Dear Chair Monnes Anderson, Vice Chair Linthicum, and Members of the Committee,

Community pharmacists are among the most (if not the most) accessible health care professionals within the United States. This access is even more pronounced in rural communities where medical care typically is lacking secondary to poor funding and availability. Oregon is no exception and has a large number of small rural communities with suboptimal community health care needs.

If we truly want Oregon to have better health care, we need to be able to provide safe medication directions and instructions that are understandable by all languages. I ask, how much information is on a label? The name of a drug, the route of administration (by mouth, per ructum, injection), how many tablets or capsules to take, how often to take the medication, how many refills of the medication a patient has. Just to name a few items of information on a prescription label.

I would like to share two stories from my own career as a licensed pharmacist.

The first is rather amusing; - an older gentleman arrives at the pharmacy counter. He asks to speak to the pharmacist. I walk over and ask what he would like to talk about. He states that he is having trouble taking his medication as prescribed. I inquire about his name and drug he is having trouble with. I offer for him to sit in our counseling area while I look up his name and medication in our computer system. The medication turns out to be Lovaza - a medication typically used to treat high cholesterol. This particular medication is a fairly large and oblong capsule that can be taken anywhere from 1-4 times per day. After further inquiry as to what his trouble was, it turned out he “just couldn’t shove those capsules up his rectum anymore!” This man had been using these “by mouth” capsules as suppositories. This was an old german man whose first language was German, not English who was given a prescription label in English.

The second, a rather more serious story; - is about a pediatric patient I had seen in the emergency room (my primary site of practice). This 3 year old patient came in with her mother after having abdominal pain. The family were primarily Spanish speaking. After further questions and work up it came to light that the child had recently been given Tylenol suspension around the clock for a fever. The Tylenol had actually been called into a pharmacy and picked up as a prescription as the insurance would cover the medication this way. The label was dispensed in english despite the mother’s primary language being Spanish. Because of language confusion, the mother had been misreading the dosing frequency on the label and been giving her daughter ~10 times the dose of Tylenol recommended. She unknowingly had severely overdosed her child with Tylenol and subsequently had the daughter had to be admitted into the hospital, transferred to a pediatric specialty hospital, and almost died. All from a label misinterpreted. A label that, if written in her primary language, would likely have prevented the mother from accidentally overdosing her own child.

SB 698 - Safe medication for all requires translation (S.M.A.R.T.) - is a vital step towards providing safe and appropriate care to our various communities in Oregon and across the United States. This bill will help prevent accidental misuse of prescription medications that all to often lead to severe health risk, adverse effects, and even death.

Thank you for your time,
Brian L. Michael, PharmD