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Canadian pharmacists can perform a number of full-scope activities, such as prescribing and administering injections. However, some pharmacists fear disciplinary action from an error or adverse event. This research reassures pharmacists that loss of a license is very rare and should not be a reason to not practise to full scope.

Les pharmaciens canadiens peuvent effectuer plusieurs activités relevant du plein exercice de leur profession, comme la prescription et l'administration des injections. Cependant, certains pharmaciens craignent des mesures disciplinaires en cas d'erreur ou d'événement indésirable. Cette recherche rassure les pharmaciens sur le fait qu'une perte de licence est très rare et que cela ne doit pas les empêcher d'appliquer toutes leurs compétences dans leur exercice.

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Will I lose my license for that? A closer look at Canadian disciplinary hearings and what it means for pharmacists' practice to full scope

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ABSTRACT

Objective: Concerns about liability from clinical errors have been cited as a barrier preventing greater adoption of practice change. Our objective was to determine the most common actions or omissions that result in disciplinary action for pharmacists and the restrictive actions imposed.

Methods: Canadian disciplinary reports were reviewed. Cases were coded as charges of professional misconduct, unskilled practice or dishonest business practices.

Results: There were 558 disciplinary cases from 10 provinces that occurred between January 2010 and July 2017. Professional misconduct charges commonly involved stealing/diverting or inappropriately dispensing narcotic drugs, pharmacy supervision/premises charges and refusing to

cooperate with the college. Charges of unskilled practice included dispensing the wrong drug, failing to assess the appropriateness of a drug order, providing the wrong dose and failing to counsel. Fraudulent billing practices and accepting rebates from generic drug companies were the most common dishonest business practices. Professional misconduct, unskilled practice and dishonest business practice charges were involved in 342 (61%), 169 (30%) and 191 (34%) cases, respectively. Most cases occurred in community pharmacies and were not caused by an isolated clinical error. Fines were the most common penalty, followed by temporary license suspensions, professional development and reprimands. License revocations were the least common (4%), often involving professional misconduct.

Conclusion: This review suggests that disciplinary action against a pharmacist for an isolated, unintentional clinical error is uncommon and that losing a license is rare. Fear of disciplinary action should not be a barrier to practice change or the provision of full-scope patient care services. *Can Pharm J* (Ott) 2018;151:332-344.

Introduction

The scope of practice for Canadian pharmacists is expanding. Pharmacists in all provinces can adapt a drug's dose, form, regimen and route. In most provinces, pharmacists can give vaccinations, prescribe for common ailments and renew or extend a prescription for continuity of

care.¹ Many provinces also allow pharmacists to provide additional services, such as prescribing, performing therapeutic substitutions and ordering and interpreting tests.¹

However, even when an expansion to scope of practice is approved by legislators and regulators, pharmacists still struggle to adopt the new skill

or service into daily practice. Barriers to adoption are numerous and have been established in the literature, including workload and lack of remuneration.²⁻⁴ But there is more to it than a need for more time and more money. For example, pharmacists say they are afraid of losing their professional licenses from adverse events that result when they provide full-scope services, such as injecting vaccines, adapting prescriptions or prescribing for common ailments.^{3,5} Pharmacists who are worried about liability spend more time assessing clinical information and documenting patient care.⁵ They are less likely to prescribe medications in general and avoid “higher-risk medications” such as anticoagulants, antipsychotics and sedatives entirely.⁵ Pharmacists also tend to lack confidence and fear new responsibilities, which contributes to uncertainty about grey scenarios or new areas of practice.⁴ When making difficult decisions, research shows that pharmacists typically defer to other authorities such as physicians or regulatory body guidelines, stating that they must follow the law so they do not lose their license.^{4,6}

Little research has been conducted on the reasons pharmacists are disciplined in North America. A recent analysis of complaints submitted to the Australian Health Practitioner Regulation Agency, which regulates 14 health professions nationally, studied the factors and complaints that are likely to result in restrictive action but did not analyze these specifically for pharmacists.⁷ Researchers in the United Kingdom conducted 2 pharmacist-specific reviews of disciplinary action.^{8,9} All 3 of these studies found that more disciplinary cases were due to professional misconduct rather than clinical care complaints.⁷⁻⁹

Given the lack of pharmacist-specific data, consideration of physician disciplinary action provides important context. A review of disciplinary action for Canadian physicians showed that the overall proportion of physicians disciplined each year was small—0.06% to 0.11%—and that the most commonly implicated specialties were family medicine, psychiatry and surgery.¹⁰ The most frequent violations were sexual misconduct, standard-of-care issues and unprofessional conduct, and the most frequent penalties were fines, suspensions and formal reprimands. Research in both pharmacy and medicine points to increased disciplinary action for men, those with more years in practice and those with an international education.⁷⁻¹¹

KNOWLEDGE INTO PRACTICE

- Pharmacists' fear of liability from clinical errors is a barrier to pharmacy practice change.
- This review of disciplinary cases from 10 Canadian provinces is the first of its kind in North America.
- Most errors involve professional misconduct or dishonest business practices. Disciplinary action for isolated, unintentional clinical errors is uncommon, and losing a license is rare.
- Fear of liability should not be a reason for pharmacists not to practise to full scope.

Although many pharmacists seem to fear losing their license, how often a license is actually revoked and what types of disciplinary complaints result in revocations are unknown. In addition, there is no research about the types of offences that more commonly result in disciplinary action, if most cases resulting in restrictive action involve unethical behaviour or clinical errors and whether unintentional clinical errors (e.g., an unforeseen adverse effect of a drug) are punished. The objective of this study is to determine the most common actions or omissions that result in disciplinary action and to explore the restrictive actions that are imposed.

Methods

Regulation of pharmacy in Canada

Each provincial pharmacy college processes complaints filed against pharmacists by colleagues, the public or other health care providers. Although each college has different committees and processes, most colleges handle complaints similarly. Depending on the complaint, it may be handled differently: 1) It may be acknowledged but not investigated, 2) the college may provide guidance on mediation between the complainant and the pharmacist/pharmacy or 3) the college may investigate the complaint further.

Typically, all complaints are initially handled by a “complaints” or “inquiry” committee; these committees deal often with less serious cases, while more serious charges are handled by the discipline committee. Depending on the charge and the province, the committee may dismiss the complaint or apply various penalties such as recommending professional guidance or development, imposing conditions or restrictions on the pharmacist's license or temporarily suspending the pharmacist.¹²⁻²¹ Disciplinary cases also arise from other

MISE EN PRATIQUE DES CONNAISSANCES

- La crainte des pharmaciens d'engager leur responsabilité pour des erreurs cliniques est un obstacle au changement de pratique des pharmacies.
- Cet examen des procédures disciplinaires des 10 provinces canadiennes est le premier du genre en Amérique du Nord.
- La plupart des erreurs concernent des inconduites professionnelles ou des pratiques commerciales malhonnêtes. Les mesures disciplinaires sont isolées, les erreurs cliniques par inadvertance ne sont pas courantes et la perte de licence est quelque chose de rare.
- La peur d'engager leur responsabilité ne devrait pas empêcher les pharmaciens d'appliquer toutes leurs compétences dans leur exercice.

sources, such as routine college inspections, insurance audits or through mandatory reporting if the pharmacist was involved with criminal activity.

Data collection

To determine the national scope of disciplinary hearings available for analysis, we started by accessing each of the 10 provinces' disciplinary reports from their respective regulatory body website. Provinces that did not publish disciplinary reports online or did not provide a link to an external source were e-mailed for this information. Most colleges replied with a link to an external source or instructions for locating the information on their website. Disciplinary cases from Alberta (AB), Saskatchewan (SK), Manitoba (MB), Nova Scotia (NS) and Newfoundland and Labrador (NL) were accessed through each college's webpage on disciplinary reports or online newsletters.^{13-15,20,21} Cases from SK from 2014 onward, Ontario (ON) and Quebec (QC) were accessed online from The Canadian Legal Information Institute (<https://www.canlii.org>).²² Cases from British Columbia (BC) and Prince Edward Island (PEI) were obtained through direct correspondence with each college due to privacy legislation. Information from New Brunswick (NB) was also obtained directly from the college since only cases from 2015 were posted on the college website. Select discipline summaries published on the NB college website were also referred to.¹⁸ The 3 Canadian territories were excluded from this study as they do not have pharmacy-specific regulatory bodies.

We included all publicly available disciplinary hearings that described both the charges

against a pharmacist and the penalties applied. When one case dealt with charges and punishments against 2 pharmacists, we counted this as 2 separate cases; this allowed us to capture the overall number of pharmacists that were disciplined. Cases that involved a pharmacist licensed in more than 1 province were counted only in the province that conducted the full investigation. As some provinces differentiate between complaints or inquiry committees and discipline committees but others do not, we did not distinguish between the 2 in our analysis.

Data analysis

Data extraction and coding were done by 2 researchers (E.A.F. and K.W.). For each case, we noted the specific allegations and restrictive action applied. We coded cases as 1) professional misconduct, 2) unskilled practice (terms borrowed from the College of Pharmacists of Manitoba's disciplinary notices) and 3) dishonest business practices.²³ See Box 1 for definitions of the codes. A.F. began by reviewing all the cases and used an inductive approach to create a preliminary set of codes. A.F. and K.W. then used this set to code 10 cases independently. Codes were reassessed to ensure they were still relevant, and new codes were added as they emerged. The final codes were reviewed with the team, and discrepancies were resolved through discussion and consensus. A.F. and K.W. used the finalized codes to independently code the data in a deductive approach. Cases from QC were read in French by K.W. and in English (using Google Translate) by A.F. Each college was invited to review their provincial results to offer additional interpretation or feedback.

Results

We analyzed 558 disciplinary cases from 10 provinces that occurred between January 2010 and July 2017. Overall, 342 cases (61%) involved professional misconduct, 169 cases (30%) involved unskilled practice and 191 cases (34%) involved dishonest business practices (note that the sum exceeds 100% as a single case may involve more than 1 error category). A total of 225 cases involved professional misconduct only, 100 cases involved unskilled practice only, 112 cases involved dishonest business practices only and 121 cases involved a combination. Notably, 42% (232/558) of all cases were from QC. QC also had a higher proportion of cases related to isolated incidents

Will I Lose My License for that?

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Most Common Types of Errors 558 cases from 10 provinces

Professional Misconduct

- Substandard pharmacy supervision
- Failure to comply with college requirements (e.g., not submitting proof of liability insurance, criminal record check, professional development)
- Inappropriate dispensing of narcotic/controlled drugs
- Stealing narcotic/controlled drugs for personal use

■ Most common errors overall

Dishonest Business Practices

- Fraudulent billing practices
- Accepting or misusing professional allowances
- Other (e.g., selling patient records, financial agreements with physicians)

Unskilled Practice

- **Mechanical**
 - Wrong drug
 - Wrong dose
 - Wrong dose interval
- **Judgement**
 - Failure to assess prescription appropriateness
 - Failure to counsel

% of cases involving:

- Professional Misconduct
- Dishonest Business Practices
- Unskilled Practice

Important Facts

9/10 cases happened in community pharmacies

Most cases involved multiple or repeated charges

13% were limited to unskilled practice (mostly from Québec)

Most Common Penalties

1. Fine Avg \$7,583 (range \$250 - 70,000) >>>>> 80% of cases included fine
2. License Suspension Avg 10 months (range 10 days - 8 years) >>>>> 44% of cases included suspensions
3. Professional Development Most common: taking a course
4. Reprimand
5. Condition on License Most common: not allowed to be a pharmacy manager
6. Publication in a Newsletter/Website
7. Fitness to Practice Assessment
8. License Revocation Only 4% of cases

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BOX 1 Definitions of the 3 overarching categories of pharmacists' errors^{23,24}

1. Professional misconduct: A violation of the professional standards of practice or the legislation governing pharmacy practice, such as drug diversion, improper use of health information, inappropriate dispensing or errors in a pharmacist's supervision of the pharmacy
2. Unskilled practice:
 - A. Mechanical errors: Intentional and unintentional errors related to the 5 rights of medication administration (right drug, right dose, right regimen, right route and right patient) and right instructions
 - B. Judgment errors: Intellectual or cognitive errors including failure to counsel, failure to assess appropriateness of a prescription and failure to follow up with a patient or prescriber
3. Dishonest business practices: Any actions or omissions with financial gain as the motive, such as fraudulent billing practices, accepting professional allowances from generic drug companies or operating an unlicensed pharmacy

FIGURE 1 Provincial distribution of cases according to the 3 categories of charges*

*Charges include professional misconduct only, unskilled practice only, dishonest business practice only or a combination ($N = 558$).

and unskilled practice compared with other provinces, including 84 of 98 cases involving an isolated incident. To illustrate this, wrong drug (44 cases) was the most common mechanical error, but 29 cases were from QC. Similarly, wrong dose was the second most common mechanical error (42 cases), but 36 cases were from QC.

The provincial distribution of cases is presented in Figure 1. The most common charges in each category are presented in Table 1, and the most common charges per province are presented in Table 2.

Of the 100 cases involving unskilled practice, 83 were from QC, 7 from BC, 3 from PEI, 2 from NL and 1 from each AB, MB, ON, NB and NS. Mechanical charges made up 39 of 100 cases,

judgment charges made up 29 cases and 32 cases involved both. Seventy-four of the unskilled practice only cases were isolated, 1-time events; 67 of these were from QC, 3 from BC (failed to recognize the drug interaction between allopurinol and azathioprine, allopurinol and mercaptopurine), 1 from AB (needlestick injury while vaccinating/failing to follow up with physician and patient), 1 from ON (failing to assess prescription appropriateness/failing to counsel) and 2 from NL (wrong patient, compounding error resulting in wrong dose). All isolated unskilled practice charges from provinces other than QC involved judgment errors. All isolated errors involving a mechanical charge were from QC, except for the case from NL involving the wrong

TABLE 1 Most common types of professional misconduct, unskilled practice and dishonest business practices charges across 10 Canadian provinces

Professional misconduct	
<ul style="list-style-type: none"> Pharmacy supervision and premises* (85 cases) Failing to comply with college requirements[†] (73 cases) Inappropriate dispensing of narcotic, controlled or targeted drugs not for personal use (70 cases) Stealing narcotic, controlled or targeted drugs for personal use (67 cases) 	
Unskilled practice	
Mechanical	Judgment
<ul style="list-style-type: none"> Wrong drug (44 cases) Wrong dose (42 cases) Wrong dose interval (24 cases) Wrong quantity (7 cases) Wrong patient (5 cases) 	<ul style="list-style-type: none"> Failing to assess prescription appropriateness (53 cases) Failing to counsel on a prescription (41 cases) Failing to follow up with a prescriber or patient[‡] (23 cases) Compounding error resulting in wrong drug or dose (4 cases)
Dishonest business practices	
<ul style="list-style-type: none"> Fraudulent billing practices (101 cases) Accepting professional allowances from generic drug companies or misusing money from professional allowances (53 cases) Other dishonest practices including selling patient records or financial agreements with physicians (31 cases) Selling unapproved medications or samples (27 cases) Unlicensed pharmacy practice such operating an internet pharmacy or dispensing unapproved drugs (16 cases) 	

*Pharmacy supervision and premises charges include leaving the pharmacy unattended, leaving the dispensary accessible to the public, not ensuring that staff are adequately trained, not having required physical structures (e.g., sinks, fridge) and improper storage of drugs.

[†]Failing to comply with college requirements includes ignoring correspondence from the college, not complying with college inspections, failing to complete drug tests ordered by the college or failing to submit proof of professional liability insurance, a history of disciplinary action, a criminal record check or professional development records

[‡]Includes failing to follow up with the prescriber or patient on a medication error or a new prescription or when the situation warrants pharmacist follow-up.

patient. Of the 67 isolated unskilled practice cases from QC, 34 involved mechanical charges, 17 involved judgment charges and 16 involved both mechanical and judgment charges.

Most cases (503) occurred in community pharmacies. Other practice sites included hospital (6 cases), family health teams (1 case) or another place of practice, such as a long-term care home (2 cases) or an unspecified place of practice (46 cases). Most cases involved multiple or repeated charges.

An average annual national incidence rate was calculated by dividing the number of pharmacists facing discipline by the number of practising pharmacists registered per year. Across all provinces, this was calculated to be 3.16 discipline cases per 1000 pharmacists per year. This rate was also calculated separately for each province, to account for variation in the number of pharmacists practising per province (Table 3).²⁵ We used pharmacist workforce data from 2014

since it was the Canadian Institute for Health Information report published closest to the mid-point of the study's time period.

Provincial trends

Trends were observed in province-specific charges. In BC, 26 of 74 cases were fitness-to-practice cases, where pharmacists were temporarily suspended and subject to fitness-to-practice assessments due to mental health or substance use disorder; these issues were not necessarily related to other professional misconduct such as stealing drugs or practising pharmacy while impaired.

In SK, 14 of 26 cases were due to “DIN spinning” in 2010—billing the drug identification number (DIN) of a certain drug but dispensing a generic that is not approved by the provincial formulary as interchangeable.²⁶ Since the dispensed drug is often purchased directly from the manufacturer who offers incentives in the form of rebates, discounts or free product, the

TABLE 2 Most common charges overall for each province

Province	Most common charges
British Columbia (<i>n</i> = 74)	<ol style="list-style-type: none"> 1. Other: Pharmacists not fit to practise pharmacy (26 cases) 2. Pharmacy supervision and premises* (15 cases) 3. Inappropriate dispensing of nonnarcotic drugs to a patient[†] (13 cases)
Alberta (<i>n</i> = 36)	<ol style="list-style-type: none"> 1. Stealing/diverting narcotics, controlled or targeted drugs for personal use (11 cases) 2. Failing to comply with college requirements[‡] (13 cases) 3. Breaching a condition on license (6 cases)
Saskatchewan (<i>n</i> = 26)	<ol style="list-style-type: none"> 1. Fraudulent billing practices (17 cases) 2. Stealing/diverting narcotics, controlled or targeted drugs for personal use (3 cases) 3. Inappropriate dispensing of non-narcotic drugs to a patient[†] (3 cases) 4. Pharmacy supervision and premises* (3 cases)
Manitoba (<i>n</i> = 17)	<ol style="list-style-type: none"> 1. Pharmacy supervision and premises* (4 cases) 2. Inappropriate dispensing of narcotic, controlled or targeted drugs to a patient[†] (4 cases) 3. Failing to keep accurate narcotic records and security (4 cases)
Ontario (<i>n</i> = 104)	<ol style="list-style-type: none"> 1. Inappropriate dispensing of narcotic, controlled or targeted drugs to a patient[†] (34 cases) 2. Fraudulent billing practices (32 cases) 3. Inappropriate dispensing of nonnarcotic drugs to a patient[†] (20 cases)
Quebec (<i>n</i> = 232)	<ol style="list-style-type: none"> 1. Misusing professional allowances from generic drug companies (49 cases) 2. Dispensing error: wrong dose (36 cases) 3. Failing to assess prescription appropriateness (33 cases)
New Brunswick (<i>n</i> = 24)	<ol style="list-style-type: none"> 1. Pharmacy supervision and premises* (10 cases; all related to administering injections without authorization from the college) 2. Failing to comply with college requirements[‡] (5 cases) 3. Stealing/diverting narcotics, controlled or targeted drugs for personal use (4 cases)
Prince Edward Island (<i>n</i> = 9)	<ol style="list-style-type: none"> 1. Practising outside of scope: not having the required training or documentation (5 cases; all related to administering injections) 2. Failing to follow-up with a prescriber or patient[§] (2 cases) 3. Dispensing error: wrong drug (2 cases)
Nova Scotia (<i>n</i> = 17)	<ol style="list-style-type: none"> 1. Stealing/diverting narcotics, controlled or targeted drugs for personal use (8 cases) 2. Practising pharmacy while impaired by drugs or alcohol (6 cases) 3. Failing to comply with college requirements[‡] (6 cases)
Newfoundland and Labrador (<i>n</i> = 19)	<ol style="list-style-type: none"> 1. Dispensing error: wrong drug (5 cases) 2. Failing to counsel on a prescription (4 cases) 3. Pharmacy supervision and premises* (4 cases) 4. Failing to comply with college requirements[‡] (4 cases) 5. Fraudulent billing practices (4 cases)

The most common charges are taken from the 3 categories of professional misconduct, dishonest business practices and unskilled practice combined.

*Pharmacy supervision and premises charges include leaving the pharmacy unattended, leaving the dispensary accessible to the public, not ensuring that staff are adequately trained, not having required physical structures (e.g., sinks, fridge) and improper storage of drugs.

[†]Inappropriate dispensing includes dispensing without authorization from a prescriber, intentionally entering the wrong prescriber, dispensing refills early, dispensing without a prescription and dispensing methadone without witnessing doses.

[‡]Failing to comply with college requirements includes ignoring correspondence from the college, not complying with college inspections, failing to complete drug tests ordered by the college or failing to submit proof of professional liability insurance, a history of disciplinary action, a criminal record check or professional development records

[§]Includes failing to follow up with the prescriber or patient on a medication error or a new prescription or when the situation warrants pharmacist follow-up.

TABLE 3 Disciplinary action incidence rates per province standardized by number of practising pharmacists

Province	Disciplinary action incidence rate (cases/1000 pharmacists/year)	Number of cases (N = 558)	Number of practising pharmacists
Ontario	1.16	104	13,805
Alberta	1.21	36	4590
Manitoba	1.83	17	1428
Prince Edward Island	2.00	9	181
British Columbia	2.25	74	5061
Saskatchewan	2.77	26	1444
Newfoundland and Labrador	3.16	19	698
Quebec	4.15	232	8600
Nova Scotia	4.19	17	1310
New Brunswick	7.65	24	845
Total	3.16	558	37962

Statistics for the number of practising pharmacists were obtained from the Canadian Institute for Health Information's 2014 report, which is closest to the midpoint of this study's data.²⁵

pharmacist makes a significant profit from the sale of the prescription as a result of "DIN spinning."²⁶ Among the other provinces, only MB and NL saw DIN spinning, each with 2 cases.

In QC, 49 of 232 cases involved misusing money from professional allowances from generic companies between 2000 and 2004; these cases were not heard until 2010.

Full (expanded) scope of practice

Twenty-four cases involved activities considered to be an expansion of scope from usual dispensing-related activities. Four cases involved renewing a prescription without authorization or adding refills without authorization or renewing the prescription with the intention to bill the patient's insurance repeatedly. Four cases involved adapting a prescription, such as adapting without authorization or adapting without documenting the proper rationale. Seventeen cases involved not having the required training to provide the clinical service (e.g., cardiopulmonary resuscitation or first aid training, injections training, prescribing authorization/prescribing a medication outside the pharmacist's scope). Other examples of not having the required training include injecting certain age

groups not included in provincial college regulations (e.g., injecting a child younger than 5 years of age in a province where this is not permitted) and administering injections without registering injections training with the college. Fines and professional development were the most common penalties applied to these cases involving full-scope services. One pharmacist had his licensed revoked; however, he was found guilty of many unskilled practice and professional misconduct charges, including pharmacy supervision charges, dispensing narcotics without authorization and sexual harassment.

Restrictive action

The 8 most common penalties in order of decreasing frequency were fines, temporary license suspensions, professional development, reprimands, conditions on license, publication, fitness-to-practice assessments and license revocations (Figure 2). These are defined in Appendix 1 and the most common penalties per province are reported in Appendix 2 (both available in the online version of the article). When multiple penalties were applied for 1 case, each penalty was recorded; most cases used multiple penalties. Some provinces were observed to apply certain

FIGURE 2 Penalties applied in disciplinary cases ($N = 558$) from 10 Canadian provinces

penalties regardless of the charge. For example, fines were applied in all cases from AB, MB and NS and in all but 1 case from SK and QC. Publication was applied in all cases from SK and NS; reprimands were applied in 100 of 104 cases from ON, and professional development was applied in 23 of 24 cases from NB. In total, 80% (447/558) of all cases included a fine or payment of the costs of the investigation. The average fine was \$7523, ranging from \$250 to \$70,000. Costs were charged as either a percentage of the costs incurred or as a dollar amount, where the average cost was \$10,183, ranging from \$500 to \$180,000 or 96% of the costs, ranging from 17% to 100%.

Forty-four percent (245/558) of cases included a license suspension, with the average suspension being 10 months and ranging from 10 days to 8 years. Of the 33% (185/558) of cases that included a requirement of professional development, the most common requirement was taking a course, such as a course in business, ethics, pharmacy practice, pharmacy management, quality assurance or methadone maintenance treatment.

Reprimands were applied in 33% (183/558) of cases and either took place before the disciplinary committee or panel or as a formal letter.

Conditions were applied in 30% (168/558) of cases. Conditions imposed on pharmacists'

licenses were similar across provinces and could include the following in order of decreasing frequency: not allowed to be a pharmacy manager, the requirement to notify future employers and the college of new places of work, not allowed to have a proprietary interest in a pharmacy, more frequent audits by the college, not allowed to work alone and not allowed to be responsible for narcotic inventory.

Publication of the disciplinary case or a summary of the case were applied in 25% (138/558) of cases. Notably, many cases are published by a college even when publication is not listed as a penalty.

Fitness-to-practice assessments were applied to only 10% (56/558) of cases, as it was typically used in cases that involved substance use or mental health disorders.

Finally, license revocation forms the most serious and least common penalty, as it prevents the individual from practising or presenting themselves as a pharmacist to the public; there were 23 revocations overall (4% of cases). Most cases of revocation involved a charge of unprofessional conduct (22/23 cases), and 1 case involved dishonest business practices only. Four cases involved a charge of unskilled practice. Seven cases involved breaching a condition on

a license, and 9 cases involved narcotic diversion or trafficking.

Some provinces assigned less common penalties such as letters of apology to the patient or their family (BC, PEI, NS), an acknowledgment of wrongdoing kept on the pharmacist's file (NB), an agreement not to repeat the conduct (BC), a donation to charity (QC) and restriction on the use of certain unauthorized designations (e.g., "Member Emeritus SCP [Saskatchewan College of Pharmacists]" in SK).

Discussion

This review of Canadian disciplinary cases shows that most cases involve professional misconduct or dishonest business practices rather than unskilled practice charges and that most cases occur in community pharmacies. Most cases involve multiple charges over time rather than an isolated event and result in multiple temporary penalties rather than license revocation. Given the time span and the number of provinces included, this study suggests that disciplinary action against a pharmacist for an isolated, unintentional clinical error is not common in any province. In addition, our results suggest that losing a license for any reason is rare. In light of this, fear of disciplinary action should not be a barrier to practice change or the provision of full-scope patient care services.

Pharmacists should not be concerned about losing their license for an isolated clinical error or an unexpected adverse event from a drug—this did not happen in any of the cases. Disciplinary action that resulted from the provision of full-scope activities did not arise because of adverse events but were largely because pharmacists were not abiding by college regulations. Pharmacists should recognize that they are usually not penalized for an error that a competent pharmacist in a similar situation may also have made. In a case from Ontario in which a pharmacist dispensed the wrong drug and tried to conceal the error by lying to the college and changing pharmacy records, the disciplinary panel said, "Dispensing errors will happen. Pharmacists are human. But it is how they are handled, once detected, that is the measure of the professional."²⁷

Some limitations to our results should be considered. First, because colleges reserve the right not to publish certain disciplinary cases (e.g., cases of a particularly sensitive nature or those where the pharmacist is easily identified),

our research might not capture all cases in the time frame. Second, our results do not tell us about the types of complaints that did not result in discipline since we included only cases that resulted in restrictive action. Third, the review did not consider the outcomes of any appeals or judicial reviews of the tribunal's decisions. Last, this study reviewed only penalties applied from the administrative law perspective (i.e., college tribunals) and did not include civil or criminal law proceedings that may also have occurred.

Similar to our results, UK researchers Phipps et al.⁹ found that violation of standards and dishonest behaviour were more common than dispensing errors and controlled-drug errors. In a review of complaints against 14 health care professions, Australian researchers Spittal et al.⁷ found that complaints related to health impairments (e.g., drug and alcohol misuse), unlawful prescribing or use of medications and sexual abuse were more likely to result in disciplinary action than clinical care complaints. In a review of disciplinary action for Canadian physicians, the 3 most common violations were sexual misconduct, standard-of-care issues and unprofessional conduct; this differs from our data, as sexual misconduct did not make up a substantial number of cases.¹⁰

In terms of who was disciplined or why they were disciplined, our findings were similar to other jurisdictions and professions. Regarding repeat offenders, a review of physician license revocations by the Texas Medical Board found that repeat offenders were more likely to have their license revoked.²⁸ Our results appear to be consistent with this. In terms of practice setting, most cases in both UK studies involved community pharmacists rather than hospital pharmacists or pharmacists not providing patient care.^{8,9} This agrees with our results and could reflect the higher number of pharmacists working in community settings. One of the UK studies also noted that pharmacists often face multiple charges.⁸ Notably, existing research on both pharmacists and physicians highlights that the frequency of being reported to regulatory agencies was low and that the frequency of a complaint resulting in a penalty was even rarer.^{7,8,10}

Our results showed that fines are the most common penalty faced by Canadian pharmacists, which is similar to the United Kingdom and Australia, but Canadian rates of suspension and revocation differed from these countries. The Australian analysis grouped license

suspension and revocation together and found that only 0.3% of cases fell into this category.⁷ In contrast, we coded them separately and found that suspensions were the second most common penalty and revocations the least common. One pharmacy-specific UK study even found a “striking off” rate of 46%, which included both suspensions and revocations, highlighting a wide range in the use of these penalties.⁸ By comparison, a review of disciplinary action against Canadian physicians was more similar to our results, where fines and license suspensions were the most common and revocations the least common.¹⁰ Given that our data are more closely aligned with Canadian physician data than UK or Australian data, it is possible that cultural norms and differences between countries factor into the distribution of penalties.

A few hypotheses might account for differences between provinces. First, most colleges have a series of committees that review complaints. A recent review of physician disciplinary action for all 50 states in the United States found significant variation in rates of disciplinary action across the country.²⁹ Their main hypothesis was that differences arise from the variety of steps in the discipline process that are contingent on decisions by medical boards combined with different standards or thresholds of each medical board. When a regulatory body is focused on deterring a specific charge, for example, they may have a lower threshold and different penalties compared with another jurisdiction. This might account for the increased number of unskilled practice cases in QC. Second, some penalties, such as conditions placed on a license, fitness-to-practice assessments and professional development, require colleges to ensure that the pharmacists abide by conditions or complete requirements. This might cause regulatory bodies to favour penalties that consume less time and resources, such as fines. Third, trends in some jurisdictions, such as DIN spinning in SK and generic rebates in QC, might have skewed the overall distribution of cases in favour of professional misconduct.

BC saw more fitness-to-practice cases than other provinces, which highlights differences in how each province handles cases that involve substance use and mental health disorders. In contrast, Ontario saw few fitness-to-practice cases, because most cases are settled voluntarily by the pharmacist who agrees to a treatment

plan, meaning that such cases do not progress to either a discipline committee hearing or a fitness-to-practice hearing.³⁰

Since scope of practice and legislation are continuously changing, the type of disciplinary cases may also change. Ontario's update to the Professional Misconduct Regulations in May 2017 and clarification of what constitutes misconduct might affect the type and number of cases.³¹ But the question remains whether increased awareness and deterrence through publication of disciplinary decisions is enough to discourage misconduct or whether other measures should be used, such as more thorough screening of pharmacy school applicants and international pharmacy graduates or more rigorous professional development requirements.

Another example of changing legislation is the stricter Canadian opioid-prescribing guidelines that were published in 2017.³² Discipline cases are typically identified through insurance audits, routine college inspections or complaints from patients or practitioners, but 2 Ontario cases in 2017 were triggered using the provincial prescription monitoring program to identify narcotic prescribing practices above the cutoffs recommended in the 2014 guidelines. If colleges begin to use the more conservative cutoffs to identify discipline cases, the effects on patients and prescribers should be watched. Furthermore, as full-scope services become the norm, pharmacists must consider that failure to provide a needed service when clinically appropriate may be considered an error of omission, with implications for patient safety and assessments of professionalism and skilled practice.

Areas for future research are numerous. Characteristics of offenders, such as gender, international pharmacy education and/or number of years of experience, and their working conditions, such as working alone or being the pharmacy manager, should be studied. Second, reasons for interprovincial differences can be explored. Third, further research can study the rate of reoffending, whether subsequent charges are similar to previous ones and if reoffending triggers more severe penalties. Fourth, many discipline cases begin as complaints, but not all complaints result in disciplinary action investigations. A review of all complaints brought to colleges could provide insight into the types of complaints that are settled informally between the complainant and the pharmacist/pharmacy compared with the complaints that

are investigated by the discipline committee. Last, our results should be compared with other health professions and over time as scope of practice continues to expand and be adopted.

We hope that our results will dispel misconceptions (or, some may argue, excuses) that hold pharmacists back from providing safe, effective care and will help them feel more confident in providing full-scope activities. Results of this project can be shared with pharmacy students and community pharmacists, as they are the ones who will lead the profession in offering these services. Our findings can be shared with chain pharmacy administrators, who have the power to decide whether to prioritize full-scope activities in their companies. This work can also be used to generate discussion with pharmacy colleges and associations about addressing this perceived barrier to uptake of full-scope services and form the foundation for future research on the factors influencing pharmacists' clinical decision-

making. Finally, our results may affect other practices, such as adverse drug event reporting. Fear of punishment and litigation should not continue to be a barrier to reporting, since our research suggests that most disciplinary cases are related to professionalism and not clinical errors and because reporting is often confidential.³³

Conclusion

This review of disciplinary cases suggests that disciplinary action against a pharmacist for an isolated, unintentional clinical error is not common and that losing a license is rare. Pharmacists should not consider the fear of disciplinary action to be a barrier (or excuse) to practice change or the provision of full-scope patient care services. Dissemination of this information to pharmacy students and practising pharmacists can dispel misconceptions regarding the disciplinary process and can encourage the uptake of full-scope activities. ■

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