

# SUBJECT TO RESOLUTION COMMITTEE REVIEW

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 501  
(JUN-21)

Introduced by: New York

Subject: Ensuring Correct Drug Dispensing

Referred to: Reference Committee E

Whereas, Medication errors affect millions of people every year with the clinical and economic consequences of those errors having been widely documented; and

Whereas, Much is known about hospital medication errors because of their well-established reporting systems for continuous monitoring; and

Whereas, In a hospital a dispensing error can be detected and prevented by nursing personnel at the administration stage; and

Whereas, *The New York Times* published an article entitled "*How Chaos at Chain Pharmacies Is Putting Patients at Risk*" which stated that pharmacists at companies such as CVS, Rite Aid and Walgreens described understaffed and chaotic workplaces which made it difficult to perform their jobs safely and can lead to "dispensing errors"; and

Whereas, Currently, in some states, any drug dispensed must bear a label on its container which identifies the name and address of the owner of the establishment in which it was dispensed, the date compounded, the number of the prescription under which it is recorded in the pharmacist's prescription files, the name of the prescriber, the name and address of the patient, and the directions for the use of the drug by the patient as given upon the prescription; and

Whereas, When a prescription is filled in a retail pharmacy, the last checkpoint for safety is the patient or caregiver who may not have the training and knowledge to know that the dispensed drug is actually the medication prescribed; therefore be it

RESOLVED, That our American Medical Association request that the United States Food and Drug Administration work with the pharmaceutical and pharmacy industries to facilitate the ability of pharmacies to ensure that a color photo of a prescribed medication and its dosage is attached to the sales receipt to ensure that the drug dispensed is that which has been prescribed. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000

Received: 03/31/21

**AUTHOR'S STATEMENT OF PRIORITY**

Providing a color photo of a dispensed pharmaceutical would reduce the number of drug dispensing errors made by pharmacies and hospital dispensaries. It would also help patients to be sure what they are taking is the correct drug. Providing as much information as possible at each step in the dispensing process would reduce the number of errors made each year. More information about a patient's medications can only help everyone in the chain of medication use. The sooner this is implemented the sooner mistakes are eliminated.

**RELEVANT AMA POLICY**

**Epidemiology of Drug Errors H-120.963**

The AMA will continue its collaborations with the Food and Drug Administration and the US Pharmacopoeial Convention, Inc., along with its own ongoing initiatives, to identify and eliminate causes of medication errors.

Citation: Sub. Res. 519, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: CSAPH Rep. 01, A-16

**Supporting Safe Medical Products as a Priority Public Health Initiative H-120.958**

Our AMA will: (1) work through the United States Adopted Names (USAN) Council to adopt methodology to help prevent "look alike-sound alike" errors in giving new drugs generic names; (2) continue participation on the National Coordinating Council for Medication Error Reporting and Prevention; (3) support the FDA's Medwatch program by working to improve physicians' knowledge and awareness of the program and encouraging proper reporting of adverse events; (4) vigorously work to support and encourage efforts to create and expeditiously implement a national coding system for prescription medicine packaging in an effort to improve patient safety; and (5) seek opportunities to work collaboratively with other stakeholders to provide information to individual physicians and state medical societies on the need for public health infrastructure and local consortiums to work on problems related to medical product safety.

Citation: Res. 416, A-99; Appended: Res. 504, I-01; Reaffirmation A-10; Modified: CSAPH Rep. 01, A-20