MR. NEUENSCHWANDER: My name is Mark Neuenschwander. I have been a patient and I am a consultant in the field of pharmacy automation.

It was 27 years ago that Wrigley's opened the door by putting a barcode on a pack of chewing gum. It was really a statement of faith because grocery stores and drugstores didn't have scanners. But their faith was not in vain. Within a decade, virtually every item on the shelves of those drugstores and supermarkets had a barcode, and the vast majority of checkout stands were equipped with scanners to read them.

Within five years, 1990, virtually every retail item had a barcode, not just Q-Tips at Walgreens and Cheerios at Safeway, but also duct tape at Home Depot and dresses at Nordstrom's. Barcodes on everything, scanners everywhere almost.

In 1991, the first unit dose medication was barcoded by a manufacturer. The door was opened. And ten years later, still two thirds of the medications that make their way from the manufacturer to the hospital bed are without barcodes, and about 3 percent it's not 1 about 3 percent of our hospitals have scanners at the point of medication administration.

The reason? For years, drug manufacturers have argued, why should we apply barcodes if hospitals don't have scanners? And hospitals have argued back, why should we buy scanners when drugs don't have barcodes?

And the whole thing reminds me of a slapstick comedy. A couple of

Keystone Cop cars come to a narrow bridge, not being able to cross, because the drivers are shouting back and forth, "After you." "No, after you." And it's been this way for the last ten years.

And I am asking you as a concerned citizen and someone who traffics in this world of healthcare, FDA, please help us get this thing across the bridge. There's a wonderful world of safety on the other side.

Now, what we all want is labels with medications that contain machine-readable codes I'll use the term barcodes that can be read at the point of administration. And we've heard all the values about point of administration scanning.

I want to reemphasize one other value, and that is documentation at the point of administration, as critical to safety, in my opinion, as verification for when a doctor comes in to evaluate a patient, he or she obvious the patient, looks at the patient administration record, and right now our patient administration records are MARs.

Too often we treat them as if M stands for memory. A nurse comes to the end of a shift, all too often, and treats the MAR the way I'm going to treat my expense account when I get at the end of this trip, trying to remember what taxi did I take, was that this day, was the hotel this date. And we end up with an approximate MAR. I want my doctor to have an accurate MAR. Scanning at bedside helps us.

Now, which symbologies do we want on these labels? I'll just put it this way: today's symbologies that today's barcode readers can read. And if the Dick Tracy micro-mini radio chips come in our lifetime, we can put them on top. But I'm tired of waiting. I think we all ought to be tired of waiting. Jeez, we've been waiting for Dick Tracy watches since 1931.

Now, what exactly is it that we want barcoded? Units of use? Unit dose? And all this nomenclature has confused us for years. And as an outsider, I sit and go, what is this? What's that? And I asked some medication safety expert, "What's the difference?" And he says, "Well, my colleague and I disagree, but here's how we define it."

An old preacher told a young understudy, he says, "If there's a mist in the pulpit, there's a fog in the pew." Doggone it, there is a fog in the pew when it comes to barcode scanning. There is not a mist in the pulpit, though, if you go back and read the FDA definitions. We're talking about immediate containers. That's the terminology when you talk about labeling.

So we're asking you to barcode all immediate containers. What should it include? Obviously, lot number, drug I mean, excuse me, drug, strength, manufacturer, lot number, and expiration date.

Let me just say this in conclusion, that hospitals have already started across this road. They are going pell-mell into bedside scanning. And they are I have been in hospitals where volunteers are slapping barcodes on

syringes.

There are a reason why we have GMPs. And when we go ahead into barcode scanning, let's not leave those GMPs behind by having hospitals who don't have to comply with those GMPs become packaging houses just so they can scan. Let's help the manufacturers catch up to all these hospitals that are going across the bridge into the future. There's room for two on the bridge.

Other than that, I have no opinion.

(Laughter)