Mr Feras Dawood, Phar21/514D

Charge

On 6 December 2021 by audio visual link, the Health Practitioner's Disciplinary Tribunal (the Tribunal) heard a charge laid by the Director of Proceedings of the Health and Disability Commissioner's office against Mr Feras Dawood, registered pharmacist of Waiuku (the pharmacist).

On 2 February 2023, an Addendum was issued by the Tribunal setting out further suppression orders.

The charge alleged that the pharmacist:

1. On an unknown date between 7 and 13 May 2019, when the pharmacist checked a technician's dispensing of the antibiotic medication rifaximin 550mg for [Ms B], he failed to detect that the anticoagulant medication rivaroxaban 20mg had been dispensed incorrectly instead of rifaximin 550mg.

   AND / OR

2. Between 27 May 2019 and 4 July 2019, when he knew that he was the pharmacist who had checked the dispensing of rifaximin 550mg for [Ms B] (for whom rivaroxaban 20mg was incorrectly dispensed instead), the pharmacist acted dishonestly when he:

   a) Disposed of the original certified repeat copy form for the dispensing of rifaximin 550mg to [Ms B];

   and/or

   b) created a new certified repeat copy form for the dispensing of rifaximin 550mg to [Ms B];

   and/or

   c) signed pharmacist, [Ms A]'s initials in the "checked by" box of the newly created certified repeat copy form for the dispensing of rifaximin 550mg to [Ms B];

   and/or

   d) told [Ms A] that she had been responsible for checking the dispensing of rifaximin 550mg to [Ms B] (for whom rivaroxaban 20mg was incorrectly dispensed instead);

   and/or

   e) told pharmacist, [Mr N], that [Ms A] was responsible for checking the dispensing of rifaximin 550mg to [Ms B] (for whom rivaroxaban 20mg was incorrectly dispensed instead);

   and/or

   f) told [Ms B] that another pharmacist was responsible for the dispensing error;

   and/or

   g) told [Ms A] that he would notify the Pharmacy Council of New Zealand of her dispensing error;

   and/or

   h) created and sent an Incident Notification Form to the Pharmacy Defence Association in which he stated that [Ms A] was responsible for checking the dispensing of rifaximin 550mg to [Ms B] (for whom rivaroxaban 20mg was incorrectly dispensed instead);

   and/or

i) advised the Pharmacy Defence Association that he intended to issue [Ms A] with a written warning in relation to her dispensing error.

Background

At the time of the incident the pharmacist had a condition on his practice that he work in association with another pharmacist at all times when dispensing medicines and that he be under the supervision of a Council-approved pharmacist. Ms A, a pharmacist at the pharmacy, was appointed as the supervising pharmacist.

In March 2019, Ms B presented at the pharmacy as a new customer with a prescription for 13 medications, including Rifaximin. Most of the medications were dispensed in blister packs and some in separate packages or bottles. On 3 May 2019, a pharmacy technician Ms C, processed future blister packs. There was insufficient Rifaximin so Ms C processed an order for this and a further medication, Clonazepam.

On 9 May 2019, the pharmacy technician prepared the patient's repeat medications. She incorrectly dispensed Rivaroxaban instead of the prescribed Rifaximin. Clonazepam was also dispensed. The technician signed the 'packed by' section of the CRC dispensing form for the Rifaximin and Clonazepam with her initials. Soon after 9 May, the pharmacist checked the medications prepared for Ms B but failed to detect the dispensing error. He signed the 'checked by' section of the CRC form with his initials.

The patient became unwell after taking the incorrect medication and was admitted to hospital for treatment.

When rung by the hospital pharmacist on 27 May, the pharmacist said he could not find the CRC form generated for the dispensed medications. On 28 May, the pharmacist entered the pharmacy by the backdoor at 6.53am. He disposed of the initial CRC form. He created two new CRC forms, one for the Clonazepam and one for the Rifaximin. Signed the 'packed by' section of both forms with the technician's initials with his initials in the 'checked by' section for the Clonazepam and Ms A's initials in the 'checked by' section for the Rifaximin. He placed the new forms in a batch with other CRC forms and left the pharmacy, returning through the front door at 8.36am as he usually did.

The pharmacist found the false forms during the morning. The pharmacist apologised to the patient but said it was Ms A who made the error. He said he told Ms A he would advise the Pharmacy Council and he completed an incident notification form to the Pharmacy Defence Association blaming Ms C and Ms A for the error.

Finding

The Tribunal found that a dispensing error did occur and that Particular 1 of the charge therefore amounted to negligence (s100(1)(a)). However, the Tribunal was reluctant to find that a dispensing or checking error on its own, is sufficiently serious to warrant a disciplinary sanction. It is the practitioner's response, or lack of response, on being informed of an error that may take the conduct over the threshold to warrant disciplinary sanction.

The Tribunal was in no doubt that the pharmacist's conduct set out in Particular 2 was highly unethical and despicable. The conduct reached the disciplinary threshold as malpractice and conduct likely to bring the profession into disrepute.

The Tribunal found that together Particulars 1 and 2 met the threshold for disciplinary sanction.

Penalty

In this case, the dispensing error itself does not warrant cancellation. However, given the pharmacist was at the time of the incident subject to conditions on his practice having failed to meet the requirements of a competence programme, together with the present conduct of dishonesty made any rehabilitative penalty inappropriate.

The Tribunal ordered:

- Cancellation of registration.
- Censure.
- Payment of a fine of $5,000.
- Payment of costs totalling $10,500 in contribution to the hearing.

The Tribunal directed publication of this decision and a summary subject to the suppression orders it imposed.

The full decision of the Tribunal can be found here: Phar21/514D.