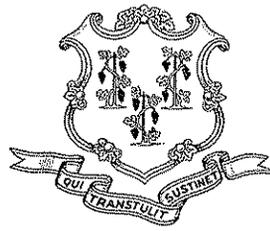


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February 5, 2009

Good Afternoon Senator Colapietro, Representative Shapiro and members of the General Law Committee. I am here to testify in support of SB 325, AN ACT CONCERNING A PHARMACY ERROR DATABASE AND PHARMACY COMMISSION MEETING MINUTES. This issue was brought to my attention by a constituent. At present, there is no way for consumers to discover which pharmacists and pharmacies have the best or worst safety records. Most healthcare providers are regulated by the Department of Public Health and last year in PA 08-109 the General Assembly extended the requirement that DPH collect certain information to create an individual public profile on each physician licensed to practice medicine in Connecticut to also include dentists, chiropractors, optometrists, podiatrists, naturopaths, dental hygienists, advanced practice registered nurses, and physical therapists licensed to practice in Connecticut. DPH also provides access to reports of discipline and consent orders on its website. I believe that the Department of Consumer Protection

should provide consumers with the same information with regard to pharmacists and pharmacies.

The constituent received two incorrect prescriptions for her infant daughter. She received **ear** drops which were marked "Put 3 drops in left **eye** every 2 hours" and she received an incorrect antibiotic which was given at 4X the appropriate dose. Fortunately, she called the pharmacy in regard to the ear drops as she could not understand why she was being instructed to put drops in the eyes of a child with an ear infection; the pharmacy admitted that the label was in error and that the drops should go in the ears. Unfortunately, the second error of type and dose of antibiotic was not apparent to a layperson. She administered the dose listed on the label and became concerned when the drug ran out days before it should have. Ultimately she discovered that her daughter should have been administered Augmentin, but the bottle contained Zithromax. The directions were for a dose that would have been appropriate for Augmentin but was far too high a dose for Zithromax. The infant then could not be given Augmentin immediately for fear of side effects from the mega-dose of Zithromax. The child has had persistent problems with her ears ever since.

After this experience, she attempted to look up the safety records of pharmacists and pharmacies. She discovered that there are no profiles for pharmacists such as the ones DPH maintains on physicians.

She contacted the Department of Consumer Protection's Drug Control Division and followed through with everything she was asked to do. She turned over the medications to help with the investigation and made herself available in case she would be needed for any hearings only to discover that citizens of the state of Connecticut are not entitled to information concerning pharmacy errors. I urge you to pass this important legislation which would provide increased transparency and allow more informed decision making by consumers.

Thank you.