ALBERTA COLLEGE OF PHARMACISTS

IN THE MATTER OF
THE HEALTH PROFESSIONS ACT

AND IN THE MATTER OF A HEARING REGARDING THE CONDUCT OF
VALAYKUMAR RAJGOR

DECISION OF THE HEARING TRIBUNAL

October 11, 2017

I. INTRODUCTION

The hearing tribunal held a hearing into the conduct of Valaykumar Rajgor. In attendance on behalf of the hearing tribunal were Peter Macek, chairperson, Christopher Heitland, pharmacist, Tanner Bengry, pharmacist and Nancy Brook, public member. Katrina Haymond acted as independent counsel to the hearing tribunal.

The hearing took place on the 12th day of September 2017 at the second floor conference center, 8215 112 St NW, Edmonton, Alberta, T6G 2C8. The hearing was held under the terms of Part 4 of the *Health Professions Act*.

In attendance at the hearing were James Krempien, Complaints Director and Craig Boyer and Annabritt Chisholm (student-at-law), legal counsel for the Complaints Director. The member, Mr. Rajgor attended along with his legal counsel Dennis Bayrak.

II. PRELIMINARY AND JURISDICTIONAL ISSUES

Neither of the parties applied to close the hearing, or any part of it, to the public. There were no objections to the composition of the hearing tribunal or the jurisdiction of the hearing tribunal to proceed with a hearing. There were no objections to the timeliness of service of the Notice of Hearing under s. 77(a) of the Act.

III. ALLEGATIONS

The Notice of Hearing was entered into the record as part of an Exhibit Book, marked as Exhibit 1. The Notice of Hearing alleged that Mr. Rajgor:

1. Between November 2, 2016 and January 23, 2017 (a period of 82 days) dispensed 614 zopiclone 7.5 mg tablets (a 307 day supply) to your patient (referred to as "[redacted]") during 12 separate pharmacy visits;

2. Between November 29, 2016 (the date on which you first prescribed [redacted] zopiclone) and January 23, 2017 (56 days) prescribed 444 zopiclone 7.5 mg tablets (a 222 day supply) to [redacted] during 8 separate pharmacy visits;

3. Accessed [redacted]'s PIN profile on 14 separate days between November 30, 2016 and January 20, 2017 and therefore had access to [redacted]'s detailed chronological prescription history and saw, or should have seen that:

    a. On 30 separate occasions between January 17, 2016 and January 9, 2017, pharmacies had refused to sell [redacted] Tylenol #1 (or equivalent) products;

    b. On March 4 and December 23, 2016 pharmacies had refused to dispense [redacted] zopiclone and stated their reasons for refusal;

c. In the 56 days, just prior to [redacted] receiving her first zopiclone prescription at your Medicine Shoppe #377 on November 2, 2016, she had obtained 451 zopiclone tablets (prescribed to be a 301 day supply) prescribed by 10 different physicians and dispensed by 10 different pharmacists;

d. Between November 2, 2016 (the first date on which zopiclone was dispensed by your Medicine Shoppe #377) to January 23, 2017, [redacted] made 30 pharmacy visits and received 1337 tablets, equaling an 831 day supply – 12 of these visits were to your Medicine Shoppe #377 for 614 tablets and there were 18 other visits to 13 other pharmacies for 723 tablets;

e. In the 82 days prior to [redacted] first being prescribed zopiclone by you on November 29, 2016, she had made 17 pharmacy visits and received 641 zopiclone tablets equaling a 401 day supply. Moreover, of these 17 pharmacy visits, [redacted] visited 12 different pharmacies and received prescriptions from 11 different prescribers (all physicians);

f. Between November 29, 2016 (the first date on which you first prescribed [redacted] zopiclone) and January 23, 2017 (56 days), [redacted] made 26 pharmacy visits and received 1147 zopiclone tablets equaling a 731 day supply, including 8 visits to you (receiving prescriptions for 444 tablets) and 18 visits to a physician (16 different physicians);

g. Between November 2, 2016 (the date on which [redacted] was first dispensed zopiclone at your Medicine Shoppe #377) and November 29, 2016 (the date on which you first prescribed [redacted] zopiclone) which was a period of 27 days, your Medicine Shoppe #377 dispensed [redacted] 190 tablets equaling a 100 day supply;

4. Failed to note that [redacted]'s prescription history both prior to and subsequent to your involvement showed that she was clearly diverting zopiclone far beyond her personal use and may have also been personally misusing zopiclone in that the PIN profile showed that [redacted] was receiving the equivalent of approximately 13 zopiclone 7.5 mg tablets daily and it would not be clinically possible for one individual to ingest this quantity of tablets daily for a 138 day period and still present as "always normal" during her approximately weekly visits to Medicine Shoppe #377;

5. Accepted [redacted]'s statements that she had lost her zopiclone or it had been stolen when these accounts were not credible having regard to the many past refusal reasons listed by other pharmacies in [redacted]'s PIN profile and when a reasonable pharmacist reviewing this PIN Profile should have determined the implausibility of [redacted]'s accounts of her zopiclone loss;

6. Failed to properly collaborate with the numerous other prescribers and dispensers of zopiclone involved in [redacted]'s care and did not proactively collaborate or directly contact the other numerous prescribers and dispensers listed on [redacted]'s PIN profile;

7. Appeared to rely primarily on the information and assurances provided to you from [redacted] to form the basis for your judgment to prescribe and dispense her zopiclone;

8. Created a Comprehensive Annual Care Plan and Best Possible Medication History ("BPMH") on November 30, 2016 but failed:

    a. to list the numerous physicians and pharmacists involved in [redacted]'s care, as identified on her PIN profile (with the exception of Dr. Eledrisi);

    b. to list Tylenol #1, Tylenol # 3, Codeine Contin, and codeine on her BPMH; and

    c. to identify any Drug Therapy Problems related to [redacted]'s: multi-doctoring/poly-pharmacy, documented misuse of zopiclone or drug seeking with Tylenol #1 products and did not indicate that [redacted] had a risk factor of "Addictions – Drugs other than Alcohol".

9. Failed to identify [redacted]'s readily apparent Drug Therapy Problems including over dosage, non-adherence; and taking a drug for no medical indication;

10. Failed to take appropriate action such as: gathering additional/credible information, implementing a plan to monitor the occurrence and impact of the Drug Therapy Problems, advising his patient [redacted] and the multiple other prescribers of [redacted]'s zopiclone of the Drug Therapy Problems and suggesting an alternative, entering into a collaborative relationship with another health care professional to manage the Drug Therapy Problems, and/or refusing to prescribe and dispense the zopiclone.

IV. EVIDENCE AND SUBMISSIONS

During the opening statement on behalf of the Complaints Director, Mr. Boyer entered into evidence an Exhibit Book on behalf of the Complaints Director and Mr. Rajgor. The Exhibit Book was accepted into evidence and marked as Exhibit 1.

The Exhibit Book included an Admission of Unprofessional Conduct, in which Mr. Rajgor admitted responsibility for the allegations. He also admitted that his conduct constituted unprofessional conduct and breached the following statutes, regulations, and standards governing the practice of pharmacy:

- Standards 1, 4, 5 and 6, 11 and 14 and sub-standards 1.1, 1.2, 2.1(d), 2.1(e), 4.1(a)(i), 4.1(a)(ii), 4.1(b)(i), 4.2(d), 4.2(e), and or 4.2(h), 5.1, 5.3(a), 5.3(b), 5.3(d), 5.3(e), and or 5.3(f), 6(a), 6.1(c), 11.8(e), 11.9 and 14.4(b) of the Standards of Practice for Pharmacists and Pharmacy Technicians; and

- Principles 1 (1, 2, 3, 7, and 15) and 11 (6) of the ACP Code of Ethics;

The Exhibit Book also included a number of documents, including an email from Dale Cooney, Deputy Registrar of the ACP, initiating a complaint, Mr. Rajgor's written response to the complaint, and documentation and records relating to the prescriptions issued.

No witnesses were called, and the only evidence that was submitted was included in the Exhibit Book that was entered by agreement of the parties.

Mr. Boyer made brief submissions on behalf of the Complaints Director. He indicated that the complaint had been submitted by Dale Cooney, Deputy Registrar, as a result of the triplicate prescription program. The issues identified included alleged deficiencies with respect to Mr. Rajgor's prescribing and dispensing of zopiclone for patient [redacted] from November, 2016 until January of 2017. Mr. Boyer indicated that the documentation included in the Exhibit Book demonstrates that Mr. Rajgor prescribed and dispensed more zopiclone than [redacted] could possibly consume. In the circumstances, Mr. Boyer submitted that the evidence clearly supported Mr. Rajgor's admission of unprofessional conduct.

Mr. Bayrak confirmed that Mr. Rajgor admitted that the conduct in the Notice of Hearing was proven, and indicated he would provide a statement at the penalty phase of the hearing.

The hearing tribunal adjourned the hearing to review the Exhibit Book. After reviewing the documents contained in the Exhibit Book, the hearing tribunal reconvened, and advised the parties that it accepted Mr. Rajgor's admission of unprofessional conduct, and found that the allegations in the Notice of Hearing were proven.

V. REASONS FOR FINDINGS

Upon review of the Exhibit Book, the hearing tribunal determined that Mr. Rajgor's admissions were appropriate, in light of the documents contained in the Exhibit Book. The hearing tribunal found that the following key evidence supported Mr. Rajgor's admission of the allegations and unprofessional conduct.

- Page 10. Complaint letter, highlighting Triplicate Prescription Program data, identifying a concern regarding the quantity and frequency of zopiclone dispensed to a single patient by Mr. Rajgor.

- Page 20-21. Data provided to the Complaints Director from Alberta Netcare identifying specific details on the provision of zopiclone to patient [redacted] from September 9th, 2016 to January 23, 2017. [redacted] had received 285 days' supply of zopiclone in the month preceding the first time Mr. Rajgor dispensed zopiclone from his pharmacy. Mr. Rajgor did not view [redacted]'s Netcare profile until after the first 4 dispenses of zopiclone from his pharmacy (this included one instance of him prescribing zopiclone). Mr. Rajgor provided [redacted] with a

total of 4 months' supply of zopiclone in that 27 day period (November 2, 2016-November 29, 2016).

- Pages 22-28. Detailed Netcare PIN profile for [redacted] from January 1, 2016 to January 23, 2017. Of note, patient [redacted] had 30 documented refusals to provide exempted codeine products and 2 documented refusals to provide zopiclone by pharmacists during this time period.

- Pages 47-53. Summary of the Sequence of Events from Mr. Rajgor's perspective in his interactions with [redacted]. Documented reasons for dispensing or prescribing [redacted]'s zopiclone between November 2, 2016 to January 23, 2017 included: [redacted] lost the medication travelling, [redacted] dropped the medication in pet food, [redacted] had to leave Alberta for 6 weeks for a family funeral in Ontario, [redacted] was going to Mexico, [redacted]'s medications were stolen at her Christmas party, [redacted] will be out of the country and will run out of medications, [redacted] quit her job due to stress, [redacted] couldn't get a doctor's appointment and was out of medication and two instances of [redacted] in distress due to father's health.

- Pages 62-83. Copies of documentation provided by Mr. Rajgor for cases when zopiclone was dispensed and prescribed from November 29, 2016 to January 9, 2017. The written prescriptions attached did not meet the Standards of Practice for Pharmacists and Pharmacy Technicians. The hearing tribunal notes that most of the documentation on the prescriptions prescribed by Mr. Rajgor was lacking a detailed assessment, indication for therapy, monitoring and follow up plan.

- Pages 87-93. Comprehensive Annual Care Plan for patient [redacted], completed on November 30, 2016. The hearing tribunal noted that Mr. Rajgor documented that the patient has good compliance with the zopiclone therapy on the BPMH form.

- Page 112-114. Complaints Director Summary of Interview with Mr. Rajgor. Mr. Rajgor indicated that he trusted [redacted], that he now sees [redacted] as an "actress" who fooled him and that he first reviewed [redacted]'s Netcare/PIN data "in detail" on January 10, 2017. Mr. Rajgor did not recall checking [redacted]'s PIN profile until January 10, 2017.

The hearing tribunal considered the evidence provided in the Exhibit Book as outlined above and has accepted Mr. Rajgor's admission to all of the allegations. The hearing tribunal finds the factual allegations, as outlined in the Notice of Hearing, are proven.

The evidence provided in the Exhibit Book, with the key evidence summarized above, clearly proves all of the allegations against Mr. Rajgor. As Mr. Rajgor has admitted the allegations, the hearing tribunal will not specifically address each allegation and the evidence supporting it.

The Standards of Practice for Pharmacists and Pharmacy Technicians provide a minimum standard in which to practice pharmacy in this province. As a self-regulated profession, it is the responsibility of each member to ensure their practice is in alignment with these standards. The Standards of Practice specifically breached by Mr. Rajgor were: Standards 1, 4, 5 and 6, 11 and 14 and sub-standards 1.1, 1.2, 2.1(d), 2.1(e), 4.1(a)(i), 4.1(a)(ii), 4.1(b)(i), 4.2(d), 4.2(e), and or 4.2(h), 5.1, 5.3(a), 5.3(b), 5.3(d), 5.3(e), and or 5.3(f), 6(a), 6.1(c), 11.8(e), 11.9 and 14.4(b).

The hearing tribunal wishes to highlight the following Standards of Practice in the context of this matter:

- Standard 4 (Pharmacists must determine whether a patient has or is likely to have a drug therapy problem): The hearing tribunal identified numerous opportunities for Mr. Rajgor to evaluate if [redacted] had a drug related problem and he did not. The Standard states that a pharmacist must consider whether a patient has a drug therapy problem, or is likely to have a drug therapy problem each time the pharmacist prescribes a Schedule 1 drug, conducts a review of a patient's drug utilization and dispenses a Schedule 1 drug. Mr. Rajgor had dispensed zopiclone to [redacted] on 12 different occasions over a period of less than three months, providing her a total of a 307 day supply. This presented Mr. Rajgor with 12 unique opportunities to evaluate the appropriateness of the prescription, including considering whether the patient has a drug therapy problem. Of particular concern to the hearing tribunal was the fact the Mr. Rajgor performed a Comprehensive Annual Care Plan (CACP) for [redacted] during the same period of time, as identified in the Exhibit Book. Allegation 8 in the Notice of Hearing identifies specific shortcomings with this patient's CACP (incomplete BPMH, omitting several physicians involved in [redacted]'s care, overlooking drug therapy problems and not identifying the correct risk factor when screening the patient). Poorly completed care plans, such as the one completed by Mr. Rajgor for [redacted], substantially diminish the value of such interventions for the residents of this province and examples such as this CACP are detrimental to the profession of pharmacy in general. Assessments such as the CACP must be completed accurately and completely in order to provide value to the public.

- Standard 14 (Prescribing at initial access or to manage ongoing therapy): The hearing tribunal notes that pharmacists in the province of Alberta have the ability to be granted additional prescribing authorization and this is a privilege not a right. The authority to independently prescribe at initial access or to manage ongoing therapy affords Alberta pharmacists the most expanded scope of practice in Canada. Pharmacists that prescribe drug therapy under Standard 14 have a great responsibility to the public to ensure that prescribing is in the best interests of the patient, must conduct a patient assessment, and must collaborate with other regulated health professionals whose care of the patient may be affected by their prescribing decision. Standard 14 is also clear that the pharmacist must develop a follow up plan, including parameters that will be monitored, expected outcome and timeframes. The hearing tribunal noted that Mr. Rajgor's use of his additional prescribing authorization when prescribing

for [redacted] did not meet the requirements outlined in Standard 14, and stresses that Standard 14 outlines the minimum requirements for this practice. Pharmacists must respect the tremendous privilege Additional Prescribing Authorization affords them and pharmacists must take full responsibility for their prescribing decisions. When a pharmacist prescribes drug therapy pursuant to Standard 14, they assume responsibility for that decision and the implications of that decision on the patient's overall health. The public must be assured that when pharmacists prescribe drug therapy it will be done based on a complete and thorough assessment of the patient. On page 109 of the Exhibit Book there is an algorithm that provides guidance to pharmacists prescribing under this standard.

- Standard 5 (Take appropriate action if there is a drug therapy problem). The hearing tribunal finds that Mr. Rajgor did not take appropriate action, as defined in Standard 5. The Standards of Practice state that if a patient has or is likely to have a drug therapy problem, the pharmacist must determine the appropriate response. Subsection 5.3 of this standard outlines several appropriate responses to a drug therapy problem, including entering into a collaborative relationship with another regulated health professional to manage the patient's drug therapy. Pharmacists must be aware of the abuse potential of certain prescribed medications. They must be prepared to not only simply notify, but actively collaborate with patients' other regulated health care providers to support patients that may be addicted or abusing these medications. The hearing tribunal recognizes that individuals who abuse or are addicted to medications are a vulnerable population. Pharmacists have a responsibility to recognize patients at risk and to support their safety. Pharmacists are uniquely positioned within the health care system to assess, screen and refer patients to appropriate care when untreated addiction or mental health issues are flagged.

The hearing tribunal finds that Mr. Rajgor's actions and inactions in the proven allegations constitute unprofessional conduct.

VI. SUBMISSIONS ON PENALTY

After the hearing tribunal confirmed that the allegations were proven, the hearing tribunal invited both parties to make submissions on penalty.

Joint Submission Agreement

A Joint Submission Agreement was entered as Exhibit 2 on the issue of penalty. Mr. Rajgor and the Complaints Director submitted the following joint submission on penalty:

The Hearing Tribunal should order:

a. A suspension of Mr. Rajgor's practice permit for a period of 3 months, with 1 month of active suspension starting on September 12, 2017, and with the further 2 months of suspension being held in abeyance on the condition that Mr. Rajgor fulfill the other orders of the Hearing Tribunal and maintain good conduct during the 2 year period following the completion of the first month of suspension. If Mr. Rajgor fails to maintain good conduct during the 2-year period, the remaining 2 months of the suspension shall be served starting on a date to be determined by a Hearing Tribunal. If Mr. Rajgor maintains good conduct during the 2 year period, the period of suspension held in abeyance shall then expire;

b. Notwithstanding the fulfillment of the 1 month period of active suspension of his practice permit, Mr. Rajgor's practice permit shall not be reinstated unless and until he has completed a course in pharmacist assessment satisfactory to the Complaints Director. (Examples of satisfactory courses are: the Patient Assessment and Triage Prerequisite & Musculoskeletal and Nervous Systems Conditions course offered by the CPhA, or the Medication Assessment and Management Course offered by the CPhA);

c. Upon reinstatement, Mr. Rajgor's practice permit shall have the condition that Mr. Rajgor shall, at his own cost, only practice under direct supervision for a period of 300 hours with a supervisor who is satisfactory to the Complaints Director, and the supervisor shall report to the Complaints Director when the supervisor is satisfied that Mr. Rajgor has completed the 300 hours of directly supervised practice and the supervisor is satisfied that Mr. Rajgor is able to practice in a manner such that the conduct proven in this matter is unlikely to recur (Mr. Sean Holland has been identified as an acceptable supervisor for this role);

d. A further condition on Mr. Rajgor's practice permit shall be that before the completion of the 300 hours of direct supervision, Mr. Rajgor shall complete the Patient Assessment Requirements from the Structured Practical Training program to the satisfaction of the supervisor and the Complaints Director and that, despite the completion of 300 hours of directly supervised practice, the condition for direct supervision shall continue until the Patient Assessment Requirements from the Structured Practical Training program are fulfilled;

e. That for a period of 3 years, Mr. Rajgor shall provide any pharmacy employer or licensee with a copy of the decision of the Hearing Tribunal so that the employer or licensee is aware of the decision and the sanction orders; and

f. That Mr. Rajgor shall pay the costs of the investigation and hearing to a maximum of $20,000.00 which shall be payable by equal installment over a 36-month schedule satisfactory to the Complaints Director.

Submissions from Mr. Boyer

Mr. Boyer submitted that the hearing tribunal may accept or reject the joint submission on sanctions. He reviewed the principle of deference and the potential implications should the hearing tribunal elect not to accept sanctions agreed upon by both the Complaints Director and the member. The principle of deference was elaborated upon for the hearing tribunal: joint submissions are in the public interest and should be followed by tribunals unless it can be demonstrated that they are unfit, unreasonable, or contrary to the public interest.

Mr. Boyer outlined the relevant principles for consideration referenced from *Jaswal v. Newfoundland Medical Board* (1996) and described the application of the factors in this case. Key points were:

- The nature and gravity of the proven allegations was serious and were subject to abuse.
- Mr. Rajgor was relatively new to practicing with Additional Prescribing Authorization.
- There were no prior complaints or disciplinary actions against Mr. Rajgor.
- The patient involved in this matter suffered from addiction and mental health issues.
- The frequency of the proven allegations was significant and outlined in Exhibit 1.
- Mr. Rajgor's actions in acknowledging the issue and taking responsibility for his actions were a mitigating factor.
- No previous financial or other penalties affected the member.
- The fact that Mr. Rajgor was very cooperative with the College was a mitigating factor.
- The need for specific and general deterrence, to protect the public to ensure a pharmacist follows the standards of practice to safely prescribe drug therapy.

- To maintain the public's confidence in safe and effective pharmacist prescribing.

- The range of sanctions in other similar cases suggested that the penalties that were jointly submitted were appropriate.

Mr. Boyer recognized that this was the first case in which a pharmacist's conduct was found to be unprofessional in connection to the use of Additional Prescribing Authorization. Mr. Boyer presented two past Alberta College of Pharmacists decisions that predated the use of additional prescribing authorization to provide context to the joint submission on sanctions. The two decisions shared with the hearing tribunal were those of Allan Zan and Douglas Weiss. Both members were found to have provided significant quantities of habit-forming medications to individuals without a thorough assessment. Both members' practice permits were suspended for a range of 3 to 4 months, with some or all of the suspension stayed based on compliance with the remainder of the orders.

Mr. Boyer finally submitted that the Joint Submission on Sanctions was reasonable, addresses deterrence to the member, the profession and protects the public. Mr. Boyer also acknowledged the cooperation of Mr. Rajgor throughout the investigation and the hearing.

Submissions from Mr. Bayrak

Mr. Bayrak submitted some personal background on the member, Mr. Rajgor. Mr. Rajgor completed his pharmacy training in India in 2009 and subsequently arrived in Canada as a refugee. Mr. Rajgor completed his internship and licensure in British Columbia, where he worked as a pharmacist for 2 years. In June 2014, Mr. Rajgor became licensed to practice pharmacy in Alberta and obtained his Additional Prescribing Authorization in 2015. He opened his own pharmacy in June of 2016.

Mr. Bayrak submitted relevant points for consideration referenced from *Jaswal v Newfoundland Medical Board* (1996):

- Mr. Rajgor's actions were isolated to one patient and Mr. Rajgor stopped prescribing and dispensing zopiclone to the patient prior to the initiation of the investigation by the College.

- The patient in question has attended the pharmacy since the investigation and Mr. Rajgor no longer fills her prescriptions for zopiclone or provides exempted codeine products.

- That zopiclone is not a narcotic drug.

- Mr. Rajgor has been practicing pharmacy in Canada for 5 years with no previous complaints against him.

- The patient appeared mentally sound to Mr. Rajgor.

- The allegations occurred several times and Mr. Rajgor acknowledged that he should have been more careful.

- Mr. Rajgor acknowledges his actions were unprofessional through his signed Admission of Unprofessional Conduct.

- That there appears to be no impact on the patient and since January 2017, Mr. Rajgor has contacted 3 pharmacies and 3 physician's offices to alert them to the patient's continued, inappropriate use of zopiclone.

- Mr. Rajgor admits that his conduct falls outside the range of permitted conduct.

- The range of sanctions in the Zan and Weiss matters were appropriate guides however the conduct in issue in the Zan case was more serious.

Mr. Bayrak submitted that the actions of Mr. Rajgor suggest those of a member that has taken steps to self-rehabilitation. Mr. Bayrak noted that in January 2017, prior to the investigation, Mr. Rajgor upgraded his pharmacy computer system to allow for real time access of Netcare to help prevent other similar issues for occurring.

Mr. Bayrak submitted that Mr. Rajgor's pharmacy was inspected by the College since the investigation and was found in compliance at the follow up visit, with the only issues identified in the initial inspection were proper name tags and increased prudence with documentation.

Mr. Bayrak submitted that the costs assessed and sanctions in the Joint Submission Agreement will total approximately $40,000 and result in significant financial impact to the member. Mr. Bayrak submits that Mr. Rajgor has agreed to all conditions, that the conditions are fair and reasonable and will provide reassurance to the public.

Clarification Sought from the Hearing Tribunal

The hearing tribunal requested additional information from the Complaints Director and the member on the Joint Submission Agreement.

The hearing tribunal requested more information from the Complaints Director and member regarding the choice of 300 hours of supervised practice rather than revoking Mr. Rajgor's Additional Prescribing Authorization. The Complaints Director noted that revoking Mr. Rajgor's Additional Prescribing Authorization was considered, but indicated that the member attained this authorization approximately 18 months ago. If Mr. Rajgor was successful in obtaining this authorization at that time, it was likely that he would be successful in reapplying. The Complaints Director submitted that the supervised practice would provide a better opportunity to ensure Mr. Rajgor's prescribing was appropriate and based on a thorough assessment. The Complaints Director indicated that the 300 hours of directly supervised practice would also provide

the opportunity for mentorship from the supervisor, including a discussion and review of each assessment completed, particularly in the context of the use of Additional Prescribing Authorization. The Complaints Director noted that direct supervision is such that the supervisor can immediately intervene when practice standards are not met.

The hearing tribunal requested clarification on the information that will be provided to Mr. Rajgor's supervisor prior to the commencing the 300 hours of directly supervised practice. The Complaints Director submitted that the following would be provided to the supervisor:

- A copy of the hearing tribunal decision in this matter,
- A copy of the Notice of Hearing, which includes the allegations,
- A copy of Exhibit 1 (with the patient's name redacted), and
- Access to the Structured Practical Training materials from the College.

The Complaints Director submitted that the resources provided to the supervisor to evaluate the member would include the Structured Practical Training program as well as any direction provided by the hearing tribunal in the form of the written decision.

The Complaints Director submitted that the key elements he would be evaluating in the report provided by the supervisor would be the completion of the Structured Practical Training program, an assessment of Mr. Rajgor's conduct to ensure the proven allegations would be unlikely to recur in the future and any other specific information that may impact Mr. Rajgor's ability to practice.

VII. ORDERS

Following deliberation, the hearing tribunal considered the following into account when considering the appropriateness of the Joint Submission on Penalty:

- Nature and gravity of the proven allegations: Mr. Rajgor's actions (inadequate collaboration, prescribing and dispensing with inadequate patient assessment, failing to identify a drug therapy problem) had serious potential consequences for [redacted].
- Mr. Rajgor's cooperation with the College and acknowledgement of his unprofessional conduct is a mitigating factor that must be taken into account.
- The need to promote both specific and general deterrence thus protecting the public in ensuring pharmacy practice is safe and proper: The public must be reassured that pharmacists are providing complete assessments at all times, especially including prescribing medications for initial access or managing ongoing therapy. The costs assessed and suspension provide general

deterrence. The orders regarding directly supervised practice and the pharmacist assessment course will safeguard the public.

- Maintaining public confidence in the integrity of the pharmacy profession: Members of the public hold pharmacists in high regard and expect that their assessments and professional decisions will be complete and in their best interest.

- The volume and frequency of the proven allegations: Patient [redacted] received large quantities of zopiclone over a short period of time, including prescribing a 222 day supply over a 56 day period.

- The range of sanctions in other similar cases: The hearing tribunal found that the sanctions proposed are similar to the previous cases shared during the Complaints Director's submission on sanctions.

- The principle of deference: The hearing tribunal respects the collaborative submission on sanction between the Complaints Director and Mr. Rajgor. In the absence of a joint submission on sanction, the hearing tribunal may have imposed additional orders relating to Mr. Rajgor's authorized prescribing, however the hearing tribunal did not feel that the jointly proposed orders were unfit, unreasonable or contrary to the public interest.

The hearing tribunal is confident that the 300 hour period of directly supervised practice following Mr. Rajgor's suspension will provide a sufficient period of time for the supervisor to directly observe Mr. Rajgor's practice and provide mentorship. The hearing tribunal is confident that the supervisor will have sufficient direction and support from the Complaints Director prior to and during the period of supervised practice. The mentorship provided by the supervisor over this period of time will protect the public by allowing Mr. Rajgor to model appropriate practice.

The period of supervised practice is a key component of the orders in this case and will assist in ensuring that Mr. Rajgor is competent in those areas that were in issue in these proceedings. In addition to the other components of the Structured Practical Training program, the hearing tribunal expects that the supervisor will focus on the following areas while supervising Mr. Rajgor's practice:

- Performing and documenting complete patient assessments, considering multiple sources of information.

- Determining whether Mr. Rajgor is appropriately utilizing information available on NetCare for patient assessments, including reviewing detailed PIN information and other relevant patient information.

- Appropriate collaboration with other care providers in providing patient care.

- Determining whether medication reviews (Comprehensive Annual Care Plan, Structured Medication Management Assessment and related follow ups) are completed accurately and providing a thorough assessment of the patient.

- Determining whether Mr. Rajgor is aware of and follows the 4 prescribing algorithms found on pages 106-109 of the Exhibit Book (adapting a prescription, renewing a prescription, prescribing in an emergency and pharmacist with additional prescribing authority).

- Evaluating Mr. Rajgor's prescribing activity to determine whether his additional prescribing authorization is documented completely and addresses the following:

    - Assessment of the patient, health history, history of drug therapy;
    - Personally assess the patient;
    - Assess potential therapy using IESA. Is it:
        - **I**ndicated,
        - **E**ffective,
        - **S**afe, and
        - Will the patient **A**dhere to therapy;
    - Obtain informed consent from the patient;
    - Reduce the prescription to writing and notify any regulated health professionals whose care of the patient may be affected;
    - Develop a follow up and monitoring plan; refer patient to another regulated health professional as required;
    - Document the rationale for prescribing in the patient record; and
    - Document all disclosures as per the Health Information Act, section 35 and 41.

- Review the patient assessment process as outlined in the Chart, Check, Chart Prescription Adaptation Guide found on pages 104-105 of the Exhibit Book.

- Assist Mr. Rajgor by providing him with information about the resources available to refer his patient population to, specifically regarding addictions and mental health.

In light of the foregoing, the hearing tribunal hereby makes orders the following pursuant to s. 82 of the *Health Professions Act:*

1. Mr. Rajgor's practice permit will be suspended for a period of 3 months, with 1 month of active suspension starting on September 12, 2017, and with the further 2 months of suspension being held in abeyance on the condition that Mr. Rajgor fulfill the other orders of the Hearing Tribunal and maintain good conduct during the 2 year period following the completion of the first month of suspension. If Mr. Rajgor fails to maintain good conduct during the 2-year period, the remaining 2 months of the suspension shall be served starting on a date to be determined by a hearing tribunal. If Mr. Rajgor maintains good

conduct during the 2 year period, the period of suspension held in abeyance shall then expire.

2. Notwithstanding the fulfillment of the 1 month period of active suspension of his practice permit, Mr. Rajgor's practice permit shall not be reinstated unless and until he has completed a course in pharmacist assessment satisfactory to the Complaints Director. (Examples of satisfactory courses are: the Patient Assessment and Triage Prerequisite & Musculoskeletal and Nervous Systems Conditions course offered by the CPhA, or the Medication Assessment and Management Course offered by the CPhA).

3. Upon reinstatement, Mr. Rajgor's practice permit shall have the condition that Mr. Rajgor shall, at his own cost, only practice under direct supervision for a period of 300 hours with a supervisor who is satisfactory to the Complaints Director, and the supervisor shall report to the Complaints Director when the supervisor is satisfied that Mr. Rajgor has completed the 300 hours of directly supervised practice and the supervisor is satisfied that Mr. Rajgor is able to practice in a manner such that the conduct proven in this matter is unlikely to recur ([redacted] has been identified as an acceptable supervisor for this role).

4. A further condition on Mr. Rajgor's practice permit shall be that before the completion of the 300 hours of direct supervision, Mr. Rajgor shall complete the Patient Assessment Requirements from the Structured Practical Training program to the satisfaction of the supervisor and the Complaints Director and that, despite the completion of 300 hours of direct supervised practice, the condition for direct supervision shall continue until the Patient Assessment Requirements from the Structured Practical Training program are fulfilled.

5. For a period of 3 years, Mr. Rajgor shall provide any pharmacy employer or licensee with a copy of the decision of the Hearing Tribunal so that the employer or licensee is aware of the decision and the sanction orders.

6. Mr. Rajgor shall pay the costs of the investigation and hearing to a maximum of $20,000.00 which shall be payable by equal installment over a 36-month schedule satisfactory to the Complaints Director.

Signed on behalf of the hearing tribunal by the Chair

Dated: October 11, 2017

Per: [Peter Macek]

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Peter Macek