulmonary edema). Evidence provided showed that Mr. Saunders was on a number of medications including: Olanzapine, Neurontin, Robaxin, Reactine®, Graval®, Insulin, Beconanse® Nasal Spray and a hemorrhoid cream. A witness testified that Mr. Saunders overdosed on the opiate Morphine.

RECOMMENDATION

The Jury made two recommendations, of which the following recommendation is relevant to pharmacists.

1. For inmates on prescriptions, they should have appropriate medical information provided to cover:
 - a. What drugs (either illicit or prescribed) should be avoided and what effects could happen
 - b. Symptoms associated with complications
 - c. What measures to take if complications arise

This information should be confirmed, [and] that a medical practitioner [has] sufficiently explained [the information] and [that this has] been understood by the inmate.

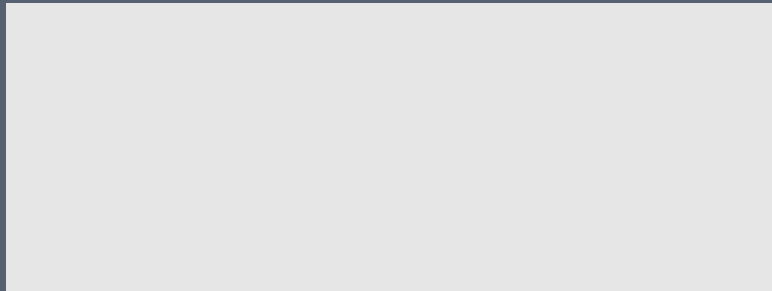
Each issue of *Pharmacy Connection* includes an up-to-date summary of all current *OCP Manual* items in the table shown. These items are available and can be printed off from our website: www.ocpinfo.com. Individual copies, or complete sets of the legislation (with binder and tabs), can also be ordered from the College. The *OCP Manual*, sold with the *OCP Policy Handbook* (complete with index and copies of reference articles), is \$85 (\$90.95 with GST). Sold separately, the *OCP Manual* is \$64.20 (GST included) and the *OCP Policy Handbook* is \$32.10 (GST included).

<p>Drug and Pharmacies Regulation Act (DPRA) * Amended 2000 Regulations to the DPRA: DPRA R.R.O. 1990, Regulation 545 – Child Resistant Packages DPRA R.R.O. 1990, Regulation 547 Amended to O.Reg. 548/93 – Dentistry DPRA Ontario Regulation 297/96 Amended to O.Reg. 180/99 – General DPRA R.R.O. 1990, Regulation 551 Amended to O.Reg. 179/99 – General DPRA R.R.O. 1990, Regulation 548 Amended to O.Reg. 705/93 – Medicine DPRA R.R.O. 1990, Regulation 550 Amended to O.Reg. 550/93 – Optometry</p>	<p>Ontario Drug Benefit Act (ODBA) & Regulations * Amended 2002 Regulations to the ODBA: Ontario Regulation 201/96 Amended to O.Reg. 395/02 – General</p>
<p>Drug Schedules ** Summary of Laws Governing Prescription Drug Ordering, Records, Prescription Requirements and Refills - January 2001 OCP Canada's National Drug Scheduling System – February 2, 2004 NAPRA (or later)</p>	<p>Food and Drugs Act (FDA) & Regulations ☼ Updated Health Canada Version as of Dec. 31, 2003</p>
<p>Regulated Health Professions Act (RHPA) * Amended 2002 Regulations to the RHPA: Ontario Regulation 39/02 -Certificates of Authorization Ontario Regulation 107/96 – Controlled Acts Ontario Regulation 59/94 – Funding for Therapy or Counseling for Patients Sexually Abused by Members</p>	<p>Controlled Drugs and Substances Act (CDSA) ☼ Updated NAPRA Version as of October 25, 2000 Benzodiazepines & Other Targeted Substances Regulations-Can.Gazette June 21/00 Precursor Control Regulations – Can.Gazette October 9/02</p>
<p>Pharmacy Act (PA) & Regulations * Amended 1998 Regulations to the PA: Ontario Regulation 202/94 Amended to O.Reg. 548/99 – General Ontario Regulation 681/93 Amended to O.Reg. 122/97 – Professional Misconduct</p>	<p>Narcotic Control Regulations ** Updated NAPRA Version as of October 25, 2000</p>
<p>Standards of Practice ▲ New Standards of Practice, January 1, 2003 OCP</p>	<p>OCP By-Laws By-Law No. 1 – June 2003 ▲ Schedule A - Code of Ethics, May 1996 Schedule B - Conflict of Interest Guidelines for Members of Council and Committees - Oct 1994 Schedule C - Member Fees - Jan 1, 2003 Schedule D - Pharmacy Fees - Jan. 1, 2003 Schedule E – Certificate of Authorization – Jan. 2003</p>
<p>Drug Interchangeability and Dispensing Fee Act (DIDFA) & Regulations * Amended 1996 Ontario Regulation Reg. 935 - General Ontario Regulation Reg. 936 – Notice to Patients Regulations to the DIDFA: Regulation 935 Amended to O.Reg. 394/02 – General Regulation 936 Amended to O.Reg. 205/96 – Notice to Patients</p>	<p>Reference ▲ Handling Dispensing Errors, Pharmacy Connection Mar/Apr 1995 Revenue Canada Customs and Excise Circular ED 207.1 Revenue Canada Customs and Excise Circular ED 207.2 District Excise Duty Offices - Oct. 10/96 Guidelines for the Pharmacists on "The Role of the Pharmacy Technician" OCP Required Reference Guide for Pharmacies in Ontario, Mar. 2004</p>

* Information available at **Publications Ontario** (416) 326-5300 or 1-800-668-9938
 ** Information available at **www.napra.org**
 ☼ Information available at **Federal Publications Inc.** Ottawa: 1-888-4FEDPUB (1-888-433-3782)
 Toronto: Tel: (416) 860-1611 • Fax: (416) 860-1608 • e-mail: info@fedpubs.com
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