April 1999

North Carolina Board of Pharmacy

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Published to promote voluntary compliance of pharmacy and drug law.

Item 997 – Disciplinary Actions

November Pre-Hearing Conference Recommendations

Linwood Hamilton, Mt. Airy (DOB March 25, 1966). Heard by Board Member Moose. Dispensing Vicodin without a prescription. Consent Order entered: Official Board Reprimand. Accepted by Hamilton November 16, 1998; accepted by the Board November 24, 1998.

Ronald C. Norris, Hendersonville (DOB February 8, 1960). Heard by Board Member Moose. Numerous dispensing errors committed during the practice of pharmacy. Consent Order entered: License suspended 14 days, stayed two years with conditions. Accepted by Mr. Norris November 16, 1998; accepted by the Board November 24, 1998.

Drug Emporium, 5401-230 A South Boulevard, Charlotte. Heard by Board Member Moose. Pharmacy operating without a pharmacist-manager for a period exceeding the 30-day allowance; misbranded and prescription drugs more than six months out of date found common with the dispensing stock. Consent Order entered: Permit suspended five days, stayed three years with specific conditions. Accepted by Mary Ann Largen on behalf of Drug Emporium November 16, 1998; accepted by the Board November 24, 1998.

Eckerd Drugs, 1115 Silas Creek Parkway, Winston-Salem. Heard by Board Member Moose. Pharmacy operating without a pharmacist-manager for a period exceeding the 30-day allowance. Consent Order entered: Permit suspended five days, stayed two years with specific conditions. Accepted by George Veltri, pharmacy operations manager for Eckerd Drugs November 23, 1998; accepted by the Board November 24, 1998.

Return Goods Hearings

The Board held hearings in December 1998 for companies whose return goods policies were not in compliance with Board Rule .2901: Cetylite Industries, Inc., Pennsauken, New Jersey; SoloPak, Boca Raton, Florida; Fujisawa USA, Inc. & Fujisawa Healthcare, Inc., Deerfield, Illinois; and Baxter Healthcare Corporation, Deerfield, Illinois. It is the order of the Board that the above listed companies' products are ineligible for use in product selection in North Carolina.

Pre-Hearing Conference Recommendations Pursuant to CE Audit – January 1999

Pre-hearing conferences resulting from discrepancies found during the 1998 continuing education (CE) random audit were held in September and heard by Board members Watts and Lockamy. After reviewing each case, a proposal was made to request an additional five contact hours of CE from deficient pharmacists during calendar year 1999, to be included on the renewal application for the year 2000. Proposals were accepted by the following pharmacists and by the Board members on January 19, 1999: Clifford Bizzell, Raleigh, and Kate Mesame Ejedepange-Koge, Fayetteville.

Item 998 - Board Member Election

Pharmacists in North Carolina should be alert to the mailing they should have received in late March or early April that contained the ballots for two elections for Board membership. There are two positions open for terms that begin in the spring of 2000, one for the south central part of the state, and the other for the northeast region. Each district has several candidates, and the time for filing had not yet expired at the deadline for this newsletter.

Please exercise your civic and professional duty by voting in this important election. North Carolina is the only state where licensed pharmacists can elect their Board representatives, and the Governor must appoint whoever is elected. Please protect this precious privilege.

Item 999 - Historical First

For the first time in North Carolina's history, as of January 1999, the majority of active pharmacists are women. Board statistics reveal that, both full-time and part-time, there are 3,227 female pharmacists active in this state and 3,223 male practitioners. These statistics reflect recent graduation statistics from pharmacy schools, which in North Carolina have been about 70 percent female.

Item 1000 - Access to Records

A recent case in Raleigh highlights the need for pharmacists to be constantly vigilant about releasing prescription records. The February 6 edition of the *News & Observer* reported on a motorist who had been stopped by police for suspicion of driving under the influence of alcohol or other drugs. His breathalyzer reading was zero, and he explained that he had been taking prescription medicine for a health condition. Cary police charged him with driving while impaired, then checked out his story by asking his pharmacy for a list of drugs purchased there. The chain pharmacist asked a supervisor for advice and was told to give the records to the officer. The court eventually ruled that the citizen was impaired by the prescription drugs and found him guilty of driving under the influence during the 1997 incident.

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NABP to Verify Licensure of Internet Pharmacy Practice Sites

The National Association of Boards of Pharmacy (NABP) has announced its decision to develop the NABP Verified Internet Pharmacy Practice Sites (VIPPS), a new program that will verify the licensure of Internet pharmacy practice sites and inform the public of those Web sites that are licensed in good standing with the appropriate state board(s) of pharmacy or other regulatory agencies. Those Internet sites receiving NABP verification will be listed in the VIPPS database on www.nabp.net, NABP's Web site, and made accessible to the public free of charge.

Explaining the Association's decision to create the VIPPS program, NABP President Kevin E. Kinkade noted, "While a growing number of legitimate Web sites are coming on-line to dispense prescription and over-the-counter medications and provide counseling, the medium has attracted a visible band of unlicensed and unscrupulous entrepreneurs who are interested only in a quick profit, often at the patient's expense. These sites frequently operate for a short time at one Web site address before disappearing and setting up shop under another name to escape detection." Kinkade said that NABP became aware of the need for the license verification service during the past year, as several states reported consumer complaints related to Internet pharmacy practice sites.

Internet pharmacy practice sites that wish to receive NABP verification will submit a detailed application that requests information about the site and its services.

"It is our intent to have a prototype of the new NABP VIPPS database completed this spring," said Kinkade. "The site is expected to be fully operational by the end of 1999."

FDA Issues Final "MedGuide" Regulation

The Food and Drug Administration (FDA) recently issued a final regulation that requires the distribution of Medication Guides, also known as MedGuides, to patients receiving prescription drugs and biological products that, in the FDA's determination, pose a serious and significant public health concern. Medication Guides, according to the FDA, will contain FDA-approved drug information and will improve public health by providing information necessary for patients to use their medications safely and effectively.

MedGuides must meet numerous specified conditions, including that they must be written in non-technical, understandable English, and must be non-promotional in tone or content. In addition, MedGuides must convey to patients specific information, including the drug product's indications and safe use, as well as the particular serious and significant public health concerns that created the need for the MedGuide.

The regulation requires that MedGuides be provided to patients if the FDA determines: 1) The drug product is one for which patient labeling could help prevent serious adverse effects; 2) The drug product is one that has serious risks (relative to benefits) of which patients should be made aware because information concerning the risks could affect patients' decision to use, or to continue to use, the product; or 3) The drug product is important to patient health and adherence to directions for use is crucial to the drug's effectiveness. The FDA anticipates that no more than five to 10 products per year will require MedGuide distribution.

The new rule takes effect on June 1, 1999. For further information, contact Nancy M. Ostrove, Center for Drug Evaluation and Research (HFD-40), FDA, 5600 Fishers Lane, Rockville, MD 20857, 301/827-2828, Ostrove@CDER.FDA.GOV.

NABP Finalizes Confidentiality Guidelines for Patient Compliance/Intervention Programs

In his State of the Union address this past January, President Clinton underscored the importance of assuring the privacy of patients' medical records, particularly with the increased use of electronic access and storage mechanisms.

Announcing his intention to confront the issue in 1999, Clinton said, "As more of our medical records are stored electronically, the threats to our privacy increase. Because Congress has given me the authority to act if it does not do so by August, one way or another, we will protect the privacy of medical records this year."

The National Association of Boards of Pharmacy (NABP) has already begun its own effort to protect the confidentiality of patients' medical information, and to prohibit inappropriate and potentially detrimental patient contact by patient compliance and patient intervention programs whose intent is to promote improved medication use behaviors. In February, NABP's Executive Committee approved "Guidelines for the Confidentiality of Patient Health Care Information as It Relates to Patient Compliance and Patient Intervention Programs," which respond to concerns raised about the practices of some of these programs.

"We want to ensure that patient compliance and patient intervention programs promote compliance with medication therapy without coercing patients to switch medications or jeopardizing the confidentiality of the patient's medical information," said NABP President Kevin E. Kinkade. "The Guidelines are meant to provide appropriate direction and information regarding the design and implementation of, and participation in, such programs."

An initial version of the Guidelines was drafted by NABP with assistance from Massachusetts-based Elensys Care Services, Inc., a company that works with pharmacy operators to develop prescription drug compliance programs to improve patient compliance with medication therapies. That version was released for comment in June 1998, and was subsequently reviewed by NABP's Task Force on Patient Compliance and Intervention Programs.

"NABP received numerous comments regarding the Guidelines," said NABP Executive Director/Secretary Carmen A. Catizone. "Our Task Force reviewed those comments and incorporated what it felt was necessary to protect the public."

Specifically, the Task Force on Patient Compliance and Intervention Programs sought to: 1) prevent the unauthorized release of confidential patient information; 2) give patients the option to participate in or withdraw from such programs at any time; and

3) protect patients from programs that may have as their sole focus economic gain or incentives to switch medications.

The complete text of the Guidelines can be viewed on NABP's Web site at www.nabp.net.

New Law Reduces Potential for Excessive DEA Fines

A recent amendment to the federal Controlled Substances Act (CSA) now makes it less likely that the Drug Enforcement Administration (DEA) will be able to impose significant fines on pharmacies found to have unintentionally violated CSA record-keeping provisions. Signed into law last October, the amendment changes the legal standard for civil violations of record-keeping requirements for control of licit drugs from "strict liability" to "negligence," and reduces the maximum penalty from $25,000 to $10,000. The provision is in response to publicity and concern over the DEA's imposition of significant civil penalties against community pharmacies for minor record-keeping violations.

The accompanying report directs the Attorney General to consider the following when assessing whether to impose civil penalties and determining appropriate fines:

- whether diversion actually occurred or if the record-keeping violations are of such a nature that it cannot be determined whether diversion occurred;
- whether actual or potential harm to the public resulted;
- whether the violations were intentional or negligent in nature;
- whether the violations were a first-time offense;
- time intervals between inspections in which any serious or no violations were found;
- whether the violations were multiple occurrences of the same type of violation;
- whether and to what extent the defendant profited from the illegal activity; and
- the financial capacity of the defendant to pay the fine assessed.

The Attorney General may take into account whether the defendant has taken immediate and effective corrective actions.

FDA Releases Draft Compounding MOU for Interstate Distribution

The Food and Drug Administration (FDA) has released for comment a draft standard memorandum of understanding (MOU) for use by states seeking to comply with the pharmacy compounding provisions of the FDA Modernization Act of 1997 (FDAMA). Developed in consultation with the National Association of Boards of Pharmacy (NABP), the "Memorandum of Understanding on Interstate Distribution of Compounded Drug Products" describes the responsibilities of the states and the FDA in investigating and responding to complaints related to compounded drug products distributed interstate, and addresses the interstate distribution of inordinate amounts of compounded drug products.

The FDAMA's provisions exempt compounded drug products from certain Federal Food, Drug and Cosmetic Act requirements, provided the compounding is conducted under either of the following conditions: 1) the state in which the drug is compounded has entered into an MOU with the FDA "which addresses the distribution of inordinate amounts of compounded drug products interstate and provides for appropriate investigation by a state agency of complaints relating to compounded drug products distributed outside such state;" or 2) the state in which the drug is compounded has not entered into such an MOU and a licensed pharmacist, pharmacy, or physician "distributes (or causes to be distributed) compounded drug products out of the state in which they are compounded in quantities that do not exceed five percent of the total prescription orders dispensed or distributed by such pharmacy or physician."

The draft standard MOU, published in the January 21, 1999 *Federal Register*, can be viewed on the FDA Web site at www.fda.gov.

Until at least 90 days after the standard MOU is finalized and made available to the states for their consideration and signature, the FDA intends to exercise its enforcement discretion. This means the FDA will not normally take regulatory action regarding the requirement that a licensed pharmacist, pharmacy, or physician may not distribute, or cause to be distributed, in interstate commerce compounded drug products constituting more than five percent of the total prescription orders dispensed or distributed.

Pharmacy Manpower Shortage Seen

A recent survey conducted by the National Association of Chain Drug Stores (NACDS) seems to contradict the widely disseminated projections of the 1995 report of the Pew Health Professions Commission that there would be too many pharmacists for the jobs available in the future. The NACDS survey found manpower shortages in almost every state, with a total of 3,510 open pharmacy positions as of August 1998. NACDS predicts that demand for full-time pharmacists in chain community retail pharmacy practice will increase more than 25 percent during the next two years.

The manpower shortage is also a concern in hospital practice settings. A recent issue of *Hospital Pharmacist Report* states that by 2006, government sources predict a 7.4 percent increase in the number of hospital pharmacy jobs, including staff and management positions. Hospital recruiters note that while they face stiff competition from retail pharmacies that may offer more attractive salary and benefit packages, the hospital setting continues to attract pharmacists who enjoy performing more clinical tasks.

Fueling the pharmacy manpower shortage is a decrease in the number of pharmacy school graduates. The American Association of Colleges of Pharmacy (AACP) estimates that the number of pharmacy graduates peaked at 8,003 in 1996 before dropping to 7,772 in 1997, the most recent year for which statistics are available. Early indications from the colleges of pharmacy to the National Association of Boards of Pharmacy (NABP) point to even lower numbers in 1998 and 1999.

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In this regard, it is helpful to review G.S. 90-85.36, which can be found at www.ncbop.org by scrolling down to drug laws and going to the above citation. It lists 14 specific instances when pharmacists may release records. It is worth noting that the word "may" in the law is permissive and not mandatory. The word "shall" requires certain action, and that is much different than the language in the statute. Records are also available to Board inspectors by rule and, of course, on subpoenas or court orders.

Item 1001 – Work Condition Rule

In the January issue, Item 992 informed pharmacists of the status of the rule on work conditions. Subsequently, the Rules Review Commission objected to the rule, placing it in limbo at the deadline for this issue of the newsletter. The members have authorized staff to pursue a remedy in the courts if necessary. You can find more recent information on the Board's Web site at www.ncbop.org.

Item 1002 – Return Goods Rule

Return Goods Rule: Pursuant to the state's Product Selection Law, the Board adopted rule .2901 in October 1991. It reads:

.2901 Return of Outdated Drugs

Adequate provisions for return of outdated drugs both full and partial containers as provided in G.S. 90-85.28(a)(5) means that drugs can be returned up to six months after the labeled expiration date for prompt full credit for replacement. A finding by the Board that a manufacturer does not meet this standard will cause that manufacturer's products to be ineligible for use in product selection.

History Note: Statutory Authority G.S. 90-86.6; 90-85.28(a)(5), Eff. October 1, 1991.

The Board has had several hearings recently for pharmaceutical manufacturers who allegedly were in violation of the rule. This included a December proceeding involving Abbott Laboratories. The net result is that Abbott has changed its policy for North Carolina pharmacies and will give credit for replacing up to six months beyond the expiration date.

A list of manufacturers who have agreed to comply with the rule can be found on our Web site at www.ncbop.org. There is also a list of those not in compliance.

Item 1003 – First Credentialing Exam

On February 24-25, 1999, the Board of Pharmacy offered voluntary credentialing exams in the disease state management fields of asthma, diabetes, dyslipidemia, and anticoagulation therapy. While the number of candidates was not large compared to a regular licensing exam, participants for future sessions are expected to increase. The tests will be offered on June 2 and 3, 1999, at the Holiday Inn Four Seasons, and September 8 and 9, 1999, at a location to be determined.

Item 1004 – Dentists Prescribing Zyban

In January, a pharmacist called the Board office to inquire about the propriety of a dentist prescribing Zyban. Both the Pharmacy Board and the Dental Board agree that prescribing Zyban or other similar products for smoking cessation is within the practice of dentistry, as it would be a treatment for a condition of the oral cavity.

Item 1005 - Toll-Free and Internet Pharmacies

Board members have expressed serious concern regarding pharmacies operating on the Internet and others soliciting business from the public via toll-free telephone. If these entities are shipping drugs to North Carolina residents, they need to comply with the Board's rule on out-of-state pharmacies. A list of the out-of-state pharmacies registered with the Board can be found at www.ncbop.org. Further developments in this area are in process; see the article on page 2 of this newsletter titled, "NABP to Verify Licensure of Internet Pharmacy Practice Sites."

Item 1006 – Immunizations

The National Institutes of Health has recommended that all hepatitis C patients receive immunizations for hepatitis A and B. Pharmacists should remember this for any patients who have a history that contains hepatitis C. It would be appropriate to contact either the patient or his or her physician as an educational reminder on this issue.

New developments in this field include a vaccine for Lyme disease, which is now available. You can be of great assistance to your patients and/or customers by keeping them informed of this development.

Item 1007 – Pharmacists Giving Poisoning Advice

The Carolina Poison Center has informed the Board of a potential problem with pharmacists giving poisoning advice. At least three situations have occurred in the last four months in which a pharmacist has told the parent of a small child to induce vomiting by sticking a finger down the child's throat. The Carolina Poison Center does not recommend this procedure under any circumstances. It can be dangerous in several ways:

1) the child can bite the finger, which is an infection risk for the parent;
2) the parent can tear the soft tissue in the child's oropharynx, causing bleeding and tissue damage;
3) this procedure may not totally empty the stomach; and
4) it may be unnecessary – the ingestion may be subtoxic or one in which inducing emesis is contraindicated (e.g., caustics, hydrocarbons). Syrup of Ipecac is the only safe method to induce emesis, and it is not recommended that often anymore. Activated charcoal is now available over-the-counter and is the preferred method of home decontamination.

Pharmacists should be giving correct information to the public. If a pharmacist is unsure whether a child needs gastrointestinal decontamination, the poison center is available 24 hours a day to assist the public and health care providers at 704/395-3795.

Item 1008 – Coordinate DME Care

The Board has received several complaints regarding the conduct of certain suppliers who do not fully inform their patients or customers of the source of their goods and services. Incidents have occurred where citizens have complained that a different supplier brought equipment into their home and misrepresented it as being from another company.

Such deceptive practices may be fraud under the Practice Act and rules governing durable medical equipment (DME). Please note that the citizen is entitled to be fully informed of the source of all goods and services prior to their delivery.

Item 1009 - Opinion on Bedding Law

Questions have arisen over a long period of time reagrding the application of the North Carolina Bedding Law as it applies to durable medical equipment (DME) and hospice agencies. John Barkley, an assistant attorney general, clarified the situation in a recent letter. Excerpts from that letter appear below.

The issue is "whether North Carolina Bedding Laws prohibiting the sale of used bedding are applicable to certain

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activities conducted by hospice, by numerous home health providers and home medical equipment companies in North Carolina. My understanding is that the problem arises from a Medicare requirement that imposes a time-limited cap on rentals of beds and mattresses to patients. The requirement states that after the cap has been reached, the bed and mattress become the property of the patient. The question is whether such action constitutes the "sale" of a mattress that invokes the requirements of the bedding laws.

"...this does not constitute a "sale" under the North Carolina bedding law, because there is no actual "sale" of the bedding at the end of the rental period, nor is there a transfer of the bedding to another person as anticipated under 130A-267. Therefore, hospice and other providers of such services are not subject to registration, licensure or sanitization requirements that would apply in the case of the "sale" of used bedding under North Carolina Bedding Laws."

"...hospice and other providers in this scenario are in no way acting as manufacturers of bedding in North Carolina and would not be required to register for a manufacturer's bedding license in North Carolina."

We trust this will aid people in the DME field in their everyday practices.

Item 1010 – Oxygen Recommendation

At the March 2 meeting of the DME (durable medical equipment) Subcommittee, it was the consensus of the members that a minimum of two days or a 48-hour supply of oxygen should be on hand for all patients receiving that therapy. The purpose of such a supply is to have an adequate amount of medication in case of severe weather, such as a hurricane or ice storm, that would prevent normal service visits. Other agencies may suggest a larger quantity, but the DME Committee believes that the two days or 48-hour supply is sufficient at this time. Each individual registrant needs to be guided not just by business concerns in this matter, but also for conscientious service to patients.

While the DME Subcommittee members were discussing this issue, the matter of setting a ratio of back-up concentrators to those in the field arose. The members ask your input on this matter by considering the following statement: for example, if a supplier has 200 oxygen patients, they should have __ backup concentrators for use in emergencies. DME registrants can have input on this issue by visiting the Board's Web site at www.ncbop.org and clicking on the line DME Survey. Mail input to the Board office is also welcome at P.O. Box 459, Carrboro, NC 27510-0459.

Item 1011 – Physician Assistant/ Nurse Practitioner Prescribing

Under current rules, physician assistants (PAs) and nurse practitioners can prescribe up to a seven-day supply of a Schedule II or III drug, providing they have a Drug Enforcement Administration registration. They can prescribe a Schedule IV drug just as a physician registrant can.

As of May 1, both PAs and nurse practitioners will be able to prescribe up to a 30-day supply of Schedule II and III drugs. Please note this change.

Item 1012 – DME Election

Each year, the durable medical equipment (DME) registrants in North Carolina elect a representative to the Board's DME Subcommittee. The position now held by Mr. Wayne Link is up for election this spring. This slot is assigned to respiratory, and nominations are now appropriate for that position. Registrants can be nominated for this position by submitting a petition to the Board office prior to April 20, 1999. Forms for nomination can be obtained from the Board office by calling 919/942-4454.

Ballots are scheduled to be mailed by May 1, 1999. Self-nominations will be accepted, and candidates should be able to represent the respiratory portion of this committee. Again, all individuals who wish to be nominated need to have their nomination form to the Board office prior to April 20, 1999.

Item 1013 – Special Week

The week of June 5-13, 1999, is being highlighted as Cancer Pain Control Awareness Week by several agencies in this state. The Cancer Pain Advisory Committee, the North Carolina Pain Initiative, the Cancer Control Program, and the North Carolina End of Life Coalition all support activities during that week.

A statewide Area Health Education Center (AHEC) teleconference is planned from 7 to 9 p.m. on Tuesday, June 8 at 12 sites, with the target audience being nurses, pharmacists, and physicians. Other planned activities include a segment on the Joe Graedon radio show on June 5 and other media efforts. Please be aware of these activities. For more information, contact Judy Wright at 252/793-9595.

Item 1014 – Grocery Pharmaceuticals

The following was prepared in Spanish and sent to Spanish language newspapers in the state.

People who shop in Latino grocery stores may find products for medicinal use that are restricted to a doctor's prescription in the United States. Scientific and government officials have determined that these drugs are not safe for use without the supervision of a doctor and pharmacist. Items included in this group include tetraciclina, amoxil, penamax, and testosterona.

In the United States, there is a clear separation between drugs available over-the-counter (OTC) and those available only by prescription. The OTC drugs that you see in American pharmacies and grocery stores are safe for use as labeled without a prescription. Other items, such as those mentioned in the first part of this article, must be obtained only by prescription.

These drugs are not "illegal" in the same way as marijuana or cocaine, but their distribution is closely regulated in our health care system. It is contrary to law in the United States to sell these items outside of a licensed pharmacy or without a doctor's prescription. Consuming these products outside of the health care system can be a waste of money at best or, at worst, dangerous due to potentially serious side effects from these powerful drugs.

American society doesn't normally view this as a criminal matter, but one of public health and safety; however, penalties can be imposed in serious cases. Authorities can and do seize these items found outside the health system in order to protect the public from their improper use. If you have health problems, the best course of action is to visit a clinic or doctor's office for the care of a physician, nurse practitioner, or physician assistant, or go to a pharmacy and talk to the pharmacist. If Spanish/English communication is a problem, bring a family member along who can translate conversations. School children can be very helpful to their parents or other family members in these situations.

Item 1015 – Odd Case

The following is a reprint of an article published in the November 29, 1998 issue of the Chapel Hill News.

Wendell Justin Williamson had been treated by Myron B. Liptzin, MD, for mental illness diagnosed as paranoid schizophrenia with delusional disorder prior to his retirement from medi-

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cal practice in May of 1994. In January of 1995, Williamson killed two unarmed persons with a rifle in downtown Chapel Hill, for which he was found not guilty by reason of insanity after a trial in November of 1995. Later, in September of 1998, Dr. Liptzin was found negligent in his treatment of Williamson, and the jury ordered a verdict of $500,000 to Williamson from Liptzin.

Had these facts unfolded 40 years ago, Wendell Williamson would have been institutionalized in a place like Dix Hospital in Raleigh at the first sign of unmanaged mental illness. A movement in the 60's declared that such incarceration violated citizens' rights for behavior that was irregular but not violative of other statutes. In that decade, the population in state mental health institutions decreased by almost 50 percent. By the 90's, less than 10 percent of the state's mental patients were in state hospitals, while over 90 percent were in the community, including Wendell Williamson.

All agree that Wendell Williamson was the perpetrator, killing two unsuspecting and innocent citizens, yet he was found not responsible for these acts. All also agree that Dr. Liptzin was the only person among the litigants in the courtroom to help, perhaps imperfectly, Williamson with his mental illness. The not guilty Williamson was sent to indefinite confinement while the helping Liptzin had a $500,000 judgment as an epitaph to his medical practice. It's obvious that something is not right here. There is an edgy feeling in the health care community about legal proceedings as well as lawyers, and cases like the Williamson matter further aggravate that emotion.

One unexamined result of this case is its effect on pharmacists faced with similar patients. An important key issue in the malpractice case was the failure of Williamson to take his medication, thereby causing his relapse and murderous behavior. The average pharmacist would not see a patient with Williamson's condition every day, but it could happen once a week. After all refills on a prescription have been used, it can be very difficult to reach prescribers for refill authorization. Under these circumstances should the pharmacist refuse to refill prescriptions for such patients and risk the results in the Williamson case? Or should the pharmacist continue to refill the prescription and eventually risk being charged with dispensing the prescription without authorization?

Key testimony in a case like this comes from expert witnesses who offer opinions expected to establish if the defendant met the standards of practice. It is normal for such witnesses to contradict each other, leaving the jury with the challenge of sorting it out. And too often such malpractice cases turn on which side presents the best expert.

North Carolina is known for being one of the most difficult states for the plaintiff to prevail in a medical malpractice case. One barrier is the contributory negligence defense, which states that if the plaintiff has contributed to his injuries, then he cannot recover damages from the defendant. Perhaps it was the plaintiff's diminished capacity or just because the trial was in Orange County, with residents known for liberal views, that caused this defense to vanish.

And this isn't over yet. The case has been appealed, and it is common for damages to be reduced on appeal. The famous case involving a defective paint job on a BMW produced an initial verdict of $2 million, which made the headlines. When this was reduced to $50,000 on appeal, essentially to cover legal fees, the print media buried it in the back pages, and the broadcast media [illegible] result.

As a direct result of my job activities in licensing pharmacists, I have received the irrational, intense, and corrosive attention of a person diagnosed with paranoid schizophrenia. He held me personally responsible for his multiple failures on the licensing exam because I signed his letter informing him of the results. He created havoc in my office, threatened me and my family, physically attacked others producing fractures, sutures, and time in Central Prison. It is clear to me that psychiatric physicians, nurses, and social workers who toil in mental health deserve our admiration, not our litigation.

The *North Carolina Board of Pharmacy News* is published by the North Carolina Board of Pharmacy and the National Association of Boards of Pharmacy Foundation, Inc., to promote voluntary compliance of pharmacy and drug law. The opinions and views expressed in this publication do not necessarily reflect the official views, opinions, or policies of the Foundation or the Board unless expressly so stated.

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