WISCONSIN DEPARTMENT OF REGULATION & LICENSING

Wisconsin Department of Regulation & Licensing
Access to the Public Records of the Reports of Decisions

This Reports of Decisions document was retrieved from the Wisconsin Department of Regulation & Licensing website. These records are open to public view under Wisconsin's Open Records law, sections 19.31-19.39 Wisconsin Statutes.

Please read this agreement prior to viewing the Decision:

- The Reports of Decisions is designed to contain copies of all orders issued by credentialing authorities within the Department of Regulation and Licensing from November, 1998 to the present. In addition, many but not all orders for the time period between 1977 and November, 1998 are posted. Not all orders issued by a credentialing authority constitute a formal disciplinary action.
- Reports of Decisions contains information as it exists at a specific point in time in the Department of Regulation and Licensing data base. Because this data base changes constantly, the Department is not responsible for subsequent entries that update, correct or delete data. The Department is not responsible for notifying prior requesters of updates, modifications, corrections or deletions. All users have the responsibility to determine whether information obtained from this site is still accurate, current and complete.
- There may be discrepancies between the online copies and the original document. Original documents should be consulted as the definitive representation of the order's content. Copies of original orders may be obtained by mailing requests to the Department of Regulation and Licensing, PO Box 8935, Madison, WI 53708-8935. The Department charges copying fees. *All requests must cite the case number, the date of the order, and respondent's name* as it appears on the order.
- Reported decisions may have an appeal pending, and discipline may be stayed during the appeal. Information about the current status of a credential issued by the Department of Regulation and Licensing is shown on the Department's Web Site under "License Lookup." The status of an appeal may be found on court access websites at: http://ccap.courts.state.wi.us/InternetCourtAccess and http://www.courts.state.wi.us/wscca .
- Records not open to public inspection by statute are not contained on this website.

By viewing this document, you have read the above and agree to the use of the Reports of Decisions subject to the above terms, and that you understand the limitations of this on-line database.

Correcting information on the DRL website: An individual who believes that information on the website is inaccurate may contact the webmaster at web@drl.state.wi.gov

STATE OF WISCONSIN

BEFORE THE PHARMACY EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY :

PROCEEDINGS AGAINST FINAL DECISION

AND ORDER

KAREN O.LOEB, R.Ph., LS9804091PHM

RESPONDENT.

The State of Wisconsin, Pharmacy Examining Board, having considered the above-captioned matter and having reviewed the record and the Proposed Decision of the Administrative Law Judge, makes the following:

ORDER

NOW, THEREFORE, it is hereby ordered that the Proposed Decision annexed hereto, filed by the Administrative Law Judge, shall be and hereby is made and ordered the Final Decision of the State of Wisconsin, Pharmacy Examining Board.

The rights of a party aggrieved by this Decision to petition the board for rehearing and the petition for judicial review are set forth on the attached "Notice of Appeal Information."

Dated this 9th day of February, 1999.

Dan Luce, Chair

Pharmacy Examining Board

STATE OF WISCONSIN

BEFORE THE PHARMACY EXAMINING BOARD

IN THE MATTER OF

DISCIPLINARY PROCEEDINGS AGAINST

KAREN O. LOEB, R.Ph. LS9804091PHM

Respondent

PROPOSED DECISION

The parties to this proceeding for the purposes of sec. 227.53, Stats., are:

Karen O. Loeb, R.Ph.

18600 Yorkshire Lane

Brookfield, WI 53045

State of Wisconsin Pharmacy Examining Board

1400 East Washington Avenue

P.O. Box 8935

Madison, WI 53708

State of Wisconsin Department of Regulation & Licensing

Division of Enforcement

1400 East Washington Avenue

P.O. Box 8935

Madison, WI 53709

This matter was commenced by the filing of a Complaint by the Division of Enforcement on April 9, 1998. On or about May 21, 1998, the administrative law judge received a Stipulation executed by Ms. Loeb; by her attorney, Stephen E. Kravit; and by Arthur Thexton, attorney with the Division of Enforcement. By the terms of the Stipulation, respondent agreed that the allegations of the Complaint could be deemed true, with the exception of paragraph 6 of the Complaint. That paragraph alleges merely that Ms. Loeb's admitted actions constitute a violation of the board's statute and code. Attached to the Stipulation is the written statement of Ms. Loeb setting forth her position in the matter, and the statement is stipulated by the parties as true. A copy of the Stipulation and Ms. Loeb's Statement is attached hereto and made a part hereof.

The only remaining issues are whether the factual allegations of the Complaint constitute unprofessional conduct by Ms. Loeb and, if so, what discipline, if any, should be imposed. Written arguments on these questions were submitted, with respondent's brief being filed on July 8, 1998, and complainant's brief being filed on July 24, 1998. Oral arguments were also received on August 19, 1998.

Based upon the entire record in this case, the administrative law judge recommends that the Pharmacy Examining Board adopt as its final decision in the matter the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. Karen O. Loeb (DOB 6/9/53) is and was at all times relevant to the facts set forth herein a registered pharmacist licensed in the State of Wisconsin pursuant to license number 9296, originally granted on December 10, 1977. Her address of record with the board is 18600 Yorkshire Lane, Brookfield, WI 53045.

2. On April 30, 1996, Ms. Loeb was employed by Pharmacy Corporation of America as a staff pharmacist. Her duties at that time consisted of checking hundreds of medication packages prepared by auxiliary personnel for nursing home patients. On that day, she was assigned to check a package to be sent to South Shore Nursing Home for resident Anna H. This patient was prescribed Coumadin® (warfarin) 0.5 mg every other day, and the prescription label read: "Coumadin 0.5 mg tablet. 1 tab every other day PO for deep vein thrombosis take at 4pm." Coumadin® is a blood thinner commonly prescribed for persons with heart conditions and phlebitis, and is familiar to practicing pharmacists. Its dosage must be carefully controlled, as overdoses are known to cause hemorrhage. A prescription for 0.5 mg is an unusually small dosage, but not unheard of, and other patients of respondent's employer were taking this dosage. Coumadin® is not manufactured in a 0.5 mg dosage, and therefore this prescription required that a 1 mg tablet (which is scored) be broken into two halves. The 1 mg tablet is a bright pink color, is a commonly used dosage, and this tablet is familiar to practicing dispensing pharmacists. The 5 mg tablet (another common dosage level) is a light peach color and is also familiar to practicing dispensing pharmacists.

3. Through error, the auxiliary person who had prepared the package of Coumadin® for the patient had selected a pre-made "bubble" or "blister" package of 5 mg tablets, instead of selecting the 1 mg tablets and breaking each tablet in half, and placing these in a blister package, or selecting a premade package of 1 mg tablets which had been broken in half.

4. Ms. Loeb failed to detect the error, and the incorrect dosage of Coumadin® was dispensed to the patient through the nursing home.

5. The Coumadin® tablets described in paragraph 2 are equally familiar to nursing home nurses. The nurses at the nursing home administered the incorrect medication on seven separate occasions, over a 14 day period.

6. The patient died on May 14, 1996, as a result of gastrointestinal bleeding. The attending nurses had failed to detect any signs or symptoms of hemorrhage in Anna H., although such signs were observed to be present after

the patient died.

CONCLUSIONS OF LAW

1. The Pharmacy Examining Board has jurisdiction in this matter pursuant to sec. 450.10(1)(b), Stats.

2. In having failed to detect that her employer's auxiliary personnel had prepared the package of Coumadin® for the patient selecting a pre-made "bubble" or "blister" package of 5 mg tablets, instead of selecting the 1 mg tablets, breaking each tablet in half, and placing these in a blister package, or selecting a premade package of 1 mg tablets which had been broken in half, Ms. Loeb has engaged in pharmacy practice which constitutes a danger to the health, welfare or safety of patient or public, in violation of sec. Phar 10.03(2), Code, and she has therefore engaged in unprofessional conduct within the meaning of sec. 450.10(1)(a)6., Stats.

ORDER

NOW, THEREFORE, IT IS ORDERED that Karen O. Loeb, R.Ph., be, and hereby is, reprimanded.

IT IS FURTHER ORDERED that pursuant to 440.22(2), Stats., Ms. Loeb shall be assessed partial costs of this proceeding in the amount of $250.00.

OPINION

The Stipulation submitted by the parties specifically permits the ALJ to take notice of the discipline imposed by the Board of Nursing on the nurses involved in the transaction described herein, and of similar disciplinary cases before the Pharmacy Examining Board, the Board of Nursing and, with respect to nursing homes, the Department of Health & Family Services.

In terms of the Board of Nursing actions, disciplinary proceedings were brought against Peter J. Drew, R.N., and Cynthia L. Ewert, L.P.N., the nurses who erroneously administered the incorrect dosage to resident Anna H. a total of seven times. The pertinent factual findings in both decisions were consistent with the findings here, and both nursing respondents were found to have failed to meet the minimum standards of nursing practice "because the criterion for safe medication administration was not followed: i.e., incorporating the procedure of checking the labeling of the medication (both front and back) three times against the Medication Administration Record (MAR)." Each nursing respondent was reprimanded, and each was required to complete an approved course in medication administration (one of the respondents had already completed such a course by the time of the proceedings before the Board of Nursing).

The ALJ has also been made aware of what are apparently all disciplinary orders issued by the Pharmacy Examining Board in the past 20 years involving dispensing errors. These include the following:

> Disciplinary proceedings against Larry Woltman, R.Ph., and Dale R. Prey, R.Ph (1993 companion cases); cases similar to this proceeding in that the dispensing error resulted in the death of the patient. In the Prey case, the respondent prepared and dispensed intravenous solutions of 0.17 milligrams of Digoxin. The prescription was for 0.017 of Digoxin, but had been entered erroneously into the computer as 0.17 by another pharmacist. The respondent failed to question such a large dose for an infant patient, who died as a result of the error. Woltman was the pharmacist who erroneously entered the Digoxin prescription into the computer. In the Woltman case, the board also found that the respondent had committed seven other dispensing errors. Both Prey and Woltman were reprimanded and ordered to pay partial costs, in the amounts of $250 and $350, respectively.
>
> John Forbes, R.Ph. (1992) -- The respondent erroneously dispensed Mysoline instead of Mebarel. He was reprimanded, and ordered to pay a $100 forfeiture and $250 of the costs.
>
> Thomas Thomas, R.Ph. (1992) -- Erroneously dispensed methyclothiazide instead of nethylphenidate. Reprimanded and ordered to pay $150 of the costs.
>
> Hubert Buss, R.Ph. (1992) -- Dispensed penicillin VK 250 mg instead of Keflex 250 mg. Reprimanded and ordered to pay $150 costs.
>
> Ernest Tanel, R.Ph. (1992) -- Erroneously dispensed Imodium 2 mg instead of Indocin 25 mg. Dispensed Keflex capsules instead of Seldane tablets. Reprimanded and ordered to pay $300 costs
>
> Jeffery John Otteson, R.Ph. (1993) -- Erroneously dispensed the wrong medication on 16 separate occasions. Reprimanded, prohibited from owning a pharmacy, and required to practice under supervision for at least two years. Ordered to pay $200 costs.
>
> Michael Malaney, R.Ph. (1993) -- Committed nine separate dispensing errors. Reprimanded, prohibited from owning a pharmacy, and required to practice under supervision for at least two years. Ordered to pay $400 costs.

Thomas Finlan, R.Ph. (1993) -- Dispensed cyclobenzaprine instead of cyproheptadine. Reprimanded and ordered to pay $450 in forfeitures and costs.

Kenneth R. Going, R.Ph. (1995) -- Committed seven dispensing errors and failed to provide required consultation with patients. Respondent had been previously disciplined in 1993, and had received a letter of warning less than a year prior to the 1995 action regarding his failure to provide patient consultations. The board ordered extensive limitations and suspended the license until Going passed the jurisprudence examination.

Robert Dustrude, R.Ph. (1996) -- Inadvertently switched labels on two prescriptions for the same client, resulting in incorrect dosages. Reprimanded and required to submit a written plan to avoid future similar errors. Ordered to pay $450 forfeiture and costs.

It is apparent that in recent years at least, the board has considered appropriate discipline for single dispensing errors without aggravating factors to be a reprimand and imposition of a portion of the costs. And this was true even in the cases of Prey and Woltman, where their errors resulted in death of the patient. One must go all the way back to 1981 to find a case where the board imposed more than a reprimand for a simple dispensing error. That case was *the Matter of Disciplinary Proceedings Against Ronald Adler, R.Ph.* The ALJ in that case found that respondent had misread Clonodine for Clonopin on a prescription, and recommended that the respondent be reprimanded. The board instead ordered a three-day suspension, reciting in its Explanation of Variance merely that "the board believes that dispensing Clonodine pursuant to a prescription for Clonopin constitutes a serious danger to the patient."

Notwithstanding the board's relatively uniform historical treatment of cases involving simple dispensing errors, complainant argues that appropriate discipline to be imposed in this case is "suspension for a period of time significant enough to make the seriousness of [Ms. Loeb's] violation clear to the profession and the public." Complainant concedes that the case presents a difficult public policy issue, stating:

> On the one hand, the Board is charged with the responsibility of ensuring that all pharmacists practice with a reasonable minimum skill and safety to the patient and public. This is not a guarantee of error-free professional activity, and if an unintentional error is made, the civil justice system exists to provide recompense for an injured party through malpractice lawsuits and presumably will result in an appropriate outcome for both parties, without need for Board action. Every pharmacist commits human error at some time or other, and whether that error results in patient harm is largely a matter of chance: to discipline pharmacists based on chance or luck is contrary to our legal tradition and perhaps the Constitution, and is intuitively unfair. (State's Argument, p. 1)

Having said that, however, complainant goes on to argue that notwithstanding the inequity in imposing discipline based upon chance or luck, public confidence in the viability of the licensing system requires that the seriousness of discipline imposed be based upon the seriousness of the outcome rather than the seriousness of the underlying conduct.

> The charge of the legislature to the board is not just that it weed out pharmacists who cannot practice competently, but that it weed out those who ***do*** not practice competently regardless of their potential. The commission of such a serious professional error does raise legitimate questions about professional competence. The lay public feels strongly that it has a right to demand that the board discipline licensees whose professional malpractice has caused such egregious injury, for the purpose of preventing errors in the future and to ensure that other pharmacists will be vigilant at all times to avoid being put in the same position. (State's Argument, p. 1) (emphasis in original)

Counsel for Ms. Loeb, characterizing Ms. Loeb's error as "the most inadvertent of inadvertent mistakes," argues that nothing more than a reprimand -- if that -- is appropriate in this case. That argument is based upon a number of factors set forth counsel's brief, to wit:

> Ms. Loeb has practiced for 21 years without incident except for this one.
>
> The error was made in the context of reviewing a large number of medication orders, not in the context of direct patient care, as in the case of the negligent nursing care rendered.
>
> Ms. Loeb made a single dispensing error, while the nurses administering the medication had 21 opportunities to correct the error had they followed nursing protocols. Nonetheless, the nurses received only reprimands.
>
> Since the time of the occurrence in May, 1996, Ms. Loeb has been instrumental in putting new systems in place to help ensure that similar errors will not occur in the future.
>
> The purpose of the board is to identify and correct problems, not to punish isolated instances of simple negligence.

> The affected nursing home received no citation as a result of this incident, despite the fact that all of their systems failed.
>
> A comparison of this case with all other cases with facts similar to the facts here suggests that no discipline should be imposed in this matter.

As to respondent's last point, complainant suggests that the only truly comparable case is the *Adler* matter in 1981, because that is the only other case that was not settled through Stipulation. What is not explained is exactly why that makes *Adler* more comparable to this matter than the other more recent cases. If the suggestion is that the give and take of the negotiating process leading to a stipulation may result in the board's agreeing to a discipline less onerous than is truly deserved, such suggestion flies in the face of the fact that Ms. Loeb would apparently have stipulated to a reprimand without hesitation. The record of this matter makes clear that the only reason this matter was carried through the hearing process was because the state would not accept a resolution consistent with what the board has accepted for many years. In the last analysis, it is entirely consistent for the board to find that the negligent act of this respondent constitutes a danger to the safety of the public within the meaning of sec. Phar 10.03(2), Code, and unprofessional conduct within the meaning of sec. 450.10(1)(a)6., Stats. Such findings make logical and historical sense. Whether it is also consistent to conclude that respondent's negligent act requires serious disciplinary action is a different matter, for to decide that discipline should be dictated by patient outcome rather than by the culpability of the pharmacist's conduct is contrary to historical precedent. The question remains whether it is also contrary to the accepted objectives of licensee discipline and to basic fairness.

Certainly the concept of fashioning a remedy based on the outcome of one's conduct rather than on the nature of the conduct itself is not a novel approach in either civil or criminal law. A negligent act by a physician which results in no harm will not support a negligence action. Exactly the same negligent act when it results in the death of the patient may support a substantial malpractice judgment against the physician. A person may drive drunk a hundred times without being caught. If caught after being stopped for a minor traffic violation, he or she will probably suffer nothing more than an expensive embarrassment. If the drunk driver is involved in a fatal accident, he or she may face Class C felony criminal charges, regardless of whether or not the accident was unavoidable.

These results make sense: The award of money damages when a patient is harmed through medical malpractice merely recognizes that the financial burden created by a physician's negligent act should be borne by the physician rather than by the victim, and that the size of the award should therefore be consistent with the damages suffered. Similarly, the greater punishment accorded to the drunk driver whose actions result in injury to another merely recognizes that a person may be charged with having intended the natural and probable consequences of his wrongful act, and that the seriousness of the punishment should therefore be consistent with the seriousness of those consequences. When one considers the objectives of discipline in proceedings against occupational licensees, however, there is no such obvious nexus between an act of negligence and the consequences of the act as would support the conclusion that the discipline to be imposed should be consistent with the seriousness of the consequences rather than with the seriousness of the negligence. Regardless of the discipline imposed, no financial burden is shifted from the respondent to the victim, and no greater culpability may be imputed to the respondent merely because, through sheer chance, the consequences of his or her act were of greater rather than lesser seriousness.

Nonetheless, counsel for the state argues that appropriate disciplinary objectives would support discipline based on the consequences of a respondent's negligent act without regard for the fact that the negligence may have been a single act of simple human error of the kind that every practicing professional can be expected to make at one time or another. In that regard, counsel states as follows in his written argument:

> The lay public feels strongly that it has a right to demand that the Board discipline licensees whose professional malpractice has caused such egregious injury, for the purpose of preventing such errors in the future and to ensure that other pharmacists will be vigilant at all times to avoid being put in the same position. The lay public is unable to protect itself against such errors, and must rely upon the licensing and discipline process to protect it from unprofessional conduct, including incompetence and malpractice. **While it may seem unfair to discipline based on outcome, it is in fact necessary to uphold professional standards and public confidence in the licensing system**. (emphasis provided) (State's Argument, p. 2)

This concept of disciplining licensees in order maintain public confidence in the licensing system is not original with complainant. In the realm of attorney discipline, it is a concept embraced by the American Bar Association and many state supreme courts. In a 1991 Note in the Stanford Law Review entitled "Why Not Fine Attorneys?," Steven G. Bene reports as follows:

> Modern attorney discipline cases mechanically recite the following goals and purposes for attorney discipline proceedings:
>
> 1. To protect the public;

2. To maintain the integrity and high professional standards of the legal profession.

3. To preserve public confidence in the legal profession.

With no explanation or justification, courts in almost every state offer up these goals before deciding the appropriate penalty in attorney discipline cases. A study of all reported bar discipline cases decided by state supreme courts in 1989 and 1990 in which some statement of the purpose of such proceedings is part of the opinion reveals a remarkable consistency in citing these three justifications for attorney discipline. Equally consistently, courts in all these jurisdictions reject "punishment" of a wrongdoing attorney as playing any part in the decision. *43 Stan. L. Rev. 907, 912*

If almost every state has adopted the cited disciplinary objectives, then Wisconsin is somewhat unique, for the Wisconsin Supreme Court in recent years has consistently characterized this state's disciplinary objectives as rehabilitation of the licensee, protection of the public, and deterrence of other licensees. In *State v. Kelly,* 39 Wis. 2d 171 (1968), the court discussed appropriate discipline of an attorney convicted in part for filing false financial statements with the Wisconsin Department of Securities. In deciding that a six month suspension of the license was appropriate, the court said:

This court considers Kelly's conduct, irrespective of how he initially embarked on this venture, to be highly reprehensible. We are satisfied that disciplinary action is warranted. While a part of the function of a supreme court in exercising control over attorneys is for the purpose of discipline of the offender and as a deterrent to others, it is also concerned with rehabilitation. We consider Robert C. Kelly to be worthy of the opportunity to rehabilitate himself and after suspension to continue in the practice of law. *39 Wis. 2d 171 at 189*.

In *State v. Aldrich*, 71 Wis. 2d 206 (1976), the court expressed the disciplinary objectives in the form it has utilized since, stating as follows:

The purposes of discipline in a professional misconduct case have been stated as: (1) The rehabilitation of the attorney; (2) the protection of the public; and (3) providing a deterrent to other attorneys. *71 Wis. 2d 206, at 209* (citations omitted)

Should there be any question whether the disciplinary objectives followed by the court in attorney discipline cases are also applicable to disciplinary proceedings involving other licensed professions, that question is resolved by the Court of Appeals' discussion of the medical board's disciplinary authority in *galang v. medical examining board*, 168 Wis.2d 695, 700 (Ct. App. 1992), where the court said,

The [Medical Examining] board has broad discretionary authority to discipline a licensee found guilty of unprofessional conduct, and license revocation is one of the available disciplinary options. Section 448.02(3)(c), Stats. The purpose of any such disciplinary action is to promote the licensee's rehabilitation, to protect the public and to deter other licensees from engaging in similar conduct. (citing *State v. Aldrich, supra*)

But if these are in fact the applicable disciplinary objectives in Wisconsin, which of them are subserved by fashioning discipline based on patient outcome rather than on the culpability of the licensee? One looks in vain to find in Wisconsin supreme court reports on attorney discipline the mechanism by which the court considers various forms of discipline to fulfill the disciplinary objectives, or the nexus between a particular discipline and the desired rehabilitative, deterrent or public protection result. In the Stanford Law Review Note cited above, Mr. Bene describes this lack of analytical framework by state supreme courts in explaining the manner in which discipline satisfies the disciplinary goals.

Though several states cite court rules and bar codes to find the stated purpose of disciplinary proceedings, this becomes a game of the judiciary chasing its own tail. For example, the commentary to the American Bar Association's Standards of Lawyer Discipline and Disability Proceedings Standard 1.1 repeats the case law focus on non-punitive sanctions, protection of the public, and the attorney's right to continue in practice. Instead of principled reasoning, Standard 1.1 merely cites another court case, *In re Echeles*, as authority for its conclusions. A court relying on the Discipline Standards . . . is therefore merely relying on the ABA's restatements of older but no more enlightening, case holdings. The entire jurisprudence of attorney sanctions thus rests on a circular, and foundationless analytical structure. Modern cases cite without argument restatements of older, but equally vacuous cases until the trail disappears into a historical mist. *43 Stan. L. Rev. 907, 915*.

But while it may not always be possible to justify a particular form or degree of discipline based upon the result sought, it is possible to demonstrate that to base discipline upon the consequences of a licensee's conduct rather than on the blameworthiness of that conduct is antithetical to the established disciplinary objectives. Considering those objectives individually:

Protection of the public. Again, complainant concedes that respondent's negligent act was the kind of human error that every pharmacist commits at some time or another, that the error in this case was not intentional, and

that it was ordinary negligence as opposed to gross negligence or recklessness (State's Argument, p. 1). The question thus becomes what protection will be afforded to the public in this case by imposing severe discipline, including a significant period of suspension of the license. Complainant argues that such discipline should be imposed "for the purpose of preventing such errors in the future and to ensure that other pharmacists will be vigilant at all times to avoid being put in the same position." Counsel fails, however, to explain exactly how either imposition of severe discipline or pharmacist diligence will prevent inevitable human error. Such disciplinary action could, conceivably, provide the public with the illusion that the licensing system is working effectively, but unless there is in fact a nexus between the severity of discipline and a diminution of human error, this appearance of effectiveness is nothing more than a chimera gained at the cost of a basic lack of fairness to the hapless licensee whose simple negligence has resulted largely through chance in harm to a patient. Counsel for the state all but concedes the point when he states in the State's Argument as follows:

> There is a legitimate body of thought in pharmacy that "human error" type practice errors are inevitable and that when they occur, Boards should confine themselves to reviewing systems, for the purpose of ensuring that every pharmacy has a functioning and adequate system for catching the inevitable human errors. (State's Argument, p. 2)

In this single sentence, counsel both concedes the futility of attempting to remedy simple human error through discipline of the individual pharmacist and suggests the one eminently logical course of regulatory action that has some possibility of actually contributing to the protection of the public.

Deterring other licensees from engaging in similar conduct. Most licensed pharmacists would undoubtedly wince at the specter of a competent and conscientious pharmacist confronting serious disciplinary action not because she committed an error of a kind that is conceded will be committed by every pharmacist at one time or another, but rather because a combination of circumstances -- including multiple instances of negligent behavior by other health care practitioners -- have led to an unfortunate patient result. To assume that the average pharmacist will be thereby deterred from making a similar error, however, assumes that he or she can, through some exercise of will, achieve perfection or something approaching it. It is certainly possible that the careless or uncaring pharmacist may derive a message from such disciplinary action, but it may not be the message intended. The inference that could well be drawn is that no matter how many dispensing errors are committed, no serious disciplinary action will be taken except in the unlikely event that serious patient harm occurs; and that no matter how careful one is, any isolated error a pharmacist commits could result in loss of livelihood if the error results in unforeseen and unforeseeable consequences. Even if imposition of rigorous discipline may have the effect of deterring the careless pharmacist, it can hardly be gainsaid that the proper circumstance for imposition of such discipline is in response to the pharmacist who cannot or will not conform his or her practice to the appropriate professional standard, rather than the conscientious pharmacist who is to some extent a victim of circumstance.

Rehabilitation of the licensee. Complainant does not claim that this respondent is in need of professional rehabilitation, and any such claim would be without basis in this record.

Finally, complainant argues that "it is reasonable to infer that respondent did work in a system that was inadequate, and that she knew or should have known of its inadequacies." If so, as the state's argument runs, she should have sought change within the system and, if unsuccessful in that effort, should have resigned. This is an allegation raised for the first time in the state's written argument, and is based on respondent's description, in her statement accompanying the Stipulation, of the system and procedure in use at Pharmacy Corporation of America at the time of the incident giving rise to this proceeding, and of the improvements made to the system since that time. Complainant thus attempts to turn mitigating evidence on its head to create an aggravating factor. The fact that the system previously in place may not have contained safeguards subsequently initiated is irrelevant to the underlying issue which is the subject of this proceeding, and should not be considered as a factor in determining appropriate discipline.

It is concluded that to impose a suspension of Ms. Loeb's license based upon the consequences of a combination of errors occurring before, during and after respondent's intervention, rather than upon the nature of respondent's negligent act, will lead to a result that is disproportionate to discipline historically imposed by the board in cases involving similar simple dispensing errors and disproportionate as well to the seriousness of the conduct involved. Such a result is

also inconsistent both with the established disciplinary objectives and with basic precepts of fairness. Accordingly, I recommend that respondent be reprimanded and ordered to pay partial costs of the proceeding in the amount of $250.

Respectfully submitted.

Dated this 10th day of December, 1998

Wayne R. Austin

Administrative Law judge