Decision of the Hearing Committee

1. INTRODUCTION

A Hearing was held with regard to the conduct of Tamala Fadelle. The Hearing Committee consisted of the following:

Susan Halliday Mahar (Chair), pharmacist,
Aiysha Al-Wardian, pharmacist, and
Tom Mahaffey, public representative.

The Hearing took place on December 2, 5, 6, 7, 9th, 2011 and also January 4th, 6th, 11th, 13th and 20th, 2012. The hearing was held at the offices of the Nova Scotia College of Pharmacists, 1559 Brunswick Street, Halifax, Nova Scotia, Suite 200.

In attendance at the hearing were:

Scott Sterns, counsel for the Nova Scotia College of Pharmacists (the "College")
Tamala Fadelle (the "Registrant");
Jim O'Neil, counsel for the Registrant, Tamala Fadelle and
Catherine Walker,QC, Independent counsel for the Hearing Committee.

Also in attendance were Bev Zwicker, Deputy Registrar for the College, and Janelle Gray, Acting Manager of Professional Accountability. There were no objections to the composition of the Hearing Committee, as confirmed by counsel in a prehearing teleconference.

In this decision, the names of patients and prescribers have been redacted to safeguard privacy.

2. ALLEGATIONS

The allegations are summarized in the Notice of Hearing (NOH) attached as Appendix 1.
No allegations were admitted by the Registrant.

3. PRELIMINARY MATTERS

There were three preliminary applications made by Registrant's counsel, Jim O'Neil. They were:

a) An application for adjournment – this application was denied and the decision of the Hearing Committee was rendered orally, and is attached in written form in Appendix 2;

b) An application for exclusion of the public- this application was also denied. The decision of the Hearing Committee was rendered orally, and is attached in written form in Appendix 3;

c) An application for a stay- this application was denied. The decision of the Hearing Committee was rendered orally, and is attached in written form in Appendix 4;

4. EVIDENCE (INCLUDE ATTACHED EXHIBIT LIST AS SCHEDULE)- SUMMARY OF WITNESS TESTIMONY

[redacted]

[redacted] testified with respect to prescriptions for [redacted] for lorazepam ("LOR") 2mg, filled December 1, 2009 and December 1, 2010 at [redacted] (Exhibit 1, pg. 79). Although his name appears as the prescriber, when asked if he had authorized these prescriptions he testified he had not. [redacted] also testified it is his general practice to prescribe in 0.5mg or 1mg dosages not 2mg, as, in his opinion, 2mg LOR is too high a dose unless under the direction of a neurologist or other specialist.

He identified a fax (Exhibit 1, pg. 76) he received from the Registrant in January 2011. In that fax, the Registrant claimed [redacted] had authorized LOR at a supper attended by both [redacted] and the Registrant. [redacted] denied having authorized any prescription for LOR at that supper, but he did recall the supper which, he stated, occurred in 2006 as he remembered his daughter was a baby at the time.

He testified to a conversation with the Registrant in January of 2011 at which time she asked if he would prescribe LOR for [redacted]. [redacted] contacted [redacted], who resides in Winnipeg, to confirm his need for LOR. After speaking with [redacted], [redacted] authorized 100 LOR 0.5mg tablets, one to two tablets to be taken at bedtime when needed. He testified that this was the only time he prescribed LOR for [redacted].

On cross-examination [redacted] stated he usually charts his prescriptions that are verbal orders. Several prescriptions (Exhibits 2,3,4) and MSI audit reports (Exhibit 5) were introduced to assert how, in several instances, [redacted] did not include all of the necessary components of a legal prescription, calling into question his record keeping. He testified he was often extremely busy in his practice, which sometimes prohibited him from filling out prescriptions in their entirety.

He recalled a visit he had with [redacted] in his driveway in 2009. He had no recollection of seeing the Registrant at that time. [redacted] was driving the Registrant's truck.

Several issues were brought up with respect to the LOR 2mg prescription for [redacted] from December 2009 and December 2010. [redacted] stated that he was very clear about how he prescribed LOR, and the request initiated by the Registrant in January 2011 was not a renewal request, but rather the first time they spoke about a LOR prescription for [redacted]. It is not his practice to prescribe LOR for people that are not his patients but he did it for [redacted] because he felt he was doing a good service for a good friend.

[redacted]

[redacted] testified as a family doctor with respect to his patients [redacted], [redacted] and [redacted]. He spoke to [redacted] history of pain management as a result of ongoing knee problems, his three knee surgeries, and [redacted] subsequent use of the narcotic pain reliever, Endocet. [redacted] testified that after [redacted] final knee surgery in 2008 or 2009 his need for Endocet decreased considerably and as of May 2009 his usage was fairly stable, 30 tablets every six weeks

[redacted] testified that in May of 2009 he issued [redacted] a prescription for 600 tablets of Endocet, to be dispensed as 100 tablets every 30 days (Exhibit 1, pg.125). In January of 2010 he received a message that [redacted] had no more part-fills remaining at [redacted] on the Endocet prescription from May of 2009 so [redacted] issued him a prescription for 30 tablets (Exhibit 1, pg 126) with the caveat that [redacted] return to the clinic in March to discuss his usage. [redacted] testified that [redacted] was still using approximately 30 tablets of Endocet every six weeks. In March of 2010 [redacted] testified that he met with [redacted] and issued him another prescription for 120 Endocet to be dispensed as 30 tablets every

6 weeks (Exhibit 1, pg 130). On cross-examination [redacted] testified that he never spoke to the Registrant regarding the apparent discrepancies with respect to [redacted] Endocet prescription.

He identified a fax (Exhibit 1, pg. 133) from the Registrant that he received at his office dated March 31, 2010. When asked if he had a copy of the fax [redacted] stated that he did have a copy but that his copy was missing the note that was present on the fax he was shown. When asked if he had authorized a particular Endocet prescription for [redacted] to be logged on file, as was shown on the fax in Exhibit 1, pg.133, he stated that he had nothing in his file to show he authorized that.

He addressed a prescription for [redacted] from November 15, 2010 (Exhibit 6) on which he authorized a large quantity of Endocet. He explained that it was an error on his part as he had a student working with him who did not see the updated notes about [redacted]s current Endocet usage. [redacted] did not ask for or want such a large quantity. When [redacted] discovered the error and found [redacted] to be using the original bottle of Endocet in February or March, 2011 he sent a fax to [redacted] to cancel remaining refills.

With respect to his patient [redacted], [redacted] testified as to the details of medications he prescribed for [redacted] for erectile dysfunction. The first time he authorized Viagra for [redacted] was November 10, 2009. He testified that he has no record of authorizing prescriptions for Viagra prior to this date. It is his usual practice to log any prescription in his computer via the "Nightingale" software system, and there is no record that appears for [redacted] prior to this timeframe. He also stated that although he has prescribed 8 tablets of Viagra at a time, his usual practice is to prescribe 4 tablets at a time. When cross-examined he elaborated that he could not recall a time when he would put six refills on any prescription as his usual practice is to authorize for five refills at a time.

On cross-examination [redacted] confirmed that [redacted] was his patient and that she advised him that she blamed the Registrant for her addiction to alprazolam ("ALP"). He testified that [redacted] told him that she had been taking six to seven tablets daily of ALP 0.5mg for a number of years before he began prescribing it for her and that she was given prescriptions from [redacted] under a false name. He stated that the first time he prescribed ALP for [redacted] was September 2, 2009.

[redacted]

[redacted] testified as a family doctor with respect to his patient [redacted] and a prescription for Viagra. He testified that he had no record or recollection of prescribing Viagra to [redacted] Three prescriptions (Exhibit 1, pg. 211, 212, 213) were shown to [redacted] both as signed hard copies from RHP and on the patient profile of [redacted] obtained from the records of [redacted]. He testified that he had no recollection or record of having prescribed any one of the three prescriptions shown to him.On cross-examination [redacted] explained that his usual practice is to keep a record of every prescription he writes and that he charts each time he authorizes a prescription for a patient. When there is a phone call looking for a prescription his receptionist brings the chart to him and he fills it in at the same time he is on the phone. When asked whether he tracked phone messages (as in phone requests to him) he confirmed that he usually would get a yellow post-it note that someone called, along with the chart.

Cindy Ingersoll

Cindy Ingersoll testified as the Manager of Professional Accountability for the Nova Scotia College of Pharmacists. Janelle Gray, Acting Manager of Professional Accountability and Inspector for the College was excluded from the hearing room during this testimony. Ms. Ingersoll outlined the investigation of the Registrant by the College. She testified that in November, 2010 the College received a call from [redacted], a former employee of [redacted]

[redacted]), identifying conduct taking place at [redacted] that, if proven, would constitute significant breaches. The College began an investigation. An NSCP Inspector visited [redacted] in January, 2011 and brought back prescriptions, patient profiles and other pharmacy records as permitted by the *Pharmacy Act* for a period of five days. Pharmacy records from ProPharm, a software company, were subpoenaed by the College along with additional records from the Registrant. Ms Ingersoll testified that a number of witnesses were interviewed- prescribers [redacted] and [redacted], and individuals [redacted] and [redacted] Based on the results of the investigation a Registrar's complaint was filed. In April, 2011 the complaint was forwarded to the College's Investigation Committee. The Registrant provided a response to the complaint, which was considered by the Investigation Committee. In June, 2011 the Investigation Committee referred the matter to the Hearing Committee, and in August, 2011 the formal notice of hearing was sent to the Registrant.

Ms. Ingersoll explained the details contained in Allegation 1, namely that the Registrant had created a fictitious person, [redacted] and processed prescriptions for ALP and LOR through [redacted] patient profile. A search for the prescription hard copies of [redacted] uncovered only 5 of the 18 prescriptions processed on [redacted] patient profile. With respect to the hard copies retrieved, Ms. Ingersoll stated that although they did not have an expert examine the handwriting on the prescription hard copies for [redacted] (Exhibit 1, pg. 38,39) she believed she had reviewed enough prescriptions signed by the Registrant to say she was confident the signature was that of the Registrant.

She then explained that she spoke with [redacted] the alleged prescriber for [redacted] and he denied authorizing any prescriptions for [redacted] She testified that a record from the [redacted] called the Patient Care History report (Exhibit 1, pg.35) showed that over half of the prescriptions for [redacted] were processed during regular business hours, when the Registrant was usually present.

Ms. Ingersoll testified about her interactions with [redacted] during the investigation and stated that [redacted] admitted she was addicted to ALP. She testified that [redacted] started to legitimately obtain prescriptions for ALP from [redacted], her family doctor, in September, 2009. Prior to this time [redacted] indicated that she obtained ALP through the filling of prescriptions on [redacted]'s patient profile or through prescriptions filled on her own profile from [redacted] and [redacted] Ms. Ingersoll demonstrated this with the aid of two prescription vials given to her by [redacted]. She stated that she was not sure of the exact date of receipt but recalled that [redacted] confirmed she had the vials when she first contacted the College. She testified that the prescription from [redacted] was removed from [redacted]'s patient profile by manual manipulation of the computer system and replaced with another drug and another doctor's name. Therefore, it did not appear on [redacted] patient profile.

Ms Ingersoll testified that based on the Prescription Analysis by Drug report (Exhibit 1, pg 41-44 plus loose inserted page) [redacted] had four patients receiving ALP 0.5mg during this period, and only two had regular prescriptions ([redacted] and [redacted]. She testified that the pharmacist would by law need to sign ALP invoices and would therefore know how many tablets were coming in to inventory and be in a position to see it is double what she acknowledges dispensing.

On cross-examination Ms. Ingersoll was asked whether [redacted] may have lied to [redacted] about her addiction to ALP and when she became addicted. Ms. Ingersoll stated that [redacted] was likely – embarrassed about her addiction and may have tried to protect the Registrant. When, on cross examination it was suggested to her that [redacted] may have set up the Registrant, she testified that if someone was diverting medication it would be unusual to have kept the evidence with someone else's name on it. She also confirmed, when asked, that there was physical evidence in addition to the initials of the Registrant on the 5 hard copies, consisting of the invoices, and that the quantities of ALP in the pharmacy were ordered for and signed by the Registrant.

Janelle Gray

Janelle Gray testified as both the Acting Manager of Professional Accountability and Inspector for the College.

With respect to Charge 2, Ms. Gray testified how the College arrived at the conclusion that there were 1430 ALP 0.5mg tablets missing (Exhibit 1, pg. 51) when they did an inspection and count on January 25, 2011. At the time of the inspection and count on January 25th, 2011, the College looked at the on-hand inventory April 29, 2009 (Exhibit 1, pg. 52), purchases during the timeframe as supported by McKesson spreadsheets (Exhibit 1, pg. 53), sales during the specified timeframe (Exhibit 1, pg. 54) and finally the on-hand count January 25, 2011 (Exhibit 1, pg. 62). Ms. Gray testified that the College is very concerned about unaccounted for benzodiazepines. Ms. Gray testified that the Registrant did not report the missing ALP. When asked about manual adjustments, Ms. Gray testified that they do need to be done in some cases (i.e. if the store is set up to place orders automatically but needs more of a particular product, a manual order can be placed and a manual adjustment done). With respect to [redacted] however, Ms. Gray testified that the volume of adjustments for ALP 0.5mg was inordinately high (26 from January, 2009 to December, 2010, Exhibit 1, pg. 64/65) compared to other pharmacies of similar size, some with higher prescription volumes, using the Nexxsys software system (Exhibit 1, pg. 65/66). Ms. Gray also testified that there were several discrepancies with respect to quantities of ALP 0.5mg being ordered manually (i.e. outside of the computer's automatic ordering system), signed for upon delivery by the Registrant, but not received into inventory. She testified that the dates and quantities were February 22, 2010 for 2x100 ALP 0.5mg (Exhibit 1, pg. 67 &71), May 17, 2010 for 1000 ALP 0.5mg (Exhibit 1, pg. 68) (Ms. Gray did explain that there was an adjustment of 842 tablets added to inventory on that day), June 21, 2010 for 3x100 ALP 0.5mg (Exhibit 1, pg. 69 & 73) and October 4, 2010 for 1000 ALP 0.5mg (Exhibit 1, pg. 70 & 72). Ms. Gray concluded her testimony on this charge by testifying that between April 29, 2009 and January 24, 2011, 1402 ALP 0.5mg tablets were manually removed from inventory at [redacted] and that there was nothing documented to account for the missing tablets.

With respect to Charge 4, Ms. Gray testified that [redacted] a patient of [redacted] who receives regular prescriptions for Endocet, may not have received all of his narcotics. The College was concerned by this because Endocet has the potential for addiction and has a high street value. Upon conclusion of their investigation, Ms. Gray testified that [redacted] was misled regarding his prescriptions for Endocet. He was entitled to, but did not receive the proper amount of his medication. However, the inventory was removed from the computer which led the College to conclude that the medication was diverted. Ms. Gray provided evidence with respect to a prescription for [redacted] from September 5, 2008 for Endocet (Exhibit 1, pg. 112). She testified that although the prescription was written for 600 tablets total, the hard copy of the prescription (Exhibit 1, pg. 113) showed "no refills." She testified that this was consistent for all fills from that prescription (Exhibit 1, pgs. 114, 115, 116, 117, 112). She testified that there was a discrepancy on RR's patient audit history for Endocet obtained from [redacted] with respect to QA (quantity authorized) showing as 300 tablets when it should have shown 600 (Exhibit 1, pg. 111). When asked how such a discrepancy could have occurred Ms. Gray stated that she could not explain it. She elaborated by saying that she contacted the software company and that she was told that the only way it could have been done would have been through a change when the pharmacy was operating under the old QS1 system which allowed changes to profiles with less security and tracking. Ms. Gray also testified that the patient audit history was missing 4 of the 6 fills for this particular prescription (Dec. 15/08, Jan. 14/09, Feb.17/09 and March 23/09) which led her to conclude that the patient did not receive these fills. Ms. Gray also expressed concern

that the part-fill shown on the patient audit history report for April 29, 2009 did not appear on Prescription Monitoring Program (PMP) reports or records.

Ms. Gray's testimony then moved to a prescription for [redacted] for Endocet that was written and then filled at [redacted] May 12, 2009 (Exhibit 1, pg. 125), less than 2 weeks after dispensing 100 Endocet to [redacted] on April 30, 2009. She stated that she was concerned that the prescription label for this prescription showed no refills (Exhibit 1, pg. 124). When asked about the next time [redacted] got Endocet from [redacted], Ms. Gray testified that it was not until January 12, 2010, 7 months later. On this day, she elaborated [redacted] went to [redacted] to get a refill and was told his prescription had expired. He was told he would need to contact his physician, which he did, and got a new prescription for 30 tablets of Endocet (Exhibit 1, pg. 126). When asked what happened to this prescription, Ms. Gray testified that it was put on hold (Exhibit #1, pg. 127), filled much later on May 27, 2010, and that one of the fills remaining on the prescription from May 12, 2009 was filled instead. Ms. Gray testified that this was a breach of the regulations that state that a pharmacist must cancel all refills remaining when a new prescription is presented for the same drug. On this day, Ms. Gray stated, [redacted] had two active prescriptions for Endocet. Also of concern, Ms. Gray testified, was that [redacted] wife, [redacted] signed for 30 tablets of Endocet (Exhibit 1, pg. 126) when his file showed 100 tablets were filled. Ms. Gray testified that the May 12, 2009 prescription was filled 3 more times after January 12, 2010 (Feb. 11/10, March 16/10 and April 15/10) when this prescription should not have been active. On March 16, 2010 Ms. Gray testified that [redacted] presented to [redacted] with a new prescription for Endocet (Exhibit 1, pg. 130) after he saw his physician to discuss his Endocet usage. She testified that she was not sure what happened to this prescription as she could not find a hard copy. However, it was dispensed June 22, 2010. Ms. Gray explained that [redacted] now had three active prescriptions for Endocet. Instead of filling the new prescription presented to [redacted], Ms. Gray testified that one of the part-fills from May 2009 was filled for 100 tablets of Endocet. Ms. Gray elaborated by saying that [redacted]'s wife signed for 30 tablets, although 100 were filled.

Ms. Gray spoke to a fax (Exhibit 1, pg. 133) sent to [redacted], [redacted] family doctor, from the Registrant, and testified that the first line of the fax that stated [redacted] received 30 Endocet tablets from RHP on March 16, 2010 was totally inconsistent with the records of RHP that show 100 tablets were filled. Ms. Gray spoke to a PMP report for [redacted] Exhibit #1, pg. 89. She testified that although the report showed that the prescription from May 12, 2009 for 100 tablets of Endocet was reported to PMP on that day the other 4 fills of that prescription (Jan. 12/10, Feb. 11/10, March 16/10 and April 15/10) do not appear on the PMP report. Not reporting the filling of those prescriptions to PMP is against the Prescription Monitoring Act and Regulations. On April 19, 2010 Ms. Gray testified that a reversal was sent to PMP to reverse the prescription that was sent to PMP on May 12, 2009. The prescription was then backdated to May 12, 2009 and all 600 tablets of Endocet were reported to PMP as having been dispensed on that day. Ms. Gray elaborated by saying that 600 tablets of Endocet were never dispensed, only 500 were. It was concerning, she testified, that a prescription is being reversed and sent back to PMP 11 months after the initial dispensing. When asked if [redacted] had anything to do with the particulars of this charge, Ms. Gray stated that she did not.

When asked to explain the particulars of Charge 5, Ms. Gray testified that the College contacted [redacted] because they were concerned that they were seeing "no refills" on prescription hard copies for his Endocet at [redacted]. She testified that when they asked [redacted] if he was aware he had refills at RHP he said he was not aware and his bottle said "no refills." Ms. Gray demonstrated this with the aid of a picture of a vial (Exhibit 1, pg. 141) that was taken at [redacted] home. Ms. Gray testified that this was inconsistent with the prescription in question (Exhibit 1, pg. 136) which clearly stated [redacted] was to receive 1440 tablets of Endocet at an interval of 240

tablets per month. When asked if [redacted] had anything to do with the particulars of this charge Ms. Gray stated that she did not.

With respect to Allegation 6, Ms. Gray testified that the College was concerned about record keeping at [redacted] and the dispensing of Endocet for [redacted]. They decided to do a narcotic reconciliation to verify inventory of Endocet, Ratio-Oxycocet and Novo-Oxycocet. She testified that these three brands are interchangeable. She testified that they looked at the opening inventory for these three molecules on April 29, 2009 (Exhibit 1 pg. 144-145), closing inventory for these same molecules on January 25, 2011 (Exhibit 1, pg. 177-181), purchases (Exhibit #1, pg. 182-186) and sales (Exhibit 1, pgs. 147-175) between April 29, 2009 and January 25, 2011 and concluded that there were 234 tablets missing. In addition, she testified, there were 450 tablets that were not submitted to PMP leading to a total of 684 tablets that were unaccounted for and not reported to the College or Health Canada.

Ms. Gray explained the details around Allegation 7(b)(i). She testified that the College became aware that prescriptions for Viagra 100mg were filled for patients that had drug plans and reimbursement was collected by [redacted] from the patient's drug plan without a valid prescription. One of these patients, Ms. Gray testified, was [redacted]. She testified that the first time [redacted]s doctor, [redacted], prescribed Viagra was November 12, 2009 for a quantity of 4 tablets at a time. The 10 prescriptions prior to that date that originate on September 30, 2008, Ms. Gray testified, were not authorized prescriptions. An examination of the hard copy for the September 30, 2008 prescription (Exhibit 1, pg. 204) showed that it was a verbal order that Ms. Gray testified was not authorized. She explained that when a claim is submitted to a third party drug plan the payment for that claim is usually sent via direct deposit into the pharmacy's bank account. [redacted] she testified, had a private drug plan that paid for Viagra prescriptions. She testified that the prescription from Exhibit 1, pg. 204 had 6 refills on it, for a total authorized quantity of 56 tablets. However, she testified this prescription was actually filled 10 times. She also testified that not only was the prescription from September 30, 2008 not authorized, the authorized quantity was changed from 56 tablets to 200 tablets, as shown in Exhibit 1, pg. 208.

With respect to Allegation 7(b)(ii), Ms. Gray testified that [redacted] was a patient at [redacted] and a relative of the Registrant. She testified that prescriptions for Viagra 100mg were submitted to [redacted] private drug plan for reimbursement without authorization from a physician. She testified that the investigation by the College revealed that none of the prescriptions for Viagra 100mg on [redacted] patient profile from [redacted] (Exhibit 1, pg. 209) were authorized.

With respect to Allegation 7(b)(iii), Ms. Gray testified that the College had concerns about fraudulent prescriptions for Viagra at [redacted]. The investigation examined computer and inventory records and discovered many manual adjustments for this molecule. According to Ms. Gray, maintaining inventory for this molecule, which comes in a box, should be straightforward. Ms. Gray testified that on three different occasions (July 8, 2010, July 18, 2010 and November 28, 2010) manual orders were placed for Viagra 100mg that do not appear to be received in the computer. She testified that the investigators spent hours and hours looking at prescriptions, pharmacy records and manual adjustments and could not find record of these manual orders being received. She testified that placing manual orders rather than ordering through the computer could be of concern because of potential diversion. She testified that they found 13 manual adjustments for Viagra 100mg during the time frame April 29, 2009 to January 25, 2011 and when they compared that to three other pharmacies, some with slightly higher prescription volume using the same computer software, they found 2 of the 3 pharmacies had no manual adjustments and 1 of the 3 stores had 2 manual adjustments.

Ms. Gray explained that Allegation 8(b)(i) involved [redacted] [redacted] patient profile (Exhibit 1, pg. 224) shows prescriptions for Xenical from [redacted] being filled monthly starting May 5, 2010

which Ms. Gray testified were not authorized by [redacted]. She testified that upon investigation of the files from [redacted] no prescription was found from [redacted] for Xenical for TRM from May 5, 2010. She elaborated by saying that the College contacted [redacted] and he did not have any record of this prescription. Ms. Gray also noted that [redacted] had a private drug plan that covered Xenical for him.

With respect to Allegation 8(b)(ii), Ms. Gray testified there were concerns around Xenical because the inventory records from RHP from April 29, 2009 to January 25, 2011 show that more capsules were sold than bought. Ms. Gray also testified that on six occasions, when Xenical was filled for [redacted] the same number of capsules were added back into inventory by a manual adjustment on the same day. Manual adjustments, Ms. Gray testified, would prevent reordering if a pharmacy did not actually dispense a product. When compared with three other pharmacies, some with slightly higher prescription volume using the same computer software, the College found no manual adjustments at these pharmacies compared to 9 manual adjustments at [redacted]. Ms. Gray testified that this is concerning as Xenical comes in boxes and RHP only had two patients taking the medication, one of which only received it twice in 2009, which should make managing the inventory straightforward.

On cross-examination Ms. Gray was asked about her background in accounting and forensic accounting. Ms. Gray testified that although she has no formal training in forensic accounting specifically, she was the sole proprietor of her own pharmacy, did her own books for approximately 10 years and has taken an accounting course. She testified that she used QS1 and Kroll computer software in her own business and although her business did not use Nexxsys she has done relief in stores that use Nexxsys software and she needs to be familiar with all computer software systems to conduct pharmacy inspections.

When asked about the statement the College took from prescriber [redacted], Ms. Gray testified that although she did not take the statement from [redacted] she did speak to him at his office and was aware that he had a conversation with Cindy Ingersoll that resulted in his signed statement.

Ms. Gray was questioned about whether she considered product shortages or returns when conducting inventory counts. She testified that she would not need to do that and that she only looked at purchases shipped to the store. Product returns, she continued, should have been noted in the inventory log for the inspector to see, along with a reason.

When asked about whether she was aware that the store was changing computer systems, Ms. Gray testified that she was aware that at the end of August, 2009 [redacted] changed software programs. When asked if she was aware there were problems with the software conversion Ms. Gray stated that it was not unusual to have issues during a software conversion. She testified that she took the conversion into account and allowed for September and October to be transition months. She was also asked whether she was aware of any hardware issues to which she testified she was not. When asked if any of the pharmacies to which [redacted] was compared were going through a conversion Ms. Gray testified that they were not. She was asked whether she was aware of a "remedy log" to which she testified she was not familiar. When asked if she was aware of ongoing software issues Ms. Gray testified that it was brought to her attention in the Registrant's response to the charges.

Ms. Gray was asked about the relationship between [redacted] and a College staff person. She was also asked whether the staff person had ever transported records between the College and RHP during this investigation. Ms. Gray indicated that the staff person may have transported records if she was going to River Hebert and it was convenient to do so.

With respect to the 1402 missing ALP 0.5 mg tablets, Ms. Gray was asked if the counts on April 29, 2009 and January 25, 2011 were "double counted". Ms. Gray testified that on April 29, 2009 there were signatures of two people on the counts (Exhibit #1, pg. 52) and on January

25, 2011 Ms. Gray confirmed with [redacted] by phone, that the counts were "triple counted" although there was nothing signed to indicate the multiple counts. When asked if the Registrant would have had no choice but to sign off on the counts Ms. Gray testified that the Registrant would have been asked to sign or to recount and then sign to show her agreement. With respect to [redacted], Ms. Gray testified that she was aware that [redacted] had become dependent on ALP and that she became aware approximately 2 weeks ago that [redacted] had keys to the dispensary (from [redacted] herself).

With respect to the term "auto-reconcile" Ms. Gray explains that this occurs when an order is automatically placed and then the order automatically gets reconciled with the invoice and received. When asked if she had ever seen an "auto-reconcile exception report" Ms. Gray responded that she had not. Ms. Gray testified that software doesn't make mistakes and that mistakes happen when a user does not know the system.

She testified about an issue that came up on investigation at [redacted] surrounding incorrect quantities being calculated for methadone mixtures. She testified that although that was an issue a fix was put in place by the software vendor.

With respect to refills being permitted on narcotic prescriptions, Ms. Gray testified that narcotic prescriptions have part-fills and that her investigation with respect to labeling focused specifically on [redacted]. It would have been time-restrictive to check all narcotics from [redacted] Computer software, she explained, can put refills on the labels and that narcotics can be labeled with refills on the labels that are sent with the patient.

With respect to whether [redacted] and [redacted] authorized Viagra for [redacted] and [redacted] respectively, Ms. Gray testified that she spoke to [redacted] on the phone and had an office visit with [redacted] and during the phone call and office visit both doctors told her they had no record of authorizing the prescriptions in question.

When asked if she had an opening and closing inventory on Xenical, Ms. Gray testified that she had the purchase records from April 29, 2009 to January 25, 2011. When asked if it would be important if there was a large opening inventory Ms. Gray testified that it would be highly unlikely to have a large amount of Xenical on hand, given the limited room and limited dispensing. With respect to manual adjustments of Xenical, Ms. Gray was asked if manual adjustments would be a way to avoid re-ordering to which she testified that it would.

Bev Zwicker

Bev Zwicker testified as the Deputy Registrar for the College. She began her testimony outlining the professional duties and responsibilities of pharmacists and pharmacy managers. She elaborated that pharmacy managers must ensure that the practice of pharmacy is in compliance with the *Pharmacy Act* and regulations and that all pharmacists hold a valid license to practice pharmacy. In addition, they must ensure the pharmacy is adequately staffed, that any misconduct is reported to the College, College inspectors receive full cooperation, and all medications are stored appropriately and securely. Pharmacists, she testified, are responsible for the security of drugs and records in the pharmacy. Further, they must ensure their practice is compliant with the *Pharmacy Act* and regulations, must verify the accuracy and validity of prescriptions, identify drug-related problems and ensure optimal patient care.

Ms. Zwicker outlined the particulars of Allegation 10, testifying that on July 2, 2009, 200 LOR 1mg tablets were dispensed to [redacted], a 92 year old woman. [redacted], a surgeon from Manitoba, was listed as the prescriber. Ms. Zwicker stated that at that time, [redacted] already had 2 active prescriptions for benzodiazepines (LOR 1mg and diazepam 5mg) from her primary care provider, [redacted], from Digby. Ms. Zwicker asserted that neither [redacted] nor [redacted] were aware that there were ongoing prescriptions from another physician for benzodiazepines for this patient.

Ms. Zwicker spoke to a chart introduced as Exhibit 1, at pg 259. She testified it showed concurrent prescriptions for LOR and diazepam from different physicians. When discussing the prescription from July 2, 2009 she expressed concern over such a large quantity of LOR being provided to an elderly patient. She stated that the College was concerned about these concurrent prescriptions because benzodiazepines put elderly patients at high risk for falls and referenced the "Beers Criteria." She also made reference to the "STOPP Study" which concluded that benzodiazepines should be avoided if at all possible in the elderly population. Ms. Zwicker went on to assert that such a prescription would warrant a conversation with both the prescribing physician and the primary care provider. The pharmacist, in Ms. Zwicker's opinion, had an obligation not to provide the prescription in this case.

When provided with a report from [redacted] showing prescriptions filled according to prescribing doctor (Exhibit 1, pg. 245-247) Ms. Zwicker testified that there were 20 instances when [redacted], a surgeon in Manitoba, was listed as the prescriber for various patients. She showed that on the report, [redacted] was listed as a locum at Highland View Regional Hospital in Amherst, N.S., which was inaccurate.

Ms. Zwicker was asked to read Line 144 of Exhibit 17, Statement of Tamala Fadelle, which stated that [redacted] was able to wean herself off of diazepam after [redacted] changed her to LOR at bedtime, in two months. Ms. Zwicker testified that was inconsistent with [redacted] patient profile, which showed that both diazepam and LOR were filled on her profile concurrently on May 26, 2009 and June 23, 2009.

On cross-examination Ms. Zwicker was asked whether [redacted] initially prescribed both LOR and diazepam for [redacted]. She stated that she could not conclude that. She elaborated by saying that between May, 2009 and June, 2010 [redacted] did prescribe both medications sequentially, but never concurrently. With respect to the issue surrounding [redacted] splitting her 200 LOR 1mg tablets, Ms. Zwicker was asked if she had assumed there was no caregiver. Ms. Zwicker testified that, in her opinion, it did not make sense to cut a tablet in half when a 0.5mg tablet exists.

[redacted]

[redacted] offered testimony as a customer of RHP. He testified that he would visit RHP now and then to get his prescriptions filled but that 99% of the time his wife would go to the pharmacy with his prescriptions and have them filled. He testified that his family doctor was [redacted] and that he would visit [redacted] every 5 to 6 months.

He provided background information with respect to his on-going knee problems, testifying that the knee problems started in 2000 and that since then he has had 3 operations, all on his right knee. He testified that he would have to guess that his last surgery was 3 years ago. With respect to the pain in his knee, Mr. [redacted] testified that in 2000 the pain was not bad but that as years went on the pain worsened. When asked about the pills that [redacted] would give him prescriptions for, [redacted] testified that he could not remember the names of them and that the doctor gave him pain pills for his knee. He testified that he would take 2 of those pain pills each day and there were days he would not take any, until 4 or 5 weeks ago when he testified he could take an extra pill and a half if the pain was really bad. He explained that the reason he knew his usage was because he would take 2 pills out of his bottle and place them into a container that sat on top of his television. When asked if he was taking 6 or 8 pain pills per day [redacted] testified that he was not taking that many.

When asked if he remembered signing his statement that he gave to counsel of the Registrant [redacted] testified that he did remember signing it but when asked by College counsel whether he knew what he was signing, he replied "No, I didn't." He testified that the Registrant asked him to come to [redacted] and that he talked to a man in the back room about his pills. He

testified that he was blind in one eye. When asked if he received 100 pain pills in any of the months of January 2010, February 2010, March 2010 or April 2010, Mr. [redacted] testified that he did not get those pills. This question and answer exchange was done with the aid of an easel on which the dates and quantities were written in large font. When asked if these quantities were more than he was taking, Mr. [redacted] testified that he only took 60 tablets per month, if that.

On cross-examination, Mr. [redacted] testified that he remembered meeting counsel for the Registrant and that although he had trouble reading the affidavit he could read it. When asked if he had ever not gotten his prescriptions from [redacted] or if he was ever shorted tablets by the Registrant he responded "no". When asked if he ever had any personal dealings with the Registrant he said that he had not but then said maybe he had. He testified that his usage of pain pills increased in November, 2011 when he was told he could take 3 and a half tablets daily if he had to. When asked if he ever told the College he takes up to 4 pain pills per day he testified that he had not done that. He testified that although the Registrant had not told him he personally could not refill his prescription for pain pills, that the Registrant did tell his wife that. When asked if he understood his prescription was to be filled as 30 tablets every 6 weeks, he testified that he did not.

[redacted]

[redacted] offered testimony as a former employee of [redacted] and of the Registrant. [redacted] testified that she completed Grade 10 at River Hebert High School and then obtained her GED in 1985. She had no formal training as a pharmacy technician and testified that she had been trained by the Registrant. She testified that she first worked for the Registrant as a housekeeper and started working at [redacted] in April of 2006 as a front store cashier. She took on dispensary duties when the existing pharmacy technician returned to school in September but still had duties in the front store at this time. When questioned about her duties in the pharmacy, [redacted] testified that she would go into a patient's medication profile, fill pills from their profile, count the pills, check the DIN and then dispense the medication. When asked who was in charge, [redacted] stated that it was the Registrant.

She offered testimony about her difficulties with ALP. She testified that she was addicted to ALP and was first given ALP by the Registrant in 2006 or 2007 when she was experiencing a migraine aura. She testified that the Registrant gave her Advil and a little pink pill to relax, which was ALP. She testified that she had been working at [redacted] for approximately 8 months when this incident occurred. During 2007, 2008 and 2009, [redacted] testified that she and the Registrant would each take 1 ALP during the day at work to calm them down. There came a point, [redacted] testified, when the Registrant could not give her anymore ALP as the Registrant was concerned that the ALP counts would be off. [redacted] testified that she then went to see [redacted] at the emergency room and told the doctor she needed a prescription for 10 tablets until she saw her family doctor, [redacted]. [redacted] testified that she was not telling [redacted] the truth in this instance. [redacted] testified that the Registrant created a false prescription for ALP for her, using [redacted] as the prescriber. [redacted] demonstrated this with the aid of a prescription vial (Exhibit #9). When asked if she would use all 100 tablets of ALP she obtained from filling this prescription, [redacted] testified that she would use all in a 1 month period. She elaborated by saying that she sometimes would not receive all 100 tablets; that the Registrant would sometimes put tablets back in the stock bottle to keep the counts up. When asked if she created the prescription, if she knew how to create a patient profile or if she created the [redacted] profile [redacted] testified that she did not although she did, at times, try to learn how to create a patient profile.

With respect to the profile for [redacted], [redacted] testified that she did not know a person [redacted] or prescriber [redacted] and that she did not create this profile; that it was the Registrant. She testified

the Registrant created the profile because she knew [redacted] was addicted. When asked if she was still addicted to ALP, [redacted] testified that she went to addiction services, is not taking the ALP anymore and is taking clonazepam now. When asked about the patient care history for [redacted] (Exhibit 1, pg. 35) [redacted] testified that she would not be able to create or work with such a document. With respect to some of the times on the report being after hours (later than 5:00 p.m.), [redacted] testified that the Registrant would never leave at 5:00 p.m. and would always be at the pharmacy late. She testified that she never went into [redacted]'s profile and put things on or take things off of the profile. When asked about the presence of lorazepam ("LOR") on [redacted] profile, [redacted] testified that she never took LOR as her drug of choice was ALP. She testified that in late August, 2010 she did not have a good relationship with the Registrant and that her employment ceased at the end of August, 2010. When asked if she got all of the ALP prescriptions on [redacted] profile, other than LOR, [redacted] testified that she did, although she did not receive the prescription from August 27, 2010 and she was not sure who did.

With respect to the medication misoprostol, [redacted] testified that she did not know what it was used for and had never taken it. She also testified she had never seen prescriber [redacted]. When asked if she saw the reference in her own profile to misoprostol (Exhibit 1, pg. 47) [redacted] testified she did see it but did not insert it into her profile.

When asked to identify hard copies of prescriptions (Exhibit 1, pg. 38) [redacted] testified that they were hard copies of prescriptions for [redacted] She testified that she did not create them, did not sign her name or the Registrant's name and that they were created by the Registrant. When asked if she had ever stolen ALP or other pills from [redacted], [redacted] testified she did not but that she did have keys that the Registrant had given her and that she was at [redacted] alone at times.

With respect to [redacted], [redacted] testified that she did not create false prescriptions for Viagra nor did she or [redacted] steal Viagra from [redacted]. She also testified that the date of birth on [redacted] patient profile, [redacted], was incorrect and that his actual birth date was [redacted].

When asked about parties at RHP, [redacted] testified that there would be parties in the pharmacy after hours. She testified that the Registrant would be present and that there would be alcohol and marijuana oil at the party. With respect to a jar in the pharmacy, [redacted] elaborated that there was a jar at the far end of the pharmacy, a "lollipop jar" that contained narcotics such as Dilaudid, Oxycontin and morphine that were returned to the store. The pills, she testified, were in vials within the jar, not loose in the jar.

With respect to an incident involving [redacted], [redacted] testified that [redacted] had headaches due to a brain aneurysm and one afternoon asked the Registrant for something for the pain. [redacted] testified the Registrant told [redacted] she was giving her Tramacet. [redacted] elaborated by saying that [redacted] went home and sometime later in the day called [redacted] complaining of nausea and vomiting. According to the [redacted], the Registrant said she must have given [redacted] Endocet by mistake and then the Registrant laughed about it.

On cross-examination [redacted] was asked about her training on the software system Nexxsys. She testified that she had 3 days of training on the Nexxsys system, that the Registrant had 2 days of training and that she had more training on Nexxsys than the Registrant. She testified that she and the Registrant were close friends at one point and that the Registrant trusted her with the keys to [redacted]. When asked if she considered herself a pharmacy assistant, [redacted] testified that she considered herself a pharmacy technician and that she had a badge. When asked how she was making out on clonazepam [redacted] testified that she does not take it very often.

[redacted] testified that if a patient dropped off a new prescription it was given to the Registrant for processing and that if the Registrant was not there then she could not proceed.

She testified that she could see prescription numbers, drug names, doctor names, refills and original authorized quantities on patient profiles.

When asked if Gravol was a pink tablet [redacted] testified that it was. When asked if she was sure that the tablet given to her when she had her migraine aura by the Registrant was not Gravol she testified that Gravol is round, ALP is oval and that she still had vision out of one eye. She testified that she was not really in a stressed condition at the time and had pressure on her head from the aura. She testified that a customer, [redacted], had upset her to bring on the migraine.

When asked if she knew what ALP was at that time, [redacted] testified that she did not know what it was at that time and that she had not worked with ALP before then. [redacted] testified that she became addicted because the Registrant gave her ALP and that the Registrant gave her some tablets to take home on the day of her migraine. She testified that she had told the lawyer for the College of this earlier and that although she could not recall the exact quantity she knew it was between 1 and 10 tablets. When this bottle was gone, she testified that the Registrant gave her more and that there was never a gap in her supply. She testified that after being at [redacted] for a year and a half, and after taking ALP for 2-3 months she was addicted. When asked if she told [redacted] that she became addicted to ALP when she received a prescription from prescriber [redacted] testified that it was a misunderstanding. When asked about her daily use of ALP, [redacted] testified that she would take 4 tablets daily on average and that 6 to 7 tablets daily would be her maximum dosage.

When questioned about the prescription on her patient profile for misoprostol and asked if she changed the name of the drug from ALP because she was concerned about getting caught, [redacted] testified that she did not have knowledge of how to do that but the Registrant did and agreed that it would be a good way to get rid of a prescription history. The Registrant, she testified, created the prescription for ALP from [redacted] so that [redacted] could get her ALP and to ensure that inventory was accurate. When asked how changing the drug name and deleting the history would ensure that inventory was accurate [redacted] testified that she was not sure.

When asked about her departure from [redacted], [redacted] testified that she asked the Registrant on Friday for the afternoon off on Monday as her daughter [redacted] had to go to the hospital for a pre-op appointment. She testified that when she returned home Monday evening from the hospital her son said that the Registrant called several times and said for her to not report to work the next day. She testified that she had no further contact with the Registrant, other than to ask for her record of employment. When asked if she tried to go into work the next day, [redacted] testified that she did go to [redacted] at 8:45am and found a note on the door saying that the store would be opening at 11:00am.

When asked if she ever gave brand name water to customers while ringing in the price for no-name water [redacted] testified that she was positive she did not do that. When asked if she was ever in the pharmacy at 6:40pm she testified that she had been. She testified that there were times when she would be in the dispensary alone, particularly on occasions when the Registrant would call [redacted], tell [redacted] that she forgot to give someone their pills and [redacted] would enter the dispensary to retrieve them. However, she testified that most of the time the Registrant was in the dispensary with her. When asked if she ever removed merchandise from the store that she shouldn't have, took pills for herself or took pills that were not hers, [redacted] testified that she did not.

With respect to a security camera, [redacted] testified that although she was aware that the pharmacy had a security camera and she had keys to the security room where the camera was located she did not take the security tape nor did she ask someone else to take it for her. When

asked if she was in the pharmacy or store after hours on August 27, 2010 [redacted] testified that she was not.

When asked about [redacted], [redacted] testified that she was an acquaintance from River Hebert. [redacted] testified that she was aware of a vacation the Registrant took in March, 2011 and that she did not tell people that [redacted] was out of business during the time the Registrant was away.

When asked if she has a niece that works for the College, [redacted] testified that she does have a niece that works for the College, that she attended a birthday party at her niece's house and that she does not recall telling the Registrant that members of the College were in attendance.

When asked about who attended the parties at [redacted] [redacted] testified that [redacted] would attend along with [redacted]. She testified that the parties occurred on more than one occasion (maybe 2 or 3 occasions) and that the parties would just happen when someone in the pharmacy would suggest having a drink after work. She testified that she worked at [redacted] for a couple of years before the first party. [redacted] testified that no one would get drunk at the parties and that they would not last long as they would leave to go to a bar elsewhere. She testified that she would drink a couple of coolers that were out in the back of the store covered up in a box. She testified that the Registrant would drink beer from the liquor store that she would buy herself or that someone else would bring. She testified that she was not sure of the day of the week but that it would be between Monday and Friday. She testified that [redacted] would bring marijuana oil to the parties but that he would not stay at the party.

With respect to prescriptions for herself and her husband, [redacted] testified that she would fill refills for herself and her husband on occasion, that she would fill pill packs for her husband on occasion and that the Registrant did not always check them.

When asked if she ever made statements saying she would put the Registrant out of business [redacted] testified she was positive she did not.

On re-direct examination [redacted] was asked if there was a time when her relationship with the Registrant deteriorated so much that she was removed from the dispensary. She testified that she left the dispensary entirely 8 months before she stopped working at [redacted]

[redacted]

[redacted] testified about her employment at [redacted] and interactions with the Registrant. She testified that she worked at RHP as an ice cream scooper for three summers (2008, 2009, 2010). She said that she would give out prescriptions that the Registrant left for pick up if she left early or patients were coming in late. She discussed two examples, one of which was a methadone prescription.

[redacted] testified that the Registrant gave her Endocet and Tramacet. She testified that the Registrant told her she had something that would help with her headache, that she retrieved a vial of mixed pills from under the cash and gave [redacted] what she said was a Tramacet tablet. She testified that the Registrant told her it had no side effects. [redacted] stated that she 'felt weird' after taking the tablet, was nauseated and vomiting. She testified she called [redacted] described the tablet, and heard the Registrant laugh and tell [redacted] that she must have given her an Endocet. She testified that she believed this took place in early 2010.

[redacted] testified that she returned to [redacted] and the Registrant gave her Tramacet. She presented the product as an exhibit (Exhibit #16).

[redacted] testified that she recalled occasions where she, the Registrant, and [redacted] smoked, drank and talked in the pharmacy before going to the bars. On one occasion, one of [redacted] friends was also present.

On cross-examination, [redacted] testified that she was at the pharmacy regularly and could not recall whether it was early or mid-2010 that she allegedly received an Endocet tablet. She said she has never had a prescription for Tramacet.

She testified that the prescriptions left for after-hours pick up were prepared by the Registrant and stored in bags under the cash register outside of the dispensary.

She testified that she could recall two parties in the pharmacy but that she could not recall the dates or times. She said that on the second occasion, an RCMP officer arrived on personal business of the Registrant's, unrelated to the social gathering underway at the time.

[redacted]

[redacted] provided background information on Nexxsys, described her involvement with it and her interaction with the Registrant and [redacted]. [redacted] stated that she is employed by ProPharm, the developer of Nexxsys, as an account representative for Atlantic and Eastern Canada. She said hardware support was delivered from Moncton, and software support via a 1-800 number out of Markham Ontario.

She said that the Registrant became a customer in August 2009. She described the general conversion process—a test conversion is done first and then the night before the actual conversion, a live extract is taken, converted and installed so the software is up and running the next day. She stated that she did not have specific knowledge of the conversion technical process or installation steps.

[redacted] testified that she had heard from the Registrant and the trainer prior to her standard follow-up visit that the conversion wasn't smooth, which can be expected. She stated that she always indicates that there is no guarantee of a perfect conversion and keeping the old system up for verification is recommended. She said [redacted]'s patient allergies and medical conditions did not come across in the conversion. She stated that a report was created at a later date that would download allergies; she indicated she was not aware if it came through as a patient note.

[redacted] was unaware of particular issues relating to the Registrant and Endocet inventory. [redacted] said that the Registrant did give her a copy of the manual adjustment report for Endocet in June 2011, she did not know where the comment originated but it was not with the pharmacist. She stated user ADM is the Administrator user, a default if not signed in as the pharmacist, and that it has the same password in every Nexxsys system. She did not know if the Markham support desk would enter the system as user ADM.

[redacted] testified that the Registrant's inventory did not convert as it should. She said while some problems are not uncommon, it is rare that inventory doesn't come across at all. She stated she had the inventory zeroed and spent a day entering inventory with a McKesson employee, completing less than half the drugs.

She testified that she received 3 or 4 calls from the Registrant and that the Registrant would deal with technical support. [redacted] testified that software does make mistakes.

On cross examination, [redacted] stated that she was not aware as to whether or not the Registrant requested her QS1 data be deleted or purged, nor, apart from the inventory deletion she herself had requested, whether there had been other requests to delete inventory data.

She said other pharmacies do not typically use the ADM user.

[redacted]

[redacted] outlined his interactions with the Registrant and [redacted] He stated that, as part of his job at ProPharm, he installed the initial hardware for the Nexxsys system at [redacted] transferred initial

data to a FTP site for conversion by a third party, put the converted data on the new system, and fixed issues. He said he installed a power supply, scanner and hard drive. [redacted] presented three work orders from August 31, 2011, September 22, 2011 and October 13, 2011 (Exhibit #13, #14 and #15) to address ordering issues. The work included updates to Windows and Internet Explorer, required to transfer the order. He testified that the Registrant had ongoing system issues, and that replacing the hard drive had favourable results. He said bad data sectors on a hard drive could affect the order upload. He stated that the Registrant had scanner difficulties and that a driver problem could cause uploading issues.

On cross examination, [redacted] confirmed that the FTP process was normal, that the service reports related to the previous 4 months, and that the hard drive replacement occurred 2 months ago.

[redacted]

[redacted] testified about his Viagra prescriptions and his interactions with Registrant and [redacted] in response to Allegation 7.

He testified that he started taking Viagra in approximately 2001 as prescribed by [redacted]. He said quite some time later he went to see the Registrant at home on a Saturday to see if she could provide him with some Viagra. He testified that he thought his prescription was still valid but as the Registrant did not have confirmation of this, he was told she would need to call his doctor. [redacted] testified that he heard the Registrant call [redacted] and leave a message saying that she was calling to confirm [redacted]s prescription and to call her back if there was a problem. He testified that he received the Viagra from the Registrant on Monday or another day early the next week. He stated that he always got the full amount of Viagra prescribed, which was usually 8 tablets per fill, but sometimes 4. He testified that he could not recall the dates he received the prescriptions.

On cross-examination, [redacted] testified that he has a drug plan and has a zero copay for Viagra. [redacted] testified that he used every tablet of the Viagra he received. He clarified that he did not pick up his Viagra at [redacted] but rather that the Registrant brought it home with her. He said most of the time [redacted] gave him a written prescription. In response to being questioned as to whether he recalled getting a prescription for more than a year's supply of Viagra, he testified that he did not keep track and that he would not have got the medication if it was not a legal prescription.

When asked to review his [redacted] patient profile (Exhibit 1, pg. 209), [redacted] stated that the address listed was out of date and the phone number listed was accurate. He testified he had no knowledge about the listed 104 authorized quantity nor about the drug plan codes.

[redacted]

[redacted], , testified about his Xenical prescriptions and his interactions with the Registrant and [redacted] in response to Allegation 8.

[redacted] testified that he takes Xenical once daily to help control his blood glucose. He testified that [redacted], his family doctor, left her practice and he needed to find a new doctor. He said he was running low on his medication and that the Registrant told him she was unable to fill it without a prescription. [redacted] testified that he asked [redacted] if he would prescribe it and he agreed to do so for a year to give him a chance to find a new doctor. He testified that [redacted] told him to have the Registrant call him. [redacted] stated that he 'let it go' until he was out of his medication and then gave the Registrant [redacted] phone number and asked her to call. He testified that she called and said that she would follow up with a fax.

[redacted] testified that there were no occasions where he expected his medication and did not receive it. He said he did have a drug plan.

On cross-examination, [redacted] reviewed his [redacted] patient profile (Exhibit #1, pg. 222) and stated that his listed address was out of date and that his listed birth date was incorrect. He stated that he did not know if he paid a copay for his Xenical.

[redacted]

[redacted] testified that she was a customer of [redacted], and that she did not have a friendship or social relationship with the Registrant. She said she did have a friendship with [redacted] and [redacted]

[redacted] testified that [redacted] counted pills, worked on the dispensary computer, and operated the cash. She said she did not know what functions [redacted] could complete on the computer. She testified that an Endocet prescription that [redacted] had filled and counted was 5 tablets short, which she said she discovered when she filled her pill case. She stated that she had got the pill case because she thought she was getting confused with her medication. She said she called the pharmacy, [redacted] answered, and she discussed the missing tablets with the Registrant. The Registrant counted the tablets, replaced the missing tablets, and after that the Registrant looked after the filling of all of [redacted] prescriptions.

[redacted] testified that when [redacted] employment terminated at [redacted], [redacted] made public statements that she would 'take down' the Registrant and [redacted] would be closed, and that [redacted] urged people to move their prescriptions. [redacted] testified that when the Registrant was on vacation, [redacted] told people that [redacted] was shut down and would not be reopening.

[redacted] testified that she offered [redacted] an Endocet and she would not take it, and that she said [redacted] told her that she had never taken Endocet. [redacted] testified that she believed this conversation took place in the summer of 2010.

On cross-examination, she testified that she was short a couple of days of pills with the previous month's prescription which prompted her to obtain the pill case. She said she did not talk to the Registrant about the previous month's alleged shortage at the time, but did include in her April 13, 2011 statement to the Registrant and her counsel that she was short 5 tablets this month and now believed that she was 5 tablets short on the previous fill too.

[redacted] testified that she handed the physical prescription to [redacted] in the dispensary and that [redacted] filled and counted the prescription that was short tablets. She testified that the Registrant was on the phone and had no involvement in the filling of the prescription. She stated she could not recall the circumstances of the previous prescription.

[redacted]

[redacted], a general practitioner and emergency medicine physician, testified as a witness for the Registrant.

[redacted] testified that he had positive dealings with the Registrant in their pharmacist-physician interactions. He testified that a narcotic prescription should not say 'refills'. He said that while it is good practice for physicians to document all verbal orders on the patient chart, he did not always chart, nor did he know any physician who always did.

[redacted] testified that the Registrant is his patient and that she requires pain treatment. He testified that her therapy is suboptimal because of concerns about how the College would view her use of long-acting narcotics. He said of late he prescribed her Tramacet with periodic use of short-acting narcotics.

Upon cross-examination, [redacted] was questioned about the two Registrant [redacted] patient profiles of [redacted] and [redacted]. He said he recalled prescribing Endocet, furosemide, LOR, chlordiazepoxide, and ALP to the Registrant but testified that without his chart he could not

speak to dates or other specifics of the prescriptions. He testified that he had never prescribed Gravol to any patient.

Tammy Fadelle ("The Registrant")

The Registrant provided background information on her pharmacy and MBA education, and experience as a pharmacist in community and hospital practice. She is currently the owner and pharmacist at [redacted], open weekdays 11-5, averaging 60 prescriptions per day. She provided background on the history of the business ownership, location, and catchment area.

The Registrant outlined how she became aware of the College investigation. She discussed community rumours, a call to the College, and receiving the College's notice of investigation.

The Registrant disputed [redacted] testimony that he did not prescribe LOR 2mg except once in outpatients under the guidance of a neurologist. She provided prescription and computer records showing prescribing of LOR 2mg for [redacted] on two occasions by [redacted]

The Registrant testified how the LOR prescription for [redacted] came about. She described their relationship and its breakdown, and [redacted] regular visits from Winnipeg to see his daughter. She described being invited to supper at [redacted] home during such a visit and she described a dinner conversation regarding [redacted] sleep issues and reluctance to have a Winnipeg doctor prescribe LOR for him. She testified that [redacted] indicated he was okay with prescribing it as needed. She stated that during another of [redacted] visits they drove together in her truck to [redacted] home and had a conversation in the driveway to say they would take him up on his offer to prescribe 100 x 2mg tablets, [redacted] would break them as needed, and this would likely last him the year. She stated that she knows she was in the driveway because she would not let [redacted] drive her truck when she is not there as he is a poor driver, and that she likes to make it as much family time as possible for their daughter when he visits. The Registrant denied that her actions were dishonest or unlawful, and that it did not make sense that she would ask [redacted] to refill something he had never prescribed.

The Registrant indicated that she knew [redacted] both professionally and socially. She submitted into evidence and spoke to examples of a number of incomplete prescriptions written by [redacted] (Exhibit 22, pgs. 67, 67, 69) that required clarification prior to dispensing. She testified that these types of incomplete prescriptions resulted in a financial loss to her pharmacy during a Pharmacare audit.

The Registrant testified as to the employees of [redacted] and the hiring of [redacted]. [redacted] first worked for the Registrant as a housekeeper; in 2006 she was hired to work in the pharmacy, first in the front store and taking more on in the dispensary when the summer student left. She indicated that [redacted] could complete all functions that she herself could on the QS1 software except entering drugs and pricing.

The Registrant testified as to the conversion of her software to Nexxsys. Her reasons for converting included the need for a more modern system (example: QS1 difficulties with PMP submissions), [redacted], a College inspector, had indicated she liked it, the Registrant knew the representative from ProPharm and found her helpful, and it was owned by Guardian, a group she was thinking of joining for more support. The Registrant discussed the difficulties she had during the conversion and described it as time-consuming and a 'nightmare'.

The Registrant outlined [redacted] training and capabilities with Nexxsys. She said that [redacted] received 3 days of training. Further, she testified that she had more experience with other software, so she stayed more in the background for the training period. She testified that she read the Nexxsys manual many times. She stated that [redacted] could enter prescriptions. The Registrant testified that while [redacted] focused on computer duties, she did much of the counting,

double-checking because of the conversion issues, counseling, reporting and auditing. The Registrant reported that she never recounted [redacted]s work although she did randomly check stock and on-hand inventory if it did not match the bottle. It was her evidence that [redacted] could enter a patient profile, dates of birth, allergies. This was part of post-conversion clean-up as allergies went to notes in the new files and needed to be updated.

The Registrant related her desire and efforts to create a more professional atmosphere in the pharmacy in response to more involved rules and regulations. She stated that there were no parties held in the pharmacy, that the front of her store is all windows and this would be visible to the public, and that she is a respected professional in the community.

The Registrant reported that she tried to help [redacted] with her financial and family issues by providing money, a loan, casual work for family members, help with Pharmacare applications and an MSI card renewal, and contacting the family doctor to provide support during a health crisis.

The Registrant described how [redacted]'s duties changed after [redacted] became ill. The Registrant attributed bubblepack errors to [redacted]s inability to concentrate and reassigned her to more front store duties. The Registrant stated that performance appraisals moved from verbal to written when she felt it had become necessary. In the summer of 2010, [redacted] was given split shifts (mornings and evenings) as the Registrant did not wish to cut her hours and she did not want her working in the dispensary.

The Registrant described the circumstances of [redacted]s employment ending at [redacted] on August 30, 2010. On Friday, August 27, 2010, [redacted] requested time off on the following Monday to take [redacted] to a pre-operative appointment. The Registrant granted the request. The Registrant testified that at this point she also had the security report from [redacted] but [redacted] was not aware of it. The Registrant indicated to [redacted] on Friday that they needed to speak about 'what was going on in the store'. On Monday, the Registrant expected [redacted] to come in for her evening shift and testified that she called and spoke to [redacted]s son when she did not appear. She said she left a message that [redacted] should not bother coming to work in the morning, and that the Registrant would see her at 5:00 pm. The Registrant described waiting for [redacted] at the store with [redacted], and stated that she did not see or hear from [redacted] for a week until [redacted] called for her record of employment. The Registrant indicated that she learned of [redacted]s differing version of the employment termination through her communications with Sandy from Employment Insurance.

The Registrant reviewed documentation of [redacted]s work performance issues from May 2010 (Exhibit 23, pg. 13.7), August 16, 2010 (Exhibit 23, pg. 13.2) and August 30, 2010 (Exhibit 23, pg. 13.6). It included reference to items that needed improvement including a more professional atmosphere, inventory and filing issues, patient charged for inhaler and diabetic test strips but not in bag.

The Registrant read the [redacted] report (Exhibit 24) and described how she came to receive it. She reported that [redacted] was previously employed in loss prevention with Shoppers Drug Mart after his military career, and was a [redacted] customer. The Registrant stated that he told her she had problems with her employee. The Registrant said that she, [redacted], and [redacted] had access to the video equipment in the basement electrical room. She indicated that room was not usually locked but she did lock it on Friday, August 27th. She reports that she subsequently found the inside of the video camera gone.

The Registrant states she viewed the video but that she was in denial and she told [redacted] that [redacted] had no reason to steal. The Registrant said she was upset to learn from the video that [redacted] was in the dispensary, but that she wanted to talk with her to find out what she was taking and what was going on.

The Registrant stated that she did not give [redacted] ALP for a migraine. She indicates she told [redacted] that there was Advil and Gravol in the OTC drawer she could use. She said that Gravol is similar in colour to ALP. She said if she had known that [redacted] was having vision problems she would have sent her home. She stated that in terms of [redacted]'s history with ALP, she was just aware of her emergency department visit and prescriptions from [redacted]. She stated that she did not create [redacted] to provide a supply of ALP to [redacted] and suggested that [redacted] did so to create a sale for a drug she was taking. The Registrant indicated that the [redacted] prescriptions would supply [redacted] with 4 ALP tablets per day. [redacted] had testified that she would take up to 6 or 7 tablets per day. The Registrant said that she believed that [redacted] must have been taking the additional tablets from the pharmacy, based on the missing inventory and the [redacted] report.

The Registrant stated that it did not make sense for her to have changed [redacted]'s prescription for ALP from [redacted] to misoprostol from [redacted]. She talked about how this would remove the sales report that matched the missing tablets, and she wasn't expecting anyone to be looking in her files.

The Registrant testified that the initials on the [redacted] hard copies were not hers. She stated that the initials were not done in red pen and did not have the same characteristics of her writing. She said the [redacted] initials on the hard copies look like [redacted]. She stated that she believed [redacted] created the hard copies so the filed prescriptions would be in numeric order.

In response to [redacted]'s testimony that she did not receive the August 27, 2010 [redacted] prescription, the Registrant stated that she was not present in the store when the prescription was filled at 16:59 as she was meeting with her accountant. She said [redacted] would be in the store at this time as it coincided with the start of her evening shift.

The Registrant stated that the prescribing doctor for the [redacted] prescriptions was not a likely choice as [redacted] is an emergentologist at Springhill Hospital, that emergentologists don't normally have family practices or give refills. She indicated that, to her knowledge, [redacted] did not know [redacted].

The Registrant testified that [redacted] helped her get policies in place and suggested starting patient care plans. The Registrant states she began by adding OTCs to her own profile. She said she included a doctor for Gravol as QS1 did not have the functionality to add it without a prescriber.

The Registrant stated that her understanding was that it was appropriate to have "No Refills" on narcotic prescriptions because narcotics cannot be refilled by law. She said "No Refills" appeared on all narcotic prescriptions for all patients at [redacted]. She said both QS1 and Nexxsys default to "No Refills" on narcotic labels. She indicated that Nexxsys assisted her in changing narcotic labels to display refills. She testified that College inspector [redacted] did not give her suggestions regarding labeling refills on narcotics.

The Registrant described issues she experienced with the Nexxsys system. She discussed system error messages, missing narcotics on the sales report, methadone quantity issue, problems with tax receipts and cash customers showing as Worker's Compensation, issues with placing and reconciling orders that required manually updating inventory regularly, support calls as described by the Remedy Log, and stated that there were other calls not logged by the support desk. She described problems with [redacted]'s Endocet part fills, frozen computer screens, and inaccurate messages that some prescriptions were over a year old. She discussed issues with narcotic compounds not being flagged for PMP, and that she did not receive the Nexxsys notice on the issue, other PMP submission issues.

The Registrant reported unauthorized access of her computer system. She said she reinforced with Nexxsys numerous times that her permission was required for their external access to her system. She stated there was activity on her computer she observed when working

late and that she hired two companies to determine if there was a security breach. She reports that she saw a data log disappear from the screen.

The Registrant said she was becoming frantic with the ongoing problems, inventory concerns and College complaints and that she did not receive help from Nexxsys until she threatened to obtain replacement software. She said a number of steps were taken to try to correct the issues including adding antivirus software, purging QS1 to improve speed, new hard drive, upgrading Nexxsys, and adding a scanner. She stated that purging QS1 was on the advice of Nexxsys. She reported that she twice asked Nexxsys to purge her inventory. The Registrant indicated she was frustrated by the responses she received and problems continued.

The Registrant testified that the manual adjustments were required to correct inventory when manual counts were done. She said the inventory discrepancies resulted from the ordering and receiving issues she experienced, not enough time to complete the manual updates as listed in the auto-reconcile exceptions reports and manufacturer shortages. She said she began to enter inventory in the drug file before dispensing to prevent the system from reordering product she already had in stock.

The Registrant testified that she believed that the inspection counts performed by [redacted] and [redacted] on January 25, 2011, were inaccurate. She discussed Ativan SL 2mg and Dilaudid 2mg, comparing January 25, 2011 and August 29, 2011 counts, sales and purchases to explain her reasoning.

The Registrant stated that the ALP 0.5mg count performed by [redacted] and [redacted] on August 29, 2011 was inaccurate. She discussed the on-hand quantity on December 9, 2011, purchase and sales in the timeframe and calculated the on-hand quantity to be 421.

The Registrant said she could reconcile the Endocet inventory to account for the tablets out of balance according to the inspectors' August 29, 2011 counts. She said the discrepancy was due to counting inventory that had been ordered and not received, and including 2 prescriptions that should have been excluded because they were filled pre and post count.

The Registrant testified that she agreed that there were missing tablets of ALP. She said that she is not certain that the inspectors' counts were accurate, that the audits were random and she did not have time to count with them. She stated that she signed the counts to say that the inspectors were present and counting. She stated that she did not detect the discrepancy in tablets and that contributing factors were manufacturer shortages and consequent switching of customer prescription strengths. She said she ordered extra stock in any format when the product was available to try to prevent being short again. She indicated that her practice at the time was to sign for receipt of the product if her employee said it came in, rather than also counting as she does for narcotics. The Registrant testified that [redacted] told her that the ALP inventory was off and needed to be adjusted sometime during the week prior to [redacted] employment ending. She said she didn't think much of it due to ongoing inventory adjustments but realized on August 30th, 2010 that it was a large adjustment. The Registrant stated she did not consider this professional misconduct. She noted she had a large amount of inventory on hand because of the previous shortages, and that the manual adjustments and [redacted] prescriptions have stopped since August with [redacted]'s departure.

The Registrant reviewed the College inspection reports and corrective action plans where applicable, and PMP audit results.

The Registrant presented copies of her prescriptions for quetiapine and ALP written by [redacted] to confirm the prescribed dates. She indicated that she had asked him not to prescribe ALP because of the investigation. She said the prescriptions were related to the anxiety, weight loss, and stress she was experiencing because of [redacted] and the College investigation. She stated that [redacted] was ill. She said she had the support of her customers and doctors.

The Registrant presented a copy of the narcotic prescription written by [redacted]. This related to the testimony from [redacted] regarding the narcotic label stating No Refills, his call to the Registrant, and clarification that there were part fills available.

The Registrant testified that she could reconcile the 234 tablets of Endocet that the College asserted was missing. She spoke about a dropped sale for 320 tablets, a duplicate prescription record for -100 tablets, 9 dropped tablets for destruction and 5 tablets short on random audit that had been attributed to a counting error. She also spoke to a prescription that was not properly accounted for in the inventory cut-off, and a duplicate prescription that was not showing as cancelled.

The Registrant presented documents showing application to destroy narcotics, authorization of same and documentation of prescription to adjust inventory.

The Registrant stated that her pharmacy practice was not typical because of the computer system issues. She said she was trying to keep computer records and perpetual inventory records. She said if she can gain confidence in the system she will wipe her inventory and have Nexxsys re-enter it so she can go back to relying on the software. She stated that the manual adjustments did not constitute conduct unbecoming because they were due to computer issues she spent hours trying to reconcile.

The Registrant described her dealings with [redacted] and [redacted], related physician communication and prescriptions written and filled for Endocet. She stated that [redacted] acted as [redacted]'s agent at the pharmacy. She said the first part fill dispensed May 2009 was labeled "No Refill". She stated that she did not receive an inquiry from both [redacted] and [redacted] in January and that her assumption is that they assumed there were no part fills and contacted the doctor. She stated that [redacted] was concerned with the smaller quantity on the new prescription she brought in sometime in January because [redacted] was using several per day. The Registrant said she then informed her that there were 5 part fills left from the May 2009 prescription. The Registrant stated that she either called or faxed the doctor or resident and got word back to use the part fills of the May 2009 prescription and to place the new prescription on hold. She testified that in March 2010, [redacted] brought in another new Endocet prescription and complained to her about the quantity and interval. The Registrant said she reminded her about the remaining part fills of May 2009 prescription, and subsequently put the new March prescription aside in a basket, intending to deal with it later. The Registrant said that [redacted] requested all possible prescriptions be filled prior to April 1st when the MSI copay maximum was reached for the year. The Registrant stated that Endocet was filled then voided with an explanation to [redacted] that it could only be filled every 30 days. The Registrant indicated that [redacted] was still upset about the March 2010 prescription written for 6 week intervals so she decided to address it in a fax to [redacted]. The fax indicated that she 'denied them that morning'. The Registrant stated that she planned to use the remaining part fills, and then use this prescription at 15 day intervals if needed to please [redacted]. She testified that she received word from the secretary or resident that it was OK to do so. The Registrant testified that the next prescription was for 240 tablets because [redacted] said he wasn't receiving enough and that [redacted] was averaging 60 tablets per month. She said he had difficulty with 30 tablets at 6 week intervals over the summer (when the on-hold prescriptions were eventually filled). She testified that [redacted] orders and picks up the prescriptions, that she has cancer and wants to make sure he has enough while she is receiving treatments. The Registrant stated that [redacted] would sometimes call in the morning, [redacted] would note the request, and they would fill when the dispensary opened. She said that [redacted] signature is on the Endocet prescriptions because she signed them when she did eventually receive them.

The Registrant testified that she later contacted [redacted] to ask him to come in to review his receipts and discuss what quantities he had received. She testified that she agreed that if the

part fills had been printed on the prescription labels this situation would not have occurred, and said that it did not make sense that she would tell him in the morning that he had no refills and then fill the part fills in the afternoon.

The Registrant discussed her health conditions as they relate to pain treatments. She indicated that her doctor wanted to prescribe Oxycontin but she was concerned about the appearance of this to the College, and because she has teenagers. She described the medications she had tried and that she now uses Endocet and Tramacet to manage pain, that her doctor is willing to prescribe and that she had no need to steal or sell it. She said [redacted] needed money.

The Registrant testified regarding the authenticity of the Xenical prescriptions for, [redacted]. She stated she sent a fax on January 7, 2010 but did not hear back. She said that she called and obtained a verbal order from [redacted] in May 2010 for 30 capsules, with refills for a year, to be cancelled if [redacted] found a family doctor. She said [redacted] asked her to follow up with a fax for his records which she sent in June 2010. She stated that she recalled that the June fax came back signed but that she didn't expect it as it was for [redacted]'s records only. She said she could not locate the signed fax. She testified that [redacted] received every prescription, and that the manual adjustments were due to ongoing inventory system issues. She said she entered 30 capsules in the inventory system before filling his prescriptions to prevent the system from reordering the product. She stated she would not risk her career and livelihood for $50 per month. She described the three statements of [redacted] as conflicting.

The Registrant testified that she did not give [redacted] Tramacet or Endocet, and that she did not have bottle of mixed pills. She stated that she had given [redacted] acetaminophen 500mg.

The Registrant discussed [redacted]'s Viagra prescriptions. She testified that [redacted] came to her house on a weekend to ask her for a Viagra refill. She said she was uncertain if he was out of refills or if his prescription at his usual pharmacy was over 1 year old. She stated she called prescriber [redacted] and left a message that she planned to fill [redacted]'s Viagra prescription on Monday. She said she probably should not have assumed it was okay to fill it if she did not hear back, but she did. She testified that she did not hear from [redacted] on Monday or Tuesday but whenever she did, she filled it. She indicated that for family members she would call for refills, but for typical patients she would normally send a fax request.

The Registrant discussed [redacted] Viagra prescriptions. She stated that she cannot be sure if the change in the prescription's quantity authorized was due to a software conversion glitch or if [redacted] changed it in QS1. She testified that she had an authorization from [redacted] for 6 months of Viagra that she interpreted as the initial fill plus 6 refills. She stated the patients both received the Viagra prescriptions.

The Registrant testified that she filled prescriptions for [redacted], [redacted] of Digby. She testified that she called prescriber [redacted] of Digby to provide continuing prescriptions for [redacted] while [redacted] was staying with family in Sackville NB. She said [redacted] did not receive any prescriptions from prescriber [redacted], that on two occasions the incorrect doctor was picked from her drop down menu when filling her prescriptions. She testified this was corrected when the error was realized. She said at one point [redacted] had run out of LOR and she was unable to reach [redacted] so she called [redacted] to authorize.

The Registrant testified that it was not uncommon for more than one physician to prescribe for a patient and that it was up to doctors to share information. She described [redacted]'s LOR usage over time. She stated that [redacted] had been taking diazepam and LOR, both prescribed by [redacted], for a number of years. The Registrant testified that while staying in Sackville, NB, [redacted] developed muscle spasms and started taking pieces of her bedtime LOR through the day. The Registrant stated that [redacted] was also having problems sleeping, and that [redacted] communicated to her

a prescription for 200 LOR with a refill so [redacted] could keep the big bottles close by for muscle spasms and have another bottle for bedtime. The Registrant testified that shortly after this, [redacted] told [redacted] to decrease and stop her use of diazepam. She said that within 2 months, [redacted] was no longer taking diazepam.

The Registrant stated that it is not uncommon for a patient to be taking two benzodiazepines. She presented [redacted] discharge medications from Digby hospital and a profile of one of [redacted] patients as examples where two benzodiazepines were prescribed.

On cross examination, the Registrant reviewed her two personal patient profiles at [redacted], under the names [redacted] and [redacted] She discussed her records including listed prescriptions for narcotics, benzodiazepines, Tramacet and Xenical, multiple prescribers, and incomplete or inaccurate doctor addresses. She stated that the information was converted from QS1, she doesn't know when glitches will appear and that she does not trust the data. She stated that the prescribers included specialists, her family doctor and outpatient and clinic doctors, and that [redacted] prescribed LOR in 2008 when her family doctor was unavailable that day and Diclectin when she was pregnant. The Registrant agreed that she should have kept better records with regards to physician addresses. Responding to the suggestion that she was a regular benzodiazepine user, the Registrant stated she took what her doctor recommended as optimal care. She indicated that while she had taken LOR and ALP, she and her doctor were trying to use other means to manage her anxiety disorder. The Registrant testified that she added OTC Gravol to her profile to keep a complete record. She agreed that she was using Nexxsys to keep an accurate record and that she filled about 60 prescriptions a day using Nexxsys.

The Registrant testified that she had no knowledge of any of the [redacted] transactions, including those dispensed during working hours. She stated that she believed [redacted] was responsible for them, and they could have been completed while the Registrant was on break. The Registrant stated she did not observe any abnormal activity in the pharmacy.

The Registrant described how [redacted] prescribed for [redacted] customers. She said that she would call him, do an assessment over the phone, and if he was comfortable prescribing, he would. She said some patients could not see a doctor in a timely way, some patients would not or could not go to Amherst to the outpatients department. She reviewed a list of patients and the therapies that [redacted] prescribed for them. She indicated that on 4 occasions she could not reach prescriber [redacted] so she contacted [redacted] for a prescription for [redacted] LOR. She said she would lend a week or so of other medications but did not want to lend LOR. She stated that while she had lent a benzodiazepine to [redacted] at the request of the doctor's secretary, she did not have a relationship with prescriber [redacted] and was not willing to take the risk that he might not authorize a prescription.

The Registrant testified about [redacted]'s access to the dispensary. She said that [redacted]'s usual work start time was 9 a.m. and her own was 11 a.m., and that they both had keys. She stated that a coffee club met in the store in the morning and the Registrant believed she would have been told about it if [redacted] was seen in the dispensary before 11. The Registrant stated that in the spring of 2010 that she preferred [redacted] to work in the front store but there were exceptions when she was in the pharmacy.

The Registrant reviewed McKesson purchase records for ALP 0.5mg. She agreed there were 3 orders totaling 1500 tablets from August 29 to Oct 4, 2010 and that she had one patient taking the drug at that time. She stated that these were backorders that arrived, that she was concerned the product would go on backorder again, and that she didn't know at the time that she didn't need the stock. She said that while in August 2010 she was the one who did the ordering and putting away, the concerns about shortages caused her to stockpile.

The Registrant discussed that in February and March 2009 she was under close scrutiny by the College, subject to scheduled and random audits, that she was working hard to do a good job and that she believed things were improving.

The Registrant testified that [redacted] did not dispense [redacted] prescription without her involvement. She said she supervised the preparation and initialed the prescription.

The Registrant testified that she did not believe that [redacted] knew she was under surveillance but that the Registrant had told her before she left on Friday, August 27th, 2010, that they needed to talk. The Registrant stated that she watched the important parts of the security tape on that Friday while [redacted] was on her lunch break. Upon questioning as to why the incident was not on her list of topics for her meeting with [redacted], the Registrant stated that [redacted] was going to deal with it. The Registrant denied wanting to fire [redacted]

The Registrant spoke to [redacted]'s title at [redacted]. She said she was a pharmacy assistant or pharmacy technician, and that she listed her as a pharmacy cashier on her record of employment because toward the end of her employment status, she wanted [redacted] on cash and in the front store more than dealing with pills. She indicated that she assigned split shifts to encourage front store involvement, and that this schedule was initiated in June or July.

The Registrant testified about employment relationships with [redacted]'s family. This included stating that [redacted] was paid as casual labour and [redacted] as a contract worker. The Registrant testified that she did not facilitate ALP prescriptions for [redacted].

In response to being asked if she recalled calling Susan Wedlake, Registrar, at the College on March 23, 2011, the Registrant stated that she called to inquire about rumours she was hearing and was told that there was no formal complaint against her. The Registrant read the March 23, 2011 entry from the Remedy log and stated that her request to purge QS1 was based on previous advice to improve the speed of her system, and that Nexxsys incorporated her QS1 data.

The Registrant reviewed the ALP sales report from April 29, 2009 until January 25, 2011 and confirmed it listed prescriptions for 4 patients and that 1430 tablets were probably missing, and denied that she lost control of her inventory. She stated that the only manual adjustment for ALP that she could recall was August 30, 2010.

The Registrant reviewed the patient profile of [redacted], produced to reflect a longer timeframe. She agreed that prescriber [redacted] inherited her as a patient taking LOR 2mg and that the profile shows that he prescribed it twice and then decreased her dosage over time.

The Registrant testified about the validity of the verbal order for LOR for [redacted] from [redacted]. She stated that she sent the fax referring to the supper conversation hoping he would remember it. She testified that she thought the dinner was after 2006. She stated that she did not mention the 2009 discussion in [redacted] driveway in her response to the College as she did not recall it until she spoke to [redacted] later. The Registrant reviewed the affidavit of [redacted] which referred to the Registrant lending her truck to [redacted], and to [redacted]. The Registrant stated that she did not lend her truck to [redacted] because he is a poor driver.

In comment to the apparent contradiction between her understanding of [redacted]'s Endocet usage and the greater than minimum prescription fill intervals by [redacted], the Registrant said he could have stockpiled or had other prescriptions filled elsewhere. The Registrant stated she had 3 Endocet prescriptions available for [redacted] but not all were active, and she was in communication with his doctor about it.

The Registrant stated that she told patients verbally that they had part fills available on their narcotic prescriptions. She testified that she thought using an auxiliary label to indicate the number of refills would be a breach, and that she was not aware of the label preferences screen on Nexxsys until after the complaint.

In relation to the manual adjustments for Endocet, the Registrant testified that she relied on her perpetual inventory records to reconcile inventory, that during this timeframe she was trying to get her computer inventory system working for her as per Inspector [redacted] suggestion and that she was using multiple brands in response to manufacturer shortages.

Upon questioning about Xenical, the Registrant stated that she accepted a box for return from a patient and redispensed, that correcting the computer inventory did not provide lasting accuracy, that she dispensed Xenical to [redacted] as a 30 day supply despite the packaging format so that his non-methadone prescriptions would come due together, and alleged that [redacted] did not chart their May conversation. She stated that she believed that the College was misleading the hearing panel.

In relation to the care of [redacted], the Registrant stated that [redacted] prescribed the 1mg tablets of LOR to keep in her walker and break in half because the 0.5mg tablets are small and hard to pick up, and that breaking tablets was his own practice. She stated that prescriber [redacted] must have known about [redacted] prescriptions at some point because he prescribed the LOR in 2009. The Registrant testified that the LOR was not for herself.

The Registrant testified, and the College agreed, that there was an error in Schedule B, whereby the May 26, 2009 LOR prescription should be classified as a refill.

5. SUBMISSIONS – SUMMARY OF COUNSEL SUBMISSIONS

Closing Submissions by Scott Sterns, Legal Counsel for the College

Mr. Sterns provided a written submission of his arguments, a Book of Authorities, which included a number of cases and also gave an oral submission. In his written submission, Mr. Sterns emphasized that the burden of proof is on the College to prove its case and that in civil cases, such as the matter at hand, the burden of proof is the balance of probabilities. He provided the Hearing Committee with an authority that described the burden of proof; page 37 of "Evidence: Principles and Problems" (Delisle, Stuart & Tanovich, Carswell: 2004). Mr. Sterns highlighted in his submission that although the charges against the Registrant include breaches that the College alleges amount to fraud and trafficking and carry a criminal context, the standard that the College must meet to discharge its burden does not change. He further emphasized his point by referencing a 2009 case from the Nova Scotia Court of Appeal, *Osif* v. *College of Physicians and Surgeons of Nova Scotia*, a 2008 case from the Supreme Court of Canada, *F.H.* v. *McDougall*, and finally a 1989 case from the Ontario High Court of Justice, *Re Gillen and College of Physicians and Surgeons of Ontario*.

Mr. Sterns emphasized that the final submission notes presented on behalf of the Registrant by her Counsel are not evidence and are only a helpful summary for the Hearing Committee. Although Counsel for the Registrant asserted that the College's case was light in detail, Mr. Sterns stated that the College had 9 witnesses, 250 pages of evidence and of the 50 exhibits, slightly more than half were presented by the College.

With respect to Lillian Berry not being called to testify, Mr. Sterns stated that there was a vast amount of information to present and that the College aimed to present the information quickly and efficiently. He elaborated that the 2 lead investigators both testified and the Deputy Registrar for the College also offered testimony. There was no gap in the evidence, he stated.

Mr. Sterns referred the Hearing Committee to Page 13 of the Summation Points presented on behalf of the Registrant by her Counsel. He asked the Hearing Committee to consider these points when assessing the issues of credibility:

1) **Assessing Witness testimony** – Mr. Sterns stated that all 15 witnesses had a reasonable attitude and demeanor and all swore to tell the truth;
2) **Assessing Prior Inconsistent Statements and truthfulness of the Registrant-** Mr. Sterns asked the Hearing Committee to consider:
    a. [redacted] – Mr. Sterns stated that the Registrant provided a patient profile that was cut off and did not show that [redacted] was inherited by the prescriber [redacted] who in fact tapered down her LOR strength;
    b. Loaning of truck to [redacted] – Mr. Sterns stated it was inconsistent that the Registrant said she would not loan [redacted] her truck as she loaned it to others ;
    c. Driveway conversation with prescriber [redacted] – Mr. Sterns stated that the Registrant never mentioned it to the College in prior submissions;
    d. Viagra prescriptions and prescriber [redacted] testimony;
    e. Xenical and prescriber [redacted] statements- his statement says he did not authorize;
3) **Assessing Consistency with Independent evidence** – Mr. Sterns asked the Hearing Committee to consider the fact that 4 independent physicians said that they did not authorize the prescriptions in question.
4) **Assessing Internal Consistency** – Mr. Sterns stated that the Registrant frequently referred to the College's policies as "ridiculous."
5) **Assessing Motive to lie/mislead** – Mr. Sterns stated that the Registrant's license and practice are on the line and that would be a very strong motive for her to lie and/or mislead.

With respect to the "Nexxsys nightmare" and the on-going computer issues and [redacted], Mr. Sterns asked the Hearing Committee to consider the fact that on April 15, 2010 (Exhibit #27), the Registrant told Nexxsys that everything was much better at the store and that she does not regret buying the system. Mr. Sterns asserted that the vast majority of computer evidence is irrelevant and does not relate to the charges.

The report from [redacted], Mr. Sterns stated, should be given less weight by the Hearing Committee because the College had no opportunity to cross-examine the witness and the College cannot be sure what his motives were.

Mr. Sterns stated that with respect to the stolen surveillance footage from [redacted], the only evidence presented that [redacted] stole the tape is that the tape is gone. Both the Registrant and [redacted] had keys and access to the room where the tape was located. Mr. Sterns elaborated by saying that if the Registrant saw the tape on Friday, why would she leave it there and not make any notes about the theft or tape on the performance review she was going to have with [redacted]?

Mr. Sterns disagreed with the Registrant's counsel with respect to the impeachment of prescriber [redacted]. Mr. Sterns stated that [redacted] would have no reason to lie and would have no fear of his own College. He is 1 of 4 doctors who says he did not authorize prescriptions.

Mr. Sterns pointed out to the Hearing Committee that on Page 31 of the Summation Points presented on behalf of the Registrant by her counsel, the table outlining Endocet usage for [redacted] only starts in January of 2010 and does not mention May of 2009. Mr. Sterns emphasized that even though the table and the records of [redacted] shows dispensing of 100 tablets per month, the Hearing Committee must consider the fact that [redacted] says he did not receive 100 tablets per month.

With respect to failing to properly label refills on narcotic prescriptions, Mr. Sterns stated that as a pharmacist, the Registrant was responsible for ensuring that [redacted] knew what he was getting, and that she did not do that. Mr. Sterns also stated that as a pharmacist the Registrant would have been aware of auxiliary labeling and also could have provided the refill information to patients through proper counseling.

Mr. Sterns clarified the definition of trafficking for the Hearing Committee by saying that it refers to the dispensing of controlled drugs without being under the authority of the regulations to do so, and referenced the Committee to Tab 1 of his authorities s.2.

Mr. Sterns stated that with respect to Viagra, both prescribers [redacted] and [redacted] testified that they did not recall authorizing prescriptions for their patients, [redacted] and [redacted] for Viagra. The Registrant testified it was a verbal order but the physicians have no record. Mr. Sterns stated that when the Registrant dispensed the Viagra from a prescription that was not authorized that this action is a breach.

Mr. Sterns concluded with the following:

Prescriber [redacted] – When the College spoke with [redacted] they disclosed that to the Registrant. If his statement was wrong, the College corrected it and disclosed that to the Registrant as well. The correct statement was disclosed to the Registrant. He did not authorize Xenical.

Xenical – Xenical comes in a blister pack. [redacted] has 1 patient on it on a regular basis. The Registrant says her computer issues would be responsible for the inventory being off. He stated to the Committee that this is not credible.

College – The Registrant was under review. The College got information that there were controlled drugs and substances dispensed to fictitious persons. The College talked to doctors who said they did not authorize prescriptions. The College investigated- that is its obligation. The College was not out to "get" the Registrant.

Summation- Mr. Jim O'Neil, Counsel for the Registrant

Mr. O'Neil provided a written outline of his arguments, a Book of Authorities, which included a three Nova Scotia Supreme Court cases on adverse inference- a 1990 case of *Scotia Fuels Limited* v *Marshall Lewis,* the 1992 case of *1874 Nova Scotia Limited and Joseph Shannon* v *Timothy Adams and Collins Barrow*, and the 1999 case *of Jessome* v *General Accident Assurance Co.* and also gave an oral submission.

Mr. O'Neil discussed the following legal points in his summation:

- To meet the burden of proof in civil proceedings there must be clear, convincing, cogent evidence that an allegation is more likely than not to have occurred. He stated that possibilities do not equal probabilities. Suspicion that an allegation is proven doesn't meet the burden;
- It is open to the Hearing Committee to draw an adverse inference as the College did not call Lillian Berry , an Inspector who was under the control of the College, as a witness;
- Keep in mind the civil definition of fraud and the criminal definition of theft, as they relate to intent. If an action was taken without intent (it was a mistake) then the action should not be defined as fraud or theft;
- Guidance from the Canadian Judicial Council for assessing testimony;
- Guidance for assessing credibility from *R* v. *DFM,* 2008 NSSC 312, per Justice John D Murphy.

Mr. O'Neil outlined the Registrant's case. Thematically, this included a submission that there was:

- Absence of expert testimony in the College's case. This included lack of a professional forensic investigator and handwriting expert, and lack of a specialist/medical expert in relation to what would constitute optimal care for [redacted].
- Bias of the College against the Registrant. Mr. O'Neil submitted that the College interpreted the evidence to fit their theory, that the investigator's belief that computer programs do not make mistakes limited the investigation, and that the College's witnesses presented inventory count evidence that was erroneous.
- Credibility issues with College witnesses. Mr. O'Neil specified [redacted] and [redacted] as examples.
- Significant software conversion and operational issues such that [redacted] was not a typical pharmacy practice, and that the Registrant had submitted evidence that her Nexxsys computer software had made mistakes.

In response to allegation 1, Mr. O'Neil stated that the initials on the hardcopies are not the Registrant's, and that the College did not present evidence from a forensic expert to show otherwise. He stated that [redacted] had the inclination and opportunity, that her testimony was not credible, there was evidence of her stealing from [redacted]/the Registrant via the report from [redacted], and that she had stated publicly that she and the College were going to close the Registrant down.

In response to allegation 2, Mr. O'Neil stated that while the Registrant agreed that ALP tablets were missing, the issues she experienced with her Nexxsys software were such that [redacted] could not be considered a typical pharmacy practice. He stated the College ignored or underplayed these issues. Mr. O'Neil pointed to [redacted] as the source of the missing tablets, her theft and resulting need for manual adjustments masked by ordering issues with Nexxsys and manufacturer shortages. He noted that manual adjustments dropped significantly once [redacted]'s employment ended at [redacted]. Mr. O'Neil also discussed the need for clear inventory cut-offs, computer mistakes, and the Remedy log.

In response to allegation 3, Mr. O'Neil stated that the Registrant would not be likely to call [redacted] for a prescription renewal if the previous prescriptions (in his name) were invalid. Mr. O'Neil stated that [redacted] was not credible because of his incomplete prescriptions and the fact that examples of two LOR 2mg prescriptions for [redacted] were produced, countering [redacted]'s statement that he never prescribes this dosage. He also suggested that [redacted] would be motivated to fabricate his testimony because he was concerned about professional repercussions from prescribing to an out-of-province patient.

In response to allegation 4, Mr. O'Neil stated that it was [redacted]'s agent, not [redacted] who submitted the prescriptions, and she wanted the part fills of 100 filled, not the new prescriptions. Mr. O'Neil stated that it was conceded that [redacted] may have misunderstood his need for a new prescription because the vial said "no refills". Mr. O'Neil said that [redacted] confirmed via his affidavit that he was never shorted in his prescriptions. He stated that there were Nexxsys conversion issues that caused lack of submission to PMP that was corrected upon discovery, and that the fax to [redacted] dealt only with timeframe, not with what was dispensed. Mr. O'Neil stated [redacted]'s claims regarding usage are erratic and that the evidence suggests that he was taking 2 tablets per day on average. Mr. O'Neil stated that the Registrant had authorization to maintain three active Endocet prescriptions on file for [redacted].

In response to allegation 5, Mr. O'Neil stated that [redacted], a College inspector, was working closely with the Registrant and was aware of her labeling practices, and that her software defaulted to "no refills" on narcotics. The Registrant believed this was consistent with the legislation prohibiting refills on narcotics. For this same reason she did not use auxiliary labels but rather counseled about the availability of part fills.

In response to allegation 6, Mr. O'Neil stated that [redacted] was not a typical pharmacy practice due to the poor conversion to Nexxsys, computer software mistakes and other challenges. He states the Registrant relied on her manual perpetual inventory records, not the computerized inventory, and that by using this record, along with clean purchase and sales cut-offs, all tablets are accounted for. Mr. O'Neil stated that the College counts were inaccurate, and that they failed to do the calculations appropriately. He stated there were no unusual patterns of manual adjustments.

In response to allegation 7, Mr. O'Neil stated that [redacted] testified that he could have confirmed a verbal order for [redacted] Viagra, and that there is no evidence that [redacted] did not receive the tablets. Mr. O'Neil also said that [redacted]'s lack of recollection is different than testifying that something didn't happen. Mr. O'Neil stated that even if you argue that the Registrant's process was wrong, she thought she was doing right and the action cannot be considered dishonest or fraudulent.

In response to allegation 8, Mr. O'Neil noted that [redacted] did not testify and that the written documents from him are contradictory and he is confused, or misquoted or misunderstood by the College. [redacted] testified he received his pills. Mr. O'Neil reiterated that [redacted] was not a typical practice due to significant software issues. He stated that the College's position regarding purchases vs sales is not reliable because there is no opening or closing inventory, and that manual adjustments were made to avoid automatic reordering.

In response to allegation 10, Mr. O'Neil stated that [redacted] did not have access to her primary physician because she was staying with family in Sackville. He said there was no evidence that [redacted] was not aware of [redacted]'s medical history. Mr. O'Neil stated that no specialist or expert testified to state that [redacted]'s care was less than optimal and elaborated by providing examples of doctors prescribing two benzodiazepines to the same patient. Mr. O'Neil stated the College made errors in this charge: [redacted] is not a pediatric surgeon and the May 26, 2009 prescription from [redacted] was referenced in the College chart as an original prescription instead of as a refill. Mr. O'Neil stated that the Registrant calls [redacted] when she feels it is in the patient's best interest, when they cannot obtain needed care locally.

6. ADVERSE INFERENCE

Counsel for the Registrant indicated in his final summation that it was open to the Hearing Committee to draw an adverse inference against the College as the College did not call Lillian Berry as a witness. Lillian Berry is an inspector for the College, and the Registrant in her testimony referenced that Lillian Berry had carried out inspections with the Registrant in [redacted]. Counsel for the Registrant submitted that the College's failure to call her is suggestive that her testimony might have been unfavourable to the College's case.

The Hearing Committee considered the argument made by counsel for the Respondent and reviewed the cases submitted from the Supreme Court of Nova Scotia. Considering counsel's argument, and having read the cases provided, the Hearing Committee has decided not to draw an adverse inference in this case. The reasons follow.

During her testimony, the Registrant referenced Lillian Berry as having been in the pharmacy with her from time to time, and also referenced some recommendations made by Ms. Berry to the Registrant which the Registrant testified she acted on. The College's position is that Cindy Ingersoll, the Manager of Professional Accountability and Janelle Gray, currently the Acting Manager of Professional Accountability and a former inspector for the College, as well as Beverley Zwicker, the Deputy Registrar for the College were the persons involved on behalf of the College in this investigation. The College stated there is no missing evidence that Lillian Berry could have been expected to provide in relation to this investigation that was not provided by the other employees of the College, and also asserted that there has been full disclosure to the Registrant, and no gap in the evidence. The issue appears to be whether the College is compelled to call as witnesses all employees who have any knowledge of the Registrant and [redacted] in any capacity. The Hearing Committee does not agree this is an obligation of the College.

The Hearing Committee finds that there were not any gaps in the College's evidence that arose by the College not calling Lillian Berry as a witness. The Hearing Committee, for the reasons cited, concludes this is not an appropriate case to draw an adverse inference against the College.

7. FINDINGS OF THE HEARING COMMITTEE

Witness Testimony

As noted in the witness summary section, the Hearing Committee received testimony from nine witnesses called by the College (prescribers [redacted], and [redacted]; Cindy Ingersoll, Janelle Gray and Bev Zwicker from the College; and patient [redacted], [redacted] former employees [redacted] and [redacted]) and six witnesses called by the Registrant in addition to her own testimony ([redacted], and [redacted] from ProPharm, patients [redacted], [redacted] and [redacted] and her own family prescriber [redacted]). The Hearing Committee considered all the witnesses' testimony in its deliberations. Not all testimony however is specifically referenced in the findings if the Hearing Committee did not find the testimony determinative in relation to the Hearing Committee's specific conclusions.

With regard to the allegations set out in the Notice of Hearing, and after careful consideration of all the evidence presented, the Hearing Committee finds as follows:

Allegation 1

This allegation is that the Registrant acted unlawfully by creating and dispensing prescriptions that were neither valid nor authentic for alprazolam ("ALP"), a targeted substance, and failed to maintain proper prescription records as described in the particulars.

For Particular (b)(i) of this allegation, evidence presented by the College included prescription and patient records and hard copies of verbal orders for these prescriptions from [redacted] ("[redacted]"). Testimony was given by [redacted] and Cindy Ingersoll that [redacted] is fictitious. The Registrant concedes that she does not know any[redacted]. The Hearing Committee, on the basis of the evidence, finds that [redacted] is fictitious, and that this particular allegation is proven.

For Particular (b)(ii) of this allegation, the College's evidence was provided through Cindy Ingersoll's testimony and exhibits, based on her investigation and communication with [redacted]. In light of the fact that the patient was fictitious, and based on the evidence heard, the Hearing Committee finds the prescriptions were not authorized by the prescriber [redacted].

For Particular (b)(iii) of this allegation, the College's evidence was provided through Cindy Ingersoll's testimony and exhibits and was based on an inspection of the [redacted] records by a College inspector, and records subpoenaed from the Registrant. Ms. Ingersoll confirmed that 13 verbal order records for the alleged false prescriptions were not in the records of [redacted]. While the Registrant initially alleged that the chain of custody for the transportation of the evidence between the [redacted] and the College may have been compromised- alleging that a staff member of the College related to a former employee of [redacted] ([redacted]) may have transported evidence from the College to [redacted]- the Registrant acknowledged on cross examination that the evidence was sealed when it was returned from the College to [redacted]. Upon review of the evidence, the Hearing Committee finds this particular also proven.

On the basis of finding the Particulars noted in (i), (ii) and (iii) proven in Allegation 1, and in respect of Section 25(5) of the *Pharmacy Act* that states that the pharmacist is responsible for the validity of every prescription, the Hearing Committee concludes that the Registrant failed to discharge her professional responsibilities as a pharmacist, pharmacy manager and the pharmacy owner with respect to permitting the creation and dispensing of false prescriptions to a fictitious person and for failing to keep proper records of a targeted substance as per the Acts, Regulations, and Standards of Practice as articulated in the Notice of Hearing.

The Registrant denies that she personally created or dispensed the fictitious prescriptions. She accuses her former employee, [redacted]. Evidence introduced by the College that the Registrant was personally involved, and not simply responsible as per Section 25(5) of the *Pharmacy Act*, included [redacted]'s testimony, the testimony of Cindy Ingersoll, and statements provided by [redacted]'s physician, [redacted]. The Registrant's evidence included her own testimony, a statement from [redacted], a loss prevention investigator, and [redacted].

Based on a review of the evidence, the Hearing Committee finds that the Registrant is personally responsible in the creation and dispensing of prescriptions for [redacted], and does not accept the Registrant's denials. The reasons follow.

According to the Registrant's testimony, [redacted] is addicted to the targeted substance ALP, is a thief, had motive, opportunity, and was capable of creating and dispensing false prescriptions. Evidence purporting to show that [redacted] was a thief was provided by means of a statement provided by [redacted], who was hired by the Registrant to monitor [redacted]. The Registrant disputes that the initials on the verbal records are her own (claiming they are forged by [redacted]). Counsel for the

Registrant argued that the College did not produce expert testimony that the initials on the false prescription were those of the Registrant.

In addition, the Registrant asserts that because several prescriptions were filled during times outside her normal working hours, she could not have filled them.

The College argues that the [redacted] report should be given little weight, as [redacted]'s testimony could not be heard and he was not available for cross-examination. The College argues that the evidence that [redacted] was a thief is not credible. According to the Registrant and [redacted]'s statement, the alleged security tape shows [redacted] removing articles from the dispensary. The Registrant alleges that the tape was eventually stolen by [redacted]. The College disputes that [redacted], who had worked in [redacted] for several years and was familiar with the security equipment, would have allowed herself to be filmed stealing items in such a blatant fashion. Because the tape was not produced for the Hearing Committee, the College argues that it should be given less weight.

[redacted] admits to an addiction to ALP which she attributes to the Registrant's actions- an addiction that she testified has now ended.

[redacted] claims that the creation of a false patient, [redacted], was at the instigation of the Registrant who wanted to find a method to provide herself and [redacted] with the drug. [redacted] readily admitted she could dispense a prescription once the patient profile was on file but denied that she was capable of creating a patient profile in the first place. She also claims she had nothing to do with filling prescriptions for [redacted] even though she admits the prescriptions were for her use and that she took the medication. [redacted] also stated that there were many times that the Registrant was in the pharmacy after her regular working hours and that she often did not go home on time. [redacted] denied that she was a thief.

The Hearing Committee heard in evidence the issues around whether [redacted] had motive and stole from the Registrant; when and what was dispensed; [redacted]'s competence; and, in particular, the Committee considered the relative credibility of the Registrant and [redacted].

Turning to the evidence that [redacted] had motive and was a thief, the Hearing Committee does not find it credible that a long standing employee of [redacted], knowledgeable of the surveillance system and with a ready supply of drugs by means of having both a false prescription for [redacted] and a legitimate prescription from [redacted], would have either motive to steal ALP, or be so reckless as to do it in full view of a security system with which she was familiar.

In addition, the Hearing Committee noted that the matter purportedly caught on tape by [redacted] relating to [redacted]'s theft, did not appear in notes the Registrant made, after she claims to have viewed the tape, as part of her preparation for an upcoming performance review meeting with [redacted].

Finally, because the tape was not produced as evidence, and because [redacted]'s evidence was entered by means of a statement only, with no opportunity for the College to cross examine him and with no opportunity for the Hearing Committee to listen to him and observe his demeanor, the Hearing Committee gives less weight to the alleged tape and statement of [redacted] and more weight to the issues of her lack of motive and [redacted]'s knowledge of the surveillance system in drawing its conclusion that [redacted] did not have motive to steal ALP from [redacted].

With regard to the testimony of [redacted], the Hearing Committee found as follows:

First, although [redacted] acknowledged that she was dependent on ALP, the Hearing Committee accepts that she is now recovered and under the care of a physician. She exhibited some embarrassment during her testimony but was not evasive or inconsistent. She was forthright about her dependency issue.

Second, the Hearing Committee accepts her testimony that she has a low level of education, very little formal training in pharmacy, no experience in pharmacy other than that gained in [redacted], and received a modest amount (3 days) of training on the [redacted] Nexxsys software. Her testimony that she could go into a patient's medication profile, fill a request for a refill, count the pills, check the DIN and then dispense the medication was credible. According to the testimony of [redacted], she was fully capable of dispensing a refill for an existing patient without supervision. The Hearing Committee therefore accepts that [redacted] could dispense.

Third, despite her testimony that she had nothing to do with the fictitious [redacted] profile after it was created by the Registrant, her initials are on the 'verbal orders' and given her admitted interest in ALP, together with her capability to dispense, the Hearing Committee finds it unlikely that she was not involved. The Hearing Committee rejects [redacted]s testimony that she had nothing to do with the profile of [redacted].

Fourth, on the issue of whether [redacted] could create a profile in the first place, the Hearing Committee rejects [redacted]'s testimony that she could not create such a profile. The Committee accepts [redacted]'s lack of training and education but finds that she had experience with parts of the system. In addition, [redacted] was using QS1 for part of this time, a system that has low levels of security. Patient profiles for 'cash' patients (those with no medical insurance coverage) are easier to create, and profiles for patients that have no allergies are also easier to create. [redacted]'s patient profile indicates she was a 'cash' patient, with no allergies. On a balance of probabilities, the Hearing Committee finds that [redacted] had the knowledge to create the fictitious [redacted] profile.

Based on the above noted findings, the Hearing Committee rejects the Registrant's allegation that [redacted] stole her ALP but finds that [redacted] had the opportunity and the knowledge to create and dispense prescriptions written for [redacted]. The Hearing Committee cannot conclude however that [redacted] acted alone. The reasons follow.

With respect to the credibility of the Registrant, the Hearing Committee heard evidence that that [redacted] had, at this time, only four patients on ALP. This included [redacted] who was receiving small quantities from [redacted], and [redacted] who received only one prescription. The only active patients receiving ALP in regular quantities were [redacted] and [redacted]. Despite such few patients, the evidence of the College through the testimony of Janelle Gray was that [redacted] was going through significant quantities of a targeted substance. Ms. Gray also testified that a large number of manual adjustments to the inventory of ALP at [redacted] were also made over this period.

The Hearing Committee finds it is unlikely that the lone pharmacist owner in a small pharmacy with so few patients taking a targeted substance – and one that regularly requires manual adjustment – would not have paid attention to a new patient, allegedly unknown to her, for whom ALP prescriptions were written by an Emergency room physician. According to the

Registrant's own testimony, that such a physician would prescribe ALP is very unusual. This was not a single fill prescription- the evidence was that the prescription was refilled 12 times and for those hardcopies that were located on inspection by the College, the Registrant's initials were on them.

It stretches credulity to accept that over many months, a targeted substance that requires special scrutiny and is simultaneously the source of an atypically large number of manual inventory adjustments, despite having so few patients, wouldn't raise significant red flags to a pharmacist given the small size of the store, and the close community it serves.

For the reasons cited above, the Hearing Committee concludes, on a balance of probabilities, that the Registrant knew about the prescriptions for [redacted]. In addition, the Hearing Committee finds that there are prescriptions for [redacted] for which examples of the Registrant's initials are substantially similar to her initials on undisputed prescriptions for other patients (examples- Exhibit 1 pg 79, 127-129, Exhibits 25 and 26). The Hearing Committee does not believe that a forensic handwriting analyst is required to draw this conclusion.

With respect to motive, the Hearing Committee finds that the Registrant had motive to conceal unusual prescriptions for benzodiazepines. She was being monitored by the College. She had a history of benzodiazepine use. [redacted], an employee of [redacted], had previously been prescribed regular quantities of a benzodiazepine by [redacted], the Registrant's ex-husband. The Hearing Committee accepts the evidence of [redacted] and Janelle Gray that these prescriptions were disguised in the patient profile, perhaps to avoid drawing notice; the name of the drug was changed from ALP to misoprostol while the prescribing doctor was changed from [redacted] to [redacted].

In addition, the Hearing Committee finds that while several prescriptions were filled during hours that the Registrant is officially off duty, it is common practice in the profession for pharmacists to work outside scheduled hours. The Hearing Committee accepts the evidence of [redacted] that this was also the practice of the Registrant at [redacted]. As such, the Hearing Committee does not accept the Registrant's testimony that prescriptions, filled after her regularly scheduled hours, constitutes conclusive evidence that [redacted] filled them. The Hearing Committee finds that the majority of the false prescriptions were filled during hours the Registrant was usually working. Given that [redacted]'s hours during this period began at 9:00 a.m. while the Registrant's did not start until 11:00 a.m., the Hearing Committee rejects the Registrant's testimony that [redacted] must have been acting alone in dispensing prescriptions for [redacted]. If [redacted] was acting alone, and hiding the [redacted] profile from the Registrant, why would she wait until the Registrant came on duty in the dispensary to then create and dispense false prescriptions? The Hearing Committee's finds this to be improbable.

The College's evidence was that the first two prescriptions dispensed under the fictitious [redacted] profile were for LOR, not ALP upon which [redacted] was dependent. If [redacted] acted entirely on her own in creating the [redacted] profile to satisfy her dependency on ALP, the Hearing Committee finds it to be improbable that she would have dispensed LOR- not once, but twice.

In summary, and for the reasons cited above, the Hearing Committee concludes that [redacted] was involved in the dispensing of the false prescriptions. The Hearing Committee also concludes that the Registrant was involved.

The Hearing Committee therefore finds the Registrant was not only responsible for the false prescriptions as a licensed pharmacist, pharmacy manager and owner but that it is more probable than not that the Registrant was personally involved in both the creation and dispensing of them as well. The Hearing Committee finds that the Allegation has been proven and that the Registrant has breached the *Controlled Drug and Substances Act*, Sections 2 and 5 and Benzodiazepines and Other Targeted Substances Regulations Sections 51 (1) ,(3) and 53 and that this constitutes trafficking, as defined. In addition, the Hearing Committee finds that the Registrant has breached the Pharmacy Act, Sections 24, 25(2)(i) and 25(5); Practice Regulations, Sections 2.10 , 2.14(1) and 2.20 ; the Model Standards of Practice for Canadian Pharmacists Professional Competency 1.8 and the Code of Ethics, Value VI .

In light of its findings, the Hearing Committee finds that these breaches bring harm to the integrity of the profession and constitute professional misconduct and conduct unbecoming.

Allegation 2

This allegation relates to 1430 missing tablets and unusual patterns of manual adjustments for Teva-alprazolam.

The College's evidence was provided by Janelle Gray and included various [redacted] records. The Registrant's evidence was provided by means of her own testimony, various records from [redacted] and ProPharm and the testimony of two ProPharm employees, [redacted] and [redacted]

On the basis of the evidence, the Hearing Committee finds that the College has met its burden of proof with respect to Particulars(b)(i) for this Allegation as set out in the Notice of Hearing.

The Registrant concedes that some ALP tablets are missing from [redacted] inventory and that there were a number of manual adjustments. The Registrant's testimony was that these issues were caused by extenuating circumstances for which she should not be held accountable. First, she contends [redacted] was not, at this time, a typical pharmacy practice due to its computer problems. Second, shortages of ALP were very common during this period due to supply issues. Third, the computer problem and the shortages in ALP concealed the inventory problems which were, in turn, caused by the theft of ALP by [redacted].

On the basis of the evidence put before it and based on its deliberations the Hearing Committee finds the Registrant failed to maintain proper records, failed to maintain control of an inventory of a controlled substance as set out in Allegation 2, and that this failure constitutes professional misconduct and conduct unbecoming. The reasons follow.

The Hearing Committee accepts four points made by the Registrant:

First, the Hearing Committee accepts that [redacted]'s computer conversion from QS1 to Nexxsys was difficult. This was spoken to during the testimony of the Registrant, [redacted] and the evidence relating to the Nexxsys call remedy log (Exhibit 27), among other documents presented.

Second, [redacted] had a key to the dispensary, authorized by the Registrant, affording her unsupervised access to the dispensary. The Hearing Committee acknowledges that such access, while it is prohibited, is not uncommon in pharmacy practices.

Third, the Registrant is obliged to report inventory theft for benzodiazepines per Health Canada Benzodiazepines and Other Targeted Substances Regulations which states that loss or theft of targeted substances must be reported to the Minister no later than 10 days after discovery. The Hearing Committee acknowledges that while such a requirement is widely known and practiced for narcotics, it is less widely known and practiced for benzodiazepines.

Fourth, the Registrant offered evidence that her employee, [redacted], suffered from an addiction to ALP. This was supported by the testimony of [redacted] herself and the Hearing Committee accepts this evidence.

While the Hearing Committee accepts these points, the Hearing Committee rejects the Registrant's testimony that [redacted] stole ALP from [redacted]. The Hearing Committee also rejects the Registrant's claim that her computer problems were of sufficient magnitude to relieve her of her responsibility to control her inventory.

Turning first to the issue of whether [redacted] stole ALP from [redacted], the Hearing Committee has already found, as part of its decision in relation to Allegation 1 that [redacted] had no motive to steal ALP.

Turning now to the role of [redacted]'s computer issues in the missing ALP and the need for an unusual number of manual adjustments, the Registrant argued that she was prevented from recognizing the loss of ALP from her inventory because of conversion issues.

While the Hearing Committee accepts, in part, that the evidence offered by the Registrant supports her position that the conversion may have been a contributing factor to her inventory issues, the Committee does not accept that the conversion relieves the Registrant of her responsibility to ensure any issues experienced did not interfere with the fulfillment of her professional responsibilities to control inventory and maintain proper records.

The Hearing Committee considered the following factors in its deliberations:

- ProPharm employee [redacted] testified that the conversion was difficult and that computers make mistakes. This was contrary to the testimony of Janelle Gray who testified that computers don't make mistakes. [redacted] in her testimony stated she is an account representative and the Registrant received online support from Markham Ontario.
- The Nexxsys remedy logs, as noted in Exhibit 27, state that as early as April 15th, 2010, the Registrant indicates that the conversion is going much better. Exhibit 27 also documents that 12 calls were made from [redacted] to ProPharm from the beginning of the conversion to the point that the Registrant states that "everything is going much better at the store" (Exhibit 27, pg. 7, entry dated April 15, 2010). The technician goes on to note "...she doesn't regret buying the system, just the time that she installed it would have been different."
- Allegation 2 cites inventory problems for [redacted] from April 29th, 2009 to January 24th, 2011. Exhibit 27 documents that during this time, only four calls related to inventory ordering issues were made to ProPharm. After the College began its investigation in February 2011,

18 calls were made to ProPharm relating to inventory ordering issues. The Hearing Committee concludes that the greater majority of calls took place after the College investigation commenced and if there were computer problems they appear from the evidence to be related more directly to a time frame outside of the investigation of the College.

In reviewing the evidence related to the role played by computer issues outside of the Registrant's control, the Hearing Committee does not accept that they are of sufficient severity to relieve the Registrant of her responsibility to control her inventory. In fact, if the computer problems were as bad as the Registrant alleges, the Hearing Committee concludes that they would heighten the obligation for the Registrant's involvement, due diligence, and security for all controlled substances.

Beyond the roles played by the computer conversion and [redacted]'s dependence on ALP, the Hearing Committee heard evidence relating to the number of manual adjustments and the relationship between the manual adjustments and the large quantity of missing ALP.

As noted earlier in the context of our deliberations on Allegation 1, [redacted] had only four patients on ALP 0.5mg during this time (Exhibit 1, pages 54-58). These patients include [redacted] (small dosages), [redacted] (single prescription), [redacted] (fictitious patient) and [redacted] (regular, monthly prescriptions). The College argues that with so few patients, the Registrant should reasonably be expected to be alerted to a possible problem when so many manual adjustments were required. Janelle Gray testified that there were 26 manual adjustments- compared to the average of 5.5 manual adjustments at four comparably sized rural pharmacies also using Nexxsys. The Hearing Committee accepts that the Registrant should reasonably be expected to have been alerted to a possible problem.

When the Hearing Committee takes into consideration the fact that ALP is a targeted drug- subject to special scrutiny- and that [redacted] was being monitored by the College at this time, it concludes that there were sufficient red flags to alert the Registrant to a problem regardless of any mitigating circumstances related to the computer conversion.

In summary, the Hearing Committee finds that the College has met its burden of proof on a balance of probabilities with respect to Allegation 2. The committee concludes that the Registrant is in violation of the Pharmacy Act, Sections 24, 25(2)(h) , and 25(2)(l) , Practice Regulations, Sections 2.1(1)(b) and (m), 2.6(1) and 2.10 , and the Model Standards of Practice for Canadian Pharmacists Professional Competencies 1.8, 4.3 , and 5.1 .

The Hearing Committee also finds that these breaches constitute professional misconduct and conduct unbecoming.

Allegation 3

This allegation relates to prescriptions for LOR to [redacted] that were not authorized by the prescriber [redacted].

The College's evidence was based on the testimony of [redacted], a physician practicing in Springhill who is listed as the prescriber for the two prescriptions in question. The Registrant's

evidence was based on her own testimony, various records from [redacted] including information about [redacted] prescribing, a patient profile for [redacted], and MSI records.

On the basis of the evidence, and as set out in the allegation in the Notice of Hearing, the Hearing Committee finds it is more probable than not that the Registrant acted unlawfully and without honesty or integrity in creating and dispensing prescriptions that were neither valid nor authentic and thereby engaged in trafficking. The Hearing Committee therefore concludes that the College met its burden of proof. The reasons follow.

In his testimony, [redacted] denied he wrote the prescriptions. He recalls seeing [redacted] and the Registrant at dinner in 2006- a date he is confident about- but was emphatic in his denial that he authorized LOR at that time. [redacted] also denied authorizing LOR during a visit with [redacted] in [redacted]'s driveway. He does recall the visit but denies that the Registrant was with [redacted] at that time. [redacted] confirmed that he did authorize a prescription for [redacted] for LOR 0.5mg in January, 2011 after a phone request by the Registrant, and after first having a conversation with [redacted] by telephone. He does not, however, have a record of that prescription in his charts.

[redacted] is also adamant that he did not prescribe the disputed LOR because [redacted] stated that he does not, in his normal practice, use LOR at strengths of 2mg, unless under the advisement of a neurologist or other specialist.

The Registrant asserted that [redacted] did authorize her to dispense LOR 2mg during the dinner conversation, but doesn't recall the date clearly. She also claimed that [redacted] authorized a prescription during the visit in his driveway for LOR 2mg and asserted that she was present for this visit. She stated in testimony that she was present at this visit for three reasons. First, her practice was to get [redacted], when he was visiting, to reconnect with his former colleagues. Second, she is committed to spending family time with [redacted] and their daughter when he visits so she knows she would have accompanied him at this visit to [redacted]. Third, she does not lend her truck to [redacted] who she says is a poor driver. The College disputed this on cross-examination of the Registrant. When presented with Exhibit 49, an affidavit of [redacted], in which he stated the Registrant loaned her truck to him and to [redacted], the Registrant again asserted that although she does loan her truck to other people she would not loan it to [redacted] because he is a poor driver.

In her testimony, the Registrant also asserted that it is not surprising that [redacted] has no records of the prescriptions because he normally prescribes in a very vague fashion. Her corroboration for this assertion was based on other prescriptions produced as Exhibits and correspondence with MSI regarding rejected insurance claims because the prescriptions were incomplete.

The Registrant also produced evidence (in the form of a patient profile for [redacted], Exhibit 22, pg. 73) to show that [redacted] does prescribe LOR in 2mg dosages in contradiction to his testimony that he does not. This was spoken to in cross-examination by reference to Exhibit 47, a complete copy of the patient [redacted]'s patient profile. The College clarified with the Registrant on cross examination that this patient was inherited by [redacted] and that over time he reduced the strength of the dosage.

Counsel for the Registrant argued that [redacted] regarded [redacted] as a friend and mentor and alleged that [redacted] was afraid to admit he prescribed LOR 2mg to [redacted] because [redacted] was an out-of-province resident. [redacted] testified that he was not sure if he could prescribe to an out-of-province resident but that he did so anyway in this case.

In arriving at its decision as to whether the prescriptions were authorized in the first place, the Hearing Committee considered the following:

First, [redacted] testified that his normal practice was not to prescribe LOR in 2mg dosages. The Registrant sought to undermine his credibility by pointing to an instance where he did prescribe at that dosage, and without a neurologist. But as was clarified in cross examination this was an inherited patient, and over time he did reduce the strength of the dosage, consistent with his practice, and the Hearing Committee found his testimony to be credible.

Second the Hearing Committee considered the evidence related to the conversation in [redacted]s driveway. The Hearing Committee accepts [redacted]'s testimony that the dinner conversation at which the first alleged discussion of LOR for [redacted] took place occurred in 2006, and also accepts the evidence that the first disputed prescription did not occur until December of 2009. As a result, the alleged conversation in [redacted]'s driveway confirming an agreement to prescribe is relevant. If this conversation did not take place as the Registrant testified then any (even disputed) authorization stemming from 2006, is out-dated.

In his testimony, [redacted] denied authorizing LOR for [redacted] during the driveway visit, and also denied that the Registrant was there to witness it. In the Registrant's fax to [redacted] sent to [redacted] after the College began its investigation, the Registrant attempts to remind [redacted] about the alleged dinner conversation. However, the fax mentions nothing about any conversation in 2009 in [redacted]'s driveway. Furthermore, neither in the Registrant's written response to the College's initial charges, nor at any other time during the investigation, is mention made of any conversation in the driveway.

Given the gravity of the College's charges that the Registrant sold LOR without valid authorization (ie trafficking), a gravity that is reflected in the Registrant's fax to [redacted] and the centrality of the conversation about LOR 2mg in [redacted]'s driveway, the Hearing Committee concludes that it is more probable than not that the driveway conversation authorizing a prescription for LOR did not occur as the Registrant asserts, and that the Registrant was not present during the visit. This conclusion is also supported by the Registrant's reference to [redacted] authorizing LOR at 1mg (not 2mg) in her fax to him (Exhibit 1, pg. 76). The Hearing Committee rejects the testimony of the Registrant on this issue.

In terms of [redacted]'s credibility, the Registrant argues that [redacted] was afraid to tell the truth about authorizing LOR 2mg because he would be potentially censured by his own College for prescribing to an out-of-province resident. The Hearing Committee rejects this. The Hearing Committee concluded that if he was concerned about potential censure, it is unlikely he would have confirmed authorizing any out-of-province prescriptions at all. Yet he did confirm that he had authorized a 0.5 mg prescription for LOR for [redacted] in January of 2011. The Hearing Committee concludes that while [redacted] may have been concerned about the out-of-province status, it did not prevent him from confirming the one prescription he says he did authorize. It would not

therefore have prohibited him from confirming he authorized other prescriptions if he had indeed done so.

With regard to [redacted]'s credibility, the Hearing Committee also considered his testimony under cross examination that he was close to [redacted] and also knew the Registrant very well. The Hearing Committee is unable to conclude, on the basis of the evidence before it, any probable explanation why [redacted] would deny authorizing prescriptions for his friend, if he indeed wrote them. If anything, because he does confirm having authorized one prescription for LOR 0.5mg, it would be more consistent with his regard for his friend and his friend's former spouse, for [redacted] to admit to two other prescriptions, as well. That he denies he authorized these prescriptions, despite the personal relationships, was considered by the Hearing Committee, on a balance of probabilities, to be credible testimony.

In summary, the Hearing Committee accepts [redacted]'s testimony as consistent, clear and compelling. The Hearing Committee further concludes that the College has met its burden of proof on a balance of probabilities and finds this charge proven. The Hearing Committee finds the actions of the Registrant constitute trafficking, as set out in the *Controlled Drugs and Substances Act*, Section 2.

The Hearing Committee also finds the actions of the Registrant to be contrary to the *Controlled Drugs and Substances Act*, Section 5, to be in violation of the Benzodiazepine and Other Targeted Substances Regulations, Section 51(1), the *Pharmacy Act*, Sections 24 and 25(5), Practice Regulations, Section 2.14(1), and Code of Ethics, Value VI.

The Hearing Committee finds that these breaches by the Registrant constitute professional misconduct and conduct unbecoming.

Allegation 4

This allegation relates to prescriptions for Endocet dispensed to [redacted]..

The Particulars are described in the Notice of Hearing, (b)(I)(1-8).

Evidence for the College was provided by Janelle Gray and various reports and documents from [redacted] and the Prescription Monitoring Program as well as the testimony of [redacted]. The patient, [redacted], also testified to this charge as a witness for the College.

Evidence for the Registrant included various reports and documents from [redacted] as well as her own testimony. In addition, the Registrant introduced a statement from [redacted] obtained by Counsel for the Registrant.

On the basis of the evidence put before it, the Hearing Committee finds the College has met its burden of proof on this allegation that the Registrant improperly dispensed and/or failed to properly dispense Endocet to [redacted] while intentionally creating a false record. The reasons follow.

There are several issues to be considered in this charge. These include:

- The extent to which the Prescription Monitoring Program was correctly advised of all prescribing/dispensing of this controlled substance;

- The issue of there being three concurrent and different prescriptions for [redacted]'s Endocet – two recorded in the computer system at [redacted] and one set aside for later use by the Registrant;

- Whether the patient, [redacted], received the Endocet that the Registrant claims he did and which [redacted]'s patient profile shows he received, or not;

- With respect to the requirements of the PMP, according to the evidence presented by the College, through the testimony of Janelle Gray, the following prescriptions for Endocet, which appear on the patient profile at [redacted], were not reported to the Prescription Monitoring Program (Exhibit 1, p.89):

    - April 29, 2009 (No hard copy presented. Exhibit 1, p.111 shows this fill on the patient audit history for RR)
    - January 12, 2010 (Exhibit 1, p. 128)
    - March 16, 2010 (Exhibit 1, p. 132)
    - April 15, 2010 (Exhibit 1, p. 134)

As per Particular (b)(i)(8), the Registrant revised a May 12, 2009 prescription for 100 tablets and submitted the entire prescription (quantity authorized) of 600 tablets. At that time only 500 of the 600 authorized tablets had been dispensed.

The Hearing Committee finds from the evidence that the Registrant acted contrary to the Nova Scotia *Prescription Monitoring Program Act* and Regulations.

With respect to multiple prescriptions, [redacted] received a prescription from [redacted] on May 12, 2009 authorizing 600 Endocet. [redacted] was issued a new prescription from [redacted] on January 12, 2010. He then received a third prescription from [redacted] on March 16, 2010. These prescriptions are found on pages 125, 126 and 130 of Exhibit 1 and include prescriptions #08097174, #08351432 and #08351476 respectively.

When asked if having three active prescriptions was acceptable practice, the Registrant testified that it is acceptable if the pharmacist is in communication with the prescriber. The Committee reviewed the evidence relating to any authorization given to the Registrant to "log" or hold the two prescriptions written in 2010.

The Registrant testified that she could not recall who she spoke to on January 12, 2010 but recalled receiving authorization from [redacted], his resident, or his secretary, to log the January 12, 2010 prescription and continue with the part-fills from the May 12, 2009 prescription of 100 tablets per month.

The Registrant also referenced her fax to [redacted] in Exhibit 1, page 133 dated March 31, 2010 as proof that she had permission to continue with the part-fills of the May 12, 2009 prescription of 600 tablets to be dispensed as 100 tablets per month. This is disputed by the College. According to the Registrant, [redacted], in his response to this fax, agreed to log the March 16, 2010 prescription. But according to [redacted]'s statement (Exhibit 1, p. 88), he states "this (fax on p. 133 of Exhibit 1) information was inconsistent with my recent assessment and conversation with [redacted] and so I disregarded the fax." The Registrant's testimony is directly contradicted by [redacted]s statement and testimony.

In its assessment of the issue of [redacted]'s credibility, the Hearing Committee also looked at [redacted]'s communication to the Registrant on March 15, 2011 (Exhibit 6) in which he recalls an appointment with [redacted]. In this communication he notes that [redacted] is not even using 60 tablets per month. [redacted] writes to the Registrant, "Therefore I want to terminate the remaining 960 on his partial fill prescription." The Hearing Committee considers this an example of [redacted]'s record keeping and careful attention to charting. The Hearing Committee also paid attention to [redacted]'s testimony that he does not like to prescribe using verbal orders and instead prefers written documentation. In addition, he testified that he doesn't recall speaking with the Registrant by phone for approximately three years. Finally, [redacted]'s stated practice in ensuring his prescribing is up to date is inconsistent with his agreeing in March of 2010 to revert back to a May 12, 2009 prescription for [redacted] for a part-fill of 100 tablets within a few weeks of having just prescribed a new regime of 30 tablets.

In summary, the Hearing Committee concludes that [redacted] was very unlikely to have agreed to the fax request from the Registrant. The Hearing Committee finds it is more probable than not that the Registrant did not have [redacted]s authorization to log his March 16, 2010 prescription. The Hearing Committee rejects the Registrant's testimony. The Committee further concludes that putting the two prescriptions on hold and continuing to dispense 100 tablets was contrary to the *Pharmacy Act* and Practice Regulations.

As part of this Allegation, the College claims that the Registrant dispensed quantities of Endocet greater than the quantity provided to [redacted]. The College specifically alleges that in January, February, March and April of 2010, the Registrant dispensed 100 tablets as per the patient profile but provided a lesser (unspecified) amount to the patient.

The Hearing Committee heard evidence concerning [redacted]'s usage patterns. According to [redacted]'s testimony, [redacted]s own testimony and the actual refill intervals as shown in [redacted]'s patient profile, [redacted]'s usage was considerably lower beginning in 2008. Depending upon the time period used, [redacted]'s usage was in the range of less than or equal to one Endocet per day.

The Hearing Committee accepted the College's evidence, through Janelle Gray's testimony, of [redacted]s usage. Immediately prior to the charge, [redacted] received a prescription (2203932, Exhibit 1, p.125) on May 12, 2009 for 100 tablets of Endocet. He did not return for a refill until January 12, 2010 (see Exhibit 1, p.104). His usage at this time is 100 tablets over a span of 210 days - less than one every two days. The Hearing Committee accepted [redacted]'s testimony and statement (Exhibit 1, p. 88) in which he says, "I confirmed with [redacted] (patient) on more than occasion that he was using less than one daily..." Finally, the Hearing Committee accepts [redacted]s own testimony concerning his practice habits and usage. [redacted] noted that he would take a tablet every one to two days.

The Hearing Committee considered and rejected the Registrant's assertion that [redacted] got Endocet from somewhere other than [redacted].

On the basis of its finding that immediately prior to the charge period [redacted] was using less than one tablet per day (Exhibit 1, p. 104), the Hearing Committee concludes that his usage is much less than warranted by the May 12, 2009 prescription of 100 tablets per month and the Registrant's alleged dispensing of 100 tablets per month in January, February, March and April (particulars b(i)(4-7)). The Hearing Committee earlier concluded that the Registrant had no authorization to continue dispensing 100 tablets per month during this time contrary to new, superceding prescriptions from [redacted] for lower quantities. The Hearing Committee finds that the patient's usage did not warrant 100 tablets per month and that the prescriber did want the patient to receive 100 per month.

The Hearing Committee also considered the evidence that immediately following the time period covered by the charge, the records from [redacted] show that [redacted]s usage was consistent with his usage before the charge period. [redacted] received the prescriptions for 30 tablets on May 27, 2010, June 22, 2010 and August 24, 2010. During this time his usage is less than one per day. On November 15, 2010 he received 240 tablets and when he next saw [redacted] in March 2011 he still had pills left. During this latter period his usage is approximately two per day which is consistent with his testimony that in early 2011 his need moderately increased.

The Hearing Committee concludes that [redacted]s usage was considerably less than 100 tablets per month for many months prior to the charge and consistently much less than 100 tablets per month immediately after the charge period .

As to whether [redacted] actually received the medications or not, the College, through Janelle Gray's testimony pointed to [redacted]'s patient profile as evidence that prescriptions for 100 tablets were processed on each of the four months in question. Ms Gray also reviewed the Registrant's fax of March 31, 2010 (Exhibit 1, pg. 133), to [redacted] that stated in part, "He rec'd 30 tab (1-2 q6h prn) on Mar 16/10" as evidence that [redacted] did not receive the full 100 tablets processed on that date. The Registrant states that [redacted] received the 100 tablets as processed in the computer system for each prescription and she was referring in this fax to the new prescription written by [redacted] on March 16, 2010, not the prescription she dispensed (the part fill of the May 2009 prescription).

The College also provided evidence through the testimony of [redacted] who was asked if he actually received 100 tablets in each of the four months. [redacted] testified he did not. Counsel for the College used a large white board and walked the patient through the questions of whether he received the 100 tablets. To each question the patient's response was emphatic and assured. Although [redacted] is elderly with some sight and hearing loss, his testimony was clear. Beyond denying that he received 100 tablets each month, [redacted] expanded his testimony in two respects. First he described a very consistent and clear process for taking his medications. According to the patient, he had a container on his television which he used for his Endocet. He would look at it each morning and if necessary he would add two tablets. He was clear that on many days he didn't need to add any tablets at all. Second, in response to questions from the College's counsel concerning whether he ([redacted]) received 100 tablets per month, [redacted] responded by noting that it

didn't make sense that he would have got 100 per month since he was only using a maximum of two per day during this time period. He volunteered the observation that if he received 100 per month he would have 40 left over at the end of each month and if he had 40 tablets left over he would not need to request a refill from [redacted]. The Hearing Committee found this part of [redacted]'s testimony to be clear, forthright and convincing. He was knowledgeable about his practices. His memory of his process for taking his medications was very specific and very clear. He did not waiver. His demeanor was direct.

Under cross examination counsel for the Registrant asked [redacted] to comment on a statement that was obtained at the [redacted] on April 13, 2011 (Exhibit 23, p. 4.3-4.7). In that statement, [redacted] attests "I always receive my full refills of 100 tablets except for May 27, 2010, June 22, 2010, August 24, 2010 when I received 30 tablets." He also attests "In all my dealing with Tammy Fadelle I have never been shorted." The Hearing Committee notes that each page of the statement is initialed by [redacted] and the Hearing Committee accepts it as a bona fide statement of [redacted].

On cross examination, counsel for the Registrant referred [redacted] to his statement signed in front of Registrant's counsel at [redacted]. While testifying, [redacted] was not able to read the statement without assistance. When assisted by Registrant's counsel, he confirmed his signature, on each page and that he had signed it, but for some aspects of his testimony on cross examination, he appeared to be confused. He did not seem to completely understand the statement.

The Hearing Committee therefore recognizes that [redacted]'s direct testimony is inconsistent with the statement he swore at the [redacted]. The Hearing Committee is therefore in the difficult position of having to decide whether the clear and forthright statements made to the Hearing Committee under direct examination are more credible than the statement he swore to with the Registrant's Counsel at [redacted].

Based on [redacted]'s testimony and comprehension of the statement during his appearance before the Committee, the Hearing Committee does not accept that [redacted] knew what he was swearing in the statement. The detailed responses to four specific dates Registrant's Counsel addressed appeared to the Hearing Committee to be more detailed than [redacted] was capable of recalling.

In his direct testimony, the Hearing Committee concludes that [redacted] clearly comprehended the questions and was able to provide additional information that went beyond the specific questions. His spontaneous observations about his method of setting out his pills each day and in particular, his unprompted observations that he only needs 60 per month "so why would I take 100 per month and have 40 leftover?" was convincing to the Hearing Committee and so the Committee accepts the direct testimony evidence as truthful and also as more credible than his statement provided to Registrant's Counsel at [redacted].

With respect to the issue of being "shorted" which was addressed in [redacted]'s statement sworn at [redacted], the Hearing Committee also considered the College's evidence provided by [redacted] that on two occasions he issued prescriptions to [redacted] for 30 tablets of Endocet (30 tablets on January 12, 2010 and then 120 tablets to be dispensed as 30 tablets every 6 weeks on March 16, 2010), and that [redacted], in January and then again in March, advised [redacted] that his prescription was now for only 30 tablets. For this reason, it is reasonable to conclude that [redacted] may not have expected 100 tablets per month. As well, because [redacted]'s agent always picked up his medication, he would not

be expected to be as clear on what was actually dispensed. [redacted]'s agent would also not have expected refills of 100 tablets. The Hearing Committee finds that [redacted]'s statement that he was never "shorted" is not the same as his affirmation that he received all 100 tablets.

The Hearing Committee considered the Registrant's testimony and her credibility in this matter. She attributed the possible discrepancy between the College's evidence of [redacted]'s decreased usage and the dispensed part fill intervals as being due to stockpiling by his agent [redacted] or [redacted] getting his medication elsewhere. Because [redacted]'s actual usage for a full seven months leading up to the charge period was less than one per day, the Hearing Committee rejects the testimony of the Registrant on this issue., and further based on the evidence before it, does not accept the Registrant's testimony that [redacted] must have been getting Endocet from another pharmacy.

According to the Registrant, immediately after the charge period, [redacted] was having a very difficult time getting by on the new prescription of 30 tablets every six weeks. This is not consistent with her view that [redacted]'s agent was stockpiling during the charge period to help [redacted] get by once the new prescriptions were dispensed. If [redacted]'s agent had indeed stockpiled during the charge period, [redacted] should not have had trouble coping with a decreased supply after the charge period. Nor is the evidence of stockpiling during the charge period consistent with [redacted]'s testimony and long term use following the charge period.

The Hearing Committee's decision to reject the Registrant's testimony on these issues was influenced by her evidence relating to having three concurrent prescriptions and the fax of March 31st to [redacted].

During her testimony the Registrant stated that she did not have any motive to divert [redacted]'s medication noting that if she wanted Endocet, she had a family doctor who would readily provide it. The College's evidence on this matter was that the Registrant knew she was being monitored and was apprehensive that narcotic use would be frowned upon by the College. In subsequent testimony, both the Registrant and her physician confirmed the Registrant's concern about the College's presumed reaction to the Registrant's use of narcotics. The Hearing Committee concludes that the Registrant did, in fact, have a motive for concealing any use of Endocet and based on the Registrant's testimony and her cross examination, the Hearing Committee is also aware that the Registrant suffers from back pain and has been a regular user of pain medications for many years.

The Hearing Committee finds the Registrant's testimony on this allegation to be both inconsistent and contradictory.

In summary, the Hearing Committee finds that [redacted]'s usage is inconsistent with 100 tablets per month in terms of his needs – both before and after the period set out in the Notice of Hearing on this allegation. The Hearing Committee also finds that 100 tablets per month, given his usage, would also be noticed by [redacted] or his agent if he was actually dispensed 100. As he stated, if given 100 while only using 60, he would have 40 left over. [redacted]'s usage of less than 100 a month is also supported by [redacted]. The Hearing Committee therefore finds that [redacted] didn't need a prescription of 100 tablets, didn't expect 100 tablets, or receive 100 tablets.

The Hearing Committee concludes that the College has met its burden of proof for each of the particulars set out in the Notice of Hearing relating to this allegation, and the Hearing Committee finds the conduct to constitute professional misconduct and conduct unbecoming contrary to the *Pharmacy Act* and Regulations and that she failed to comply with the laws, regulations, standards and policies of the profession as per the *Pharmacy Act*, Section 24.

The Hearing Committee finds that the Registrant violated Sections 25(4) and 25(2)(i) of the *Pharmacy Act;* Sections 2.10 and 2.20 of the Practice Regulations and as manager she did not ensure that patient records were prepared and maintained in accordance with the Standards of Practice of the Nova Scotia College of Pharmacists. The Hearing Committee finds that the Registrant's actions are in violation of the Narcotic Control Regulations, Sections 31 and 38. Furthermore, the Hearing Committee finds that because the Committee has concluded that [redacted] did not receive 100 tablets on 4 occasions in 2010 the actions of the Registrant do, therefore, constitute trafficking as per the *Controlled Drugs and Substances Act*, Sections 2 and 5. The Hearing Committee finds that the Registrant violated the Code of Ethics, in particular, Value II, and Value VI. Finally, the Registrant's lack of documentation with respect to the alleged authorization to log prescriptions and continue with part-fills concurrently violates Model Standards of Practice for Canadian Pharmacists, Professional Competency 1.8.

Allegation 5

This allegation relates to prescriptions dispensed to [redacted] and whether they were labeled improperly.

The College's evidence consisted of records from [redacted], a photograph of one of [redacted]'s pill bottles (Exhibit 1, page 136), the testimony of Janelle Gray, and an email from ProPharm. The Registrant's evidence consisted of records from [redacted], a College reference chart on prescription requirements, and the Registrant's own testimony. [redacted]'s testimony also spoke to this charge on behalf of the Registrant.

Although the College specifies two prescriptions in the particulars, no evidence was provided for the March 10, 2011 prescription.

On the basis of its review of the evidence, the Hearing Committee concludes that the Registrant labeled [redacted]'s November 15, 2010 Endocet prescription as "No Refill" even when part fills were available and that it is more probable than not that this labeling practice was intentionally designed to mislead. The reasons for the Committee's decision follow.

At issue in this allegation is the Registrant's knowledge of the practice requirement and whether she intentionally sought to take advantage of her patient's possible misunderstanding when she labeled [redacted]'s prescription with "No Refill".

The Registrant's testimony is that she did not believe that it was permitted to indicate refills on narcotic prescriptions. She testified doing so would be a breach. For this reason, she testified that she labeled all narcotic prescriptions that are part fills with "No Refills" and not only the ones for [redacted]. In her testimony, she asserts that this is her regular practice, based on her understanding of the rules, and not an intention to mislead [redacted] or others. To support this argument, she referred the Hearing Committee to Exhibit 22, p.77 that contains Prescription

Requirements for Community Pharmacists in Nova Scotia that notes "No" for refills for narcotics. In reviewing the information contained in Exhibit 22, p.77, the Hearing Committee notes that the Prescription Requirements for Community Pharmacists in Nova Scotia also stipulate "yes" for part fills for narcotics.

The Registrant further asserted that [redacted] did not indicate on any inspection that labeling all narcotics as "No Refills" was not in keeping with College regulations and policy.

The Registrant also testified about several issues related to her software system. First, she testified that software her system did not permit "Refills" for narcotic labels and that this is justification for her practice. Later, when she learned that her software does allow for such labeling, she testified that "No Refills" is the default, and thus corroboration for her practice.

In response to the Registrant's testimony, the College introduced Exhibit 50 during cross examination. Exhibit 50 is a screenshot of the Nexxsys label preferences screen and email communication from ProPharm's Manager, Pharmacy Systems Atlantic. The Hearing Committee notes that the email in this Exhibit states "I am not sure what the system default is for this field...these fields are (normally) reviewed with the user...I will be in touch when I am able to confirm what the default selection would be. Keep in mind however of the default – the user had the last ability to set that according to their needs." On the basis of this email, the Hearing Committee rejects that the default for the software is "No refills" when installed. The Hearing Committee concludes that the Registrant's software permits "repeats on narcotics" as a label preference; that the Nexxsys staff member can't confirm what the default setting was on installation; and that the user has the option to specify her requirements. The Registrant had earlier testified that information on refills was not in the user manual which she had read many times.

Support for the Registrant's contention that "refills" are not allowed on narcotic labels was provided by [redacted]. [redacted] testified that he called the Prescription Monitoring Program to find out the requirements and was told that a prescription for 1000 would be listed as 1000 in part fills of 250 (as an illustration). [redacted] confirmed that it was also his own understanding "no refills" was the correct procedure. The Hearing Committee accepts [redacted]'s testimony concerning his own understanding but rejects his expertise with respect to guidelines which govern labeling requirements for pharmacists.

The Registrant, when presented with a sample label (peel off refills auxiliary label, Exhibit 51) by the College's counsel, and asked if such a remedy would work given the Registrant's testimony that her software would not permit narcotic refills labelling, responded by affirming her view that such labels would represent a breach of the Pharmacy Regulations and that she would not use them. The Registrant's solution, to help her patients understand their therapy, was to verbally counsel them. To support this view and its efficacy, the Registrant's counsel noted in his summation that the Hearing Committee could see that the process works because [redacted] returned for his March refill.

The College's response to the efficacy of verbal counseling in lieu of proper labels was to point out to the Hearing Committee [redacted]'s testimony that his agent had been refused a refill. This is corroborated by [redacted] who notes in his statement (Exhibit 1, p.88) that [redacted] called [redacted] in January 12, 2010 saying he needed a new prescription (even though the patient was positive he

still had some). As noted in the discussion under Charge 4, [redacted] still had a valid prescription from May 2009, with many part fills not yet used. The Hearing Committee also notes that [redacted] received a new prescription from [redacted] on March 16, 2010 (Exhibit 1, page 130), written on the same day a part fill of his May 12, 2009 prescription was filled, suggesting that [redacted] was in fact not clear on the status of his prescriptions at [redacted]. Additionally, the College pointed out that during [redacted]'s testimony, the dispensing process for her prescription (for Endocet) was done entirely by [redacted]. At least in three instances then, the Hearing Committee does not agree with the Registrant's assertion that her verbal counseling was effective.

In its review of the evidence put before it, the Hearing Committee starts from the provisions in the statutes cited in the charge's particulars. The Pharmacist's duty is to help his or her patients understand their therapy and to be able to use their prescriptions safely and effectively to help achieve optimal care. This starting point was used to assess the Registrant's behavior in this case.

The Hearing Committee does not consider the Registrant's justification of her process to be internally consistent. On one hand, the Registrant contends that the issue is that she shouldn't label "refill" on a narcotic prescription. She asserts that the issue wasn't whether she could label but whether she was permitted to label. This is not consistent with her rationale that the software wouldn't allow it (first), or may allow it but is set to not enable it (second).

In the final analysis the Hearing Committee concludes

- The prescription requirements for narcotics are clear and that the distinction between refills and part fills does not pose a problem for practicing pharmacists;
- The relevant Act and Regulations make it clear that the pharmacist's duty is to her patients and that patients need help in understanding and participating in their medication therapy;
- The Registrant's contention that she was providing effective verbal counseling is not consistent with the evidence;
- [redacted] was confused and misled;
- The Registrant is an experienced pharmacist, has worked in other pharmacy practicies and knew or should have known that "no refills" on narcotics that have remaining quantities is not consistent with optimal care.

The Hearing Committee concludes that it is more probable than not that the Registrant knew or should have known what other pharmacists know when it comes to labeling narcotics and based on this conclusion, the Hearing Committee further concludes that the Registrant's continued mislabeling, in the face of [redacted]'s confusion, is evidence that the practice was intentional. This conclusion is consistent with, and supported by, the evidence presented to the Committee as part of Charge 4. The Hearing Committee finds that the College has met its burden of proof with regard to the particulars noted in (b)(i) for the November 15, 2010

prescription and also with regard to the allegation that the Registrant intentionally mislabeled prescriptions, contrary to the Pharmacy Act Sections 24 and 25(2)(c); Practice Regulations, Sections 2.1(b) and 2.13; the Code of Ethics, Value II; and the NSCP Policy Prescription Labels, and that the breaches consititute professional misconduct and conduct unbecoming.

Allegation 6

This allegation is that unusual patterns of manual adjustments were made by the Registrant at [redacted] to the computer inventory for Endocet within certain timeframes. The Hearing Committee finds that the College did not lead evidence to support the particulars of this charge as articulated and dismisses this charge in its entirety.

Allegation 7

This allegation is that the Registrant created and dispensed invalid prescriptions for Viagra, fraudulently billed insurers for those prescriptions, and failed to maintain proper records at RHP. Particular (b)(i) relates to prescriptions written for [redacted] which record the prescriber as [redacted].

The College's evidence included the testimony of Janelle Gray, patient and drug records from RHP, and testimony from [redacted]. The Registrant's evidence was based on her own testimony and related testimony of her computer problems and documentation.

In its review of the evidence, the Hearing Committee noted that patient records for [redacted] showed 8 occasions in 2009 in which he allegedly received false prescriptions, not the 10 occasions set out in the allegation. Two other occasions- including the originating prescription- occurred in 2008 (Exhibit 1, pages 188, 189, 204).

On the basis of its review of the evidence, the Hearing Committee finds that the College has met its burden of proof that [redacted]'s prescriptions were false and that on 8 occasions in 2009 his insurance company was thereby fraudulently billed for a total of 64 tablets.

Janelle Gray introduced [redacted] records related to the disputed prescription (#6710090; Exhibit 1, page 204) for Viagra. This disputed verbal order from September 8, 2009 was originally authorized for a quantity of 56 tablets. According to prescription records from [redacted] (Exhibit 1, pg 208), this prescription was altered to allow the total quantity authorized to increase from 56 to 200. Ms. Gray testified that this allowed the prescription to be filled ten times, instead of the seven fills reputedly authorized by the original verbal order. The Registrant asserts that this change was due to either the software conversion from QS1 to Nexxsys or due to deceit by her employee, [redacted].

[redacted] testified that [redacted] is his patient, that he had prescribed erectile dysfunction medications for him, and that he first prescribed Viagra for him on November 10, 2009. The Hearing Committee found [redacted] to be credible, based on his attitude and demeanor; his testimony with respect to process, procedure and policies related to his prescribing practice; the consistency between the prescriptions he acknowledged and his practice; and finally his

testimony that he does not recall authorizing it. Overall, the Hearing Committee found [redacted]s testimony to be internally consistent. The Committee was also persuaded by his evidence of record keeping. Throughout his testimony, [redacted] referred to his records using his laptop.

[redacted] testified that:

- His practice is to prescribe in quantities of 4 tablets. While not claiming he always prescribes 4 tablets at a time, he stated that this is his normal practice. The allegedly false prescriptions were for 8 tablets. Beginning with the November 12, 2009 prescription (#7205275; Exhibit 1, page 188) which is the first prescription that [redacted] acknowledges writing, 4 tablets are dispensed, which is consistent with his usual practice;

- The original prescription, a verbal order (#6710090; Exhibit 1, page 204) which [redacted] does not recall authorizing, is for 6 refills. [redacted] testified that he typically does not provide six refills; he provides 5 refills when he is prescribing for a 6 month period.

- [redacted] has very clear records of his prescribing for [redacted] His records show him providing [redacted] in 2007 with Cialis and Levitra (his records were precise enough for him to know the Cialis was provided by way of 'sampling') and only acknowledges prescribing Viagra, for the first time on November 10th, 2009 (#7205275, Exhibit 1, page 188)).

The Hearing Committee concludes it is improbable that [redacted]s first prescribing of Viagra would occur via a disputed telephone order he does not recall. On cross examination, [redacted] was asked if it was possible that he gave this verbal telephone order for Viagra. He answered that 'anything is possible' but also noted that he has no record of the prescription, does not recall talking to the Registrant for several years and noted explicitly that he likes to write all his prescriptions specifically to avoid misunderstandings.

The Hearing Committee, on the basis of its observations of [redacted] and his testimony, concludes his testimony is credible.

The Registrant's testimony is that the verbal order of September 30th, 2008 was a telephone conversation with [redacted]. She asserts that she had authorization and testified that [redacted] filled the prescriptions and, after the Registrant signed them, [redacted] took them home. She argues further that [redacted] is busy and that his records can't be relied upon. The Hearing Committee also heard evidence from [redacted] that in his personal opinion, doctors who claim to always chart everything are wrong.

The Registrant testified that the verbal order is valid. She recalls no details of the circumstances of the verbal order. She did not testify why, or attempt to explain why, the prescription was for a drug not used for this patient before. She says she interpreted 6 months to be an original fill plus six refills, not five. She offered no testimony regarding the frequency

with which [redacted] gives verbal orders. She offered no testimony that contradicted [redacted]'s testimony as to his prescribing practices or procedures.

On balance, the Hearing Committee finds [redacted]'s testimony to be more credible than the Registrant's. The Hearing Committee concludes that the prescriptions for Viagra that were dispensed to [redacted] on eight occasions in 2009 for 64 tablets were false. The Hearing Committee finds the College has met the burden of proof, that these prescriptions were false, and as they were billed to the patient's insurer, the Hearing Committee also finds the billing to be fraudulent. These actions breach sections 24, 25(2)(l) and 25(5) of the *Pharmacy Act*; Practice Regulations 2.1(b), 2.10 and 2.14 (1), 2.20, the *Food and Drug Act*, Section 15, Food and Drug Regulations C.01.041 (1.1), Value VI of the Code of Ethics, and Model Standards of Practice Professional Competencies 1.8 and 5.3. The Hearing Committee does not find there has been a breach of Practice Regulation 2.1(g).

Particular 7(b)(II)

Particular 7 (b)(ii) alleges that on 14 occasions between January 2009 and December 2011, the Registrant created false prescriptions while fraudulently collecting from the insurer for 112 tablets of Viagra for [redacted].

The College's evidence consisted of records and testimony from Janelle Gray and from the testimony of [redacted]. The Registrant's defense was based on her own testimony and the testimony of [redacted].

On the basis of its review of the evidence, the Hearing Committee finds that the Registrant created false prescriptions and thereby fraudulently collected reimbursement from [redacted]'s insurer on 13 occasions for a total of 104 tablets. The College's particulars state the time period is from January 2009 to December 2011, but evidence from page 209-10 of Exhibit 1 includes one prescription from September 2008 which is not included in the charge period. This prescription would be the first of the 14 occasions if it had been included in the specified time frame of the allegation.

The College alleges that three separate false prescriptions were entered into the [redacted] records as verbal orders. All three listed [redacted] as the patient and [redacted] as the prescriber. The prescriptions are #701903 (Exhibit 1, page 211), #6709669 (Exhibit 1, page 212), and #7219462 (Exhibit 1, page 213).

[redacted] testified that [redacted] was one of his patients. [redacted] however testified that he had no recollection of prescribing Viagra to [redacted] on the three occasions in question. He further testified that he keeps records of every prescription he authorizes and that he regularly charts his prescribing activity. During his direct testimony and under cross examination, [redacted] reaffirmed his procedures. He didn't waiver in terms of his avowed and particular process for prescribing and charting.

[redacted]'s testimony was that he asked the Registrant for a Viagra refill and that she told him she would have to confirm with [redacted]. [redacted] testified that he did this on a Saturday and testified he was present when the Registrant left a message on [redacted]'s phone indicating that unless she heard back from him, she would renew [redacted]'s prescription. [redacted] received his prescription

from the Registrant early the next week. He testified he didn't know the quantities authorized or number of refills, only remembering that he got his pills.

The Registrant testified that she probably shouldn't have taken 'no response' from [redacted] as confirmation of the prescription's validity and that this was not "good procedure". When asked about this during cross examination she noted, "I can't tell you if he ([redacted]) didn't call back, that's what happens in my world". The Registrant pointed out that she was only trying to sincerely help [redacted] and [redacted].

The Hearing Committee received [redacted]'s evidence as support that he needed a prescription and received his tablets. His testimony did not address the legitimacy of the prescriptions.

The Hearing Committee finds the Registrant's testimony to be indicative of a casual approach to prescribing and dispensing and a lax regard for procedures. The Registrant testified that she probably should have acted differently.

The Hearing Committee considered [redacted]'s testimony to be very credible. That testimony went beyond the Registrant's defense in two important areas. First, [redacted] testified that when he is given a phone message, he also gets the chart and he is particular about charting. Second, [redacted]'s testimony was that he has no recollection of any verbal order- not just the one the Registrant claims to have received by means of her phone message. As presented by Janelle Gray, there are three verbal order prescriptions, not just one. The Registrant only speaks to one of these. The patient, [redacted] only speaks to the same one. The Registrant did not testify as to the validity of the two remaining verbal orders attributed to [redacted].

In summary, the Hearing Committee finds that the Registrant created false prescriptions and thereby fraudulently collected reimbursement from [redacted]'s insurer on 13 occasions for a total of 104 tablets. Its finding is based on [redacted]'s lack of knowledge of the legitimacy of these prescriptions, its acceptance of [redacted]s testimony, and rejection of the Registrant's testimony on this allegation and the lack of any contradiction, in the Registrant's testimony, of [redacted]s evidence with regard to the remaining two verbal orders., By virtue of these prescriptions being false, and billed to [redacted]s insurer, the Hearing Committee also finds that the billing was fraudulent. As such, the Hearing Committee finds the College has met its burden of proof and finds that the Registrant has breached sections 24, 25(2)(i) and 25(5) of the *Pharmacy Act*; Practice Regulations 2.1(b), 2.10 and 2.14 (1), 2.20, the *Food and Drug Act*, Section 15, Food and Drug Regulations C.01.041 (1.1), Value VI of the Code of Ethics, and Model Standards of Practice Professional Competencies 1.8 and 5.3.The Committee does not find that there has been a breach of Practice Regulation 2.1(g).

Particular 7(b)(iii)

The College alleges that its analysis of the records of [redacted] shows a significant discrepancy of tablets between April 29th 2009 and January 24, 2011. Specifically, it is alleged that there were three days of purchases of Viagra that should be in the computerized inventory but which were not. Furthermore, the College alleges that there are unusual patterns of manual adjustments to the inventory.

The College's evidence includes records from [redacted], an analysis of the comparative number of adjustments of Viagra at similar pharmacies that also use Nexxsys software, and the testimony of Janelle Gray. The Registrant's evidence is based on her ongoing difficulty with her computer software system, especially as it relates to inventory.

On the basis of its review of the evidence presented, the Hearing Committee does not find that the College has met its burden of proof.

Considerations taken into account by the Hearing Committee include the following:

- The number of manual adjustments at [redacted] compared with other pharmacies;
- The pattern of manual adjustments;
- The explanation underlying discrepancies in purchases, sales and computerized inventory counts

The Hearing Committee agrees that the number of manual adjustments at [redacted] is far greater than at comparator pharmacies with a similar or higher volume also using Nexxsys. The College found 13 adjustments at [redacted] for Viagra during the period in question compared to no adjustments in three other stores and two adjustments at a fourth pharmacy.

The Hearing Committee agrees with the College that it is very unusual to have two manual adjustments on the same day for a product for which [redacted] has few patients. Moreover, there were two manual adjustments on the same day on four separate days.

The Hearing Committee also accepts evidence introduced by Janelle Gray that the computer records at [redacted] do not align with McKesson's shipments. However, the Hearing Committee saw no evidence to say that the tablets which were purchased and not in the computer inventory record were not actually in the store- despite not being accurately recorded in the computer.

The discrepancy between what was purchased and dispensed can't, in the Hearing Committee's view, be explained by the computer record unless augmented by a physical count. Furthermore, [redacted] did not testify, so no evidence is available to say he did not receive the Viagra that [redacted] claims to have dispensed, and [redacted] did testify to say he did receive all his medication. Janelle Gray's testimony that Viagra was dispensed but not received by the patient does not persuade the Hearing Committee. Without a more robust explanation for the discrepancy, the issue of manual adjustments is admitted to be unusual in both pattern and number but not proven fraudulent in intent. The activity represents poor record keeping but is not of a magnitude or severity (Viagra is not a controlled substance) to support a professional misconduct conclusion.

The Hearing Committee finds the College has met its burden of proof with regard to particulars (i) and (ii) related to the false creation and dispensing of Viagra to [redacted] and [redacted] and to fraudulent billing of those prescriptions to the patients' respective insurers. The Hearing Committee dismisses particular (iii) related to inventory.

The Hearing Committee finds the Registrant's behavior constitutes professional misconduct and conduct unbecoming.

Allegation 8

This allegation is that the Registrant created false documents, dispensed without a valid prescription and fraudulently billed for those prescriptions. The formal charges, amended November 22nd, 2011 via the pre-hearing administrative conference call, reduced the number of alleged false prescriptions and capsules. The final particulars specify that the Registrant dispensed Xenical 9 times without a valid prescription for a total of 270 capsules.

Evidence for the College included investigative material gathered by Cindy Ingersoll and Janelle Gray as well as testimony by Janelle Gray. Defence evidence was provided by [redacted] and the Registrant.

The Hearing Committee finds that the College has not met its burden of proof in relation to this allegation. Although there are unresolved concerns related to the Registrant's dispensing habits in this charge, the absence of direct testimony from the physician who denied authorizing the disputed verbal orders led the Committee to find as it did. The reasons follow.

According to the College, [redacted]'s prescriptions for Xenical were not legitimate fills as authorized in [redacted]'s January 7th, 2010 return fax (Exhibit 40) to the Registrant. Exhibit 1, pg. 239 is a statement from [redacted] in which he recalls authorizing [redacted]'s renewals for Xenical, including four refills. In this statement, and in an earlier and revised statement presented by the Registrant (Exhibit 39), [redacted] confirms that the only prescriptions he authorized were based on the January 7th, 2010 fax sent by the Registrant.

According to the Registrant, earlier correspondence between [redacted] and Cindy Ingersoll of the College (Exhibit 39) is evidence that the College misled[redacted]. The Hearing Committee rejects this allegation. It is clear that the statement provided in Exhibit #1, page 239 incorporated the revisions [redacted] made to Cindy Ingersoll's draft statement of her March 14th, 2011 conversation with him. As such, the evidence before the Hearing Committee is that [redacted] denies authorizing Xenical for [redacted] except in January 2010. Evidence presented by Janelle Gray was that [redacted] falsely received 9 prescriptions of 30 capsules from May 5, 2010 to January 12, 2011 (Exhibit 1, page 224) rather than receiving what the College asserts was the valid January 2010 prescription and 4 refills. These 9 occasions, for 270 capsules, are at issue.

According to the testimony of [redacted], his family doctor [redacted] was leaving her practice and he would eventually need to find a new doctor. [redacted] testified that he spoke with the Registrant who advised him that he would need prescriptions soon. [redacted] then asked [redacted]- who the patient was seeing for a different condition- to help him out. According to [redacted], [redacted] agreed and told [redacted] to have the Registrant call him with the list of required medications.

According to the Registrant, she faxed (Exhibit 22, pg 285) a list of the required medications to [redacted] on January 7th, 2010 (as noted in [redacted]'s statement). [redacted]'s notation on the fax (Exhibit 40) which he says he returned to the Registrant, specifies 30 capsules of Xenical with 4

refills. The Registrant asserts that she never got this fax and because [redacted] had remaining refills from prescriber [redacted], she did not pursue it.

When, according to the Registrant, the refills from [redacted] were depleted, she called [redacted] to follow up on her January fax. She testified that during their phone conversation, [redacted] authorized one year of renewals and asked the Registrant to fax him, for his records, documentation which the Registrant says he needed because [redacted] is a methadone doctor and doesn't normally follow patients' other medical needs.

The Registrant eventually faxed a request to [redacted]- intended, she asserts, for his records and not as authorization inasmuch as she claims she had already received verbal authorization during the May phone conversation. The June fax (Exhibit 1, page 238) to [redacted], lists the required medications. [redacted], in his statement, acknowledges receiving the fax but denies doing anything with it. He also says he has no recollection of any telephone conversation with the Registrant about this fax.

The Hearing Committee took the following factors into consideration during its deliberations:

- [redacted]'s statements (Exhibits 37 and 39) which are clear, and after the revisions he made to Cindy Ingersoll's draft, internally consistent;
- [redacted]'s history of Xenical use;
- [redacted]'s willingness to prescribe for [redacted];
- Prescriptions authorized by [redacted]'s family doctor, [redacted] (Exhibit 18)

According to the Registrant, [redacted]'s prescription for Xenical (Exhibit 18) permitted refills for one year following the March 19th, 2009 original prescription (#6713227). This is consistent with the Registrant's testimony that the January fax to and from [redacted] (Exhibit 40) was in anticipation of [redacted] needing renewals but which were not critical at that time as [redacted] still had valid refills from prescriber [redacted] remaining. The Registrant denied ever receiving the fax (Exhibit #40) back from [redacted] authorizing (only) 4 refills. Instead, she says she used [redacted]s prescription until May, and then called CBL. The Hearing Committee accepts this to be a plausible explanation. Based on the Registrant's practices, if the Registrant had received the January fax back from [redacted], she would likely have kept it until [redacted]s refills had expired. The refills prior to May are from [redacted]. In May and June when she has no authorization, she testified she called/faxed [redacted]. Had she received the January fax back from [redacted] the Hearing Committee concludes she would not have obtained further authorization until five months after [redacted]s prescriptions had run out in May 2010. For these reasons, the Hearing Committee believes the Registrant did not receive [redacted]'s return fax.

What cannot be explained with this rationale is the following:

- Why the Registrant, who asserts that the June fax (Exhibit 1, page 238) was only for [redacted]'s use, and not her own use because she had already received verbal authorization by phone in May, would clearly label this fax with a fax back # and a space for [redacted]'s signature. If only for [redacted]'s use,

these would not be needed. Nor does the fax say anything about the phone conversation. In fact, it starts with a preamble that would make more sense in the January fax.

An alternative explanation is that the May conversation did not occur and because the Registrant did not receive the January fax authorizing refills, the fax she sent in June needed the physician's signature and she needed to have it faxed back. If this is true, and she did not receive the June fax back, and [redacted] states he did not sign or return it, then the Registrant improperly took 'no response' to be authorization for a long list of medications beginning in June of 2010.

The May conversation is therefore important. If it occurred, there would be no need for [redacted] to return the fax to the Registrant. If the call did not occur, the June fax is a required authorization which was not signed thereby making the original and all refills invalid. [redacted] in his statement indicates he has no recollection of the alleged May telephone call. The Registrant testified before us that it took place. The issue hinges on this call and therefore rests on the credibility of the Registrant and [redacted], and the nature of the evidence before the Hearing Committee.

Because [redacted] did not testify, the Hearing Committee did not have an opportunity to hear his testimony; the Registrant's counsel had no opportunity to cross examine him and the Hearing Committee has no insight into his practice that would help us understand whether the May telephone conversation did or did not take place.

For the reasons noted above, the Hearing Committee finds that College has not met its burden of proof and dismisses this allegation.

Particulars 8 (b)(ii)

The College alleges that between April 29, 2009 and January 24th, 2011, [redacted] sold more Xenical (738) than it bought (588) and further alleges that an unusual pattern of manual adjustments occurred.

Evidence for the College consisted of computer records from [redacted], McKesson data, and the testimony of Janelle Gray. Evidence for the Registrant consisted of her own testimony, additional [redacted] records, as well as related evidence provided in the testimony of [redacted].

On the basis of its review of the evidence, the Hearing Committee finds that the College has not met its burden of proof for this part of the allegation. The reasons follow.

In terms of the discrepancy in capsules, Janelle Gray provided evidence (Exhibit 1, page 241) on behalf of the College that 738 capsules of Xenical were sold but only 588 were purchased (Exhibit 1, page 240). Ms Gray testified that such a discrepancy is a violation of the requirements for proper record keeping and is an indication of fraud.

According to the Registrant, the discrepancy can be explained by her testimony that her computer system is problematic, and that a patient ([redacted]) returned some Xenical and the Registrant refunded the purchase price, and returned the stock to inventory. The Registrant then testified that she re-dispensed the capsules to [redacted].

In the view of the Hearing Committee, the returning and re-selling of [redacted]s Xenical, while inappropriate, does help to explain some of the discrepancy, and earlier in testimony, Janelle Gray noted that she did not do a count of opening inventory. The Hearing Committee believes that a count of opening inventory may have also helped to explain additional discrepancies. At the time, the Registrant had two patients using Xenical- [redacted] and [redacted] It would not be unreasonable for the Registrant to have inventory on hand. This opening inventory, when added to the purchases, may help to reconcile the shortfall between what was purchased (McKesson data in Exhibit 1, page 240) and what was sold ([redacted] data in Exhibit 1, page 241). For these reasons, the Hearing Committee was not prepared to conclude that a significant discrepancy exists between the Registrant's purchases and sales.

In terms of manual adjustments, the Hearing Committee accepts the evidence of the College presented through Janelle Gray that the number and pattern of manual adjustments are irregular. The Hearing Committee heard the evidence of the number of manual adjustments in similar practices (Exhibit 1, page 243) . During the same time period, Exhibit #1 page 243 documents eight manual adjustments for Xenical at [redacted], and no manual adjustments at all in four other comparator pharmacies using the same software.

Similar to its deliberations on Charge 7 however, while the Hearing Committee accepts the evidence of unusual manual adjustments, if the discrepancy of capsules can be reconciled, if the drug is not targeted or controlled, and if the patient's testimony corroborates that they received the medication, the issue of manual adjustments becomes one of irregular inventory adjustments.

In this case, while there is clear evidence of inventory issues at [redacted], Xenical is not a targeted or controlled substance and the Hearing Committee is inclined to treat the manual adjustments with less rigor because there is no evidence of diversion. As noted by [redacted] during his testimony, he has been on Xenical for a long period of time and appeared to the Hearing Committee to be sincere and credible in his assertion that he needs the medication, and gets it.

The Hearing Committee therefore dismisses Particular 8 (b)(ii).

Based on the Hearing Committee's finding that neither Particular (b)(i) or (ii) have been proven, allegation 8 is dismissed.

Allegation 9

This allegation was withdrawn by the College.

Allegation 10

This allegation is that the Registrant failed to provide optimal patient care to [redacted]. The particulars (b)(i) state that the Registrant dispensed 200 tablets of ("LOR") (1mg) to [redacted] aged 92. The prescribing doctor was [redacted], a surgeon practicing in Manitoba who is not [redacted]'s primary doctor. Furthermore, [redacted] was already receiving LOR and diazepam at the time. The College alleges that neither [redacted] nor [redacted]'s primary care provider, [redacted], were aware of each other's full prescribing for [redacted].

The College's evidence was provided through the testimony of the Deputy Registrar, Bev Zwicker and various patient and drug records from [redacted]. The Registrant's evidence consisted of her own testimony, records from [redacted], and a Digby Hospital discharge calendar for [redacted].

On the basis of the evidence before it, the Hearing Committee concludes that the Registrant breached the Act, regulations, Code of Ethics and standards of practice as articulated in the Notice of Hearing. However, the Committee does not believe that the Registrant's breaches meet the threshold of professional misconduct or conduct unbecoming. The reasons follow.

The College, through the testimony of Ms. Zwicker, raised several concerns with the Registrant's practices related to [redacted]'s care. In the College's summation, discussed further below, the College asked the Hearing Committee to note in both this, and other allegations, the LOR trail. LOR is a drug that appeared several times throughout Hearing testimony, and specifically in relation to Allegations 1 and 3, in addition to 10. However, the College did not lead any evidence to support diversion, nor any evidence to suggest JP did not prescribe LOR legitimately in relation to [redacted], so the Hearing Committee's review of the evidence is restricted to its assessment of this specific allegation.

The Hearing Committee's review of the evidence on optimal care included the use of multiple doctors for benzodiazepines; multiple benzodiazepines for a single patient, the role of the pharmacist in collaborating and ensuring collaboration among prescribers; the actual prescription itself including its quantity and indicated use, and finally, the patient's age, circumstances and relationship with the Registrant and one of the prescribers.

Turning first to the issue of the number of doctors and the extent of collaboration among them, including the pharmacist's expected, and actual role, the College's evidence shows that three physicians are listed in [redacted]'s patient profile (Exhibit 1, pages 249-258) for benzodiazepine prescriptions. The Registrant clarified that only two were involved, that the prescriptions authorized by prescriber [redacted] resulted from a data selection error in filling the prescription and that these prescriptions were really authorized by [redacted]. The College accepted this explanation.

With the remaining physicians, evidence was reviewed concerning their knowledge of each other's prescribing and the role that is expected of the pharmacist. The College evidence was that [redacted] did not know [redacted] was prescribing (Exhibit 45) LOR, and that [redacted] would have investigated further if he had known. [redacted] is [redacted]'s primary doctor.

In terms of [redacted], the Hearing Committee was not presented with any evidence that he was unaware of [redacted]. Because [redacted] is the Registrant's ex-husband, and would know [redacted] as the Registrant's grandmother, the Hearing Committee accepts that he would be somewhat familiar with [redacted]'s therapy. The Hearing Committee does not accept though that a surgeon in Manitoba is a logical or preferred choice for prescribing LOR to an elderly patient, regardless of his familiarity with the patient- especially when the patient has a family doctor.

The Hearing Committee does not accept the Registrant's explanation for why [redacted] has prescribed LOR regularly for [redacted] and only LOR. The Registrant testified that on multiple occasions over several years, she was unable to get in touch with [redacted]'s family doctor to reorder

LOR. She also testified that she would not loan LOR to [redacted] as she was not on familiar terms with [redacted]. The Hearing Committee does not accept this. [redacted] is the Registrant's grandmother and the Registrant has loaned benzodiazepines to at least one other patient in the past. Therefore, on the issue of the role of the pharmacist when a patient has multiple doctors, the Hearing Committee concludes that the Registrant's behavior breaches section 1.5 of the Model Standards of Practice related to effective consultation. There is no apparent need for the Registrant to ask a Manitoba surgeon to prescribe LOR over a period of several years. Further, the Hearing Committee finds that the Registrant failed to consult or advise [redacted] that [redacted] was prescribing LOR.

Turning to the issue of multiple benzodiazepines, Ms. Zwicker presented evidence that [redacted] was getting two different benzodiazepines- LOR and diazepam- at the same time. The Registrant testified that both prescriptions were valid and were prescribed by a competent physician; that such prescribing was found in [redacted]'s profile in the past, and that she is not accountable for the physician's prescriptions. The Hearing Committee is inclined to accept that although concurrent and different benzodiazepines are a concern, such prescribing patterns are not uncommon in practice.

Turning now to the use of LOR for this patient, at this quantity, and for the indicated use, the Hearing Committee reviewed the following evidence. On the issue of the July 2nd 2009 [redacted] prescription for 200 (1mg) LOR for [redacted], at the same time that [redacted] was receiving monthly supplies of LOR 1mg (30 tablets) from [redacted], the Registrant testified that based on the Registrant's conversations by telephone with [redacted] in Manitoba, it was identified that [redacted] should have 'extra' LOR, in a dose that was double the needed strength of 0.5 mg, to keep in her walker so that [redacted] would not need to get her other LOR from upstairs. As noted above, the Registrant did not advise [redacted]'s family doctor of this therapeutic plan.

In terms of optimal patient care:

- Two hundred tablets is a very large quantity to dispense to an elderly patient. In this population, best practice is commonly understood to be aiming to reduce the usage of benzodiazepines. Beyond the quantity itself, the Hearing Committee also took into account that the [redacted] prescription of 200 on July 2nd, 2009, was only one week after [redacted] received 30 tablets from [redacted] on June 23rd and only three weeks before she received another 30 tablets from [redacted]. In a time span of one month, [redacted] therefore received three prescriptions for LOR (1mg) for a total of 260 tablets (Exhibit 1, page 259). Regardless of mitigating circumstances, the Hearing Committee finds this to be an unnecessary risk for the patient.

- One mg dosages require that the tablet be broken to satisfy the Registrant's claim that [redacted] wanted [redacted] to take 0.5 mg, despite the fact that a 0.5 mg dosage form is available. Bev Zwicker testified that this stretched credulity. The Registrant argued that her mother was the caregiver and could break the tablets. The Hearing Committee finds this to be unusual.

- A second prescription for LOR to provide a second source of supply makes no sense. If the patient's needs for LOR increased, the primary health care provider should be advised, and if indicated, the primary health care provider can increase the quantity prescribed. That a second source was necessary to avoid using the first, or to have a second source in the patient's walker rather than have the patient have some of her first supply readily available, is not optimal care.

- LOR for muscle spasms is not a typical first-line drug therapy, particularly long-term and in the absence of a primary care physician's physical assessment (Model Standards of Practice 1.4). The Registrant's counsel argued that drug experts were not called to give evidence to support the College's position. In this case, the Registrant testified that the [redacted] prescription for 200 LOR for muscle spasms, was a legitimate prescription and she filled it. She noted "I'm not accountable for [redacted], just for filling the prescription he ordered." The Hearing Committee finds that the Registrant's behavior and rationale demonstrate that she abdicated her responsibility to apply her professional judgment.

As part of its defence, counsel for the Registrant noted that Schedule B of the Notice of Hearing page 0010 of Exhibit 1, states that [redacted] was dispensed two different benzodiazepines (LOR and diazepam) on May 26, 2009,, both original prescriptions- one from [redacted] and one from [redacted].

Counsel for the Registrant noted that if true, this schedule would document that the Registrant must have been able to reach [redacted] on that day which is contrary to her testimony that she only ever asked [redacted] to prescribe when she couldn't reach [redacted]. The Registrant was able to show that the [redacted] prescription was in fact a refill. For this reason, it could not be claimed that [redacted] was available on the same day that [redacted] prescribed LOR. The College agreed that the [redacted] prescription was a refill.

The Hearing Committee therefore did not conclude that [redacted] was available on May 26th, 2009, the same day as [redacted] prescribed LOR. Counsel for the Registrant returned to this issue in his summation. The Hearing Committee found it to be insignificant that there was an incorrect use of the term 'original' for prescription #6713665. Having said this, the Hearing Committee accepts the College's argument that it is not probable that the Registrant would only ever need to use [redacted] for LOR (and no other medication) over a number of years because on all these occasions she was not able to reach [redacted]'s primary health care provider. The Hearing Committee does not accept the Registrant's testimony that [redacted]'s unavailability was the reason she used [redacted] for [redacted]'s LOR.

To summarize, the Hearing Committee acknowledges that concurrent prescriptions for different benzodiazepines are not optimal but do occur in practice. The Hearing Committee also notes that having more than one doctor prescribing benzodiazepines is not optimal, but does occur. The Hearing Committee finds the need for a prescription for 200 LOR tablets (of 1mg) to be used in doses of 0.5 mg to be very unusual, but no evidence was led to dispute the validity of the prescription.

The Hearing Committee does not accept the Registrant's assertion that it was necessary to involve [redacted] given the evidence heard. This necessity, when coupled with the Registrant's failure to collaborate with [redacted], and the Registrant's stated view that she had no responsibility to review [redacted]'s prescription for appropriateness for this elderly patient given its quantity, dosage and indicated use, leads the Hearing Committee to conclude that the Registrant failed to exercise her professional judgment.

Specifically, the Hearing Committee finds that the Registrant breached Sections 24, 25(1), and 25(2) (d) and (f) of the *Pharmacy Act*; Practice Regulations 2.10 and Professional Competencies 1.4 and 1.5 of the Model Standards of Practice; and the Code of Ethics Values I and II.

Despite its conclusions regarding the Registrant's active role in actually creating a non-collaborative approach to [redacted]'s care and for not exercising her professional judgment, the Hearing Committee does not find that there is evidence that this behavior endangered the patient. The patient is the Registrant's grandmother, was being cared for by the Registrant's mother who is an [redacted], and lives close to the Registrant. The Hearing Committee concludes that the Registrant would not jeopardize her grandmother's health. The Hearing Committee finds it difficult to reconcile the Registrant's role in [redacted]'s care with her stated insistence that she has her grandmother's best interest in mind. Counsel for the College has requested that the Hearing Committee 'follow the trail of LOR' in the various charges. The Hearing Committee accepts that such a trail exists, and also accepts that this would explain the Registrant's behavior with respect to Allegation 10. But on the basis of the evidence before it and while finding several breaches, the Hearing Committee does not find the Registrant's care of [redacted] to have reached the threshold of professional misconduct or conduct unbecoming.

8. SUMMARY OF FINDINGS

By way of summary, the findings of the Hearing Committee, for the reasons set out above are as follows:

Allegation 1
- Particular (a)- proven
- Particular (b)(i)- proven
- Particular (b)(ii)-proven
- Particular (b)(iii)-proven

Allegation 2
- (a)- proven
- Particular (b)(i)-proven

Allegation 3
- (a)-proven
- Particular (b)(i)-proven

Allegation 4
- (a)- proven

Particular (b)(i) 1-8-proven

Allegation 5
(a)-proven
Particular (b)(i)- proven with respect to the November prescription

Allegation 6
(a)- dismissed
Particular (b)(i)-dismissed

Allegation 7
(a)-proven
Particular (b)(i)- proven for 8 occasions
(ii)-proven for 13 occasions
(iii)-dismissed

Allegation 8
(a)- dismissed
Particular (b)(i)- dismissed
(ii)- dismissed

Allegation 10
(a)-proven in part
Particular (b)(i)- proven in part

9. **Sanctions**

The Hearing Committee will reconvene March 5th, 2012 at the offices of the College to hear submissions from counsel as to sanctions.

Signed on behalf of the Hearing Committee by the Chair

Dated: Feb 24, 2012

Per: _____
Susan Halliday Mahar, Chair