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REGULATION OF TRADE IN DRUGS

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HEARINGS BEFORE THE CONSUMER SUBCOMMITTEE OF THE COMMITTEE ON COMMERCE UNITED STATES SENATE NINETY-FIRST CONGRESS

SECOND SESSION

ON

S. 1575

TO REGULATE TRADE IN DRUGS AND DEVICES BY PROHIBITING THE DISPENSING OF DRUGS OR DEVICES BY MEDICAL PRACTITIONERS AND THEIR PARTICIPATION IN PROFITS FROM THE DISPENSING OF SUCH PRODUCTS, EXCEPT UNDER CERTAIN CIRCUMSTANCES, AND FOR OTHER PURPOSES

JUNE 16 AND 17, 1970

Serial No. 91-81

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REGULATION OF TRADE IN DRUGS

TUESDAY, JUNE 16, 1970

U.S. SENATE,
COMMITTEE ON COMMERCE,
CONSUMER SUBCOMMITTEE,
Washington, D.C.

The subcommittee met at 10 a.m. in room 5110, New Senate Office Building, Hon. Frank E. Moss (chairman of the subcommittee) presiding.

Present: Senators Moss, Hart, and Pearson.

Senator Moss. Good morning.

I am pleased to welcome you this morning to the Senate Subcommittee for Consumers and the opening day of our hearings on S. 1575, the Regulation of Trade in Drugs Act.

OPENING STATEMENT BY THE CHAIRMAN

Senator Hart, as the principal sponsor and long-time advocate of this measure, was scheduled to open the hearings this morning, but has been detained and will not be able to attend for a half-hour or so.

I would like to open this morning with a statement of the view Senator Hart and I share on this bill.

At issue in these hearings is the doctor-merchant: Does he serve the public interest?

The bill before us answers: Generally not. However, it does provide that doctors who are dispensing drugs and devices in the public interest may continue.

What are we attempting to eliminate? Let me list some examples:

First are deaths. More than 60 persons allegedly died because "fat doctors"—those specializing in obesity control—passed out handfuls of "rainbow pills." The pills, we learned in earlier hearings, either should not have been taken by those patients—or should not have been taken together by any patient.

Second is illness. It is unknown how many patients have been made ill by doctors who gave them unneeded medication as a way of bolstering the sales of their pharmacy or drug repackaging company. We do know it is not unusual for patients on the diet pills to become seriously ill.

Third are inflated bills—both to tax-supported programs and to individuals. One doctor, for example, wrote \$10,000 in welfare prescriptions one year. But the next year—after buying his own pharmacy—the figure was \$50,000.

Staff member assigned to this hearing: John Cary.

Fourth is unnecessary illness. Many patients, we have been told, lingered in their illness because the most effective medication didn't happen to be stocked in the doctor's office, pharmacy, or drug company.

Fifth is overspending for the right medication. Patients have met costs up to 1,000 percent higher when the doctor-merchant prescribed a drug packaged by his company rather than the identical drug called by its generic name.

Sixth are bankruptcies or economic hurt to competitors. Numerous—probably hundreds—of drugstores and drug companies have felt this because they didn't have either the foresight or good luck to have doctor-owners.

In short, we seek to eliminate the same bad fruit of these arrangements that the American Medical Association found distasteful up until 1955.

Until then, the AMA Code of Ethics read:

An ethical physician does not engage in barter or trade in the appliances, devices, or remedies prescribed for patients, but limits the source of his professional income to professional services rendered the patient.

Unfortunately, that ethic was modified after 1955. And the number of doctor-merchants has been growing.

During earlier investigations of the Antitrust and Monopoly Subcommittee there was some hope that the AMA could at least deal with part of the problem: doctor ownership of small drug repackaging companies.

In 1964, the Antitrust and Monopoly Subcommittee turned over to the AMA the names of 140 companies which had doctor-stockholders. The AMA promised that because they still had an ethical rule against such ownership, they would take care of this matter.

Two spot checks—one of them earlier this month—revealed that the doctors are still stockholders in these companies.

I had hoped for the AMA report at these hearings but, unfortunately, the AMA has declined to appear.

But, I think we can lay to rest any talk that this is a problem which the profession can handle.

As that list in the beginning of this statement indicates, if war is too important to be left to the generals, so too, control of doctor-merchants be left to the doctors.

Congress has a responsibility—for the health both of the people and their pocketbooks. We have been dallying too long. All I can add is that I hope this is the beginning of the final round of this problem which we are considering here today.

(The bill and agency comments follow:)

1 sions by medical practitioners in connection with the supply-
2 ing of such products to patients, except under certain limited
3 circumstances, is inconsistent with the best interest of the
4 public health, denies consumers free access in an open market
5 to such products moving or having moved in interstate
6 commerce, and tends to induce unfair trade practices in con-
7 nection with trade in such products.

8 DEFINITIONS

9 SEC. 3. As used in this Act—

10 (a) The term “medical practitioner” means any person
11 licensed by any State, or by any professional association or
12 society under the law of any State, to engage in the practice
13 of medicine, osteopathy, chiropody, or podiatry, and in such
14 practice to administer or prescribe drugs or devices, but
15 such term does not include any person engaged in practice
16 exclusively as an ophthalmologist, optometrist, homeopathic
17 physician, dentist, or veterinarian.

18 (b) The term “drug” means any article (1) recog-
19 nized in the official United States Pharmacopeia, the official
20 National Formulary, or in any supplement to such pharma-
21 copeia or formulary, (2) intended for use in the diagnosis,
22 cure, mitigation, treatment, or prevention of disease in man,
23 (3) intended to affect the structure or any function of the
24 body of man, or (4) intended for use as a component of
25 any article described in clause (1), (2), or (3) of this

1 paragraph, but such term does not include any device or
2 any components of a device.

3 (c) The term "device" means any instrument, ap-
4 paratus, or contrivance intended (1) for use in the diagnosis,
5 cure, mitigation, treatment, or prevention of disease in man,
6 or (2) to affect the structure or any function of the body
7 of man, but such term does not include glasses or lenses
8 intended for the correction of vision.

9 (d) The term "pharmacy" means an office, pharmacy,
10 drugstore, or other establishment which engages in the
11 sale of drugs or devices at retail.

12 (e) The term "community pharmacy", when used in
13 relation to a medical practitioner, means a pharmacy situated
14 within 10 miles of any place at which such medical practi-
15 tioner maintains an office for professional practice.

16 (f) The term "lessor's interest", when used in relation
17 to a medical practitioner, means any pecuniary interest of
18 such medical practitioner as a lessor of real property occupied
19 by a lessee engaged in the operation of a community phar-
20 macy under a lease which provides for the payment by the
21 lessee of a rental which (1) is based in whole or in part
22 upon the income of the lessee derived from the sale or fur-
23 nishing of drugs, devices, or drugs and devices, or (2)
24 exceeds in amount the rental customarily charged for com-

1 parable facilities in the vicinity of the place at which such
2 real property is situated.

3 (g) The term "drug company" means any person
4 engaged in the manufacturing, processing, packaging, or dis-
5 tribution of drugs, but such term does not include a pharmacy.

6 (h) The term "person" means any individual, and any
7 partnership, firm, corporation, association, or other business
8 entity.

9 (i) The term "State" means any State of the United
10 States or any political subdivision thereof, the District of
11 Columbia, the Commonwealth of Puerto Rico, and any ter-
12 ritory of the United States.

13 PROHIBITION OF PECUNIARY INTERESTS IN DRUG

14 COMPANIES

15 SEC. 4. It shall be unlawful—

16 (a) for a drug company to give or sell to a medical
17 practitioner any legal or beneficial interest in the com-
18 pany or in the income thereof with the intent or for the
19 purpose of inducing such medical practitioner to pre-
20 scribe to his patients the drugs of the company. The giv-
21 ing or selling of such interest by the company to a medi-
22 cal practitioner without such interest first having been
23 publicly offered to the general public shall be prima facie
24 evidence of such intent or purpose;

25 (b) for a medical practitioner to acquire or own a

1 legal or beneficial interest in any drug company, pro-
2 vided it shall not be unlawful for a medical practitioner
3 to acquire or own such an interest solely for investment,
4 and the acquisition of an interest which is publicly
5 offered to the general public shall be prima facie evi-
6 dence of its acquisition solely for investment; and

7 (c) for a medical practitioner to solicit or to know-
8 ingly receive from a drug company, or for a drug com-
9 pany to pay or to promise to pay to a medical practi-
10 tioner, any rebate, refund, discount, commisssion, or
11 other valuable consideration for, on account of, or based
12 upon the volume of wholesale or retail sales at any
13 place of drugs manufactured, processed, packaged, or
14 distributed by the company.

15 PROHIBITION OF DISPENSING OF DRUGS AND DEVICES BY
16 MEDICAL PRACTITIONERS

17 SEC. 5. Except as otherwise provided by this section,
18 it shall be unlawful for a medical practitioner to engage
19 directly or indirectly in the dispensing of drugs or devices.
20 Nothing in this subsection shall prohibit—

21 (1) a medical practitioner from furnishing a
22 patient any drug or device in an emergency;

23 (2) the administration of a unit dose of a drug to
24 a patient by or under the supervision of such medical
25 practitioner;

1 nection with the administering of any public assistance and
2 medical assistance program by any Federal or State agency
3 by a medical practitioner, pharmacy, or drug company under
4 conditions prohibited by this Act.

5 ENFORCEMENT

6 SEC. 8. The several district courts of the United States
7 shall have jurisdiction to prevent and restrain violations of
8 this Act. It shall be the duty of the several district attorneys
9 of the United States in their respective districts, under the
10 direction of the Attorney General, to institute appropriate
11 proceedings to prevent and restrain such violations. Upon the
12 filing of a complaint under this section and the service thereof
13 upon the defendants named therein, the court shall proceed
14 as soon as may be possible to the hearing and determination
15 of the action.

16 ACTIONS FOR DAMAGES

17 SEC. 9. (a) Any person who shall be injured in his busi-
18 ness or property by reason of any violation of this Act may
19 sue therefor in any district court of the United States for
20 the judicial district in which any defendant resides or is
21 found, without respect to the amount of controversy, and
22 shall recover threefold the damages sustained by him, and
23 the cost of suit, including a reasonable attorney's fee.

24 (b) Any action instituted under this section shall be
25 forever barred unless commenced within three years after
26 the date on which the cause of action arose.

1

EFFECTIVE DATE

2

SEC. 10. This Act shall take effect on the first day of the

3

sixth month beginning after the date of enactment of this

4

Act.

THE WHITE HOUSE,
Washington, D.C., July 29, 1970.

Hon. WARREN G. MAGNUSON,
Chairman, Committee on Commerce,
U.S. Senate, Washington, D.C.

DEAR SENATOR MAGNUSON: This is in response to your request for the views of this office on S. 1575, the Regulation of Trade in Drugs Act of 1969, a bill "to regulate trade in drugs and devices by prohibiting the dispensing of drugs or devices by medical practitioners and their participation in profits from the dispensing of such products, except under certain circumstances, and for other purposes."

The bill would prohibit the pecuniary interests in drug companies and pharmacies by medical practitioners and prohibit the dispensing of drugs and devices by medical practitioners except in the cited circumstances of (1) emergency; (2) administration of a unit dose of a drug; (3) dispensing a drug or device where there is no community pharmacy available to the patient; (4) occasional dispensing but not as a usual course of doing business. The bill prohibits Federal financial participation in expenditures for drugs and devices dispensed in connection with any public assistance program by any Federal or State agency by a medical practitioner, pharmacy, or drug company under conditions prohibited by this Act.

As Special Assistant to the President for Consumer Affairs, I endorse the objectives of this legislation as in the interests of the consuming public and support enactment with the inclusion of amendments which I respectfully recommend to increase the legislation's effectiveness.

This legislation would serve to implement the concept of "Buyer's rights" stated by President Nixon in his 1969 Consumer Message to the Congress, especially the buyer's right to make an intelligent and free choice among products and services.

Ownership of interests in pharmacies and drug companies by medical practitioners and the potential for personal monetary gain through the physician-directed sale to consumer-patients is not consistent with the principle of free consumer choice and fair trade practices in a just marketplace.

There might be some circumstances in which the sale of drugs and devices by medical practitioners may serve the consumer-patient's interest, but the potential for disservice to the consumer far outweighs those occasions when it might benefit him. When the physician stands to gain financially from the drugs and devices he prescribes, a conflict of interest is inherent. It should be pointed out that the conflict of interest and the potential exploitation of patients in such situations was so apparent that in 1967 the American Medical Association declared it to be unethical.

Patients of a physician who both prescribes drugs and stands to gain financially from the sale are in effect captive consumers denied the free choice to make their purchase where they choose or to purchase where the price might be lower.

Evidence has failed to show that average prescription prices charged by physician-owned pharmacies are lower than those charged by other pharmacies, or that nonphysician-owned pharmacies are any more or any less likely to dispense improper medication.

On the other hand, the potential for the exploitation of patients through higher costs for drugs from the pharmacy in which the prescribing physician has a financial interest is significant. Particularly at this time when medical costs are high and rising, it is imperative for every effort to be made to eliminate possibilities for exploitation of consumers in drug sales and to open all doors to lower drug costs.

Amendments this office would propose for strengthening the effectiveness of S. 1575 would include:

Section 3(d), definition of pharmacy, be amended by changing the wording after the word "engages" to read "in the retail sale of drugs or devices, a substantial portion of such drugs or devices or their components which shall have moved in interstate commerce."

Section 3(g), definition of drug company, be amended by adding after the word "drugs" the words "a substantial portion of which are intended for sale in interstate commerce."

Section 8, enforcement provision, be amended to incorporate provisions of Section 4 of the Sherman Act (15 U.S.C. 4) which authorizes issuance of tem-

porary restraining orders and preliminary injunctions pending outcome of litigation.

Section 10, provision on Effective Date, be amended to provide for divestment of presently held interests in drug companies and community pharmacies within one year from the date of enactment.

The Office of Management and Budget has advised that there is no objection to the submission of this report from the standpoint of the Administration's program.

Sincerely,

VIRGINIA H. KNAUER,
Special Assistant to the President for Consumer Affairs.

OFFICE OF THE DEPUTY ATTORNEY GENERAL,
Washington, D.C., August 4, 1970.

HON. WARREN G. MAGNUSON,
*Chairman, Committee on Commerce,
U.S. Senate, Washington, D.C.*

DEAR SENATOR MAGNUSON: This is in response to your request for the views of the Department of Justice on S. 1575, a bill "To regulate trade in drugs and devices by prohibiting the dispensing of drugs or devices by medical practitioners and their participation in profits from the dispensing of such products, except under certain circumstances, and for other purposes."

The Department endorses the objectives of S. 1575 and recommends enactment subject to suggested amendments. Congressional hearings on two previous bills of similar character (S. 260, 90th Congress; S. 2508, 89th Congress) have developed a record demonstrating that physician ownership of interests in pharmacies and drug companies and certain practices resulting therefrom may have an adverse effect on competition and on the public interest and welfare. It is recognized that there may be circumstances in which the sale of drugs or devices by medical practitioners may benefit consumers and, in fact, have the effect of providing such commodities at lower prices. On the other hand, the dangers involved in the sale of drugs or devices by practitioners, or practitioners' ownership of pharmacies or dispensaries, are sufficiently great, and the practical problems of preventing abuses of such relationships sufficiently difficult, to warrant absolute prohibition of the type of financial interest proscribed by the bill.

The Department of Justice recommends that the bill be amended in the following ways to make the legislation more effective and to facilitate its equitable enforcement:

(1) The sale of drugs or devices and the conduct proscribed by the bill should be expressly related to interstate commerce. We suggest, therefore, that the definition of the term "pharmacy" in section 3(d) be amended to require that a substantial portion of the drugs or devices, or their components, shall have moved in interstate commerce. Section 3(g) should also be amended to add after the word "drugs" the words "a substantial portion of which are intended for sale in interstate commerce."

(2) With respect to enforcement and the jurisdiction of the District courts, we suggest that section 8 be amended to incorporate the provisions of section 4 of the Sherman Act (15 U.S.C. 4) which authorize the issuance of temporary restraining orders and preliminary injunctions pending the outcome of litigation.

(3) It is also suggested that section 10 of the bill be amended to provide for the divestment of presently held interests in drug companies and community pharmacies within one year from the date of enactment.

The Department of Justice recommends enactment of this legislation amended as suggested above.

The Office of Management and Budget has advised that there is no objection to the submission of this report from the standpoint of the Administration's program.

Sincerely,

RICHARD G. KLEINDIENST,
Deputy Attorney General.

FEDERAL TRADE COMMISSION,
Washington, D.C., August 7, 1970.

HON. WARREN G. MAGNUSON,
Chairman, Committee on Commerce, U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: This responds to your letter requesting a report by the Federal Trade Commission on S. 1575, 91st Congress, 1st Session, a bill "To regulate trade in drugs and devices by prohibiting the dispensing of drugs or devices by medical practitioners and their participation in profits from the dispensing of such products, except under certain circumstances, and for other purposes".

The objectives of S. 1575 are to prevent physicians from exploiting their privilege of practicing medicine by selling drugs or devices to patients, or owning a legal, beneficial, or lessor's interest in a community pharmacy, or acquiring or owning a legal or beneficial interest in any drug company, or to solicit or knowingly receive rebates, refunds, commissions, or other valuable consideration from such drug companies.

The Commission endorses the objectives of the bill. The Commission would, however, urge that the bill be modified in several respects.

The Commission suggests that the definition of "drug company" in section 3(g) of the Act be amended to include any person engaged in the manufacturing, processing, packaging, or distribution of drugs or devices. It is also suggested that the words "or devices" be added to line 5 of section 4(a) after the word "drugs," and that the words "or devices" be added to line 7 of section 4(c) after the word "drugs." These suggested changes will clarify the apparent intent of the bill to give similar coverage to drugs and devices.

With regard to section 5, the Commission urges consideration of an additional exception which would permit a practitioner to sell drugs or devices at his cost if his purpose and effect in so doing is to save his patients money.

The Commission would further suggest the inclusion of a provision that the bill shall not be construed as preempting any law of any State, Territory, Commonwealth, or the District of Columbia which regulates the practice of medicine except that any law of any State, Territory, Commonwealth, or the District of Columbia shall not provide immunity to acts or practices declared unlawful under the bill. Such a provision would make it clear that the bill would not preempt a State's right to regulate the practice of medicine and do its own housecleaning.

Section 8 authorizes the Attorney General to institute appropriate proceedings in the district courts to prevent and restrain violations of the provisions of the bill. The Commission recommends that this section be clarified to specifically authorize the Attorney General to seek temporary injunctions where the public interest warrants immediate action.

Finally, the Commission recommends that the effective date of the bill, as provided in section 10, be extended from six months to one year in order that medical practitioners have a more reasonable period to divest themselves of holdings which would be unlawful under the bill.

In conclusion, while the Commission supports the objectives of the subject bill, it does urge consideration of the foregoing modifications.

By direction of the Commission, with Chairman Weinberger not participating.

CASPAR W. WEINBERGER,
Chairman.

Senator MOSS. I am happy to have Senator Pearson, the ranking minority member of this subcommittee here this morning. Do you have an opening statement, Senator?

Senator PEARSON. I have no statement, Mr. Chairman.

Senator MOSS. Thank you very much.

Our first witness this morning will be Dr. Jesse L. Steinfeld, the Surgeon General. Will you come forward, Dr. Steinfeld. We are glad to have you here this morning, sir.

STATEMENT OF JESSE L. STEINFELD, M.D., SURGEON GENERAL,
USPHS, DEPUTY ASSISTANT SECRETARY FOR HEALTH AND
SCIENTIFIC AFFAIRS, DEPARTMENT OF HEALTH, EDUCATION,
AND WELFARE

Dr. STEINFELD. I have a prepared statement with me.

Senator MOSS. If you would like to, you may read the statement or if you would like to summarize, you may.

Dr. STEINFELD. Thank you, Mr. Chairman. I would like to read it, if I may.

Senator MOSS. All right, sir.

Dr. STEINFELD. Mr. Chairman and members of the subcommittee, I am pleased to appear before you today to discuss the views of the Department of Health, Education, and Welfare on S. 1575, the Regulation of Trade in Drugs Act of 1969, introduced by Senator Hart who serves as vice chairman of this subcommittee, on behalf of himself, Senator Moss, and Senator Magnuson.

S. 1575 would make it unlawful for a drug company to give or sell to medical practitioners any legal or beneficial interest in the company for the purpose of inducing those practitioners to prescribe for their patients the drugs of that company. It would make it unlawful for medical practitioners to acquire or own an interest in any drug company except solely for investment purposes, or for medical practitioners to solicit or knowingly receive—or for a drug company to pay or promise to pay—any rebate, discount, refund, or commission in connection with the prescribing of the company's products by the practitioner.

Medical practitioners would be prohibited from engaging directly or indirectly in the dispensing of drugs or devices except (1) furnishing a patient any drug or device in an emergency; (2) administration of a unit dose of a drug to a patient under medical supervision; (3) dispensing a drug or device to a patient where there is no community pharmacy available within 10 miles of any place where a medical practitioner maintains an office for professional practice; or (4) occasional dispensing but not as a usual way of doing business.

The bill would also make it unlawful for medical practitioners to own directly or indirectly a legal, beneficial, or lessor's interest in a community pharmacy. Medical practitioners would also be prohibited from soliciting or receiving any rebate, refund, discount, or commission from such a pharmacy for income received from the sale of drugs or devices to the practitioner's patients. Community pharmacies would be prohibited from offering or paying such considerations.

In connection with any Federal or State public assistance or medical assistance program, Federal financial participation would not be available for drugs or devices dispensed by a medical practitioner, pharmacy, or drug company under conditions prohibited by this act.

The objective of the bill is to prohibit both direct and indirect opportunities for financial gain by practitioners in connection with the supplying of drugs and devices to patients, a problem which was the subject of hearings held in 1965 and 1967 by the Subcommittee on Antitrust and Monopoly of practices of the Senate Committee on the Judiciary. The problem has also received extensive consideration

elsewhere. The Department of Health, Education, and Welfare looked into the matter through a task force that made a 2-year study of prescription drugs. The American Medical Association, individual practitioners and consumer groups have studied it.

The objective of removing the temptation for practicing physicians to make an exorbitant profit on the drugs their patients use is a commendable one. Practicing physicians do not need to make money on drugs—they have ample opportunity to make a living by following their chosen profession.

If a physician wishes to make money on drugs he should stop treating patients and devote his energies to the other activity: manufacturing, repackaging, or dispensing drugs as the case may be. But this is not to say that a physician should be forbidden by Federal law to dispense drugs. There are physicians who wish to dispense drugs in the course of their practice, and there is a real question as to whether, in the absence of any exploitation of the patient, the practice need be barred to the extent contemplated by the bill under consideration.

Should the Government, for example, forbid a physician to dispense drugs to his patients at no cost, or at 1½ times or 2 times cost? That may not be the way most doctors practice. The time the doctor spends in the act of dispensing may be time that would benefit society more if he spent it in treating another patient and let a pharmacist do the dispensing. But is this a problem requiring Federal control?

In fact, Mr. Chairman, the bill before this committee raises fundamental questions that go far beyond the dispensing of drugs. These are questions about the extent to which the Federal Government should attempt to control the practice of medicine—or beyond that the ethics of physicians or other professional groups.

Lest I be misunderstood, I would emphasize the fact that the Department of Health, Education, and Welfare recognizes areas in which Federal intervention is necessary. These are activities that assume much more than a local character and clearly are beyond the capacity of peer groups or local or State governments to control. On a number of occasions licensed, but unethical physicians have devised schemes of regional or even national scope through which they promoted their prescriptions on a mass production basis with inadequate or nonexistent efforts to diagnose or give patient care. Fake cancer treatments and dangerous reducing pill schemes come to mind and you emphasized those in your introductory remarks.

But, there are other areas of poor medical practice that in no way approach the regional or national scheme. There is the occasional surgeon who is too willing to apply the scalpel. There is the occasional general practitioner who may augment his income by prescribing and administering an excessive number of parenteral injections or shots of a variety of drugs.

In fact, most if not all professions or trades have members whose performance is not in keeping with accepted practice, is repugnant to their honorable peers and is expensive to their victims.

In our view the basic question raised by S. 1575 is whether the time has come to place the Federal Government in the business of regulating shady practices of professionals, or tradesmen, which practices are local in their effect. Stated for my own profession, the

question is whether the time has come for the Federal Government to begin regulating the ethics of doctors?

Certainly we deplore the kinds of abuses whose regulation is sought in S. 1575. We would like to see kickbacks from drug manufacturers to prescribers, M.D. ownership of pharmacies, rebates from pharmacies to doctors for drugs prescribed, and similar abuses stopped. We clearly oppose conflict-of-interest situations involving the prescribing and dispensing of drugs and devices for reasons other than the medical needs of an individual patient. The long-range implications of extrapolation of the controls this act would impose, deserve further consideration, not only for the doctors and pharmacists, but also for other groups that may have some representatives whose practices deviate from those accepted by the majority, in our view, deserve further consideration. But we feel that the abuses we seek to correct can be carefully specified and delineated. And we do not feel that extrapolations beyond those listed are justified at this time.

These hearings, in our view, are serving a real need by focusing attention on a situation of great importance to those who are ill and those who minister to them.

Some physicians find it necessary to sell drugs directly to patients in medical emergencies, or because they practice in areas isolated from regular pharmacy services, but such situations would seem to be relatively uncommon. In view of the physician shortage, the need to make the best use of the professional skills which only they possess, the possible conflict of interests which may be involved, and the general availability of other professionals who can perform these functions at least as well, we believe that there is only a limited need for a physician to dispense drugs and devices himself. We endorse limitations on the direct dispensing of drugs and devices by a medical practitioner to his patients. We would prefer that the Secretary of Health, Education, and Welfare be authorized to determine by regulation the exemptions under which a medical practitioner may dispense drugs and devices, rather than having such exemptions specified in law.

An example of an additional exemption which would be advisable is the matter of prepaid group practices which include drugs and devices as a part of their health maintenance benefits. In this situation, the physician is motivated to provide optimal amounts of drugs and devices to keep people healthy; thus, prepaid group practices which include drugs and devices would seem to be appropriately exempted from the prohibition against direct dispensing by physicians.

The ethical status of physician-owned pharmacies has been under consideration by the American Medical Association, the Department of Health, Education, and Welfare, and other groups in recent years. It has been held that such pharmacies offer particular convenience to patients, that they can often purchase drugs from manufacturers or wholesalers at prices which are not available to many community pharmacists, that they can maintain small inventories, and that they are more likely than community pharmacies to ensure that patients will receive the proper medication.

Although low inventories and relatively low acquisition costs could result in lower drug prices to patients, there is no evidence that the average prescription prices set by physician-owned pharmacies are

any lower than those set by other pharmacies in the community, nor is there any evidence that physician-owned pharmacies are any more or less likely to dispense improper medication. Furthermore, patients treated by a physician who both prescribes drugs and has a financial interest in the pharmacy which dispenses the drugs could be a captive audience, with no freedom of choice on where they will have their prescriptions filled. With the physician occupying a dual role as prescriber and dispenser, there is an obvious conflict of interest.

We endorse the prohibition in S. 1575 against physician-ownership of pharmacies. However, there are undoubtedly some circumstances under which a physician's patients would not otherwise have ready access to drugs and devices. We believe that these situations could best be provided for under the authority which we recommend be vested in the Secretary of Health, Education, and Welfare to determine by regulation the circumstances under which a practitioner may dispense drugs and devices himself.

A drug repackaging company is one which purchases drugs from the manufacturer, usually in large quantities at a relatively low price, and then repackages under its own brand names—and at its own prices. When such a drug repackaging company is controlled by one or more physicians, the potential conflict of interest is evident. If the physician-owner prescribes for his patients by his own brand name—thus requiring the pharmacist to dispense—products repackaged by his company, he is able to control his own profits. The cost to the patient under these circumstances can be needlessly high. The conflict of interest and the potential exploitation of patients in such a situation are apparent and the American Medical Association in 1967 declared it to be unethical.

In its final report dated February 7, 1969, the task force on prescription drugs recommended that products marketed by physician-owned repackaging companies be considered unacceptable for reimbursement in any medicare programs except in those instances where the Secretary determines that the availability of products marketed by such companies is in the public interest. There was general agreement with the latter recommendation among the non-Government experts appointed by this administration to review the report of the task force on prescription drugs. We endorse the provisions of S. 1575 which would prohibit the conflict of interest involved in physician-control of drug repackaging and other types of companies within the purview of section 4.

There are certain clarifying amendments to S. 1575 which we believe would better carry out the overall purposes of this legislation. We would very much like our staff to work with your staff in developing these things, Mr. Chairman.

As examples, and not being all-inclusive, the bill would appear to make it unlawful for a medical practitioner to own an interest in a grocery or general or department store, located or operating a branch within 10 miles of his office, if that store sells foods with medical claims or over-the-counter drugs such as aspirin or medicated toothpaste.

We recommend revising the definition of "pharmacy" in the bill to mean a "pharmacy, drugstore, or other establishment which engages

in the sale or dispensing, whether or not exclusively, of prescription drugs or devices to the ultimate consumer." The term "prescription drug" or "prescription devices" could then be defined as a "drug or device which under applicable law may be sold or dispensed only on a practitioner's order or which is in fact so sold or dispensed."

We suggest that section 5 of the bill be amended to read, "Except as otherwise provided by this section, it shall be unlawful for a medical practitioner to engage directly or indirectly in the dispensing of drugs or devices to his patients," since any other sale by a medical practitioner within the purview of the bill would seem to be covered by section 6.

As now drafted, the general prohibition in section 5 of the bill against the sale of drugs or devices by a practitioner, would be subject to several exceptions. We recommend that authority to establish these exceptions be vested in the Secretary of Health, Education, and Welfare.

We clearly oppose any conflict-of-interest situations involving the prescribing and dispensing of drugs and devices for reasons other than the clear medical needs of the particular patient. Such dangerous abuse of patients' trust for financial gain is grossly unethical and represents malpractice.

For these and other reasons we believe that legislation of this type is needed, and recommend its enactment with consideration being given to our suggested amendments to the bill. We would welcome the opportunity to work with the subcommittee on these or other areas of the bill.

I appreciate the opportunity to discuss these important problems with you and will be pleased to answer any questions.

Senator Moss. Thank you, Dr. Steinfeld, for that very good statement. I particularly appreciate your offer to work with the staff and to discuss the possibilities of the amendment that you have suggested. Every piece of legislation has to go through careful scrutiny and obviously many changes are often made as we go through that consideration. But what we do appreciate is the constructive efforts to help us improve the bill such as the one before us. So I think perhaps we can cooperate in this manner very well.

I have wondered about—I quoted from this code of ethics of the Medical Association that has been abandoned. What about that? Can you tell me about that? This is the one that until 1955 was in the code of ethics. It reads: "An ethical physician does not engage in barter or trade in the appliances, devices, or remedies prescribed for patients, but limits the source of his professional income to professional services rendered the patient." Now, this was modified after 1955. If I heard your testimony right, you indicated to me that this was still the ethical requirement to a medical doctor.

Dr. STEINFELD. I don't know if it is an established policy. It is eminently reasonable. What I will do, Senator, is attempt to find out if indeed it has been modified and the reason for that modification, and I will supply the information for the record.

(The information follows:)

The statement in the 1955 American Medical Association Code of Ethics asserted that an ethical physician does not engage in barter or trade in the appliances, devices, or remedies prescribed for patients, and that he limits the source

of his professional income to professional services rendered the patient. It is our understanding that the AMA has since decided that it is not unethical for a physician to dispense drugs or to own a pharmacy so long as the patients are not exploited.

We further understand that the current official policy of the AMA is that, while there may be circumstances in which physicians may ethically engage in the dispensing of drugs, the Association urges physicians to avoid the regular dispensing and the retail sale of drugs to patients wherever the drug needs of patients can be met adequately by a local, ethical pharmacist. "Accordingly, the AMA would consider a physician's accepting a rebate or discount from a drug company to be unethical. Owning an interest in a drug company or pharmacy, however, would not be considered unethical.¹

Our information indicates that the AMA seriously questioned, in 1964, the ethical status of physician-owned pharmacies and that it reversed its stand on this matter the following year. General reasons for the AMA's abandoning the 1955 Code of Ethics include the cumbersome nature of the Code and a belief that there exist many individual situations in which the patient is best served by receiving his drugs from the physician.

Senator Moss. All right. We would appreciate that. That gives me some concern.

Now, your recommendation that these exceptional situations where a doctor may dispense or prescribe drugs that are given in section V ought not to be written into the legislation but left to the regulation by HEW. Is that given for the reason of flexibility? Why do you think they shouldn't be written into the law itself?

Dr. STEINFELD. Well, I think that there would be greater flexibility. We can think of several instances. There may be additional ones that we have not been able to think of before the law actually goes into effect. Certainly, in a big group practice, the incentive is to use as few drugs as necessary; not underutilize because if one doesn't use drugs appropriately, the patient may become more sick and go in the hospital and require more expensive care. So, in such a situation, if a big group had its own drugstore and provided the drugs, it would seem appropriate for them not to be forbidden to do so. There wouldn't be an opportunity there, I don't believe, for conflict of interest or exploitation of a patient.

There might be a physician who buys drugs and gives them to patients. Here, I am not thinking of a physician who would increase his restricted forms of practice, perhaps in allergy or hypertension, where drugs are used, and the physician himself may give the drugs to the patient. In such a situation where the drugs are provided at cost, or no cost, or we might figure out what would be an appropriate sum which would be less perhaps than the patient might have to pay if he went elsewhere. I don't see a reason for prohibition there. I think we want to curb abuses, not unnecessarily get involved in the practice of medicine.

Senator Moss. Do you think this bill, as such, does regulate the practice of medicine or is this for regulating the practice of dispensing and selling drugs?

Dr. STEINFELD. Well, it becomes almost a philosophic question. I think the bill's intent is to curb abuses. I wholeheartedly support that intent. I think there are people who may misinterpret it and there are all kinds of interpretations, as you know, mentioning something other than what it is. I think this we would want to avoid. Certainly, there are abuses that can be curbed effectively.

¹ Correspondence with Edwin J. Holman, Director, Department of Medical Ethics of the American Medical Association on July 10, 1970.

Senator Moss. Of course, you have recited some of the abuses that have been practiced by some licensed doctors. How is the medical profession itself making an adequate effort to police its own range, as it were, from these abuses from those who indulge in these practices that are considered unethical?

Dr. STEINFELD. Well, I think the medical profession is increasingly attempting to correct abuses. If one reads history in terms of—not in terms of a few years, but in terms of a hundred years or so—I think our medical profession has done a very fine job. I think we have as good a medical practice in this country as anywhere else in the world. Unfortunately, there are people who don't behave appropriately. I think this is true in all professions. I don't believe that the sanction that the medical profession itself has are adequate to cope with the task, or at least they have not been invoked. This is the reason that you have felt the need for this legislation and that we support it.

Senator Moss. Senator Pearson, do you have some questions for the doctor?

Senator PEARSON. Doctor, would it come to your attention as the Surgeon General of Public Health Service if a drug company should give an interest in that company to a physician?

Dr. STEINFELD. I don't think it would come to our attention.

Senator PEARSON. To whose attention would that be directed? The Ethics Committee? The AMA?

Dr. STEINFELD. I may have misunderstood you, Senator.

Senator PEARSON. I put this proposition to you. The allegations have been made that it is a conflict of interest and undesirable practice for drug companies to give a physician an interest in that drug company or to give him a rebate or discount. Now, if that should happen, who would know about it? Would your office know about it?

Dr. STEINFELD. I don't think our office would know about it unless somebody brought it to our attention.

Senator PEARSON. Has anybody brought any such circumstances to the attention of your office?

Dr. STEINFELD. Not since I have been in the office.

Senator PEARSON. I am just trying to find the source of the evidence as to this particular complaint. Can you help me or help the committee indicate where we could find such information if it exists?

Dr. STEINFELD. You mean regarding the practices the act alleges to occur?

Senator PEARSON. Yes.

Dr. STEINFELD. We will do our best to find evidence of these practices in conjunction with some of the national organizations—medical, pharmaceutical, and others.

(The information follows:)

There is no agency or organization at present to which complaints about the practices, to which S. 1575 refers, would come regularly. Some of the more visible instances of those practices (physicians owning pharmacies, owning drug repackaging companies, dispensing drugs for profit, and receiving rebates or discounts from drug companies) have come to the attention of state boards of pharmacy, state pharmaceutical associations, the American Pharmaceutical Association, the American College of Apothecaries, state medical societies, and the American Pharmaceutical Association has cited two instances of such practices.

Senator PEARSON. Well, the allegation is also made that a physician holding an interest in a pharmacy might exploit patients. Where would we find evidence of that?

Dr. STEINFELD. The physician—I think one would have to look at his records very carefully to determine whether indeed he was prescribing drugs that the patient needed, prescribing by a particular brand name, look at the charges he has made and compare them to the prices prevailing in his area.

Senator PEARSON. I have a memorandum here from a physician in Kansas who is president of the Kansas Association of Medical Practice Groups, who is opposed to this legislation. In reference to their position that this legislation is discriminatory, he cites the fact that less than 1 percent of the estimated 70,000 retail pharmacy outlets in the United States fall into the classifications or categories set forth in this bill. Does that sound like a reasonable estimate to you?

Dr. STEINFELD. I don't have any basis on which to make a judgment. However, I did try to make the point that while abuses occur in every profession, I think the vast majority of physicians are ethical and behave in an extremely ethical way.

Senator PEARSON. I agree.

Dr. STEINFELD. I wanted to make a point that in no way should our support of this bill be interpreted as signifying that physicians are as a group behaving unethically. There are opportunities for abuse. If these exist and are not being covered through voluntary agreements, then a law may be necessary to curb them.

Senator PEARSON. The point is also made in this memorandum that this legislation would constitute a burden upon the physician to know when he can dispense drugs and when he cannot. Do you feel that this is a proper objection to this legislation?

Dr. STEINFELD. I think, Senator Pearson, this is what we had in mind when we suggested that the Secretary of Health, Education, and Welfare be empowered to determine what the exceptions should be. I could conceive of many instances where a physician might dispense drugs and save his patients both difficulty and travel from one place to another, as well as expense. This would be in the best interests of the patient. Such exceptions where they would promote good patient care should be made.

Senator PEARSON. In my State, and I am sure in the chairman's State, we have quite a problem with medical services in the rural areas. Some years ago Dr. Franklin Murphey, who became a chancellor of the University of Kansas and went on to become chancellor of UCLA—you probably know Franklin Murphey very well—was a pioneer in his encouraging of young doctors going out into the rural areas. Well, we did well for awhile. Now the condition is very severe in most of the rural parts of the country. The memorandum that I have here in opposition to this legislation says that it fails to take into account those special circumstances of the rural practitioner or of the rural area. Do you think that is a valid objection?

Dr. STEINFELD. I think it is. This is what we had in mind, again, with respect to the Secretary determining the exceptions. I think where it is to the benefit of the patient we should make exceptions. What we are interested in is curbing abuse or the potential for abuse.

We are not interested in making it difficult to obtain good patient care. I would hope and I would expect that the Secretary would proceed carefully, in cooperation with representatives of the medical profession and pharmacy profession and consumers, as well as with the Congress, in determining what these exceptions should be.

Senator PEARSON. I should like to know what action these said agencies of the various States, if any, have taken in this particular field. Would it be possible for you to acquire that information and to supply it for the record?

Dr. STEINFELD. What the various State laws might be in this regard?

Senator PEARSON. State laws or State legislation.

Dr. STEINFELD. Yes, sir; we can do that.

(The information follows:)

Seven states (California, Iowa, Maryland, Michigan, Nevada, North Dakota, and Pennsylvania) prohibit physician ownership of pharmacies by statute. Five states (Colorado, Minnesota, Montana, New Mexico, and Utah) prohibit, by regulation, such ownership. Mississippi by statute permits ownership but by regulation has prohibited pharmacists from accepting employment from any prescriber. Arizona, New Mexico, and Utah have pharmacy Acts which preclude physician dispensing, but all state Medical Practice Acts appear to implicitly sanction such dispensing. Since 1966, legislation on matters covered by S. 1575 has been introduced and defeated in at least fourteen states.

Senator PEARSON. I suppose we could get this from the record of the hearings. We have been having hearings on this bill, I understand, since 1963. Would it be possible through your testimony to have a summary of what voluntary actions have been taken by the various medical associations?

Dr. STEINFELD. Yes; I think we can pull that together and provide it for the record.

(The information follows:)

In at least sixteen states (Alabama, Connecticut, Illinois, Indiana, Iowa, Maryland, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Rhode Island, Texas, Oregon, and West Virginia) the state pharmacy association and state medical association have adopted codes of interprofessional conduct. The Iowa code has served as a model for many of the others.

Senator PEARSON. Thank you, doctor.

Mr. Chairman, I have this memorandum here. I am not sure that I agree with all of it or even a substantial portion of it. It is a sensible intelligent discussion of this particular piece of legislation by some outstanding people of my State. With the reservations that I have already expressed, I think it will serve the record if we insert this memorandum and make it part of the file or part of the record. It is submitted by Dr. H. Thomas Gray, who is the president of the Kansas Association of Medical Practice Groups.

Senator Moss. Without objection, it will be put in as part of the record.

(The material follows:)

I am writing to you as President of the Kansas Association of Medical Practice Groups to express the views of the Association in opposition to the above Bill which has been referred to the Senate Committee on Commerce. I understand that hearings on the Bill will be held before the Committee this Fall. The Association which I represent has a membership of 13 clinic groups located in various

Kansas communities. Approximately 200 physicians are associated with the 13 clinics. Three of the clinics lease space to pharmacies, and ten clinics own and operate pharmacies.

The purpose of our Association is to develop and disseminate information of mutual interest to member clinics and to improve the standards, economies, and efficiency of group medical practice in Kansas.

In substance, S. 1575 proposes to make it unlawful for any person who is licensed to practice medicine, osteopathy, chiroprody, or podiatry, to dispense drugs or devices, to own any interest in a pharmacy, to receive any consideration or income from any pharmacy, resulting from the furnishing to patients of drugs or devices by such pharmacy, or to own any interest in any drug company, other than a publicly owned company. The Bill contains certain definitions and exceptions. It also provides for jurisdiction in the United States Courts to enjoin and restrain violations and for damage suits upon the part of any person who claims to be "injured in his business or property by reason of any violation of this Act" with stated potential liability on the part of the defendant for "threefold the damages" sustained, and costs, "including a reasonable attorney's fee."

Although there are numerous valid objections to proposed legislation of this character, I shall limit my comment to the following:

1. In Section 2, the Bill is premised, in part, upon the erroneous assumption that the dispensing of drugs and devices by medical practitioners, directly or indirectly through ownership of pharmacies or interests therein, is inconsistent with the best interest of public health, and denies "consumers free access in an open market . . . and tends to induce unfair trade practices . . ."

The fact is that pharmacies owned by medical groups, or which occupy space leased from medical groups, are numerically infinitesimal. Less than 1% of the estimated 70,000 retail pharmacy outlets in the United States fall into such category or classification.

Although a purpose and objective of the Bill is purportedly to free and broaden the market for drugs and devices and to curtail alleged unfair trade practices, the obvious result of its enactment would be the reverse. It could only serve or tend to limit or restrict the ownership of pharmacies, thereby reducing the market opportunities of the consumer, at his ultimate expense.

2. The Bill is discriminatory in that it is applicable only to persons who are licensed to practice medicine, osteopathy, chiroprody or podiatry. It seems unjust and unfair to single out members of those professions when the same factors which proponents of the Bill cite as justification for its enactment, if they exist, may be equally applicable to persons licensed to practice other professions. Neither this Bill nor any other type of legislation of which I can conceive, can fully protect patients or clients from the few unprincipled professional men or women who do not abide by the tenets of their profession. But if this Bill has merit, shouldn't it be extended to include optometrists who do refractions and prescribe and dispense correctional lenses, dentists who prescribe drugs in the course of their practice, and veterinarians who dispense and prescribe drugs? The practitioner of any profession (medicine, pharmacy or other), if he is inclined to be unfair, may "take advantage" or gain unreasonable profit from his professional status or relationship with his patient or client.

3. Section 5 of the proposed Bill would make it unlawful "for a medical practitioner to engage directly or indirectly in the dispensing of drugs or devices" with certain exceptions.

The term "drug" as defined in Section 3(b) includes any article "(2) intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man, (3) intended to affect the structure or any function of the body of man, . . ." The term "device" is defined in Section 3(c) to include "any instrument, apparatus, or contrivance intended (1) for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man, or (2) to affect the structure or any function of the body of man . . ." The verb "dispensing" is not defined in the Bill.

The exceptions contained in Section 5 would not prohibit "(1) a medical practitioner from furnishing a patient any drug or device in an emergency; . . . (4) the dispensing occasionally, but not as a usual course of doing business by a medical practitioner."

If a medical practitioner uses any device in treating his patient, such as splints, casts, bandages, adhesive tape, and slings, or uses any device such as X-ray, electrocardiograph or laboratory and physical therapy equipment in his diagnosis

and treatment, with the cost thereof, directly or indirectly, included in his charges, it is conceivable that such would be deemed the dispensing of such devices, and a violation of the proposed Act.

I submit that the broad definitions, the absence of any definition of the verb "dispensing," and the burden which would be imposed on the medical practitioner of determining whether or not the circumstances, as to each patient, are within one of the exceptions to the unlawful acts, place an unreasonable and unjustifiable burden upon the physician in his use of drugs and devices in the treatment of his patient. His primary concern, and that of his patient, is proper treatment and care. Who is to judge what circumstances constitute an emergency; what constitutes dispensing of a drug or device; and when dispensing is occasional and not a usual course of doing business? If this Bill should be adopted, a physician would determine such matters at his peril.

4. In Section 3(e) of the Bill, "the term 'community pharmacy,' when used in relation to a medical practitioner, means a pharmacy situated within 10 miles of any place at which such medical practitioner maintains an office for professional practice." Under Section 5, one of the exceptions from what would otherwise be unlawful in the dispensing of drugs or devices by a medical practitioner, is, "(3) dispensing a drug or device to a patient by a medical practitioner where there is no community pharmacy available to the patient; . . ."

Although such a definition and exception may be meaningful and practical to proponents of this Bill in metropolitan areas where a number of pharmacies likely are located within a 10-mile radius of the practitioner's office, this legislation, if enacted, could only impose great harm and hardship upon patients residing in rural and sparsely populated areas. In such areas, there likely would be only one pharmacy with one pharmacist. When there is need for a drug or device to be dispensed to a patient, the pharmacy may be closed and the pharmacist unavailable. If the prescription is written during normal business hours, the roads between the practitioner's office, the pharmacy, and the patient's home may be dangerous or impassable due to weather. The patient in all likelihood will not desire to drive up to ten miles each way in order to obtain the drug or device. A mother needing a prescription for her sick child, or the aged, may not have transportation to the pharmacy. Many other situations, often arising in the course of a rural practice, could be cited to illustrate the unnecessary hardship to patients which would result from enactment of this Bill, which simply does not recognize circumstances as they exist in rural communities.

It also is a fact that many of the pharmacies located in the small towns in Kansas do not always maintain drug inventories adequate in quality, quantity or variety, comparable to those maintained by pharmacies associated with clinics.

I should also call attention to the question of who is to determine if a community pharmacy is "available to the patient."

5. Section 9 of the Bill provides that anyone "who shall be injured in his business or property by reason of violation of this Act may sue therefor. . . . and shall recover threefold the damages sustained by him, and the cost of suit, including a reasonable attorney's fee." This provision, particularly in view of the scope of the prohibitions and the vagueness and uncertainties of the exceptions contained in the Bill, will subject the medical practitioner to multitudinous and vexatious lawsuits.

6. It is to be observed that it is not the patients nor representatives of the public generally who are advocating the passage of this kind of legislation. Notwithstanding inferences and biased statements and testimony from the proponents of similar proposals upon which hearings were previously held before the Senate Judiciary Subcommittee, the facts, which can be documented by impartial study, are that the patient is not the "captive" of his physician in respect to drugs and devices prescribed or used for the benefit of the patient. He is not exploited by the physician. Except in very limited and unusual cases, the patient is free to buy and does buy his drugs from the pharmacy of his choice, and customarily he does his buying after taking into account the factors of convenience, price, service, confidence, and reliability.

Recently, our Association made a survey of comparative prescription costs at retail in the communities served by the member clinics. The survey was made in respect to a number of drugs, which were selected at random and which are commonly prescribed. Purchases were made from independent pharmacies, clinic pharmacies, and discount drug outlets, in the respective communities. The prescription was identical in every respect, relative to each comparative purchase. This survey showed that generally the retail cost to the patient for

such drugs was less at the clinic pharmacies than at the independent pharmacies, but that discount houses (which are for the most part chain drug companies) sold the same drugs for lower prices than either the independent or clinic pharmacies.

7. On the matter of ethics, the position of the American Medical Association is that it is not unethical for a physician to own or operate a pharmacy so long as there is no exploitation of the patient. The Judicial Council of the AMA, in respect to the relationship between physicians and pharmacies, has established the following advisory principles:

The patient is entitled to a copy of his prescription for drugs or appliances. The patient must have a clear right to have his prescription filled wherever he chooses.

The physician must not enter into any agreement to dispense prescription in code.

The Council looks with disfavor upon use of a direct telephone line between physician and pharmacist.

Prescription blanks should not include the name of any pharmacy.

You may be assured that the member clinics of the Association which I represent, concur in and abide by those principles.

8. This proposed legislation represents an encroachment upon the basic rights and privileges of the individual practitioner, who may be found in violation of this Act, regardless of whether or not under any fair and just standard he has committed a bona fide wrongful act or is guilty of professional misconduct.

The Act would prohibit a medical practitioner from investing in legitimate business, even though through such an investment, he provides convenience and service to and fulfills the need of the patient.

9. The proposed legislation does violence to my understanding of the rights and powers vested in the respective States. The States have jurisdiction in respect to the licensing of physicians and pharmacists; and the States have established appropriate regulatory agencies. If, in any State the practices complained of by proponents of this Bill are extensive (which certainly I do not believe is the case in Kansas), then corrective action should and will be taken within such States, by the appropriate regulatory agencies or professional associations. I do not believe there is any need or cause for Federal intervention or encroachment.

I trust that I have been helpful to you in your consideration of S. 1575. If I may furnish additional information or answer any questions, please let me know.

Senator Moss. I would agree that we ought to have before us a rational discussion of the problem and certainly one that has been prepared in that manner. It is set forth for our consideration, it ought to be in this record for us to look at as we consider this bill. We do thank you, Dr. Steinfeld, for coming and testifying for us. We appreciate your statement of general support of the bill and your offer to confer further if need be on any proposed amendments that you might have to improve the bill. We appreciate that.

Our next witness will be Mr. William E. Woods, the Washington representative of the National Association of Retail Druggists and he will be accompanied by three other gentlemen who I will ask him to introduce when he comes to the table.

We are pleased to have you gentlemen here. I will ask Mr. Woods to introduce each of those at this time.

I am going to have to leave because I am involved in another hearing. I will ask my colleague, Senator Pearson, to continue with the hearing. I understand that Senator Hart will be here very shortly now. It is important that we have a good record made so that this committee may act on the record and we appreciate all of your efforts in coming here to help us make this record.

Senator Cranston would like to introduce the next group of witnesses.

Senator CRANSTON. You are most thoughtful. I appreciate your thoughtfulness and graciousness in permitting me to say just a few words. I did not come here to testify on the legislation. I came here to say a few words about a Californian who is here as a witness. J. Martin Winton who is a long time friend and associate of mine in California. I simply wanted to say that he has an outstanding record as a pharmacist for many years and has been a leader in the pharmaceutical field and his activities and leadership in California have been wonderful. His testimony indicates various very important positions he has held in the State advisory organizations and in the profession in California. I simply wanted to urge the committee to give particular weight to what he has to say.

Senator PEARSON. Thank you, a great deal.

Senator CRANSTON. Martin, hello to you.

Mr. WINTON. Thank you.

STATEMENT OF WILLIAM E. WOODS, WASHINGTON REPRESENTATIVE, THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS, WASHINGTON, D.C.; ACCOMPANIED BY WILLARD B. SIMMONS, EXECUTIVE SECRETARY-GENERAL MANAGER, NATIONAL ASSOCIATION OF RETAIL DRUGGISTS, CHICAGO, ILL.; MARTIN WINTON, FORMERLY PRESIDENT OF CALIFORNIA STATE BOARD OF PHARMACISTS, FRESNO, CALIF., AND RALPH ROOKE, CHAIRMAN, NATIONAL ASSOCIATION OF RETAIL DRUGGISTS, COMMITTEE ON NATIONAL LEGISLATION, RICHMOND, VA.

Mr. Woods. Mr. Chairman, it is an honor for representatives of the National Association of Retail Druggists to appear before this important Consumer Subcommittee of the Commerce Committee of the U.S. Senate.

On behalf of our entire membership who own some 40,000 independent retail drugstores where about 75,000 pharmacists practice their professions we are here today to give strong and unqualified endorsement to S. 1575. In fact, strong resolutions supporting such legislation have been adopted at our annual convention for many years.

NARD is a professional and business association organized almost a century ago so that the owners of independently operated retail pharmacies might have a strong voice to act in the public interest and to meet competition effectively. The wisdom of establishing this association is proven by the spirit and size of our owner membership which is greater than that in all other national pharmacy organizations combined.

About 75 percent of all prescriptions dispensed in the United States each year are dispensed in NARD member stores.

We appear before you today with mixed emotions. Naturally we are glad for the opportunity of being invited to explain why we feel S. 1575 is a vital necessity for consumers and our members. On the other hand, we are concerned and discouraged that consumers are still being denied the protection which S. 1575 would provide after more than 6 years of hearings and several volumes of testimony.

We realize, Mr. Chairman, that you share this concern and we feel the public owes you and others who have fought so long and so unyieldingly for this legislation a great debt of gratitude.

We will set forth in detail the many reasons NARD strongly endorses the enactment of S. 1575 but we would like to emphasize at the outset there is a greater need today for S. 1575 than there was in the early 1960's when investigations into the subject matter of this proposed legislation began. The previous hearings have documented that organized medicine is either unwilling or unable to terminate the bad practices and patient abuses which are the target of S. 1575. Since the earlier investigations were initiated, the Government has gained several years of experience with the medicare-medicaid programs. This experience should leave absolutely no doubt that S. 1575 is a public necessity for medicaid regulations are inviting and encouraging all of the practices that S. 1575 would eliminate. While we will give detailed attention to these medicaid regulations later in this statement, it should be emphasized that both the American Medical Association and the Department of Health, Education, and Welfare have confused the effect and extent of the present regulations which flip-flopped after pressure from physicians. Dispensing physicians are receiving Federal funds under medicaid in many States. These payments are not limited to dispensing physicians in only a few States as was represented.

For another medicare related reason it is in the consumer's interest that S. 1575 be enacted without further delay. The greatest deficiency in the present medicare program is the absence of drug coverage for the medicare home patient, but it is expected this addition will arrive in the next year or so. The present posturing of medical groups and HEW officials with their regulations and reports would create a "pot of gold" for certain dispensing physicians under medicare if passage of S. 1575 is delayed.

Senator PEARSON. Why would that be so?

Mr. WOODS. We feel that under the present medicaid regulations there would really be no curtailment of dispensing physicians. We feel they would invite more dispensing. We will cover that in more detail in the statement. We also know that the task force report has been issued by Social Security within the last year or so after they had made an extensive study on the possibility of including drug coverage for the medicare home patient. In all of those task force reports there have been indications that they planned to pay the dispensing physician. We don't know to what extent, Senator, this possibility would be provided. But, there has been nothing in any medicare task force report that would indicate that they want to curtail the dispensing physician. We know that the present medicaid regulations do invite and encourage physicians dispensing.

Senator PEARSON. Well, that would be particularly significant to our organization. But what relevance does it have to the patient?

Mr. WOODS. Mr. Chairman, I believe that we do cover some of that in the statement.

Senator PEARSON. Fine. Just continue with your statement then. You will cover that in what you have to say.

Mr. WOODS. One other thing that I would like to mention at this point. The hearings in 1964 and 1967 did set forth many instances of

patients' abuse as a result of physicians dispensing. I think it has been well documented in the previous hearings and we continue to receive additional information of this nature, sir.

Senator PEARSON. Would that be in relation to higher cost or the dispensing of drugs which are not required?

Mr. WOODS. Well, perhaps both. Certainly the first. And in other situations where the patient receives drugs no record is kept or they are dispensed in improper containers. At one point we had mentioned in this statement we heard from Wisconsin where cardiac patients are receiving nitroglycerin in envelopes. The drug is known to decompose in an envelope which is an improper container. We find many instances, Senator. And, I have some doubt whether the term "dispensing physician" is a fiction or not, because usually a lay person is doing the dispensing, not the physician.

Senator PEARSON. Continue with your statement.

Mr. WOODS. It should also be recorded that we are now receiving complaints that even private patients with prepaid health insurance are also finding they are denied the freedom of choice of drugstores. It is unknown whether these insurance contracts with "participating dispensing physicians" are attempts to mimic the existing medicaid regulations or whether they reflect pressure from physicians. In any event such contracts are not limited to the dispensing physicians in a few Midwestern States.

At this point we would like the record to show that the National Association of Retail Druggists realizes that there are many competent, hardworking, conscientious physicians in this country who are not engaged in the practices which S. 1575 seeks to eliminate which are so unfair to patients. Our remarks are addressed to the physicians who are profiteering from the medications they prescribe and dispense for their patients. We have met with representatives of the American Medical Association on many occasions and expect to continue doing so effectively in the future but frankly we have quit talking about this subject for many reasons. Very few of the AMA leaders are engaged in these practices and while they may have reservations about the activities of their colleagues who are so engaged, they are unable to adopt policies consistent with S. 1575. The pressure and influence on AMA from clinic groups with physician-owned pharmacies is thought to be out of proportion to their representation in total AMA membership. In the previous hearings on this legislation it has been established without question that AMA formerly branded these practices unethical.

With respect to the group practice of medicine, a new development at HEW concerning medicare would make legislation like S. 1575 necessary if it were not already before Congress. I refer to part C of title XVIII which has been proposed but not enacted. The part C would encourage more group practice physician-owned clinics, and the number of physician-owned pharmacies with attendant abuses of patients would no doubt explode all over the country.

It is not our intention to prolong the discussion of Government medical care programs or medical care costs in general for they have been documented in many ways by congressional investigations but

certainly these are subjects about which consumers are doing much agonizing. It is a well-known fact that the high cost of medical care has increased at a rate that surpasses almost every other consumer service. It has been established historically that the physician is the one who orders the many medical care services such as institutional care, X-rays, and drugs. Experience has shown that these costs will be predictably higher if the ordering physician shares in the profits. It is significant that drugs are the only component in medical care costs whose share has not significantly increased in recent years. We feel it is primarily because of the competition existing at the retail level.

In recognition of the fact that the physician is the primary decision-maker in the health team and is in a position to control costs, the Government should act now to separate the physician from the temptation to profit from the medications he prescribes.

We have emphasized our concern with the high costs of medical care and the abuses consumers have experienced as a result of the evils S. 1575 would curtail. We do not pretend that the interests of our members are confined to these two subjects only. In specific areas, our members have found it is not possible to continue to operate their retail pharmacies because of either dispensing physicians or because of physician-owned pharmacies. Our members find it is impossible to compete with a physician who is determined to deny his patients freedom of choice by whatever method of persuasion the physician chooses to use on these patients.

Our association has been following these problems for our members for many years and we have no doubt the time for S. 1575 is now. There is no doubt that the time for this idea is now.

Efforts on State legislation have been tried and failed, but even more important the national character of Government and other third party insurance programs make State legislation totally impractical for coping with many of the problems. Organized medicine has demonstrated their inability to deal with the problem voluntarily through a code of ethics. All of the circumstances are now present for a mushrooming of the consumer abuses if S. 5175 is not enacted to establish Federal controls.

Turning now to the provisions of the bill, sections 4, 5, 6, and 7 prohibit the practices that we believe are the basis for most of the complaints and abuses. Since previous hearings have dealt with the prohibitions against pecuniary interests in drug companies, physician dispensing and physician ownership of pharmacies we will not dwell on them at length. Since section 7 of the bill which prohibits payment of Federal funds to physicians engaged in certain activity is new we like to set forth our views in greater detail.

Earlier we mentioned that many physicians are not engaged in any of the practices which would be prohibited. In fact, most pharmacists and physicians have a good relationship as they work together in the patient's best interest, each performing responsibilities for which they are trained. The problems for our members and the patients arise when a physician and often his lay assistants undertake to perform pharmaceutical roles for which they are not trained in a manner which removes the patient's freedom of choice.

SEC. 4. Prohibition of Pecuniary Interests in Drug Companies

At the 1964 hearings on similar legislation, the AMA joined NARD in condemning closely held drug repackaging companies which are owned in whole or in part by doctors. But the AMA solution that "within a reasonable time, physician ownership of drug repackaging companies will, in the main, disappear" had not come to pass when the 1967 hearings were held.

Since there seems to be no disagreement that such ownership by physicians should be prohibited, we conclude in view of the record and AMA's inability to stop the practice that a Federal statute prohibiting such activity is the only effective way to deal with the problem. We believe that the reports from Iowa in the last year that physicians have been branching out into ownership of local wholesale drug houses and other suppliers of medical and surgical supplies are further evidence of the need for this legislation.

When the physicians own closely held drug companies they may be in the unique position of charging the patient for professional services, for which we find no fault, and then in addition collecting for drugs dispensed to the patient and finally realizing a profit from the company which manufactured the medication prescribed.

Such company ownership will not be disclosed by physicians to any professional association or any State pharmacy or medical board. The many ways for disguising physician ownership in such companies are also so well known that they commend the need for Federal legislation.

SEC. 5. Prohibition of Dispensing Drugs and Devices by Medical Practitioners

Previous hearings have established the numerous abuses to patients which may result from drug dispensing in physicians offices. The potential for harm to patients is considerable because physicians are too busy to dispense so this function is turned over to someone else in the office such as a nurse but more often a receptionist or girl in the office.

The earlier hearings brought out the types of practices found in the office of dispensing physicians which can lead to abuse: unauthorized personnel dispensing drugs, failure to keep accurate records, drugs dispensed in envelopes or other improper containers, drugs from unknown companies dispensed, excessive charges, frequent sales of drug samples given the physician by manufacturers and giving patient wrong drug or wrong strength of drug intended.

Dispensing physicians deny patients freedom of choice. The essential element in consumer protection, choice by consumer, is totally eliminated—both the drugstores and consumer are injured financially.

From the complaints NARD continues to receive about physician dispensing it would seem there is a higher incidence of this practice in smaller communities or towns, even though there are adequate retail pharmacy services available in the community. In many areas the small town is soon deprived of a drugstore because a dispensing physician has made it impossible for the pharmacist to stay in business. We have just received information from Wisconsin that there

are 400 dispensing physicians in the State and from the State of Virginia about 300 dispensing physicians.

Recently we were told of cardiac patients going to a drugstore in a small midwestern town in search of amber colored bottles in which to keep their nitroglycerine products given to them in paper envelopes in the dispensing physician's office. This medication decomposes quickly in envelopes.

In September 1969, the National Association of Board of Pharmacy received five reports from various parts of the country describing abuses including deaths which resulted from drug dispensing in physician's offices. This information contained in the report points up the fact that unauthorized personnel are usually handing out the drugs and refills in dispensing physician's offices. We would be happy, Mr. Chairman, to make available for the record a summarization of these five instances by the National Association of Pharmacists.

Senator HART (presiding). I would ask our staff to receive them in an appropriate form and make them a part of the record.

(The information was subsequently received for the record:)

NATIONAL ASSOCIATION OF BOARDS OF PHARMACY,
Chicago, Ill., September 12, 1969.

SENATOR PHILIP A. HART,
Senate Office Building,

DEAR SENATOR HART: The report of the N.A.B.P. committee on legislation given at the Montreal convention last May suggested that this office determine opinions of various boards relating to numerous specific pieces of Federal legislation. One of which was your bill, Senate 1575, referred to the Senate Commerce Committee.

We recently mailed questionnaires to the various licensing agencies throughout the United States who hold membership in this association asking them to give us information which might be of some use to those proponents of your bill in the interest of the protection of the public health. We sought information directly related to public health which were as follows:

Demonstrations of persons who had received medication from a physicians' office or clinic and had been harmed in some way. We concerned ourselves with the physical aspects of this harm: 1. Overdose; 2. Improper medication; 3. Medication errors; 4. Changes in medication; 5. Others.

We would like to present you with certain case situations as they come to our office in the hope that this will assist you in proving to your colleagues that passage of this Federal legislation is in the interest of the protection of public health. We will not document the specific state wherein these incidents have occurred. We would add, however, they they are true situations, and documentation can be provided you should this be necessary.

CASE NO. 33-1

About three years ago, a license to practice medicine issued to a doctor in an eastern state was revoked for the indiscriminate sale of "reducing pills". This medication was packaged by the doctor, and his office assistant, and made available to interested parties without in some instances, even seeing the patient. Many of the transactions were consummated by telephone, and the doctor would leave the package of pills on the waiting-room table, where the "customer" would obtain them at her convenience. The Board of Pharmacy and the Attorney General received several complaints from females who had taken the doctor's "reducing pills", and had suffered the usual untoward reactions associated with overdoses of amphetamines.

CASE NO. 33-2

An eastern physician surrendered his license to practice medicine approximately six weeks ago, after it was determined that he was selling amphetamine tablets to teenagers. One young man died as a result of an overdose of tablets supplied by this doctor.

CASE NO. 34-1:

About 1955, a physician in a southern state conducted a clinic next door to a pharmacy. The physician "coded" all prescriptions so that they might be filled at the pharmacy next door only. It was stated that there was a "kick back" arrangement existing between the physician and the pharmacist. As a result of a disagreement the arrangement was dissolved and the physician began to dispense his own drugs with the assistance of his wife who did most of the dispensing. On one occasion, the wife dispensed a Boric Acid-Alum douche powder on an order for an antacid powder. The patient died due to renal malfunction. The physician's insurance company settled the matter out of court and the physician was never prosecuted. He was called before the Board of Medical Examiners but no action was taken against his license. The local medical society expelled him and denied him hospital privileges for some five years.

CASE NO. 36-1:

One of the state boards from a central state indicates violation of drug laws by personnel employed by dispensing physicians. We can state that this board indicated that numerous complaints from pharmacists have been received to the effect that all kinds of drugs were dispensed by office personnel. This was done at times when the physician was not present. Inspectors of the Board of Pharmacy had subsequently investigated these complaints, found some of them to be true, but had stopped the illegal practice without resorting to criminal prosecution.

Dispensing doctors permit their office staff to dispense drugs to patients as a routine part of their duties, and once this procedure is established; it occurs when the doctor is out of the office, out of the city, out of the state, and frequently, out of the country. Stricter enforcement of the laws in this matter is most difficult, and on one or two occasions, the Board has tried to "make a case" in the courts, and the courts have been less than uncooperative. The Board has spent much time and effort and money, particularly with no worthwhile results. Doctors have been warned, but these have been dismissed and the staff has been more careful. Under subsequent investigation, it is virtually impossible to collect evidence.

Any further information which comes to our attention regarding harm caused from indiscriminate dispensing of pharmaceuticals in doctors' offices by unqualified persons will be passed on to you for your information.

Sincerely,

FRED T. MAHAFFEY,
Executive Director.

Mr. Woods. Thank you sir. With the extreme shortage of medical personnel in this country it is astonishing that some physicians, often father and son combinations, persist in dispensing drugs in their offices when fine retail pharmacies are nearby.

SEC. 5. Prohibition of Pecuniary Interests in Pharmacies by Medical Practitioners

The earlier hearings have set forth the common abuses arising from physician-owned pharmacies. The evidence then as now speaks of how consumers and retail pharmacies are financially injured.

While physician ownership of pharmacies may exist anywhere this practice is often found in a city large enough for a clinic with several doctors. When they own the pharmacy they are seeking to increase their income by the medications they prescribe. Certainly not all clinics are engaged in the practice but where such a monopoly does exist, it is not unusual to find overprescribing, exorbitant prices, denial of freedom of choice to patient, use of unknown products, and prescriptions dispensed by unauthorized personnel.

It is often more difficult to determine when a physician has an interest in a retail pharmacy than it is to discover a dispensing physician. Consequently it is almost impossible as the earlier hearings established to report the number of physician-owned pharmacies today. We know they are still in abundance and may be increasing because last week we received complaints from Mississippi and Indiana that unauthorized personnel in physician-owned pharmacies are filling prescriptions.

If the physician-owned drugstore charges higher prices than prevailing at competing pharmacies the patient as a consumer is immediately injured financially. But even if the prices are competitive, the competing drugstore is directly injured in that the drugstore is deprived of an opportunity to compete. And, the consumer is indirectly injured in that the physician has decreased the patient's freedom of choice thereby decreasing competition and the likelihood of low prices which the American system of free competition brings, further, the doctor's actions to eliminate competition leads to a monopoly and a subsequent increase in prices.

In previous hearings, AMA and other opponents of S. 1575 did not seriously contest the evidence by NARD on the potential and actual abuses by physicians who own drugstores. Rather, AMA as the principal opponent seemed to suspect our position of saying physicians generally violate their ethical and fiduciary duties and take advantage of patients. The AMA pointed to its code of ethics as lending moral backbone to the medical profession.

NARD has always made its position clear that our criticisms here do not involve the vast majority of physicians in this country who disapprove of the practices we are discussing. But the hard fact is that despite the ethical traditions of the medical profession, the AMA has not been able to police its membership to prevent the unscrupulous prescription drug practices by many of those doctors who own drugstores.

Moreover, the AMA Code of Ethics on this point is a case of "shifting sands" which places their views on physician ownership of a drugstore in a gray area. It is doubtful that the position of the association representing medical clinics will be any more clear. On this point the AMA during the period of 1954 to 1963 amended the code of ethics three times and issued three clarifications of the final wording.

The current AMA principle of ethics, covering drugstores was adopted in 1957: "Drugs, remedies, or appliances may be dispensed or supplied by the physician provided it is in the best interest of the patient." This formula is so simplistic as to be unhelpful: Physician dispensing to an ailing patient is always helpful to the patient's immediate medical need—except in the area of overdosage, wrong drug, or poor choice of drugs. But, ownership by a physician of a drugstore may not be in the best interest of the patient's financial condition if the charge for the drug is excessive. And, ownership by a physician of a drugstore is never in the best interest of the patient's financial condition in that it restricts his freedom of choice, his interest in fostering competition among drugstores and his interests in avoiding

a drug monopoly which, having eliminated competition, might raise drug prices.

It is interesting to note that at the previous hearings AMA stated that doctor ownership of drug repackaging companies represented a potential temptation for the doctor to prescribe unnecessary or expensive drugs and such ownership should be prohibited, but the AMA is unwilling to extend this principle to doctor-owned drugstores.

When a physician owns a drugstore he is tempted strongly to satisfy the patient's medical needs but place his own financial needs before the financial needs of the patient. This bill, S. 1575, will remove the physician from this financial temptation.

SEC. 7. Federal Financial Participation in Drug Expenditures

When the original guidelines for the title XIX medicaid program were issued in 1966 by HEW to assist the States in planning for State medicaid programs the HEW policy indicated that Federal financial participation would be available in expenditures for drugs dispensed by licensed pharmacists but in 1969 this policy was changed to also pay dispensing physicians. The two policies are quoted below.

The 1966 version reads:

Drugs—with respect to prescribed drugs, as defined in D 5141, item 12a, Federal financial participation is available in expenditures for drugs dispensed by licensed pharmacists or legally authorized practitioners, where no adequate pharmacy services exist or are available when needed, and the practitioner dispenses such drugs on his written prescription and retains records thereof.

The present policy appeared on page 9786 of the June 24, 1969, Federal Register:

With respect to prescribed drugs, Federal financial participation is available in expenditures for drugs dispensed by licensed pharmacists and authorized practitioners in accordance with the State Medical Practice Act. When dispensing, the practitioner must do so on written prescription and maintain records thereof.

These policies are promulgated by the Medical Services Administration of the Social and Rehabilitation Service of the Department of Health, Education, and Welfare which administers the medicaid program.

Early in 1967 the American Medical Association complained when told that the medicaid guidelines would not allow Federal reimbursement to dispensing physicians unless no adequate pharmacy services are available. The AMA, on June 2, 1967, wrote HEW that "Physician dispensing is a common practice among many physicians in Midwestern States for their private patients" and that the medicaid regulation restricting the practice of physician dispensing is "an unwarranted interference in an accustomed pattern of practice for private practitioners." The AMA letter "strongly" urged that the regulation be changed to allow physicians to dispense to medicaid patients without any restrictions except "on written prescriptions and retains records thereof."

The HEW replied July 6, 1967, that "serious consideration was given to the many facets of the problem by the medical staff of the Bureau of Family Services by various consultant medical advisory committees and by professional organizations.

Mr. Chairman, we will be glad to make available for the record this

explanation of correspondence between Secretary Blasingame of the American Medical Association and Health, Education, and Welfare.

Senator HART. It will be received.

(The letters follow:)

AMERICAN MEDICAL ASSOCIATION,
Chicago, Ill., June 2, 1967.

Mr. JOSEPH H. MEYERS,
Department of Health, Education, and Welfare,
Washington, D.C.

DEAR MR. MEYERS: In Section D-5150, "Federal Financial Participation," of *Supplement D* of the *Handbook of Public Assistance Administration*, issued by the Bureau of Family Services, the following statement appears:

"*Drugs*.—With respect to 'prescribed drugs,' as defined in D-5141, item 12 a, Federal financial participation is available in expenditures for drugs dispensed by licensed pharmacists and, when dispensed by legally authorized practitioners, where by no adequate pharmacy services exist or are available when needed, and the practitioner dispenses such drugs on his written prescription, and retains records thereof."

During your meeting March 17, 1967, with the Committee on Welfare Services of the Council on Medical Service, American Medical Association, it was made clear that you interpret this wording as meaning Federal reimbursement will *not* be available in Title XIX programs for payment of physicians for drugs they themselves dispense, unless "no adequate pharmacy services exist or are available when needed."

Physician dispensing is a common practice among many physicians in mid-western states for their private patients and is specifically included as part of medical licensure in some states. Utilizing the *Handbook* to restrict the practice of physician dispensing is an unwarranted interference in an accustomed pattern of practice for many private practitioners and prohibits to Title XIX beneficiaries a physician's service which is legally authorized and provided to private patients in a number of states.

The Association therefore strongly urges that Section D-5150 of the Supplement be changed by substituting the following:

"*Drugs*.—With respect to 'prescribed drugs,' as defined in D-5141, item 12 a, Federal financial participation is available in expenditures for drugs dispensed by licensed pharmacists and, when dispensed by legally authorized practitioners, under the following circumstances: where no adequate pharmacy services exist or are available when needed, or where the practitioner dispenses such drugs on his written prescription, and retains records thereof." [Additions to the statement are indicated by underlining.]

The net effect of this change would be to make payment for physician dispensing permissive with the individual states, rather than restricting this practice through Federal regulatory action.

The Association urges your serious consideration of this proposed change. If Title XIX is truly to become a means for enabling the needy and medically needy to obtain first-class medical and remedial care, it is essential that Federal standards not prevent them from receiving services which physicians have been accustomed to provide to their private patients.

Sincerely,

F. J. L. BLASINGAME, M.D.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
July 6, 1967.

F. J. L., Blasingame, M.D.,
American Medical Association
Chicago, Ill.

Dear Dr. Blasingame: Thank you for your letter of June 2, 1967, concerning a change to Section D-5150 of Supplement D Handbook of Public Assistance Administration concerning prescribed drugs.

In the development of the present policy, serious consideration was given to the many facets of the problem by the medical staff of the Bureau of Family Services, by various consultant medical advisory committees, and by professional

organizations. However, we can appreciate the concerns as expressed in your letter.

I will certainly review the matter as you suggest including very careful consideration of the particular revision proposed by the American Medical Association.

Sincerely,

JOSEPH H. MEYERS,
Acting Commissioner.

Mr. Woods. Pressures from physician groups and physicians in HEW continued until the new policy appeared in the Federal Register November 5, 1968, as Interim Policy No. 19 which is identical with the final policy quoted above that appeared in the Federal Register June 24, 1969.

On November 29, 1968, NARD objections to Interim Policy 19 were filed with HEW, a copy of which we are pleased to make available for the record.

(The letters follow:)

THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS,
Washington, D.C., November 29, 1968.

Re Interim Policy No. 19

HON. MARY E. SWITZER

Administrator, Social and Rehabilitation Service, Department of Health, Education, and Welfare, Washington, D.C.

Dear Miss SWITZER: Reference is made to section 12(a) of Interim Policy No. 19 as it relates to "prescribed drugs" and more specifically to the following wording which appears in section 12(a):

"With respect to 'prescribed drugs,' Federal financial participation is available in expenditures for drugs dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act."

On behalf of the member drug stores of the National Association of Retail Druggists, which is the only national voice for independent retail pharmacy exclusively and such members being the drug providers most adversely affected by the proposed Interim Policy No. 19, we herewith respectfully submit our strenuous objections to the proposed change. The NARD represents the ownership of some 40,000 retail drug stores.

At the outset it should be stated that the subject policy change proposed in No. 19 is an effort to change Section D5150, entitled "Federal Financial Participation," which appears in the Handbook of Public Assistance Administration, Supplement D, Medical Assistance Programs. Section D5150 does not encourage physician dispensing of drugs under the Medicaid program, as does Interim Policy No. 19. Section D5150 reads as follows:

"*Drugs.* . . . With respect to 'prescribed drugs' as defined in D5141, item 12a, Federal financial participation is available in expenditures for drugs dispensed by licensed pharmacists and, when dispensed by legally authorized practitioners, where no adequate pharmacy services exist or are available when needed, and the practitioner dispenses such drugs on his written prescription and retains records thereof."

From the foregoing it is clear that Interim Policy No. 19 is intended to expand physician dispensing rather than confine such practices to only those situations where they can be justified, as is fairly provided in Section D5150.

A recent survey published in *Modern Medicine* shows that a dramatic drop has taken place in physician dispensing over the years. In 1923, about 39% of the physicians dispensed medications to one half or more of their patients. It is estimated that this figure was no more than 8.7% in 1967. We feel that if Interim Policy No. 19 is adopted it will reverse this trend and bring about more physician dispensing. Consequently the policy will frustrate the public and members of both the medical and pharmacy professions.

As we have stated to you in previous correspondence and in various conferences with the competent staff of the Medical Services Administration of SRS, we appreciate the consistently high regard that SRS has shown for the private sector and for vendor drug programs which recognize the outstanding pharmacy services

provided in the retail drug stores of this country. We like to think the Medicaid drug program is the outstanding government drug program which demonstrates daily what can be accomplished by a government—free enterprise partnership. NARD has many times complimented the Medicaid drug program because it has not sought to encourage physician dispensing, drug stations in institutions, mail order prescriptions, and government drug dispensaries.

The wording of section 12(a) of Interim Policy No. 19 is objectionable to NARD for many reasons. The wording is ambiguous in that it would be impossible for a state to set standards for compliance with the proposed new policy. We certainly hope that No. 19 is not intended for the purpose of paying physicians a double fee: one for physicians' services and another for dispensing drugs. It is well known that there is a critical shortage of physicians in the United States, and it would seem to be against public policy for the Department of Health, Education and Welfare to enunciate a policy statement that would either drain physician services into the area of drug dispensing or encourage receptionists, secretaries, and other unqualified personnel in physicians' offices to dispense highly dangerous drugs for Medicaid recipients in violation of numerous state and Federal laws.

It is also known that some pharmaceutical manufacturers charge physicians notoriously low prices in contrast with what they charge retail drug stores, but 12(a) is not related to any other SRS criteria for reimbursement of physicians. Continuing efforts to eliminate such price discrimination practices and unfair competition will obviously be more difficult if Interim Policy No. 19 is finalized.

Is it the intention of SRS to make Federal financial participation "available" to all physicians in the "Medical Practice Act" states? Would it not be a reasonable requirement for such a physician to make a showing to his Medical Society, make application to the state board of pharmacy, and to the single state agency explaining why his drug dispensing activities are in the public interest and in the interest of the Medicaid program?

Failing this and other requirements in Interim Policy No. 19, we are assured of protracted hearings on Federal legislation directed to the subject issue. If Congress intended that physicians be reimbursed for drug dispensing under government medical programs, as will be possible under Interim Policy No. 19, it is respectfully submitted that the Medicare law would never have been so restrictive as to limit physicians to claims for only those drugs that cannot be self-administered.

In brief, here are some of the reasons set forth by Mr. Willard B. Simmons, NARD Executive Secretary, to the National Health Conference on Medical Costs, June 28, 1967, explaining why NARD strongly opposes physician dispensing:

There is no supporting evidence that dispensing physicians provide drugs to patients as cheaply as do drugstores. (An increase in physician dispensing might well raise costs of drugs the government provides under Title XIX.)

There is considerable evidence that the quality of pharmaceutical service in the retail pharmacies is superior to that found in the offices of dispensing physicians.

Some of the improper practices associated with physician dispensing are: patients denied freedom to purchase drugs in retail pharmacies of their choice; poor record keeping of drugs dispensed and on number of refills; use of inadequate containers such as paper envelopes which may bring about rapid drug deterioration; inadequate and improper labeling; dispensing of samples representing several different lot numbers mixed, making checks during a drug recall meaningless; patient denied copy of prescriptions; and state and federal drug laws not complied with regarding record keeping.

Dispensing physicians are less likely to discontinue prescribing an obsolete drug until their personal supply is exhausted.

Dispensing of drugs may be done illegally by clerks and receptionists. It is our sincere belief that it is in the public interest to continue in effect, as it has successfully operated for over two years, the requirements of D5150, which limits physician dispensing to areas where no adequate pharmacy services are available. We strongly urge that the conflicting language of section 12(a) of Interim Policy No. 19 be rescinded. It is inconceivable that 12(a) would be published with such open-ended wording that provides no prohibitions, no standards, tests or criteria for states to use as yardsticks for measuring practices and unbridled dispensing by physicians in terms of public good.

From our discussions with many state welfare officials, we are confident a large majority of them share NARD's views that Interim Policy No. 19, section 12(a), respecting reimbursement of physicians for drug dispensing will complicate effec-

tive administration of the program and will unnecessarily precipitate discord among program administrators, physicians and pharmacists in states where joint efforts are now harmoniously dedicated to bringing high quality and economical pharmaceutical services to Medicaid recipients. Several state administrators have stated forthrightly that they are simply not going to pay physicians to dispense under state Medicaid programs.

We assure you of NARD's continuing interest in Title XIX drug programs. We will be glad to discuss further this matter with SRS representatives at their convenience.

Sincerely yours,

/s/ WILLIAM E. WOODS,
Washington Representative.

Excerpted from Interim Policy No. 19, which appeared in the Federal Register, Volume 33, Number 216, Tuesday, November 5, 1968.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Social and Rehabilitation Service
(Interim Policy Statement No. 19)

AMOUNT, DURATION, AND SCOPE OF MEDICAL ASSISTANCE

Notice of Interim Policies and Requirements

Notice is hereby given that the regulations set forth below (made pursuant to section 1102 of the Social Security Act, 42 U.S.C. 1302) prescribe certain interim policies and requirements for Social and Rehabilitation service programs which were approved, with binding effect on States, on August 15, 1968, by the Administrator, Social and Rehabilitation Service. Interested persons who wish to submit comments, suggestions, or objections pertaining thereto may present their views in writing to the Administrator, Social and Rehabilitation Service, Department of Health, Education, and Welfare, 330 Independence Avenue SW., Washington, D.C. 20201, within a period of 30 days from the date of publication of these interim policies and requirements in the FEDERAL REGISTER. The final regulations will be codified in Title 45 of the Code of Federal Regulations.

Dated: August 15, 1968.

[SEAL]

MARY E. SWITZER,
Administrator, Social and Rehabilitation Service.

Approved: October 25, 1968.

WILBUR J. COHEN,
Secretary.

. . . . (12) Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select. (a) "Prescribed drugs" are any simple or compounded substance or mixture of substances prescribed as such or in other acceptable dosage forms for the cure, mitigation, or prevention of disease, or for health maintenance, by a physician or other licensed practitioner of the healing arts within the scope of his professional practice as defined and limited by Federal and State law. With respect to "prescribed drugs," *Federal financial participation is available in expenditures for drugs dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act.* When dispensing the practitioner must do so on his written prescription and maintain records thereof.

(Italics added by NARD)

Mr. Woods. It should be noted that our investigations show that medicaid payments are being made to physicians in States not located in the Midwest which it was originally claimed were the only States having State medical licensure acts authorize physician dispensing. There have been some expressions from HEW that they would only allow dispensing physicians cost or cost plus 3 percent when they submit reimbursement claims for medicaid prescriptions. Our best information is that dispensing physicians are not willing to accept

only their cost. This was made clear in a legislative fight on this issue in the Indiana Legislature last year, according to reports we have received.

NARD has filed further complaints with former HEW Secretary Finch and the correspondence between NARD Secretary Willard B. Simmons and Secretary Finch is offered for the record. The reply bases the HEW policy on State medical practice acts. Secretary Finch stated "where the medical practice act permits a physician to dispense, I consider this to be overriding. This applies to private patients as well as those in public assistance."

(The letters follow:)

THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS,
Chicago, Ill., August 21, 1969.

HON. ROBERT H. FINCH,
Secretary, Department of Health, Education, and Welfare,
Washington, D.C.

DEAR MR. SECRETARY: During the last two years representatives of The National Association of Retail Druggists have had numerous conferences and correspondence exchanges with representatives of HEW, SRS and MSA concerning the matter of HEW authorizing the use of federal funds for the states to pay physicians who dispense drugs in their offices for Title XIX Medicaid patients.

It is our understanding that HEW is currently considering the issuance of guidelines that will authorize and further encourage physician dispensing by use of federal funds. The National Association of Retail Druggists strongly opposes physician dispensing and the use of federal funds to encourage such unnecessary and ill advised physician activity. The many evils that flow from the practices of dispensing physicians are well known throughout the land. The State of California led the way prior to Medicaid in prohibiting physician dispensing and drug store ownership. It is the purpose of this letter to reiterate our strong opposition to the revision of Medicaid regulations and to proposed guidelines that encourage physician dispensing. We are prepared to document our objections and to emphasize that physician dispensing is not in the best interest of the public health or consistent with a high quality program for the delivery of medical care.

We are confident the two professions of medicine and pharmacy are making significant contributions daily to insure better health care for all Americans, but we do not believe that Medicaid funds should be used to encourage and finance the highly questionable practice of physician dispensing.

We would appreciate your consideration of this matter and we assure you of NARD's continuing interest in Title XIX Medicaid drug program.

Sincerely,

WILLARD B. SIMMONS,
Executive Secretary.

P.S. It was a pleasure to have had the occasion to meet you at the dinner in honor of Dr. Fishbein and I hope to see you again in the near future.

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., October 15, 1969.

MR. WILLARD B. SIMMONS,
Executive Secretary, National Association of Retail Druggists,
Chicago, Ill.

DEAR MR. SIMMONS: Thank you for your letter of August 21, 1969, concerning the Department's authorization of Federal funds to States to pay physicians who dispense drugs in their offices for title XIX Medicaid patients.

I can well appreciate your concern about the reimbursement of physicians who dispense drugs to title XIX Medicaid patients. However, the policy statement is predicated on non-interference with a State's medical practice act. Where the medical practice act permits a physician to dispense, I consider this to be overriding. This applies to private patients as well as those in public assistance.

The greatest number of prescriptions are dispensed by retail druggists, and we

are confident that most physicians will continue to prescribe for medications to be dispensed by pharmacists. You may be sure that HEW guidelines are not intended to encourage additional physician dispensing. Our basic policy was issued so that Federal regulations would not be more limiting than existing State medical practice acts.

Your continued interest in the title XIX Medicaid drug program is appreciated. I was pleased to have met you at Dr. Fishbein's dinner.

Sincerely,

ROBERT H. FINCH,
Secretary.

Mr. Woods. For the many reasons set forth in our statement today in opposition to physician dispensing we are opposed to this medicaid regulation. Also we doubt seriously that payments are now being denied physicians in any State regardless of the wording of the State medical practice acts. While some States are prohibiting payments to dispensing physicians, other States seem to be making Federal funds available to physicians for drugs dispensed even though the State medical practice act is silent on the point which has so impressed the AMA and HEW.

Again, passage of S. 1575 would prohibit further use of the taxpayers money to provide another bonanza for dispensing physicians. It would also protect the medicaid patients from the many abuses which can arise from physician dispensing.

In conclusion Mr. Chairman, we support S. 1575 because we know it is legislation that will provide much public health protection for the consumer who deserves freedom of choice in purchasing all of his health needs. It will contribute significantly to reducing medical care costs, prevent abuse of Federal expenditures, and enable our members as professionals operating small businesses to compete fairly and effectively in the American system of free enterprise. All previous attempts at the conference table and in the State legislatures have been totally unproductive in curtailing the evils which are the subject of S. 1575.

We appreciate this opportunity to appear before you on behalf of the members of the National Association of Retail Druggists.

Mr. Woods. Mr. Chairman, Mr. Winton from California has a brief statement that he would like to make available for the record and would be glad to take questions in any manner that you would like to handle them, sir.

Senator HART. Thank you, Mr. Woods. The statement from Mr. Winton will be printed in the record.

(The statement referred to follows:)

STATEMENT OF J. MARTIN WINTON

Gentlemen: My name is J. Martin Winton. I am the founder of the Vista Pharmacy, 4233 East Tulare Street, Fresno, California 93702, and I have been practicing retail pharmacy continuously at the above address since September 9, 1932. During this period I have also had the privilege of serving as the President of the California State Pharmaceutical Association, President of the California State Pharmaceutical Institute (the Legislative Organization in California for Organized Pharmacy), and as President of the California State Board of Pharmacy.

Winton's Vista Pharmacy now has on file in excess of one million two hundred and sixty thousand physicians' prescriptions.

Physician-ownership of retail pharmacies has never been a problem within the Fresno, California trading area, except with those dispensing physicians involved with weight-reducing mills and the sale of amphetamine and other dangerous drugs.

The California State Board of Medical Examiners has been reluctant to move against such licensees even though California State Board of Pharmacy employees have, on many occasions, brought the problem of the sale of such commodities by licensed California Physicians to both the President of the Board of Medical Examiners and to their Secretary.

As a Member of the California State Board of Pharmacy at the time the Code of Professional Conduct on Commissions, Gratuities and Rebates was established, it was my responsibility to sit as a Board Member throughout the hearings. When the burden of proof was against ONLY the pharmacist, and the person licensed under Division 2 of the Business and Professions Code could not be held accountable under the regulation, the need for Section 4050.5 became apparent.

The California Physician-Ownership Bill, limiting the medical practitioner from having a license to own a pharmacy, has failed to restrict the corporate practice of pharmacy in California. Requiring licensed physicians' names to appear on the permit, to be posted in a conspicuous place, has been some help in regulating Pharmacy Ownership.

Having taken part in the California Hearings, read the Committee Reports, and being aware of the testimony you are to receive today, may I submit the above information to your Committee Members, and be available at any time to answer questions on the subject of the evils of the ownership of community and hospital pharmacies by the prescriber of medical drug products.

Sincerely

J. MARTIN WINTON.

CALIFORNIA PHARMACEUTICAL ASSOCIATION,
Sacramento, Calif., June 10, 1970.

J. MARTIN WINTON,
Fresno, Calif.

DEAR MARTIN: In response to your inquiry concerning the Hart Bill, SB 1575 I wish to advise that the California Pharmaceutical Association is on record in support of this important legislation. Attached is a copy of a Resolution adopted at our recent Annual Meeting re-affirming the position of the Association.

We sincerely believe that the passage of SB 1575 is necessary if the interest of the citizens of this country is to be protected.

The intent of the Holmes Act in California is being circumvented by greedy physicians wishing to profit from the medications required as a result of their diagnosis as well as for their usual physician services.

In recent testimony presented before the Assembly Health & Welfare Committee, much concern was expressed regarding the incidence of dispensing amphetamines and other dangerous drugs. These problems occur when the physician can profit from the sale of medications which he prescribes.

The California Pharmaceutical Association urges the passage of SB 1575.

Sincerely

EDWARD ALSTROM,
President, California Pharmaceutical Association.

COPY OF RESOLUTION REFERRED TO IN ABOVE LETTER

CALIFORNIA PHARMACEUTICAL ASSOCIATION,
June 6, 1970.

Be It Resolved, That the California Pharmaceutical Association continue support of SB 1575 (Hart Bill) and urge local associations to also lend their support.

NORTHERN CALIFORNIA PHARMACEUTICAL ASSOCIATION,
San Francisco, Calif., June 8, 1970.

Mr. MARTIN WINTON,
Fresno, Calif.

DEAR MARTIN: This letter to you is to confirm the strong position taken by the members and the Executive Board in support of Senator Hart's S-1575, Trade and Drug Act, and Congressman Corman's bill on the same subject; the dispensing of medication for payment by a Physician or other prescriber, to his patients. The evils attendant on this practice were even recognized as long ago as 1240 AD when by the Imperial decree of Frederick II of Sicily, Pharmacy and Medicine were separated as two distinct health disciplines, each rendering their unique service toward a healthier life for the public.

The Pharmacists stand ready to assist the Physicians at all times in their consideration of therapeutic treatment for the patient. It is an extra "fall back" system of drug choice that is essential for proper patient safety and efficient economical treatment.

In my experience all practicing Pharmacists and the great majority of Physicians agree with this position.

We strongly urge the passage of these bills into law.

Sincerely,

JAMES BOYNTON, *President.*

SOUTHERN CALIFORNIA PHARMACEUTICAL ASSOCIATION, LTD.,
San Fernando, Calif., June 9, 1970.

Mr. J. MARTIN WINTON,
*Vista Drug,
Fresno, Calif.*

DEAR MARTIN: The Officers and Executive Board of this Association have repeatedly and on every occasion taken the position that physicians should diagnose, and pharmacists dispense.

They support the Hart Bill without question, as they feel that the Public Welfare would be better served if the physicians did not own and operate the point of sale and dispensing of prescription drugs.

Kindest regards,

CECIL M. BLACKHURST,
Executive Director.

CALIFORNIA STATE BOARD OF PHARMACY,
San Francisco, Calif., June 11, 1970.

Mr. J. MARTIN WINTON,
*Vista Pharmacy,
Fresno, Calif.*

DEAR MARTIN: This is in response to your request for additional information pertaining to physician-ownership of pharmacies in California.

As you know, the California State Board of Pharmacy has consistently supported legislation which would prohibit physicians from owning financial interest in a pharmacy.

Our reasons are based on a tendency which exists, and a temptation which is placed, in the mind of the physician-owner to prescribe:

- (a) drugs when they were not needed;
- (b) in excess of the amounts called for;
- (c) only those drugs which are in stock in the captive pharmacy;
- (d) by trade rather than generic name because of the higher price of the former;
- (e) by grade name and cause to be filled by generic name—viz., illegal substitution because of the lower price of the latter.

Accordingly, it supported several bills at the California Legislature designed to financially divorce the physician who prescribes from the pharmacist who dispenses (as does Senator Philip Hart's Bill S. 1575).

Of special significance to us in California was the Holmes Act (AB 2509 which added Chapter 1303—Statutes of 1963). This added Section 4084.5 and Section 654 to the Business and Professions Code.

Briefly, Section 4080.5 prohibits the Board of Pharmacy from issuing any new permit to conduct a pharmacy to a licensed physician; Section 654 requires a licensed physician to divest himself of any membership, proprietary interest, or co-ownership in any form, in or with a licensed pharmacy, by June 1, 1967.

By 1965 the intent of the legislation was challenged in an action brought for declaratory relief by Magan Medical Clinic, et al, vs. California State Board of Medical Examiners.

The Court rules that individual doctors or partnership of doctors could not own a pharmacy; but the law did not prohibit a corporation (whose stock was wholly owned by physicians) from owning and operating a pharmacy. All of this is well known to Senator Hart since it was ably presented to him by Benjamin Kingwell from the California Pharmaceutical Association on January 25, 1967 (see copy enclosed).

Since this interpretation clearly circumvented the express intent of the Legislature, additional attempts were made to close the loophole. AB 1691 introduced by Assemblyman Powers in 1967 would have prohibited physicians from owning any interest in any corporation which owns a pharmacy or which leases or rents space to a pharmacy at more than the prevailing rates, regrettably, it failed of enactment.

A survey conducted in California during 1961 revealed the following:

There were 219 physician-owned pharmacies; 541 physicians were involved in ownership of these pharmacies; 144 of the 219 were hospital pharmacies; 75 pharmacies were owned by physicians either as individuals, partnerships, or corporations.

During 1963 (when the Holmes Bill was enacted), our records showed that: 14 Retail pharmacies were owned by corporations whose officers were physicians

Hence, it can be concluded that 61 retail pharmacies were owned by physicians or partnerships of one or more physicians.

Since then, and probably as a result of the Magan Medical Clinic case decision, the number of retail pharmacies owned by corporations partially or wholly controlled by physicians has increased to 27, or almost double the 1963 figure.

It must not be presumed that the above figures necessarily reveal the entire extent of physician-ownership. It is suspected that there are instances where controlling interest by physicians is hidden. This can be accomplished by: transferring ownership to relatives, or to trust funds, or by other subterfuge.

We should urge Congress to press for passage of the Hart Bill, since legislation enacted at the state level has been only partially successful in eliminating the evils inherent in a situation which permits the physician to become a profit-seeking businessman.

We trust that this may be helpful to you in your presentation of testimony in behalf of S. 1575.

Very truly yours,

JOSEPH F. BOTTINI,
Executive Secretary, California State Board of Pharmacy.

[From the Oakland Tribune, Aug. 11, 1963 (Parade Section)]

Is it true that many doctors today have become money-grubbers in search of the fast buck?

Is it true that many doctors today practice needless surgery?

Is it true that many doctors today treat a patient by first feeling his purse?

Is it true that many doctors today charge what the traffic will bear?

Is it true today that doctors, surgeons, and dentists, earn more money than any other professional men?

The American Medical Association, which operates one of the richest and most powerful lobbies in the country, will shout NO! It will point out that never before in our history has the nation been tendered more efficient health care. Never before has the medical profession reached such high standards of practice. Perhaps, it will concede, there are a handful of unethical men practicing medicine—as in every other profession. But the vast majority of doctors are kind, selfless men, who care more for curing the sick than earning some of the best livelihoods in America.

Undoubtedly what the American Medical Association contends is true. But equally true is the contention that the old-fashioned public image of the American doctor as a combination hero figure and Good Samaritan is now rapidly deteriorating.

One reason for this: More and more doctors are making more and more money, from such allied fields as pharmacies and hospitals.

Prior to 1954, the AMA laid down a strict rule for doctors: Limit your income from your profession to "services rendered the patient." But that rule has long since gone by the board.

Take the question of pharmacies.

Are medical ethics endangered when a doctor is also owner of a drugstore?

Is there a possibility that a doctor faces perilous temptations in writing prescriptions if he has an interest in the prescription-filling pharmacy?

The American Medical Association cannot make up its mind.

In November 1962, its Judicial Council said: "It is unethical for a physician

to participate in the ownership of a drugstore in his medical area unless adequate drugstore facilities are otherwise unavailable."

In March 1963, however, the AMA Judicial Council changed its policy with this statement: "It cannot be considered unethical for a physician to own or operate a pharmacy, provided there is no exploitation of the patient."

But there has been exploitation of the patient.

For example, at a recent hearing conducted by the California State Board of Pharmacy, Charles Markley of the Contra Costa County Welfare Department testified that a Richmond, California doctor who was writing prescriptions for welfare patients at the rate of \$10,000 a year, opened a pharmacy next to his office in 1960. In the next 12 months the doctor's prescription business zoomed to \$50,000 without any correspondent increase in the number of patients he treated.

THE WHOLE TRUTH

Verbatim testimony from the public hearing follows:

Q. During a usual month for Dr. Benedict before he acquired the Sixth Street Pharmacy in Richmond, what were his average bills?

A. Less than a thousand dollars a month.

Q. Subsequent to his acquisition of the Sixth Street Pharmacy, what was the average bill submitted by Dr. Benedict?

A. Five thousand.

Q. Would you describe for the Board the physical relationship between Dr. Benedict's office and the Sixth Street Pharmacy in Richmond?

A. They are adjoining.

Q. By "adjoining"—was there a door from the doctor's office into the pharmacy?

A. Yes.

Q. Did you have occasion, sir, to examine the—and collect affidavits from patients of Dr. Benedict?

A. Yes, we did, from the District Attorney's office.

Q. And the results of this investigation indicated that the prescribing habits of Dr. Benedict were somewhat unusual?

A. Yes, very.

Q. Let me ask you, sir, specifically in regard to the purchase of penicillin drugs, what your investigation revealed as to Dr. Benedict's prescribing penicillin, or how he handled the particular thing.

A. You mean how much quantity? By the gallon.

Q. How many gallons a month?

A. Three.

Q. Did your investigation also reveal the fact that some of his patients, or many of his patients, received penicillin?

A. All.

Q. Every patient that consulted him received a shot of penicillin?

A. Yes.

Q. How many patients did Dr. Benedict see, according to your figures, every day, 365 days out of the year?

A. 70.

Q. And every one received a shot of penicillin?

A. Yes.

Q. Would you also advise this Board as to how Dr. Benedict's habits—physically what would he do with his patients? As they left the office, what would he do?

A. He took them to the pharmacy.

Q. By the hand?

A. Practically.

Q. And normally, if I understand the investigation that has been made, he would shout through his office to the pharmacy, is that accurate?

A. This is true.

Q. Let me ask you, sir, the amount of money Dr. Benedict, from his medical practice, received from the County of Contra Costa?

A. \$75,000.

Q. How much did Dr. Benedict receive from his pharmacy located next door?

A. \$50,000.

Q. I think your testimony also was that—or let me suggest that our discussions have revealed that Dr. Benedict after his acquisition of the pharmacy, could you state for the Board, in percentages, his increase in writing of prescriptions?

A. 500 percent.

Q. Do you have any present knowledge of the whereabouts of Dr. Benedict?

A. He's in Europe.

In California where 526 physicians are known to own more than 252 pharmacies—the figures may be much larger since it is impossible to document all physician-ownership interests in drugstores—a common procedure is for a group of doctors to erect or lease a medical building, establish their own clinic and own the pharmacy. That way they get the patients coming and going.

Edward Berger, a Canoga Park pharmacist, has testified that the doctors who owned a pharmacy in a Los Angeles clinic asked him to manage their pharmacy for \$15,000 a year.

Previously these doctors had leased out the drugstore to a licensed pharmacist on a 12 per cent of the gross basis. The pharmacy did so well that the doctors decided to take it over themselves.

They asked Ed Berger to "front" for them so that patients would think it was HIS pharmacy. To induce Berger to take the job they agreed to sweeten the pot by giving him 2 or 3 per cent of the gross. They told him this would prove to be a considerable amount since they could pad their prescriptions.

"You know," one doctor told Berger, "I can write two prescriptions instead of one. I can write them bigger; instead of giving 50 pills, I can write for 100."

Here's another case of how doctors throughout the nation are profiting from the prescriptions they write, prescriptions to be filled by drugstores they own outright or in partnership with pharmacists. Six Los Angeles doctors own a hospital and its pharmacy. They employ a pharmacist to run it for them. In 1961 on an inventory of \$10,000, this pharmacy earned a net profit of \$90,000.

HOW DO THEY DO IT?

How did the doctors manage so exorbitant a profit? One method was to have their pharmacist fill prescriptions with generic rather than brand-name drugs.

For example, one doctor would write a prescription for Mrs. Jones for Serpasil tablets to bring down her blood pressure. Serpasil is a brand name for a drug generally known as reserpine. The pharmacist would give Mrs. Jones reserpine tablets, which cost 50 per cent less than Serpasil, and charge her for Serpasil.

Let's you think these are isolated examples, take the case of Jenny Gonzales. Her doctor gave her a prescription to be filled at a pharmacy. The prescription read: "T.P.A.B. oz. 83: t.i.d." Jenny took it to a pharmacy other than the one recommended by her doctor. The pharmacist could not understand it and phoned Jenny's physician. Said the latter, "It's a special formula available at the Metropolitan Pharmacy. That's where she should have gone."

Jenny's doctor owns the Metropolitan Pharmacy.

To prevent such abuses as the above and to get doctors out of the pharmacy business, the California legislature a few weeks ago passed a bill prohibiting physicians and surgeons from having full or part ownership in retail pharmacies.

The law becomes effective September 20. It forbids the State Board of Pharmacy from issuing any new licenses to physicians to operate pharmacies. Those physicians who are already licensed have until June 1, 1967 to get rid of their interests.

The law has several loopholes. It¹----- owned pharmacies located in hospitals and says a physician may own the building in which a pharmacy is located but must lease out the store.

The law is aimed at preventing possible patient exploitation by not permitting the person who writes a prescription to fill it.

How do doctors themselves feel about pharmacy participation? The magazine "New Materia Medical" took a nationwide random sampling of physicians and asked if they thought it unethical for physicians to own a pharmacy. Of the doctors questioned, 46.1 per cent said "Yes," upholding the AMA statement of November 1962, and 53.9 per cent said "NO," upholding the AMA position of March 1963.

¹ Printing was not clear on copy from which this typing was done.

The magazine then asked: "Would medicine's public relations be hurt if patients knew that doctors had a financial interest in a pharmacy?"

"Yes" said 64.1 per cent of the doctors, medicine's image is injured when patients learn that a physician has a financial stake in a local pharmacy.

In short, many doctors see nothing unethical about owning a pharmacy; they just don't want the public to know about it.

Doctors work long and hard. They invest \$80,000 and as many as 15 years of their lives before they become doctors. They deserve and are entitled to earn ethically as much money as possible—but not in allied business which pose a definite conflict of interest.

The opinion of spokesmen for the AMA on this subject is split. But Dr. Edward L. Fitzgerald of Hutchinson, Kansas has wisely observed that "when the physician who prescribes and the pharmacist who dispenses are financially divorced from each other, the physician can freely exercise a genuine interest in prescribing for his patient as economically as it is possible to prescribe."

Senator HART. Let me thank all of you for testimony of the character that you have just voiced. I think it is an objective analysis of the proposal sharing your point of view. Of course, I am not the best fellow to cross-examine you. But let me ask you this one, whether it be to Mr. Woods or whoever wants to answer it.

I was in attendance at a meeting over on the House side and unable to be here myself when Dr. Steinfeld testified. My staff, however, tells me that he, the Surgeon General, earlier today gave qualified support to the bill that we are considering, S. 1575. He made clear that he recognized the significant conflict of interest that was indicated by the bill. However, he suggested that the bill went beyond—went too far. The specific point that he made, on which I would like your reactions, was that the Secretary of HEW be empowered to determine by regulation instances in which physicians might dispense or might own their own pharmacies rather than the flat provision of the bill. He said, let it be a matter for the Secretary to determine. How do you react to that suggestion?

Mr. WOODS. Well, Mr. Chairman, certainly we are pleased to have an endorsement of the bill by anybody from HEW. To be frank with you, first, the Surgeon General I believe does not have the responsibility there—maybe I am wrong—with respect to regulations that we complained of. Those regulations were developed over in the title 19 department. Second, I would say that if our experience in the past is any indication of the results that we will get in the future from an HEW regulation, we would much prefer the law.

Senator HART. I see your associate is nodding in agreement.

Mr. SIMMONS. Yes.

Senator HART. You have just described the experience you have had on the title 19 business. Is that the sort of thing that you fear would occur if, rather than prohibiting ownership and dispensing, we authorize the Secretary to establish regulations and limitations on it? Is that the sort of thing you are worried about?

Mr. WOODS. Yes, sir. Really, we had many discussions with the people in the Medicaid Department of HEW. Let me say generally, that we have strongly supported the Medicaid program because of its vendor aspects and generally the patient's freedom of choice. We think it was a good program in that respect. But, in our discussions with the people in HEW, and some of them were physicians with whom we had friendly discussions, we filed our objections with the Department, which we have offered for the record. Our letter stated

our opposition to the medicaid proposal for physicians dispensing. As far as I can tell the letters were filed, but no change was made in the original HEW proposal to allow physicians dispensing. The first proposal that they made to us was the one that was the final regulation. We feel it encourages and invites physicians to dispense. Another thing I think that is interesting is that the original contention by HEW was that physicians dispensing would only happen in about seven States and that we should not be concerned about medicaid drugs being dispensed by physicians in other States. HEW wanted to make this change for only seven states, where the medical licensure act says that physicians dispensing is allowed, and these would be the only States where this would take place. But, it just isn't so. We find reports now from other States, Virginia is one, where physicians are dispensing. I understand there are some 300 dispensing physicians in Virginia. We sent a questionnaire out within the last couple of weeks, and from many States we are getting reports back that they don't know how much but certainly there are some physicians that are submitting drug claims under medicaid. Physicians dispensing is not limited to the States we were told it would be limited to when HEW first proposed this change in medicaid regulations.

Senator HART. Mr. Winton, California has this statute that prohibits physician ownership of pharmacies, I understand. How does it work?

Mr. WINSTON. Senator Hart, the intent of the Holmes law in California was to prevent physician ownership of drugstores. But the law did not prevent a doctors corporation in the practice of medicine from entering into an agreement among themselves and the corporate officers to practice pharmacy.

I want to tell you frankly that I have spent almost 25 years in California in the problem of physician-owned pharmacies and physician dispensing. I sympathize with you in your 6 years or longer that you have been involved in this problem, and I certainly hope that we can bring this to a satisfactory conclusion.

There are 22,000 licensed physicians in California. There are 12,000 licensed pharmacists and 4,500 drugstores. The problem of physician dispensing or physician ownership of pharmacies in his professional area has developed in the southern part of the State of California and in the northern part of California. For 16 years I was led to believe that a code of professional conduct or a regulation by the board of pharmacy would correct this problem, along with legislation.

Senator Pearson this morning introduced a letter to this committee that one of his constituents, which I presume is in Kansas. One of the great leaders for the legislation which has been introduced was another Kansas physician, a member of the American Medical Association who in June of 1961 wrote a letter to the Honorable Estes Kefauver. He is Edward L. Fitzpatrick, M.D., of Hutchinson, Kans. While this letter is in the 1964 record, I would like very much for Senator Pearson to have a copy of this statement to go along with the one that he read prior to the time that you got here this morning.

Senator HART. We will put it in at this point in the record.

(The letter follows:)

HUTCHINSON, KANS., June 26, 1961.

HON. ESTES KEFAUVER,
U.S. Senator,
Senate Office Building, Washington, D.C.

DEAR SENATOR KEFAUVER: As an active physician and a member of the Reno County Medical Society, the State medical society and the American Medical Association, I usually do not take the time or have the inclination to write anyone in Washington. However, I was so pleased to learn that your subcommittee was interested in investigating the physicians-owned and/or controlled pharmacies, that I felt I should give you some of the facts.

First may I point out that the growth, progress, and advancement of the entire medical program has been developed because dedicated physicians served unselfishly to promote and protect the health and life of his fellow man, without plans or designs on how much income he could make from his practice or an allied profession, which in this case is pharmacy. When we, as physicians, deviate from these privileged principles, which are the very foundation of our profession, then we deserve, for the benefit of the public, Government intervention.

Please allow me to set out the reasons why I believe you should investigate physicians-owned, controlled, rented on percentage lease basis, in clinics, removed from clinics but serving as income to the prescribing physicians. I am hopeful you will consider these thoughts.

(1) For years the American Medical Association considered it unethical and not in the interest of the public for a physician to profit directly or indirectly on the medication dispensed on his own prescriptions.

(2) The unfortunate patient should not be placed in the middle position, where on one end the physician collects medical fees, and on the other end the same physician profits on the drugs the same physician prescribed.

(3) In practice the physicians'-owned pharmacies destroy the patient's freedom of choice and the competitive advantages that result from private competing pharmacies.

(4) When pharmacies are financially divorced from the prescribing physician, the physician is sincerely interested in how little and how economically he can prescribe for his patient. When the reverse is true, the physician is tempted into how much he can prescribe and how much longer he can keep his patient on his profitmaking medication.

(5) It behooves men in responsible positions, as yourself, to protect the public against plans of conflicting interest. Certainly the disjoins of pharmacies from physicians has served as a check and balance, and the pattern has become an American heritage. In a large measure this has helped to keep each profession honorable and without public accusation of merchandising medicine on the American public.

(6) The public would not tolerate for General Motors to own the filling stations, or for the electric power companies to have the corner on electric appliances. Federal food and drug laws are very restrictive. They demand that a private pharmacy cannot dispense, sell, give away, or even consume his own stock of legend prescription drugs, which is about 90 percent of his prescription drug stock. The only avenue for a private pharmacy to dispense his prescription drug stock is on a bona fide physician's prescription. When we allow physicians to put in their own pharmacies, it usually follows that by direction or designed convenience the physicians-owned pharmacy get all the prescription business, and the private pharmacy is helpless to dispense his prescription drugs.

(7) Several years ago the Justice Department broke up an arrangement in which physicians were getting a profit on the spectacles he prescribed, via a kickback from the optical companies. As I recall, in addition to a heavy fine, an order was issued to "forever cease and desist this practice." Perhaps this order covers the current problem and trend in which a minority of physicians are engaged with respect to profiting on prescription drugs.

(8) The public demands and industry accepts controls to avoid monopolies in business, since physicians and pharmacists are dealing in matters of health, illness, and life itself, it seems even more important that we not allow arrangements that lend themselves to monopolies on a defenseless and uninformed public.

(9) In isolated rural areas there are occasions in which a country physician has to personally dispense his own drugs in the absence of a pharmacy in the area. However, this should not be confused with a practice of physicians forming clinics and installing their own pharmacy to dispense their wares through

what appears to be an innocent private pharmacy but is actually owned by the physicians. This is being done in the presence of a number of private pharmacies competing in the immediate area of the clinic.

Let me assure you I have no reason to defend private pharmacies by virtue of relatives or friends in the field. I do feel we both have much at stake when monopolies threaten to destroy the freedom of the public to enjoy the benefits that come from trading with competitive private enterprises. I am equally certain if we permit the above-mentioned practice to prevail, the profession of the physician and the profession of the pharmacists will both decay.

I appreciate your interest and the respect you have earned by delving into some of our complex monopoly problems and I urge you to vigorously pursue this investigation.

As a dedicated public servant I am sure you agree, when each of us in his own field will first consider the interest of the public, then together we can make a worthwhile contribution to society and help preserve the ways of American life that have made this country great.

Yours sincerely,

EDW. L. FITZGERALD M.D.

Mr. WINTON. My work on the code of professional conduct for pharmacists in the United States was based a great deal on the men of the American Medical Association that we worked with in those days. A letter within my statement from the secretary of the board of pharmacy, Joseph Bottini, pointed out the problem that we have with the Holmes Act in California. This legislation would correct the errors with the Holmes bill and prevent the corporate practice of pharmacy within the State of California.

We in California have worked closely with the physicians and with 99 percent of our colleagues in the practice of medicine in California and we have no problem.

You asked a few minutes ago about the overutilization of the welfare program in California. The 22,000 physicians in California write prescriptions and drugs in excess of \$500 million a year for their patients. Some of these are written for a longer period of time, even though the patient is only authorized for a 30-day period to receive medication. If the physician is paid his usual and customary fee for seeing welfare recipients, which he is in California, and if he owns his own dispensary and he prescribes medicine which his pharmacist under his authorization dispenses, we have a captive situation there that is almost unbearable for the taxpayer in our State: 50 percent of our money for medical aid covers this; 30 percent is from the State and 15 percent from our county. We lost an election here where we would be placed in this entire responsibility of county participation back in the State capital. Does that answer your question?

It can't be presumed that you can put your faith in the physician. We have found that since the Holmes bill, which covers the ownership of pharmacies by the other members of physician's families, doctors will cover up ownership of pharmacies by using names of employees.

Senator HART. Wouldn't they do the same thing with the Federal law?

Mr. WINTON. I think not, if the enforcement was left with you people. We found as soon as California required the physicians to put their names on the pharmacy license and the license to be displayed in a conspicuous place, the ownership of pharmacies by physicians dropped considerably. This was during the nine years that I spent on the California Board on the State Board of Pharmacy.

I also spent 16 years on the Board of the Pharmaceutical Association in California. I worked with Dr. Fitzgerald from Kansas on this problem and the members of the CMA in trying to do what your legislation does through a code of professional ethics. When we presented it to the Board of Pharmacy in 1963 a licensed pharmacist who entered into an agreement with a medical practitioner and we took the pharmacist's license away from him. The ink wasn't dry on the order before the doctor was out promoting a discount from some of the other drugstores in the community.

Senator HART. Senator Pearson?

Senator PEARSON. Mr. Woods, I cited a statistic this morning that a physician-affiliated pharmacy represented about one percent of all the pharmacies in the country, and in your testimony you indicated that you felt like that practice was increasing considerably. You have gotten communications from Mississippi, et cetera. Do you think the statistics that were furnished me by a Kansas physician is an accurate one? Is it one percent?

Mr. WOODS. Well, Senator, I don't know what figures the doctor was basing his statistics on. I would say, first, if his percentage of physician-owned pharmacies in the country is as inaccurate as his reference to the number of drugstores in the country, then he may not be too accurate. He mentioned 75,000—

Senator PEARSON. 70,000, I think.

Mr. WOODS. There are only about 53,000 drugstores in the country. Now, I don't know how he could come by the figure 1 percent. We just recently received a statement from the secretary of the board of pharmacists in Mississippi, and he said 5 percent. That State really amazed me, because I didn't think there was much physician-dispensing or ownership either there. Another reply we recently received from North Carolina estimated 100 physician-owned drugstores. That amazed me again, because I didn't think there were too many physician-owned pharmacies in North Carolina. It was pointed out in one of the earlier hearings that a survey to ascertain these facts was being conducted annually by one of the national drug publications up until 1960. At that time they were talking about something like 2,000 drugstores. They quit making the survey because it was impossible to get the information. As Mr. Winton just pointed out, the ownership may be in the wife's name or some other relative's name. Some boards of pharmacy request this information and some do not. I just don't know how this information could be obtained.

Senator PEARSON. If that would be the case, this legislation would not cure that.

Mr. WOODS. Well, first, there is no State legislation that speaks to this point except California. The difficulties there were explained by Mr. Winton. If this legislation were enacted—

Senator PEARSON. Let me interrupt you to say that I am in error. I think the legislation does cover it. Senator Hart is directing my attention to section VI where it says it should be unlawful for a medical practitioner to own directly or indirectly a legal, beneficial or vestor's interest in a community pharmacy. So, I think probably it is covered.

Mr. WOODS. Right.

Mr. WINTON. I think your figure is probably correct. We consider

that in 9 years on the board of pharmacy, we had approximately 2 percent of the 4,500 drugstores in California that were physician-controlled or physician-owned. With the advent of the Holmes Act, this dropped to about 1 percent. The when the corporate practice act went into effect, the other 1 percent picked up the ownership again.

Mr. WOODS. There is a lot of blending of the problem of physician-dispensing and storeownership. For instance, I understand in southern Indiana that there are a lot of either dispensing or pharmacy ownership by clinics. It gets into a gray area whether the doctor is dispensing or whether he has a drug room down there that would be called a pharmacy where a nonpharmacist is dispensing the drugs.

Senator PEARSON. I thank you very much, Mr. Woods. Thank you, Mr. Chairman.

Senator HART. Mr. Cary?

Mr. CARY. Do you see any objection to a pharmacy being physically located in a medical clinic?

Mr. WOODS. The problem really is there when a physician benefits by the drug he prescribes and where he is writing the prescription and is going to benefit for profit by what he prescribes. If there is a clinic with the pharmacy and it is owned by the pharmacist, not the physician, we see no difficulty, unless, and I believe the bill covers this, there is some exorbitant lease requirement that again would enable the physician to profit by the number of drugs dispensed. We hear some pretty phenomenal lease percentages as to the take the physician would get in one of these clinic pharmacies. We are very much opposed to that.

Mr. WINTON. Prior to the time, gentlemen, that the percentage lease arrangement in the clinic was established in California whereby the board of pharmacy reviewed all of the leases for pharmacies and clinics, we found—these are not exceptions—where leases were based on 50 percent of the total volume of the business by the pharmacy. This then led the board of pharmacy to establish a procedure whereby the rent of the medical building for the pharmacist would be on a square-foot basis. This arrangement might not be a bad idea for lab technicians who are also captive administrators of the physician-owned pharmacy building.

Senator PEARSON. May I ask, Mr. Chairman, are there not some circumstances caused because of the geographical conditions in the upper part of Michigan or in the western highlands of Kansas where the physician-pharmacist combination is desirable and feasible?

Mr. WOODS. You mean physicians dispensing?

Senator PEARSON. Yes.

Mr. WOODS. There is no problem. The bill provides for this where adequate pharmacists' services are not available in rural communities. We couldn't complain. The bill enables a physician to dispense under those circumstances.

Senator PEARSON. Thank you.

Senator HART. Mr. Simmons and Mr. Rooke, do you have anything you would like to add?

Mr. ROOKE. Senator, I think that this whole matter has been covered very comprehensively. I would like to say as chairman of the Committee on National Legislation, I received endorsements and

support of S. 1575 from all over the country. I have a tremendous file from these pharmacists throughout the country that would like very much to have this legislation passed. Over in the State of Virginia, just across the river, for the sake of comparison, we have about 1,200 drugstores. We have about 300 dispensing physicians. We have the same provisions that are provided for in S. 1575. The physician may be licensed in rural areas where pharmaceutical services are not readily available. We have 80 such physicians licensed in Virginia. We do have an increasing problem with medical center pharmacies being owned by physicians and the leases being on some percentage basis such as prescriptions and some even on gross volume that are rather inequitable to the pharmacist. If the physician owns the building, the leases are pretty hard to live with I think most of the State pharmaceutical associations in the country are on record as endorsing this legislation. Ours has been ever since its inception. I think that is about all I can add to what has been said here.

Senator HART. Mr. Simmons?

Mr. SIMMONS. Mr. Chairman, of course I would like to first express our sincere thanks and gratitude to you for the fine leadership you have provided for this proposal. We are indebted to you, of course. I think the pharmacists will be benefited to some degree because after all, Mr. Chairman, I think it means the life and death of a business in some rural communities in this country and some small towns and some of the larger cities where the pharmacists spend a tremendous amount of money for his education, the investment in his business. When he competes with a physician down the street dispensing medication, then I think that we are losing something that is valuable to that particular community, a retail pharmacy. Of course, we have had records and letters from pharmacists and others in the communities throughout this country supporting this bill. Obviously the public will be benefited by this legislation and we are grateful to you.

I want to thank you again for permitting us to file this with you this morning.

Senator HART. Again, gentlemen, thank you for coming. If there is not objection, I will put the letter in the record from a physician in Minnesota. It is dated June 11, and excerpts from it run like this:

I would just like to let you know that many of us in medicine support heartily your efforts in the drug and appliance trade as it relates to the practice of medicine. * * *

It is impossible for a physician to be impartial in prescribing medication or appliances in which he has ownership. * * *

I am sure you have heard many testifying to the contrary, but I feel our opinion is just as valid and represents just as many people in organized medicine as the opposition would indicate they represent. I would just guess from my experience that the younger physicians in particular are particularly concerned about this questionable ethical business alliance.

(Letter follows:)

JOHN R. HOLTEN, M.D.,
Moorhead, Minn., June 11, 1969.

Senator PHILLIP HART,
Senate Office Building,
Washington, D.C.

DEAR SENATOR HART: I would just like to let you know that many of us in medicine support heartily your efforts in the drug and appliance trade as it relates

to the practice of medicine. Far too many individuals and groups are tied so closely with a pharmacy, an optical shop, and an orthopedic appliance shop that it is difficult for them to divorce their clinical practice from their business practice. I feel all of these outside trades represent an honest profession that someone else could well handle without having a physician ownership. It is impossible for a physician to be impartial in prescribing medication or appliances in which he has ownership. We would strongly urge you to continue your efforts to divorce those businesses from the practice of medicine. I am sure you have heard many testifying to the contrary but I feel our opinion is just as valid and represents just as many people in organized medicine as the opposition would indicate they represent. I would just guess from my experience that the younger physicians in particular are particularly concerned about this questionably ethical business alliance.

Several other small items I would hope you would support in the field of medicine. John Knowles, the administrator of Massachusetts General Hospital, Boston has been opposed by the AMA to become Deputy under Secretary of HEW. I feel this opposition is unfounded and not to the best interests of that department. I would urge you and your colleagues to support his nomination without regard to the AMA's opposition. You only have to know who runs the AMA to recognize why they oppose so many social economic problems.

Also I would urge you to look into the possibility of a national fee schedule. As you know, we are now under a system of "usual and customary fees". I feel this has been ruthlessly exploited even though the concept was valid and just. I am afraid physicians are like any other group in America today and have exploited this beyond bounds. The only answer lies in federal legislation in a national fee system with possible adjustments for localities. I think most of the profession expects this although they hope that this windfall will not quit.

I hope you continue to remember that no other consumer in America has so little voice in the product he buys as does the medical consumer. This poor individual is completely at the mercy of the winds. Somebody must be their watchdog and I am afraid the Federal government will have to step in and do just that.

Sincerely yours,

JOHN R. HOLTEN, M.D.

Senator HART. Thank you, gentlemen, very much.

Mr. WINTON. Senator Hart, before closing, I certainly want the committee members to understand that the vast majority of pharmacists throughout our Nation understand that the majority of doctors are kind people and are more interested in taking care of the medically deserving citizens of our community. We get along fine with these people. The people that are creating the problem are a very, very small minority and I think your legislation solved this problem. An along with Mr. Woods, we strongly support your legislation.

Friday is Senator Cranston's birthday and I will go up and wish him a happy birthday.

(The following information was subsequently received for the record:)

THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS,
Washington, D.C., July 9, 1970.

HON. FRANK E. MOSS,
Chairman of the Consumer Subcommittee, Committee on Commerce,
U.S. Senate, Washington, D.C.

DEAR SENATOR MOSS: Illustrating and amplifying the point made by the National Association of Retail Druggists in its June 16 Statement to the Consumer Subcommittee of the Senate Commerce Committee on S. 1575, N.A.R.D. wishes to submit the title pages of two contracts used by Blue Cross in Virginia.

The two contracts equate pharmacies with dispensing physicians and pay each on the same basis for drugs dispensed. The titles of these two contracts are "Prescription Drug Agreement between Virginia Hospital Service Association and Cooperating Pharmacy" and "Prescription Drug Agreement between Virginia Hospital Service Association and Cooperating Physician." The contracts are identical in wording except that physicians are being invited to increase their drug

dispensing by the contract for a "cooperating physician" which is intended as a substitute for the "cooperating pharmacy" contract.

Sincerely yours,

Wm. E. Woods,
Washington Representative.

Enclosures.

PRESCRIPTION DRUG AGREEMENT BETWEEN VIRGINIA HOSPITAL SERVICE ASSOCIATION AND COOPERATING PHARMACY

(Virginia Hospital Service Association, P.O. Box 656, Richmond, Va. 23205)

PRESCRIPTION DRUG AGREEMENT BETWEEN VIRGINIA HOSPITAL SERVICE ASSOCIATION AND COOPERATING PHYSICIAN

(Virginia Hospital Service Association, P.O. Box 656, Richmond, Va. 23205)

Senator HART. Our next witness is Dr. Harold D. Caylor who speaks for the American Association of Medical Clinics.

Dr. CAYLOR. Mr. Chairman, I am substituting for Dr. Edward Wurzel who, because of a conflict of dates, could not appear.

I would like to read a portion of his statement.

STATEMENT OF DR. HAROLD D. CAYLOR, CAYLOR-NICKEL CLINIC, BLUFFTON, IND., ON BEHALF OF DR. EDWARD M. WURZEL, EXECUTIVE DIRECTOR, AMERICAN ASSOCIATION OF MEDICAL CLINICS

Dr. CAYLOR (reading):

I am Edward M. Wurzel, M.D., Executive Director of the American Association of Medical Clinics.

The American Association of Medical Clinics is a voluntary, non-profit, professional association representing approximately 250 group practices in this country and 1 in Canada. The Association was formed in 1949. Its objectives include elevating the standards of medical practice in clinics, improving graduate education and research in medical group practices, increasing scientific knowledge relating to group practice and providing two-way communications between the legislators in the health field and the physicians and other professionals engaged in the group practice of medicine.

The Association is currently deeply involved in improving the health care delivery system. Until 1969 only multi-specialty groups were eligible for membership. We now have a class of membership for single-specialty groups, a number of which are already members.

AAMC maintains an Accreditation Program, publishes a monthly journal, Group Practice, an annual Directory—

a copy of which I have here for you—

and topical bulletins as indicated, sponsors national and regional conventions, has an associated research foundation, and supports 17 committees in fields of appropriate interest.

There are 81 member clinics which own pharmacies on their premises; 91 rent space to pharmacies; 59 which have no pharmacy on the premises. Definite information is lacking on about 20 other member groups.

I will not take the valuable time of this committee with too many details about the Association; I believe that most of the members are already familiar with it. I am, however, attaching a Directory of the Association to the original of this report for the benefit of those who may wish to see the distribution of our membership and the organization of the clinics represented.

I would like to bring to the attention of the committee excerpts from our member clinics referring to the current bill. They will indicate that the statement

appearing in the findings of fact of this bill, S. 15175, do not apply to the group practices we represent. It is our hope that the bill can be altered in such a way that it will not work contrary to its purpose by including these group practices in the prohibition envisioned by the act.

The bill includes the following phrases: "* * * the Congress finds and declares that the dispensing of drugs and devices directly or indirectly * * * by medical practitioners * * * is inconsistent with the best interest of the public health * * *, denies consumers free access to an open market for such products moving in or having moved in interstate commerce and tends to induce unfair trade practices in connection with trade in such products."

The statements which follow show that quite to the contrary of being inconsistent with the best interests of public health the maintenance and operation of pharmacies by our members is decidedly in the best interest of public health; that rather than denying consumers free access to an open market, it assures them of free access; and that rather than inducing unfair trade practices in connection with trade in such products, it contributes to fair trade practices.

Then follows a series of statements from practically all over the United States, which I won't bore you with. You can consult these at your leisure.

Here is one from South Dakota:

It certainly is true in our situation that we can control the quality of the drugs, dispensing of them and control the quality of the drugs, dispensing of them and control the profit that is made on these preparations. It has always been our policy to supply the drugs to the patient with a normal profit. The profit being the one suggested by the manufacturer or below this, which we feel many times is advisable because of the cost of the drug and the amount of profit that would be realized. We feel that our prices aid to control the prices of the surrounding drug stores since we are well aware that any of the pharmacies that are more than 40 miles away, universally carry a higher retail price on their drugs than the clinic dispenses theirs for.

Here is another one from Missouri:

We make no restriction on the prescription given our patients. They may get them filled at our pharmacy, or any of the other pharmacies in our city or surrounding area. For some of our referred or out of town patients we suggest they get their prescription filled in their locality for convenience, particularly if refills may be necessary.

Then we go to Kansas where it says:

Although there are numerous valid objections to proposed legislation of this character, I shall limit my comment to the following:

1. In Section 2, the Bill is premised, in part, upon the erroneous assumption that the dispensing of drugs and devices by medical practitioners, directly or indirectly through ownership of pharmacies or interests therein, is inconsistent with the best interest of public health, and denies "consumers free access in an open market * * * and tends to induce unfair trade practices.

"The fact is that pharmacies owned by medical groups, or which occupy space leased from medical groups, are numerically infinitesimal. Less than 1 percent of the estimated 70,000 retail pharmacy outlets in the United States fall into such category or classification.

"Although a purpose and objective of the Bill is purportedly to free and broaden the market for drugs and devices and to curtail alleged unfair trade practices, the obvious result of its enactment would be the reverse. It could only serve or tend to limit or restrict the ownership of pharmacies, thereby reducing the market opportunities of the consumer, at his ultimate expense.

"* * * Except in very limited and unusual cases, the patient is free to buy and does buy his drugs from the pharmacy of his choice, and customarily he does his buying after taking into account the factors of convenience, price, service, confidence, and reliability.

Then Illinois, where it says:

We have a small prescription pharmacy whose main function is to serve our patients and has a very limited clientele outside our own clinic patients. Our

prices are extremely competitive with those in the area particularly those of the other prescription pharmacies. We cannot compete with discount houses because we give credit and have a delivery service.

We do not in any way attempt to use code prescriptions or any other devious means. The patient is never forced or coerced to use our pharmacy.

Finally, going to the last page:

The Association wishes to submit a few copies of prescription blanks as used by some of our clinics and referred to in the above statements, showing the legend "Take to the pharmacy of your choice" or something similar.

In conclusion it has been the effort of the AAMC to present to the members of this Committee a point of view, substantiated by examples and reasons, which it is hoped will convince you that it is desirable to modify the proposed Bill in such a way that it will not deprive member clinics of the valuable asset to health care delivery represented by their right to operate pharmacies in conjunction with their physician-guided, consumer-oriented, community-based, incentive-motivated, comprehensive health care organizations.

Senator HART. Doctor, thank you for a statement which is in itself comprehensive. I know your voice it out of deep conviction. Eliminating for a moment that section of the bill which would prohibit the physician owning a pharmacy but directing our attention to the section that would prohibit physicians from dispensing or owning shares of repackaging companies, do you, as an individual or does the American Association of Medical Clinics support that feature of the bill?

Dr. CAYLOR. Yes; we are against the repackaging of course. It is obviously wrong.

Senator HART. I agree with you. It is obviously wrong. Why do you say it is wrong?

Dr. CAYLOR. It is just wrong. If you are going to be right be in line. It isn't a wavy line. It is right or wrong and it is pretty black or white.

Senator HART. It is wrong I take it because it is obvious that there is an economic insensitivity that is created, is that right?

Dr. CAYLOR. Each of us has an economic incentive. I come to work because I have to feed my family. It is perfectly just as long as it is within the reasonable bounds.

Senator HART. It is obviously wrong to own an interest in a repackaging firm but it is obviously right to own a pharmacy? Does that oversimplify your position?

Dr. CAYLOR. That is oversimplification.

Senator HART. That is why I was asking you to develop the reasons you feel that are so clearly wrong to own an interest in a repackaging firm.

Dr. CAYLOR. Well, I am a substitute for Dr. Wurzel, sir. I know what my own experiences have shown me. I have been a member of this association ever since it started. I was one of the founding members.

Senator HART. I respect that reply and explanation of course. With respect to your own experience, is yours a clinic with its own pharmacy?

Dr. CAYLOR. You are asking me about my own situation.

Senator HART. Yes.

Dr. CAYLOR. We have had an odd situation, sir. We are in a town of 7,500 people with a 180-bed hospital and a 25-doctor clinic. Now obviously that town will not support our effort. Thirty years ago we outgrew the county. In order to have all the specialties and all these

particular things we had to build the hospital ourselves and borrow the money.

Senator HART. The clinic physicians themselves built the hospital?

Dr. CAYLOR. Yes, sir. We are in debt for one million and a quarter dollars.

Senator HART. And that construction program, what arrangements were made for pharmacy?

Dr. CAYLOR. It is in there. It is the hospital pharmacy there. It is licensed as a hospital pharmacy. Every clinic that has a hospital has to have a hospital pharmacy. The big clinics, for example, the Cleveland clinic, all of them have to have hospital pharmacies. That is because they are hospitals.

Senator HART. If I am the patient in your hospital and you are my attending physician, and in your judgment I require a prescription drug, just how does that—what are the physical steps? How do I get that drug?

Dr. CAYLOR. I assume you are a patient confined to the hospital. That is the basis of your question.

Senator HART. That was the question.

Dr. CAYLOR. I write the order on the order blanks for the hospital. The pharmacist makes it up and it is brought to the floor and given by the nurse.

Senator HART. What if I am an ambulatory patient?

Dr. CAYLOR. If you were an ambulatory patient at the clinic and I am giving you a prescription, the first block at the top of the prescription blank would indicate whether the prescription is to be filled inside or outside the clinic. I would ask you do you want to fill this in our pharmacy or do you want to take it with you? Of course that is the first place we mark off.

The second block is how many times it can be repeated.

Senator HART. There are in this 7,500 population community one or more pharmacies?

Dr. CAYLOR. There are three other pharmacies other than ours. There are six other doctors that are not in the clinic too in the town. They are in another hospital.

Senator HART. Do any of those six physicians own an interest in any one of those other pharmacies?

Dr. CAYLOR. I can't answer that. I don't know.

Senator HART. To the extent that you do know, is the operations with respect to the filling of prescriptions in the other hospitals similar to your operation?

Dr. CAYLOR. I am not familiar enough to give you a correct answer. They have a pharmacist who comes in part of the day a week to satisfy the State requirement because they can't afford to hire a full-time pharmacist.

Senator PEARSON. Doctor, I don't ask you to agree or to concede this, but just for purposes of amplifying your testimony and the position of your testimony, if there are abuses, if there is a conflict of interest, if there is an unfair trade practice in a physician owning a pharmacy, what is the distinction in a medical clinic having an interest in a pharmacy within its clinical setup? What is there about the clinic, about the medical clinic that distinguishes it from the case of a given physician and owning a given pharmacy?

Dr. CAYLOR. I think the whole philosophy, sir, of group practice is different than solo practice of medicine. A man interested in group practice must first of all be willing for a team effort. He can't be an extreme individualist and be in a group practice.

Senator PEARSON. It is one of the real necessary developments we are going to have to have in the years ahead.

Dr. CAYLOR. If we want to keep up with what we want to do. I am sold on it. I am biased. I had my training up in Mayo Clinic. I have been in group practice all my life. The patient gets the breaks instead of paying for four or five overheads and four or five specialists' offices it is all lumped in one place.

We have got one typing room that types up all the doctors' letters and everything else. It is just a good practice if you want to consider it that way. What does a business do when it gets bigger. Look at all the big firms. Lawyers grouping in a group. Architects and engineers, any of the professions. This is just a natural growth.

Medicine is so sophisticated and the volume of literature is so wide that if I did nothing else but read in my specialty of general surgery I would never have time to see any patients.

Senator PEARSON. Back to my original question. What is it that distinguishes medical clinic in group practices from the individual physician owning a pharmacy?

Dr. CAYLOR. For want of a better answer let me say that group practice is the supermarket of medicine. You can go in a clinic and get anything that you want. The specialty is service, and ENT man service, X-ray, physical therapy, even hospitalization in some places and your drugs that you need. This is just a natural growth of this philosophy of taking care of sick people.

Senator PEARSON. Let me ask you this. Is the general practice that in a given clinic, your clinic or the Wichita Clinic that I am familiar with, an outstanding group of people generally speaking? Do all the doctors in the clinic share in the ownership of the pharmacy if one is connected with the clinic?

Dr. CAYLOR. The pharmacy is just one of the facilities just like the hospital and physical therapy or anything else. Generally speaking, the funds that are obtained from physical therapy, from X-ray, from clinical pathology all go into a pot. We are all paid out of it on a salary or whatever the remuneration basis is.

The pharmacists are all on a salary just like the doctors are. It is all a part of the team efforts trying to deliver the best possible health care to the most people in the cheapest possible way by keeping down the overhead.

Senator PEARSON. So, I take it that if a large number of doctors having an interest in the several departments of the clinic, that the incentive which we have heard so much about of prescribing drugs that may not be needed or allegations that the prices are boosted up that are incentives would not be so strong in a group practice as it may be with an individual situation in an individual pharmacy.

Dr. CAYLOR. I think that is true. Because in group practice it is just like a family almost. You are associated, particularly with the doctors. If you get out of line, you don't get out of line very long or somebody corrects your records. You are watched very closely. It is part of the psychology of the whole effort.

Senator PEARSON. Do you believe the professional regulations, the value under the regulations of the medical profession, the AMA and other organizations have been adequate in this field?

Dr. CAYLOR. Well, it depends on what area in time you are talking about. When I started in group practice, group practice was a baby. We were a pariah. Everybody was asking for individual practice. This was it. But now because of the passage of time and all these other things, group practice is coming into its own as the way to take care of sick people.

Senator PEARSON. Do you have a view as to the physical position taken by AMA and other volunteering regulations within the profession as it relates to this particular situation, this particular problem?

Dr. CAYLOR. I agree with the AMA code if that is what you are asking me. I am dumb and I am sure I do not get all the implications of the question.

Senator PEARSON. The limitation is not mine, I didn't make my question clear. I was asking whether or not you agreed that the ethical position adopted by the AMA and any other medical associations that have addressed themselves to this problem.

Dr. CAYLOR. Yes. We are trying to follow the way.

Senator PEARSON. That is all.

Senator HART. Doctor, in reply to Senator Pearson's question, you indicated that you thought in the cases of clinics, the economic interest in prescribing would be less, even though the clinic owned its pharmacy. If that would be the case, then what would be the case if an individual physician owned the pharmacy?

Wouldn't you eliminate entirely any question of conflict in clinic operations such as you have prescribed by simply leasing the space to an independent pharmacist?

Dr. CAYLOR. Well, that depends I think on the local situation and this varies. On an average situation it works out better for all of us to be on a salary. There is nothing wrong with it. The greatest incentive is that a good physician should have is to cure the patient. That is it. It is just that simple. All this other razzmatazz about money and things like that—any doctor that is worth his salt and will work can make a living. Just three things.

Honesty, effort, and intelligence.

Senator HART. Would honesty and effort and intelligence be impeded or diluted if we simply said that you would not own your own pharmacy, but you could have a pharmacy in the clinic operated by an independent pharmacist on a straight leased basis?

Dr. CAYLOR. I don't care how you arrange it. A pharmacy should be in a clinic where the sick people are.

Senator HART. Mr. Cary?

Mr. CARY. I have nothing.

Senator HART. Thank you very much, Doctor.

(The attachments to the statement follow:)

EXCERPTS FROM COMMUNICATIONS SUPPORTING THE POSITION OF THE AMERICAN
ASSOCIATION OF MEDICAL CLINICS

OHIO

"The pharmacists are important members of our total health team. Consider these services which they render to our Medical Staff and our patients:

(a) Frequent informal conferences concerning choice of drugs, drug action, incompatibilities, etc.

(b) Formal conferences on occasion when a pharmacist is invited to discuss the professional pharmacy services with our Medical Staff.

(c) Product identification. Many patients with medication prescribed elsewhere which can only be identified by a professional pharmacist. In cases of overdosage and accidental poisoning this service can be vital.

(d) Dissemination of information concerning cost of drugs to physicians. Physicians are generally ignorant of the cost of prescriptions. Our pharmacist has prepared lists to show the cost of various agents so that more economical prescription writing is possible.

(e) Some degree of standardization of prescription writing has been undertaken so that quantity buying of a smaller number of items can accomplish economies. This is a feature which deserves to be further developed in our Clinic. It does not in any way limit the physician in the range of drugs which he can prescribe, but avoids unnecessary and expensive duplication of identical or highly similar products.

(f) Avoidance of over-long refilling of old refillable prescription in which the need may no longer exist. The pharmacists have easy and direct access to the physicians to determine whether such prescriptions should in fact be refilled. The Clinic pharmacists make such inquiries quite frequently—more often, I believe, than do outside pharmacists.

(g) Although the pharmacy operates on a cash basis, there is no hesitation on the part of the Clinic Staff to request some temporary credit for a prescription urgently needed by a patient who is short of funds. Such a request probably would not be made to an outside pharmacy.

(h) In general, as close associates of the physicians, the pharmacists feel a keen interest in total health care. It is to their personal interest to operate efficiently and keep the cost of prescriptions as low as possible. Theirs is a highly regarded profession and in the Clinic setting their education is not wasted in operating a general store.

Senator Hart, of course, implies that we are all tainted with the same commercialism and urge to exploit our patients as a few peddlers of reducing pills who serve as his horrible examples. Certainly, most of us could find far subtler ways of fleecing our patients if this were our motive. As a surgeon my opportunities are legion, for example, to recommend appendectomy for every bellyache. I do not wish to belabor that point. Let me point out that there are strong economic deterrents to prescribing unnecessary drugs of any sort. As a physician my professional income is derived entirely from fees for services which I and my partners render to our patients. It is largely carried on as a credit service and often the patient is hard pressed to meet all of his expenses. It is to my own self-interest not to prescribe any drug unnecessarily, or to advise any service which is not needed; to do so tends to reduce the available funds for the payment of my professional services. Any small profit I might derive from a prescription item is minuscule, by comparison with the direct earnings from my professional services. In the market place my services are in competition with every good which my patient may need or desire. It is self-defeating to add further to the items which he requires."

SOUTH DAKOTA

"I think the clinic owned pharmacy gives another service during these times when physicians are very difficult to obtain, especially out of the large city areas. The fact that we do have some additional income makes it possible for us to pay physicians a little higher salary than they would be given if it were not for this added income. The same is true of medical facilities. This added income from the pharmacy helps to maintain higher standards as far as equipment is concerned in these outlying areas. I believe that these are some of the definite advantages of clinic owned pharmacies."

MISSOURI

"We opened our pharmacy in 1946 as a convenience for our patients and as a means by which we could control the amount of refills of potent drugs, particularly, those which might be habit forming, and also a way in checking the cost of these drugs to the individual patients. The pharmacy has made it possible for us to keep the cost of our office calls and other out-patient care down to a minimum. As an example, our average office call runs between \$3.00 and \$5.00 which is much

lower than the national average. Indigent patients who cannot qualify for either Medicare or Medicaid are furnished drugs without cost.

We have a multi-specialty group and in the rural area in which we live the number of indigent patients and cost care patients are much greater than some of the more industrialized areas. In order to support our multi-specialty group and give the patients the care which we feel they are entitled the pharmacy has become one of the necessary means of supporting both our clinic and hospital."

MINNESOTA

"Our clinic has operated a pharmacy since the founding of the group some fifty years ago; it now appears that well intentioned, but probably ill advised, legislation may force its closing. Upon joining the group some ten years ago, I had some reservations regarding clinic operation of pharmacies, but during the ensuing years have developed some different viewpoints.

There is no doubt in my mind that the pharmacy operation has contributed to the development of a high quality group practice in this particular community. Appropriate usage and fair charges for ancillary services contributes to clinic income and has enabled us to offer specialist services in pediatrics and internal medicine in this community with a fee schedule (\$5.00 office call) that is low by national standards. No effort is made to have prescriptions filled at the Clinic pharmacy and it is estimated that only thirty (30) per cent of the prescriptions written by our group physicians are filled by our pharmacists. Thus, the pharmacy is not so productive of income that we will be unable to adjust to that loss; it is likely that closing our pharmacy would require upward adjustment of some of our professional fees. As previously stated, the income of physicians is what remains after overhead expenses; and, although we do not unfairly compete with local pharmacists regarding price structure, our patients benefit indirectly by lower professional fees.

Our clinic is over a mile from the nearest pharmacy. Although this is considerably less than the ten mile limit of the proposed legislation, for many patients who come by bus or taxi, it would add considerable expense and time if they would have to fill prescriptions elsewhere. Several of the more aggressive local pharmacies encourage telephone prescriptions which are then delivered; this practice avoids written prescriptions and involved delivery of the medication by an unknowledgeable delivery boy—both of these being undesirable practices. Also, telephone prescriptions encourage patients to later make request for more telephone prescribing for self-diagnosed illnesses that they believe physicians should be willing to treat without examination.

Not to be overlooked are the professional benefits to the clinic practice by having close association with pharmacists. The ordering and stocking of all pharmaceuticals used in the clinic practice is performed or supervised by trained pharmacists. As well as responsibility for the pharmacy stocks, the pharmacists closely supervise all the narcotics, antibiotics, vaccines, biologicals, and other drugs used in the medical group practice so that they are properly stored and rotated to avoid deterioration or expiration dates of potency. Package inserts of drugs are always available in the event that the prescribing physician should desire more detail. Identification of tablets brought in by patients is usually readily accomplished by pharmacists in the building and often this is of great benefit in managing the patient's problem. Pharmacists and physicians can readily consult on available drugs, costs, quality, and effectiveness.

Any physician exploiting such a situation is likely to exploit his patients in other ways and probably should be curbed by other methods."

ILLINOIS

"Perhaps two additional points can be made based on our experience at our clinic: First, the doctors and nurses make no effort to direct patients to the clinic pharmacy; those who find it convenient and desirable to have their prescriptions filled there do so. It is clearly stated on the bottom of the clinic's prescription form "This Prescription May Be Filled At Any Pharmacy". Secondly, our doctors write generic names of drugs on their prescriptions with few exceptions. This designation permits our pharmacist to dispense that brand which can be purchased at the most reasonable price and this provides a saving to the patient. We have conducted a survey of the regional drug stores and found that we were filling prescriptions at cost below 28%, equal to 63%, and above

9% of other pharmacies. The 9% comprised the . . . chain drug stores in the area. It should be recognized that the chain does not provide such services as free delivery of prescriptions, keeping of family records (important for tax purposes), or charge accounts. Patients have furthermore complained that they have to wait between one half to one hour for prescriptions to be filled, which time I presume the management hopes is spent in making other purchases in the store. It would seem, therefore, that the . . . chain policy establishes prescription services as a 'loss leader' with the expectation that general merchandising will more than compensate the loss."

KANSAS

"* * * It also is a fact that many of the pharmacies located in the small towns in Kansas do not always maintain drug inventories adequate in quality, quantity or variety, comparable to those maintained by pharmacies associated with clinics."

IOWA

"During the past years we have tried to give our patients every advantage possible. The low income group are given 25% discount on medicines and since we extend credit we have numerous persons who never pay anything and we can open our books to prove this.

* * * Because of the added income from the pharmacy, we have been able to keep many of our other charges to the patient lower than average for our area. This supports your policy statement that clinic ownership of the pharmacy helps keep down the total cost of medical care for the patient. For your information I am sending samples of our drug, office, laboratory, and X-ray charges with this letter."

PENNSYLVANIA

"* * * it allows better quality of supervision of drugs, plus the fact that a patient can probably get started earlier on his or her medication, and that clinic pharmacies usually have all drugs available which are ordered by their physicians which may not be available in the community pharmacy."

ILLINOIS

"The main value of this clinic pharmacy has been the excellent convenience for our patients, which eliminates another stop to pick up the drugs we have prescribed. It allows us to have rather good control over the drugs and it has been our policy to use nothing but standard American pharmaceutical agents. We have never used any mail order drugs or drugs from any company other than the first line American pharmaceutical firms who are engaged in research and such."

SOUTH DAKOTA

"I firmly believe that the patients benefit in many ways from being able to obtain their prescriptions from a pharmacy within the confines of a medical clinic. His records are readily available as to the medicine he receives. The date of refills are also documented and readily available to the physician and a more competent and careful control of the prescriptions for any particular patient is effected in an efficient manner."

* * * * *

WASHINGTON

"We believe that we are entitled to a fair and reasonable profit from the operation of our pharmacy. Further, that because of convenience and many other factors when considering the overall costs to the patients, that the medical clinic with its ancillary services and facilities, including the pharmacy in many instances improve the efficiency of the health care delivery system, and thus, contribute to maintaining reasonable medical and health care costs. It may be well to ask the opponents of clinic owned and operated pharmacies to indicate factually the manner in which they provide drugs and appliances contributes to maintaining costs and aids in improving the efficiency of the medical and health care delivery system. Also, perhaps how by making it unlawful for clinics to own and operate pharmacies, improves the health care system and reduces the cost to the public."

TEXAS

"I believe that clinic ownership of pharmacies makes it possible to achieve lower costs to the patient for drugs by operating a pharmacopoeia so that such a drugstore does not have to carry large duplications of drugs which sit on the shelves unused. In our case, even though we charge the usual prices in the community when we do delivery and other full drugstore services, we have many patients of limited means for whom we provide drugs at lower prices or at cost. Many of our patients would rather pay a full price and have prompt service while those of limited means or those who are more frugal with their money prefer to get cash and carry drugs, an arrangement we have made with many patients, particularly those who have trouble meeting their bills. Since the doctor in the clinic is well aware of the need for expensive drugs and the limited means of some patients he can make recommendations for special charges. We make this approach even though we do not recommend our drugstore to any patient. We recommend that they compare prices with any other drugstore in the community and strongly urge that they get their drugs somewhere else if they find it less expensive and if price is a consideration. Furthermore, our clinic owns only 80 per cent of our drugstore and the pharmacist owns 20 per cent."

HAWAII

"We have had a pharmacy incorporated into the framework of our clinic ever since its inception in 1921. When I started the practice of medicine in Honolulu in 1935 it was the general practice for physicians to prescribe medicines directly from their office. This was a hangover from the days when there were no pharmacies in the islands except in Honolulu, and since at that time the large majority of physicians in Honolulu had first practiced on the plantations and other rural areas, they brought the custom of office prescribing with them when they moved to the city. Even now, a large proportion of solo practitioners prescribe most of their medications directly from their offices.

We have never looked upon our pharmacy as a "money maker" but instead as a definite service to our patients. Of course, we make some money from it, but not as much as some might think considering the fact that we sell only prescription items. Our building is open 24 hours a day with a nurse and doctor in attendance to 11 P.M. and we also have "emergency" office hours on Sundays and holidays.

We do not fill prescriptions between 5 P.M. and 8 P.M. because we lack personnel for this, but we do fill prescriptions between 8 and 11 P.M. because at this time most of the pharmacies in town are closed. In other words, we are providing an afterhours service. This service we also provide on Sundays and holidays.

We made a recent check with 23 local pharmacies and discount stores and found that our prices, except in the case of 'loss leaders' such as birth control pills, etc., were lower. This is especially true when medications are prescribed in small quantities, since we do not charge a 'professional fee' as is done by outside pharmacies.

All of our prescriptions are labeled in large letters in red, 'This may be filled at any pharmacy of your choice'. However, 90% of our patients choose to have their prescriptions filled at the Clinic. I know it would be a great disservice to our patients if the pharmacy were done away with. Also, if a separate commercial venture operated it, I am sure that it would find that they were not very enthusiastic about the after-hours, week-ends and holidays service which we now furnish at a loss."

OHIO

"Perhaps there is a question of unfair competition, that some way we hold our patients as captive customers of the Clinic Pharmacy. Certainly, this is in no wise true of our operation. All of our Clinic prescriptions are fillable in any pharmacy of the patient's choice. There is no direction of patients to the Clinic Pharmacy. Indeed, out of town patients are expected to take their prescriptions home so that refilling can be done more easily. Many patients have a strong preference for a neighborhood pharmacy. Phoned prescriptions go to whatever pharmacy the patient directs.

Our prices are competitive. Some prescriptions are as low in cost as any pharmacy. Many are slightly higher than commercial pharmacies charge, particularly the cut-rate. Our pricing structure is based on the best buying that the pharmacist

can accomplish with the volume of sales which he has. The pharmacists are well paid and the Medical Center, Inc. derives a reasonable profit on its sales. Those profits go to improve the facilities for health care which we provide. It is doubtful if the chains would put the profits to better use.

The Medical Center Pharmacy cannot buy in the quantities and at prices which obtain for the large drug chains. Nevertheless, the Medical Center Pharmacy does fill about 50% of Clinic prescriptions. Why? The most likely reasons are convenience, service, and the fact that the price differential is so small as to render it unprofitable to drive to another pharmacy. This constitutes our competitive force in the market place. Our pharmacy can only survive by keeping its prices low and rendering the best possible service. And mark this, the competition which we provide can only be met by better service and still lower prices on the part of every commercial pharmacy in the area. In the market place we make a significant competitive contribution to keeping cost of medical care low for *all* patients in the community—not just Clinic patients!”

WISCONSIN

“We compare our costs, expenses and sales against reliable area and national surveys and make a continuing analysis. We try to give the customer the best possible service for his dollar. I feel that this is a legitimate method of operating on our part. I would see no more criticism to this than to any other business enterprise.”

CALIFORNIA

“It is a business activity and can be run efficiently, providing the patients with a great deal of added service, and it should function competitively with other pharmacies in the area. I believe the prime safeguard to provide is that there shall be no direct or indirect pressure on the patient to utilize the clinic pharmacy in preference to other pharmacies available in his community. The argument that there is no need for the service of a pharmacy if there is a drugstore in the vicinity would not apply to a pharmacy undertaken by anyone else in the community, and I see no reason why it should be permitted to apply to the clinic. If the clinic pharmacy is unable to compete, then it shouldn't exist.”

CONNECTICUT

“I would expect these arguments to be based upon evidence that the group had made an unfair profit from the operation of their pharmacy or that they had shown some cases of pressure requiring their patients to purchase pharmaceuticals in their own pharmacy. In the absence of such evidence, I would feel that there was no other basis for disapproving of the ownership of a pharmacy by a clinic. I imagine that the competition of the clinic pharmacy is somewhat of a threat to them, but that does not mean that it is half as much of a threat as some of the chain store pharmacies. I can not believe that any of the clinic pharmacies will be trying to greatly under bid other pharmacies. They have nothing to gain by doing so.”

SOUTH DAKOTA

“It certainly is true in our situation that we can control the quality of the drugs, dispensing of them and control the profit that is made on these preparations. It has always been our policy to supply the drugs to the patient with a normal profit. The profit being the one suggested by the manufacturer or below this, which we feel many times is advisable because of the cost of the drug and the amount of profit that would be realized. We feel that our prices aid to control the prices of the surrounding drug stores since we are well aware that any of the pharmacies that are more than 40 miles away, universally carry a higher retail price on their drugs than the clinic dispenses theirs for.”

MISSOURI

“We make no restriction on the prescription given our patients. They may get them filled at our pharmacy, or any of the other pharmacies in our city or surrounding area. For some of our referred or out of town patients we suggest they get their prescription filled in their locality for convenience, particularly if refills may be necessary.”

NEW HAMPSHIRE

"Early in 1947, long before many of us were members of the clinic, the group at that time decided to establish a pharmacy adjacent to the clinic building in the downtown area, primarily for the convenience of its patients many of whom were from out of town and also as a convenience to the doctors themselves. This pharmacy has existed from that time until this. It has had either two or three pharmacists in it at all times. It has run in what I would consider as perfectly good harmony with three or four other pharmacies in town. There is a good relationship among the pharmacists. There has been no gouging, no price fixing and no directing on the part of the physicians that patients should buy at a given place. There have been no coded, or numbered, or tricky or special prescriptions given to patients that could be only obtained at our pharmacy. We have recently remodeled this building for the future convenience of our patients and feel that we are rendering a perfectly justifiable service in the community. A little over two years ago, at a time when we were re-assessing our entire operation, we seriously asked the pharmacists if they would like to purchase this pharmacy from us and rent space and run it as their own and all three declined to do this, preferring to receive their salary rather than get involved in the funding of the operation."

CALIFORNIA

"As you know, the California Pharmacy Association lobbied and passed a bill in California for restriction of ownership of all pharmacies to licensed pharmacists. This passed in spite of our concerted efforts to prevent it and was upheld in spite of continued opposition on the part of the clinics in California. It became necessary for the clinics to divest themselves of the pharmacy and sell them to a pharmacist except in certain cases in which the ownership was a corporation. I might add that in our experience the cost of drugs to the patient has not decreased but rather has increased with the pharmacist owning the clinic pharmacy.

"Our Association should make a concerted effort to appear before the Commerce Committee and testify against the Hart Bill. I anticipate that if this is passed, it will be quickly spread to include the dispensing of glasses and might even involve the ownership of the clinical laboratory and x-ray department in each clinic."

KANSAS

"Although there are numerous valid objections to proposed legislation of this character, I shall limit my comment to the following:

1. In Section 2, the Bill is premised, in part, upon the erroneous assumption that the dispensing of drugs and devices by medical practitioners, directly or indirectly through ownership of pharmacies or interests therein, is inconsistent with the best interest of public health, and denies 'consumers free access in an open market . . . and tends to induce unfair trade practices . . .

The fact is that pharmacies owned by medical groups, or which occupy space leased from medical groups are numerically infinitesimal. Less than 1% of the estimated 70,000 retail pharmacy outlets in the United States fall into such category or classification.

Although a purpose and objective of the Bill is purportedly to free and broaden the market for drugs and devices and to curtail alleged unfair trade practices, the obvious result of its enactment would be the reverse. It could only serve or tend to limit or restrict the ownership of pharmacies, thereby reducing the market opportunities of the consumer, at this ultimate expense.

. . . . Except in very limited and unusual cases, the patient is free to buy and does buy his drugs from the pharmacy of his choice, and customarily he does his buying after taking into account the factors of convenience, price, service, confidence, and reliability."

ILLINOIS

"We have a small prescription pharmacy whose main function is to serve our patients and has a very limited clientele outside our own clinic patients. Our prices are extremely competitive with those in the area particularly those of the other prescription pharmacies. We cannot compete with discount houses because we give credit and have a delivery service.

We do not in any way attempt to use code prescriptions or any other devious means. The patient is never forced or coerced to use our pharmacy.

Our drug store has not been a particular success from the profit margin point of view, inasmuch as we have paid good wages to the pharmacists and have kept the prices at a very competitive level. If one of the business men on the Senate Committee would investigate our books, he wouldn't feel very happy about it from the point of view of the tax point. I believe the important points that we could make is that the patient is entirely free to go to our pharmacy or any other one he wishes. His prescription is given to him in the office or a call to another pharmacy whichever the patient wishes. Many of them use the discount pharmacies or have charge accounts with other pharmacies. Our prices are reasonable and in line with those of the community. It has been our policy to use this pharmacy more as a convenience to the patient more than any other thing. The profit we make is legitimate, modest and is a normal, though not outstanding, return on our investment."

SOUTH DAKOTA

"I recognize that there may well be some pharmacies operating within doctors' offices and clinic practices that are unethical with respect to the prices charged and the medicines prescribed, but I am also confident that this represents a very small minority of those clinics and doctors prescribing medications from their offices and clinics. I see no reason at all for an individual doctor or a clinic to prescribe medication and to sell the medicines at a cost less than that price which is generally adhered to in the comparable community. I could not condone, however, a cost factor greater than offered in generally accepted, comparable communities."

Copied below is the section on pharmacies which is part of the preliminary questionnaire submitted by group members requesting accreditation surveys by this Association.

Pharmacy:

1. Is there a pharmacy in the clinic building? -----
 2. If the answer to question #1 is yes, is it owned by the clinic? -----
 3. If the answer to question #1 is no, explain. -----
 4. What space is allocated to pharmacy? ----- sq. ft.
 5. How many registered pharmacists are employed? -----
 6. How many prescriptions filled in last year of record? -----
 7. Is the pharmacy under the direction of a clinic pharmacy committee? -----
 8. Indicate method of assuring that patient has free choice of pharmacist and is under no pressure to patronize the clinic pharmacy. -----
-
-
-
-

TROVER CLINIC
PHONE 851-7171
1000 WASHINGTONVILLE, KY.

FOR: _____
ADDRESS: _____
D.V.E. _____

THE WICHITA CLINIC
3244 East Douglas
Wichita, Kansas 67208

PHONE 693-8661
REG. NO. _____
C.N.O. _____
DATE: _____
FOR: _____
ADDRESS: _____
R

LABEL Yes, No
REFILL _____ TIMES

Take this prescription to the pharmacy of your choice _____ M.D.

REFILL 0 1 2 3 P.R.N.
REG. NO. _____ M.D.
(Take this prescription to the Pharmacy of your choice)
MR 196

BOULDER MEDICAL CENTER
3700 BROADWAY PHONE 447-4830 BOULDER, COLORADO

FOR: _____
ADDRESS: _____
DATE: _____

CHENSTIE CLINIC
1000 W. 10TH ST.
WICHITA, KANSAS 67208

FOR: _____
ADDRESS: _____
DATE: _____

Box No. _____
THIS PRESCRIPTION MAY BE FILLED AT THE PHARMACY OF YOUR CHOICE
Refill _____ times. Refill P.R.N. _____ for a period of _____
Do not refill _____ Label with name and size of drug _____
May use generic equivalent if less expensive _____
Dose lines
Fillings
Time
Price

M.R. P.R.N.
ASPHETIC _____ TIMES
 Print name of drug on label
U.S. Registrar No. _____ Date _____ 19____ N.D.

THIS PRESCRIPTION MAY BE FILLED AT ANY PHARMACY

Senator HART. Mr. Cary advised me that the president of the Interstate Drug Exchange, Inc., Mr. Marvin Sandler, is present and has asked the opportunity to state the position of the National Association of Mail Order Pharmaceutical Suppliers, Inc.

If there is time, we will be glad to hear him. I think at 12:30 the Democratic policy luncheon is taking place. Maybe Senator Pearson has a 12:30 Republican luncheon.

Senator PEARSON. I do, as a matter of fact.

STATEMENT OF MARVIN SANDLER, INTERSTATE DRUG EXCHANGE, INC., FOR NATIONAL ASSOCIATION OF MAIL ORDER PHARMACEUTICAL SUPPLIERS, INC.

Mr. SANDLER. Mr. Chairman, my name is Marvin Sandler and I am associated with the Interstate Drug Exchange, Inc., of Plainview, Long Island, N.Y. I am here representing the National Association of Mail Order Pharmaceutical Suppliers, Inc. I appreciate the opportunity of expressing our views on S. 1575.

The members of this association are in the business of selling drugs, sundries, and surgical products to practitioners licensed by their respective States to write prescriptions or to fill them. In other words, we do not fill prescriptions ourselves, nor do we sell to the general public.

I think it would serve a useful purpose in rounding out the introduction to my remarks if I would point out to this committee that the members of our association have been most instrumental in bringing generic drugs to the market and thereby substantially reducing the cost of drugs and medicines to the American public.

The bill in question is under consideration by the Committee on Commerce, and the bill concerns itself with the regulation of trade in drugs and devices that are introduced into interstate commerce. In essence, therefore, the bill concerns itself with a doctor's financial relations with drug companies, his financial relations with pharmacies, and with his relations with his patients. Please note that in the latter respect I have omitted the word "financial."

To begin with, we must compliment the sponsors of the bill on the spirit and intent of the law, and we wholeheartedly support most of the findings of fact and resulting prohibitions. In particular we endorse the provisions of sections 4 and 6 which serve to deter practitioners from unethical conduct in which economic considerations might be placed before the welfare of the patient. These provisions are actually a guide to moral conduct in any business or profession. Furthermore, these provisions in no way interfere with the practitioner's freedom to practice his art as he chooses, with the best interest of the patient in mind. In situations covered by sections 4 and 6, the relationship between the doctor and the drug company and the relationship between the doctor and the pharmacy is purely financial, and quite properly falls into the scope of conduct that should be subject to the regulation of a congressional Committee on Commerce.

However, we feel compelled to take exception to section 5, which, in effect, interferes with the practitioner's freedom to practice medicine in accordance with the laws of his State—a purpose for which he has been specifically licensed. Furthermore, I urge the committee not to

consider a doctor-patient relationship in the same spirit that you have quite properly considered the relationship between the doctor and the drug company and the doctor and the pharmacy.

A doctor-patient relationship is certainly not the same as the other relationships described in the bill nor, for that matter, is it typical of the relationship that would exist between two persons. The doctor-patient relationship involves faith and trust on the part of the patient, and the patient will speak to his doctor with the full knowledge that professional discretion will be exercised and the matter will be kept in complete confidence. Accordingly, the relationship is quite often very personal, with the doctor taking into account both the emotional and financial status of the patient. A doctor is often in a position to dispense and/or prescribe a generic drug in an effort to reduce costs to the patient. I should like to point out, however, that when prescribing he has no guarantee that the lower priced generic will be used.

According to the Raymond Gosselin Co., one of the leading statistical compilers for the pharmaceutical industry, a substantial percentage of all generically written prescriptions are filled with higher priced brand name pharmaceuticals.

In support of this, I have an article involving the survey showing the relative number of prescriptions that were generically given but which were filled with higher priced brand name drugs. I will supply this to the committee for the files of the record, as I see fit.

Furthermore, I have a 74-page report that was issued by the California attorney general regarding the dispensing of drugs that were generically done. One of the parts of the report stated "in situations where an inexpensive generic drug could be dispensed, the patient shall be given it." In the State of California in its medical program it can't be assured of what the patient will get. I wonder if the doctor did.

I also have an article on a HEW report which indicates that the pharmacist might not necessarily dispense a lower cost generic drug, and I will submit that also.

Accordingly, the physician, because of his intimate knowledge of the financial status of the patient, will very often dispense, rather than prescribe, if he feels that it is in the best interest of the patient.

Actually there are a number of reasons, both medical and financial, why a physician will dispense. Obviously the committee recognizes these in several exceptions that have been made, and which include those situations (1) in an emergency, (2) in a unit dose (ordinarily where an injection is necessary), and (3) where there is no community pharmacy in the area. There is no need to dwell on these exceptions since they have already been recognized and are incorporated into the proposed bill.

However, there are many other compelling reasons—medical reasons—why a physician will dispense as follows: (4) to make sure the patient actually gets the medication (5) to make sure his physical condition is checked once again before a refill of the medication is recommended (6) in connection with the fitting of certain devices (7) the administration of drugs preparatory to examinations, tests, and operations.

Evidently the medical profession feels that the reasons listed above cover a number of valid medical reasons for dispensing, and ap-

parently these reasons provide adequate justification for the elimination of section 5, since many medical groups, and the AMA, to the best of my knowledge, have gone on record as opposing section 5 in its present form.

I should also like to point out that Dr. James Goddard while he was head of the Food and Drug Administration, also testified in front of hearing in Senator Hart's committee, that he felt the dispensing was not necessarily detrimental. We have just had testimony today from the Surgeon General indicating that there are certainly a number of instances where dispensing is not only useful, but beneficial. Up to this point I have listed medical reasons why a physician will dispense. However, before continuing to economic reasons, I feel that a clear distinction should be made. The findings of fact of the proposed legislation refer to the best interest of public health, and then continue on to a consideration of unfair trade practices in interstate commerce, an obvious economic reference. The committee should realize that these two interests do not necessarily coincide, and this has been recognized by both the medical and pharmaceutical professions, as well as by legislatures of many different States. In particular, I would like to mention the State of New Jersey in which a 1966 law was upheld by the State supreme court, regarding the advertising of prescription prices. There are a number of other States that have similar laws on their books. I have documentation to the fact that there are 35 different States which have similar laws or to the code of ethics.

The New Jersey State Legislature passed a law in 1966 which specifically prohibited the advertising of prescription prices. There certainly can be no question about the fact that the removal of advertising resulted in a reduction in competition, since it is only through advertising that a customer can be made aware of the fact that price differentials are available. The only other alternative would be to go to a number of different stores and to price the prescription at each one, which would probably be a hardship on a person who had to have a prescription filled presumably because he was not completely healthy.

The law was later contested by a discount pharmacy in New Jersey, who felt that advertising was the only means by which it could get its message across to the public and to indicate that the same prescription could be filled at its store for a lower price.

The case was brought before Judge Mintz of the New Jersey State Supreme Court and the law was upheld. The logic in the decision is quite interesting and I quote:

If the customer frequents one pharmacy for all his prescription needs the pharmacist in that pharmacy is in a position to check his records and thereby determine if a prescription is in anyway antagonistic or contra-indicated by his previous prescription record. The legislature concluded that this important function of pharmacists would be impaired if they were permitted to advertise and thus encourage Rx price shopping.

A copy of the complete decision by Judge Mintz is now in the files of the Subcommittee on Anti-Trust and Monopoly, since I submitted it when I testified before the subcommittee during February 1967.

I wish to bring out that the judge's decision in this case indicates that the public health is of paramount importance and that the price paid by the consumer is of secondary importance, and that the two interests do not necessarily coincide. The AMA has recognized the importance of both interests, and although they correctly continue

to stress the health of the patient they also give considerable attention to the economic aspect. The AMA has come out with a policy statement: "Medical considerations must be paramount in the selection of drugs. In addition, the physician also has an obligation to be mindful of the economic consequences of the treatment he prescribes."

This is followed by the statement: "He (the physician) has a clear responsibility to protect the economic as well as the medical interest of his patient."

Obviously the AMA, in marked contrast to the various State and national retail pharmaceutical associations, has given a clear mandate to its members in an attempt to lessen the burden of medical costs.

Now, in this respect, I submitted at the last hearing approximately 104 orders. I think that it was that much, in which the patient's check accompanied the order. It was clearly shown in those cases that the patient was paying for the medication. The check was made out to my firm and the patient was aware of the costs of the medication.

Again, I have approximately 108 orders this time. I believe I have something like 150 patients' checks covering these. I would like to submit these for the record.

Senator HART. We will receive them.

Mr. SANDLER. I would like to have these submitted, but I wouldn't want the names published, for the protection of my customers.

Senator HART. It will be received and kept in the subcommittee files.

Mr. SANDLER. The committee has an obligation to request documentation of any effort whatsoever on the part of organized retail pharmacy to lower prices. In northern California the pharmaceutical association was indicted and convicted of attempting to fix prices at an artificially high level. In both Michigan and Massachusetts the State Boards of Pharmacy have tried to stop the licensing of pharmacies of certain chains who are obviously meant to be discount operations. In New York State a pharmacy bill was proposed which would restrict pharmacy ownership to licensed pharmacists, thus reducing competition severely. Without exception, organized pharmacy has supported fair trade legislation which would support prices at a higher level than competitive situations would dictate.

Furthermore, organized pharmacy has advocated legislation which would prohibit the advertising of discounts, as cited earlier in this testimony, and in those cases where legislation could not be obtained the same prohibitions were placed into professional codes of ethics. As mentioned earlier, there are 35 States now who have either codes or laws of that nature.

Legislation has also been promulgated at the urging of organized retail pharmacy, which would restrict the number of pharmacies in certain states in order to limit the RX business to a chosen few and to limit competition.

These measures, and measures similar to them have been espoused in the name of protection of the health of the patient.

However, when it suits the purpose, the question of the patient's health sometimes becomes secondary and chameleon-like, organized pharmacy champions the cause of competition.

As an example, there is a case whereby organized pharmacists are requesting the cooperation of the OEO, claiming it is putting the pharmacist out of business. All of the evidence of facts are that

they supported S. 260, which is a bill that would have restrained monopolies. In addition, a group of organized pharmacists opposed it under the contention that it would reflect freedom of competition.

S. 1575 refers to unfair trade practices and is concerned with the effect of dispensing on retail pharmacies. In past hearings on S. 260, the Medical Restraint of Trade Act, witnesses testified regarding isolated cases where pharmacies claimed to have been financially injured because of physicians dispensing in their local community.

At those hearings I presented detailed evidence from the Lilly Digest, which attested to the health of retail pharmacy operations. I should like to submit extracts of the latest Lilly Digest, which is a summary of pharmacy operations for the year 1968. These figures indicate that the average community pharmacy owner earned a record \$24,669 during 1968. Furthermore, I have a supplemental report on 1969 operations which show that his income rose to \$26,943—an increase of 9.2 percent over the year before.

The Digest also points out that the prescription department, the only department that would be affected by dispensing physicians, has increased both in total sales volume and as a percentage of total sales for the past 20 years without a single exception. In 1949 the prescription department accounted for 19 percent of the total sales. By 1968 it had increased to 43.2 percent, and the supplement for 1969 indicates that it increased to 43.8 percent. In 1949 the average pharmacy had total sales of \$77,813, whereas by 1968 it had \$198,917, and thus, in the 20-year period, total sales had somewhat less than tripled.

The prescription department, on the other hand, went up more than six times in volume from a 1949 figure of \$14,806 to a 1968 figure of \$85,953.

Thus the prescription department, the one department that is affected by dispensing physicians, has been increasing at a rate much faster than all other departments of the average retail pharmacy. This trend was continued in 1969, when the prescription department increased 12 percent over the 1968 figures whereas the other departments increased by 9.3 percent. Thus, the Lilly Digest points out in patently clear terms that a health business, run by good management, is doing better than ever.

I also introduced a document in the last hearings which is known as the failure record. This is published by Dun & Bradstreet and it contains a comprehensive listing of all failures of retail operations in the United States by category. In the document that I presented, and which is now a part of the subcommittee's files, it was shown that retail pharmacies ranked third from the bottom among all retail categories in the United States in number of failures. In other words, they had the third best record, and just to give you statistical figures, the total number of failures in 1966 was 155 retail pharmacies of a total of more than 50,000 in the United States. I am sure that everyone present will agree that 155 failures out of 50,000 stores is a remarkably fine business record.

The facts, as expressed in the Lilly Digest and in the Dun & Bradstreet failure review, do not support the contention that dispensing physicians are materially affecting the operations of retail pharmacies. On the contrary, both documents would indicate that pharmacy is one of the healthiest segments of American retail business.

Earlier in this testimony I offered a number of medical reasons why physicians will dispense. However, since the AMA has clearly stated that a physician has an obligation to be concerned with economic aspects we should turn our attention to our position on section 5 as we feel it would affect the patient. One of the stated purposes of this bill is to prevent unfair trade practices. However, we believe that the proponents of the bill also had a sincere interest in the reduction of the cost of medication to the patient.

During the original hearings of the Subcommittee on Antitrust and Monopoly, chaired by the late Senator Kefauver, and later followed by hearings under the chairmanship of Senator Hart, my firm and several of my competitors were mentioned by name and were commended for providing prescription drugs at minimum cost to the physician, and through him to the patient.

Now, getting back to the list of the cost to the patient, there is an article in the latest survey showing that the average Rx cost was \$3.05 to the patient. The average for all Rx was \$3.86. This covers a survey of independent retail pharmacists. Now, according to this figure, there is an .81 cent differential between the cost of the average Rx and the cost of a generic Rx. I have to question at this point whether the patient would have trouble getting the benefit of a generic Rx.

Now, I have taken as an example the average reimbursement fee of \$2 for the professional cost. This will vary depending on the State you are in, but I tell you that \$2 is average. Achromycin is \$12.50 per hundred. The cost of Tetracycline is \$1.75 per hundred. In the fee of \$2, 15 capsules of Achromycin could be gotten for less, and thus the entire prescription would cost \$3.87 and a half, which is about the \$3.87 figure.

Tetracycline, on the other hand, for the same prescription calling for a professional reimbursement fee of \$2 boost the cost of 15 capsules to \$2.26 and a quarter.

Now, obviously the patient would not be getting the advantage of a lower generic price. I have run off a number of other comparisons on these things—*Equanil v. Meprogamate*, *Serpasil v. Reserpine*, *Meticorten v. Prednisone*, and *Pentids v. Penicillin*.

We submit that the dispensing physician is today the largest single force in the private sector of the economy promoting generic drugs, and consequent savings to the public. Pharmacy as a whole has never demonstrated much interest in the promotion of generics, and in some cases has actively opposed it.

As examples of this, I have a survey in which Indiana pharmacists held 13 to 1 that we were in favor of pharmacies offering generics. I have a copy of a letter that Senator Long wrote to the head of a large pharmaceutical firm when they opposed his generic formula. As a matter of fact, in the very testimony of the NARD this morning, they make every effort in cases to physicians' offices selling drugs and the use of unknown products, which I assume would be a reference generics.

To the best of our knowledge, until a short while ago, there was only one major wholesaler in the country—McKesson & Robbins—who actively engaged in the promotion of generic drugs. I should further like to point out that the dispensing of generic drugs by physicians has had a carryover into the area of retail pharmacy, even

though in many cases it apparently was against the wishes of the individual pharmacist.

We have been able to estimate fairly accurately that more than one-fifth of all the pharmacies in the United States patronized the members of our association to one degree or another. A pharmacy can buy its name brand needs from its local wholesaler at prices that are the same as ours, and, in addition, presumably receive better service, since the wholesaler is located within the pharmacies' trade area. As a result, it is quite clear that these pharmacies have turned to us for their generic needs.

Thus, more than one-fifth of all the pharmacies in the country are now using generics, and it is our opinion that many of them use the generics because of the competition of dispensing physicians.

In particular, I cite a comment made during the opening days of the 1967 hearings by Mr. Jack Holly, a senior vice president of Webbs City, Inc., a large retail discount pharmacy. On January 25, 1967, Mr. Holly indicated that his firm meets the competition from dispensing physicians and clinic pharmacies by supplying generic drugs on all unspecified prescriptions. In this statement he pretty well summed up one of our arguments: What would happen if there was no competition from dispensing physicians?

We feel certain that the abolition of dispensing by physicians would result in a gradual phasing out of generics in the private sector of the economy, and thus bring about a higher drug cost to the patient.

Furthermore, there would be no assurance that the patient would receive the benefit of lower generic prices even in those cases where generic drugs were available to patients on an individual basis, who did not receive the benefits of Federal, State, or private insurance coverage.

It is our feeling that the major effect of dispensing by physicians has been to reduce the costs of medication to the patient. Not only will the physician himself bring down the cost by dispensing generic drugs, but the very competition of a dispensing physician will force many retail pharmacies in the area to carry generic drugs in stock, and to dispense them when prescriptions are written. As cited earlier in this testimony many generic prescriptions are filled with higher priced brand-named drugs simply because of the fact that the pharmacies in question do not carry generic drugs in stock.

Now, the survey shows that 8.8 percent of all prescriptions last year were written generically. It is not in the pharmacists' interest to carry a duplicate set of inventory if the prescriptions having inventory indicate such a small interest in this generic.

There is another thought that should be brought to the attention of the committee. A great deal of concern has been expressed at past hearings with the possibility of a monopoly being created by 250,000 physicians. I wonder if it has been pointed out that the abolition of dispensing, which may very well eliminate the monopoly potential on the part of physicians, may, at the very same time, create a monopoly potential for the 50,000 pharmacies in the country. It has been demonstrated that there is a growing trend in the country toward the consolidation of retail operations, and it has been predicted that the present system of 50,000 independent pharmacies may some day evolve into 300 or 400 large chains, plus a few hundred or a few thousand independent retail pharmacies. As an example, there are three

major retail chains in the metropolitan Washington, D.C. area, and they control 87.5 percent of all retail pharmacy sales. I have the documentation with me. Further, there are figures that show that chain pharmacies comprise 30 percent of the total number of pharmacies in the country and they do 54 percent of all the business. There is no reason to believe that this trend will not be continued in other areas. Thus, in a sense, you are setting up a monopoly potential for the 300 or 400 large chains that may someday dominate retail pharmacy.

The bill as it is presently proposed covers a wide range of abuses, some of which we have recognized in the testimony given, and which we consequently support. However, the section to which we object will not really accomplish the stated purpose. We feel the committee should think not in terms of what it would like to do, but what it would actually accomplish. Section 5 would attempt to regulate moral and ethical behavior through economic legislation. This is a difficult, if not impossible, task.

We were grateful to see the inclusion of the fourth exception from the prohibition on dispensing which we feel came about in part because of testimony that we gave at the 1967 hearings. In particular we appreciate Senator Hart's careful attention to this very sensitive area, and his responsiveness and awareness of the problem, which has been demonstrated in the inclusion of the fourth exception. However, we genuinely feel that the inclusion of the fourth exception is merely another indication of the complex nature of the problem and it points out the very weakness of the entire section regarding the prohibition on dispensing. The sentence in question allows an exemption in the case of "dispensing occasionally, but not as a usual course of doing business by a medical practitioner." At this point we must question the definition of "occasionally." Who is to decide what is "occasional" dispensing—will it be the practitioner himself, or possibly someone with a grievance against the practitioner, who because of the vagueness of the wording will have grounds for a capricious charge under the terms of the bill. Now, I feel that eventually a limit will have to be defined. In earlier proposals there was a reference made to where a minute pharmacy is not available. In this legislation it has been defined at length, I believe. Now, somewhere along the line a definition of "occasional" will have to be brought in also.

Now, will this not set a legal limit on larceny. Will you not in effect say to a man, you might, in effect be saying to him you can clip your patients 30 percent of them, but, after that, it is against the law? Furthermore, I feel that the law in itself—the wording of this particular section, would be setting a boundary on conscience. What happened when you have a man who is in a situation of trying to help his patient. Now, the law defines that arbitrarily 30 percent dispensing or higher is illegal. This means that the physician in question can help 30 percent of his patients but could not help the rest because it would be in violation of the law. In effect, you are setting a limit for the largeness and setting a boundary for the man with conscience.

It is our contention that the total number of physicians who abuse the dispensing privilege is quite small in relation to the number of physicians who use the privilege beneficially to their patients. Now, as an example of my last testimony, I introduced 104 orders that have been directed in 1 day which was accompanied by 120 patient's

checks. Today, I have about 108 orders which are accompanied by 150 patient's checks. Now, numerically, if you add this up and take them over the period of time that these hearings have been going on, I think you will find that the statistical balance is greatly in favor of the man who has been helping the patients.

Hearings and investigations have been going on by this committee and earlier committees for several years. Admittedly, you have turned up cases of abuse. How many hundreds would you have if you did? At the same time, if I were to have collected these orders at the rate of 100 or more—well, there are six firms just like mine. I think it would take us two or three trucks just to take care of the documentation of the physicians who are trying to help their patients. Furthermore, it is our belief that the prohibition on dispensing would not affect the man who is deliberately abusing his dispensing privilege. If you pass a bill that prohibits him from dispensing he can just as easily turn to injecting, since injecting is specifically exempted under the second paragraph of section 5. For every tablet that can be given there is usually a comparable injection, and the true abuser will simply start giving his patient injections. If you then pass a bill which would prohibit him from injecting he could begin to require unnecessary diagnostic tests on patients that he sees. Thus, to take an example, if a patient went to see a doctor with a complaint of feeling listless, one man in good conscience could examine him and determine that he might need a vitamin supplement or possibly a week's vacation. Another man, under the guise of a more thorough examination, might require a urine analysis, blood test, basal metabolism, and any other tests that he deemed necessary for complete diagnosis of the problem.

In essence he would not be practicing bad medicine, although in all likelihood he would be practicing unnecessary medicine. The point that is to be made from these two examples is that there is more than one way to skin a cat, and the prohibition on dispensing would not stop a man who truly falls into the category of an abuser. The question of this man's activities are really moral and ethical, and the proper means of dealing with him would be through moral and ethical legislation rather than through economic legislation such as S. 1575.

On the other hand I ask you to consider the case of a physician who, in the interest of his patient, is dispensing medication in order to help the patient financially. This man could possibly be subject to a capricious charge brought against him, and rather than go to any sort of trouble for a matter that is simply being done as a favor, he probably would rather forget about dispensing altogether. Accordingly, the net effect of section 5 would be to drive out the physicians who try to help their patients, while in no way affecting the physicians who profit unduly.

Perhaps the AMA has the answer, in their advocacy of dispensing where, in the opinion of the physician, it is in the best interest of the patient. This I believe is also the same position that was taken by the Surgeon General this morning. The AMA's position is a moral position, and we feel it is more appropriate in keeping with a problem that is basically moral. As I have pointed out earlier in the testimony, it is difficult, if not impossible, to control moral behaviour through economic legislation.

Similarly it should be mentioned that the very exceptions that are made in the enclosed bill point out some of the safeguards that are already inherent in the system, and which would partially be negated if the bill were to be passed in its present form.

At the present time the patient who lives in a big city is partially protected from unfair practices because of the fact that there are many physicians as well as many pharmacies within his local area. That is, if there was a dispensing physician or group of dispensing physicians to whom he objected, he would have the freedom to go to another physician.

At the other end of the extreme we have the case of the lone country physician who does quite possibly have a monopoly potential, but who at the same time has been specifically exempted from the provisions of the proposed bill because of valid medical reasons. In the middle we have the semirural area which supports one or possibly two drug stores, and at the same time may have one, two, or possibly more physicians. The lone pharmacy in a rural area has a de facto monopoly, and we feel that the potential of a dispensing physician in the area serves as a deterrent to abuse of this monopoly. If the potential for dispensing is removed, there would be nothing left to protect the patient from possible abuse by the pharmacy.

We are aware of the tremendous job of study and research which this committee and which the Committee on Antitrust and Monopoly and their staffs have devoted to the problem, and we wish to congratulate both committees on the job that has been done. We wish to reiterate our support for sections 4 and 6 of the proposed legislation, and we sincerely hope that the committee, and later Congress, will act favorably on these provisions of the bill.

We do hope, however, that our remarks regarding section 5 will be kept in mind when a final draft of the bill is prepared. Although we recognize that there are those who might disagree with our concern respecting section 5, we suggest that the bill without this section, or modified along the lines suggested by the AMA covers substantially most of the abuse that has been demonstrated in the field. We believe that section 5 should be eliminated, or modified, as suggested, and the bill should be passed in its present form. A period of time can then elapse, and we are certain that no great harm will result in the interim, while the impact of the bill on the general public, the dispensing physician and the pharmacist will be tested. If amendment be required, it can then be done on the basis of the achievements of this legislation and the possible shortcomings. Frankly we believe that the bill without section 5 will substantially cure the abuses that have been brought to the attention of the subcommittee, with great benefits to the public, and without any undue hardship to either the medical profession or to the profession of pharmacy.

Once again I urge the committee, as a Committee on Commerce, to remember that the relationship between a physician and patient is quite distinct from the relationship between a physician and a drug company or a physician and a pharmacy, and I ask you to consider section 5 in a different spirit from sections 4 and 6.

Thank you for permitting me to appear here today and for allowing me to present the views of the National Association of Mail Order Pharmaceutical Suppliers, Inc.

Senator HART. Mr. Sandler, I am glad we had an opportunity to hear rather than read your testimony. Additionally, it will enable us to have some of those references that were not included in the testimony. In view of the meeting of the policy committee, which as scheduled for 12:30, I suggest that if it is agreeable with you, we direct such questions as we have to you in writing and you can then respond and the questions and answers will be a part of the record at this point.

Mr. SANDLER. I will be happy to do so sir.

Senator HART. Thank you.

We will adjourn to resume at 9:30 a.m. tomorrow.

I thank everyone.

(Whereupon, at 12:40 p.m. the subcommittee was adjourned, to reconvene at 9:30 a.m., Wednesday, June 17, 1970.)

REGULATING TRADE IN DRUGS AND DEVICES

WEDNESDAY, JUNE 17, 1970

U.S. SENATE,
COMMITTEE ON COMMERCE,
CONSUMER SUBCOMMITTEE,
Washington, D.C.

The subcommittee met at 10 a.m. in room 5110, New Senate Office Building, Hon. Frank E. Moss (chairman of the subcommittee) presiding.

Present: Senators Moss and Pearson.

Senator Moss. The subcommittee will come to order.

We will continue with our hearings this morning on S. 1575, a bill to regulate trade in drugs and devices by prohibiting the dispensing of drugs or devices by medical practitioners and their participation in profits from the dispensing of such products, except under certain circumstances, and for other purposes.

We have several very interesting witnesses to appear before us this morning. Our first will be Dr. William Apple, who is the executive director of the American Pharmaceutical Association, and I understand you will have with you Mr. Sacks, Mr. Roberts, and Mr. Olson. Is that right?

Dr. APPLE. That is right, Mr. Chairman.

Senator Moss. I know Mr. Olson, of course. He is from Bountiful, Utah, and I am very glad to have been able to see him before the beginning of the meeting and I am happy that he is here.

I think, Dr. Apple, if you would identify these gentlemen as they are seated at the table, so our reporter will know them in the event we ask questions of any of these men.

**STATEMENT OF DR. WILLIAM APPLE, EXECUTIVE DIRECTOR,
AMERICAN PHARMACEUTICAL ASSOCIATION, WASHINGTON, D.C.,
ACCOMPANIED BY CARL ROBERTS, DIRECTOR, LEGAL DIVISION;
PHILIP SACKS, VICE SPEAKER OF HOUSE OF DELEGATES; AND C.
ALBERT OLSON, PRESIDENT, AMERICAN PHARMACEUTICAL
ASSOCIATION ACADEMY OF THE GENERAL PRACTICE OF
PHARMACY**

Dr. APPLE. Thank you, Mr. Chairman. As you indicated, Mr. Olson, to my right, is the president of the APHA Academy of the General Practice of Pharmacy. Seated to his right is Mr. Philip Sacks, the vice speaker of our house of delegates, from Illinois, and to his right, Mr. Carl Roberts, director of our legal division.

Senator Moss. We welcome you all, gentlemen. Glad to have you with us.

Dr. APPLE. With your permission, Mr. Chairman, I would like to have Mr. Sacks present our testimony.

Senator Moss. Very good. You may proceed in that manner. We will hear from Mr. Sacks first.

Mr. SACKS. Thank you, Mr. Chairman.

As you know, the American Pharmaceutical Association is the national professional society of pharmacists in the United States. Its approximately 50,000 members are composed of practicing pharmacists, pharmaceutical educators, pharmaceutical scientists, and pharmacy students.

APhA's objective as a professional organization is the continual improvement of the pharmacy profession as a part of the Nation's health care services.

I am Philip Sacks of Chicago, Ill., vice speaker of the APhA House of Delegates. I am a practicing pharmacist, president of the Illinois Pharmaceutical Association, and member of the Illinois Board of Pharmacy. I am accompanied by Dr. William S. Apple, executive director of APhA, Mr. C. Albert Olson of Bountiful, Utah, president of the APhA Academy of the General Practice of Pharmacy, and Mr. Carl Roberts, director of the APhA Legal Division.

We are appearing again in support of legislation introduced by Senator Hart, Senator Magnuson, and you which is designed to rectify serious conditions in the delivery of health care which are harmful to consumers and a threat to both the professions of pharmacy and medicine. In fact, these conditions benefit only a small percentage of physicians throughout the country.

We refer, of course, to instances involving physician-owned pharmacies, physician-owned drug companies, and physicians who, for their own financial benefit, regularly dispense drugs to patients.

Since the first hearings on this subject in 1964 by the Senate Antitrust Subcommittee, there has been amassed a substantial and dramatic record of existing and potential abuses which are likely to occur when physicians are engaged in activities which would be prohibited by S. 1575.

In our previous testimony on S. 260, we have detailed pharmacy's total lack of success in attempting to resolve this problem on an inter-professional basis with the medical profession and its chief spokesman: the American Medical Association. We feel that members of the Commerce Committee should have the benefit of this background and we have appended excerpts from our 1967 testimony to this statement.

We have not come here today to rehash what is now documented history. Nothing has changed. Rather, our objective today is to place the problem in present-day context and to illustrate that, as time goes on without resolution of the problem, its effects become more widespread, more insidious, and a more potent threat to decrease the quality of health care received by the Nation's citizens and to increase the price paid for it.

It is hardly overstating the case when we tell you that this Nation is in the throes of a health-care crisis. Note that we are not saying the Nation faces a health-care crisis; we are saying that the crisis is upon us and is worsening.

Only a few years ago the Nation was concerned about the inability of many to pay for needed health care. Congress responded with the medicare and medicaid programs. Today, our citizens are concerned

not only for those who find it difficult to pay for health care, but also for those who are financially able to pay for it, but are unable to obtain health care for want of sufficient numbers of health-care facilities and health-care personnel.

With your permission, Mr. Chairman, I will skip a few pages.

Senator Moss. You may do so, but the whole statement will go in the record.

Mr. SACKS. Thank you, Mr. Chairman.

Today's drastic shortage of physicians to provide medical services has been widely documented. We need only point to the American Medical Association's own policy position within the past year which would encourage the training of nurses to serve as so-called "physicians assistants." We might also point to expanding interest in the training and development of new types of paramedical personnel.

Yes, we could even point to the development of broader roles for the pharmacist, including a primary responsibility as a drug consultant and drug therapy planner for the physician.

The point is that we don't have enough physicians in this country to perform those functions for which the physician is trained, namely, the diagnosis and treatment of disease. It is incredible, in the face of this shortage, that a small but significant segment of the medical profession is attempting to perform not only their traditional health care role, but also the health care responsibility traditionally assigned to the pharmacist.

Pharmacists spend an average of 6 years being trained as experts in the preparation, storage and handling, and dispensing of drugs. This training and pharmaceutical practice make the pharmacist the most knowledgeable member of the health care team with regard to pharmaceutical products.

This expertise is wasted to a great extent, because the pharmacist is prevented from exercising his knowledge by overly restrictive laws and inhibited by the attitudes of many physicians. The threat of the physician dispensing hangs over every pharmacist's head. We will make further reference to one aspect of this problem shortly and show how physician's ownership of drug interests can seriously degrade health care.

Another aspect of this waste is attributable to dispensing physicians whose knowledge of drug product quality is limited at best, and whose selection of drug products frequently reflects the salesmanship of drug manufacturers rather than pharmaceutical training and knowledge.

The question which Congress must face squarely at this time is whether or not it is in the public interest to continue the use of pharmacists as members of the health care team.

If pharmacy is guaranteed a professionally independent and economically sound future, the pharmacist will continue to serve the public health needs of the Nation. He will, in fact, take on an expanded and far more important role in the delivery of health care services than that performed today.

On the other hand, if pharmacists are not guaranteed the freedom to exercise professional judgments within their own area of expertise and the freedom to practice their profession with assurance of a reasonable, secure financial future, major incentives to recruit new pharmacists will have been destroyed.

We have brought with us several examples of the inferior methods of dispensing physicians which are a threat to health care. These samples of drugs dispensed by physicians were provided us by the Michigan State Pharmaceutical Association.

Some were gathered in the emergency room of St. Lawrence Hospital in Lansing in connection with accidental poisoning cases. Pharmacists know that similar samples can be obtained in virtually every State. In the office of such physicians, the drug dispensing function is often relegated to a nurse, or worse, a totally untrained assistant.

If you will examine these envelopes, you will note that their labeling is totally inadequate, and directions for use are either confusing or nonexistent. The name of the patient is not indicated and the date when the drug was dispensed is not given.

Moreover, all of these drugs have been dispensed in small envelopes with absolutely no regard for the storage standards which are established to assure the stability and therapeutic value of the drug.

Thus, most of the drugs in these samples are required to be stored in prescription vial type containers according to the standards of the official compendia, which, as you know, have been adopted as the Federal standard for drugs under the Federal Food, Drug, and Cosmetic Act, as well as State acts.

We would point out that under sections 502 and 503(b) of the Federal act, and also under the State acts, every one of these samples would be deemed to be misbranded and subject to seizure if dispensed by a pharmacist. When Federal and State laws require specific dispensing practices to protect public health, how does the public health benefit when drugs are dispensed in this fashion by a physician? The fact is that there is no Federal enforcement of these provisions of the FDC Act against physicians who dispense drugs. The further fact is that physicians who dispense are either unaware of the requirements of the law, or "too busy" to comply with them.

With your permission, Mr. Chairman, I would like Mr. Olson to read excerpts from a letter in regard to physician dispensers, and have it put in the record.

Senator Moss. Very good.

Mr. OLSON. This happened in Kansas—Hillsboro. It was a town that was serviced by dispensing physicians, and this pharmacist decided he would put in a pharmacy in Hillsboro. These are examples he has collected after 2 years of practice in this particular town. He states:

As there had not been a pharmacy in town for fifteen years, the patients are rather reluctant in asking for prescriptions, and these defensive questions certainly discourage them.

(1) One doctor was overheard to say that, should the Hart bill pass, he would go to seven dollars on his office calls and put medication out free.

(2) Another example, a lady received a prescription for her medication. The doctor charged for the office call, plus one dollar for the prescription, since she wasn't getting the medicine from him.

(3) A lady brought in a bottle from the doctor's office with a tablet in it, and asked me what my price would be for thirty of these tablets. I told her I wouldn't charge anything for thirty tablets like that one. I then pointed out to her that the tablet was imprinted "sample" and hadn't cost the doctor anything. She said that she had certainly paid for them.

(4) A man brought in a bottle from a doctor's office with a tablet in it, and wanted some more. I was sure that I knew what the drug was, and told him I could not let him have any, but would be glad to call the doctor for him. The doctor confirmed the tablet; however, he said that he would like to see the man's wife before she got any more tablets, which is good medical practice.

I told the man that and he said it wasn't necessary, as he could get them from the girl in the office. I saw him the next day, and asked him if he had gotten the tablets. He said that he had gone directly to the doctor's office from my pharmacy, handed the bottle to the girl in the office, and had received the tablets, which was definitely not good medical practice.

(5) A lady was in last week and said that she had asked her doctor three times for prescriptions for medication her husband was taking. He would not give it to her, so she changed doctors. She knew what she was taking and wanted to know what a month's supply of these cost. I priced it and it came to twelve dollars. She had been paying forty dollars. Maybe this is why her prior physician wouldn't give her the prescription.

(6) Another customer was in and priced medication she had been getting from a doctor's office. I was able to identify the tablet and she said she got sixty at a time. I priced the tablets to her for \$.90. She was very surprised as she had been paying the doctor \$10.80.

(7) When doctors are out of town or on vacation, the offices remain open and the girls in the office continue to dispense medication.

Thank you, Mr. Chairman.

Senator Moss. Thank you, Mr. Olson.

Mr. SACKS. Mr. Chairman, I will continue with our testimony.

Senator Moss. All right.

Mr. SACKS. Senator Hart's prior hearings on physician ownership of pharmacies and manufacturing and repackaging companies, as well as his hearings concerning the dispensing practices of the so-called fat doctors, have dramatically exposed individual practitioners to public view. Unfortunately, there are always some on whom such lessons have little or no effect. Abuses, both real and potential, continue.

At this point, we wish to submit two such instances for the record. Appended to our statement is an article which appeared in the Louisville, Ky. Times on April 16, 1970. The situation described in that article relates to a small Kentucky drug firm, which apparently numbered among its stockholders a substantial number of physicians or members of their immediate families.

It illustrates a classic example of the need for S. 1575. While the article speaks for itself, we feel there are several points which should be emphasized.

Firstly, the Kentucky and Indiana Pharmaceutical Associations had received inquiries from their members about this company, and the sudden change in many physicians' prescribing habits to prescribing products of this firm by brand name. As the article points out, so-called anti-substitution laws in almost all States prohibit a pharmacist from dispensing the same drug in dosage form manufactured or distributed by a different company if a prescription is written for a particular brand name product. In other words, if a prescription is written for ampicillin under the trade name of one manufacturer, the pharmacist may not legally dispense ampicillin of any other manufacturer.

We seek the repeal of such State laws because they represent an unacceptable encroachment on the professional prerogatives of the pharmacist and specifically his unique ability to exercise professional judgments in selection of quality drug products. Antisubstitution laws, applicable to most pharmacists, prohibit them from selecting a quality product available at the most reasonable cost to the patient, and frequently force the pharmacist to dispense a product of lesser quality against his best professional judgment.

We point out that the pharmacist is placed on the horns of this dilemma not because he willingly purchases products of lesser quality,

but because prescribers are writing prescriptions for them. We would also point out that the patient often pays a premium for such products, certainly in terms of the price paid in relation to the cost of the product. There can be no question but that the physicians in this situation were given or sold stock to increase sales of the company's brand-name products.

I would like to refer to the last page of the testimony and read part of a letter from the American Medical News, of June 1, 1970:

Another alternative which will be exercised by many physicians is increased dispensing. Since any physician can buy prednisone and tetracycline for \$1.30 a hundred, and since these cost the patient a minimum of \$10.00 a hundred on prescription, the margin for "doing well by doing good" is fairly wide.

As a practicing pharmacist, and I practice daily, I cannot buy tetracycline or prednisone for \$1.30 a hundred, and I do not charge anywhere near \$10 for those products.

Secondly, we would point out that ethical considerations were apparently insufficient to keep the physicians involved with this firm from resisting the temptation of financial gain, even to the point of attempting to disguise their ownership interests by having stock issued in the names of their family members.

A second situation which we would bring to your attention is described in articles appended to our statement which appeared in the Des Moines, Iowa Tribune, on October 23, 1969, and F-D-C Reports ("The Pink Sheet") on May 4, 1970. The staff of the Senate Antitrust Subcommittee is intimately familiar with this situation.

It involves Woodland Drug Holding Co., a subsidiary of the Woodland Corp. in which physicians own a very substantial interest. Through Woodland Drug Holding Co., the Woodland Corp. owned three wholesale drug companies in Iowa, a distributor of medical and surgical supplies and equipment, and a pharmacy franchising firm.

Although, the "Pink Sheet" article describes, the financial fortunes of Woodland Drug Holding Co. have fallen upon hard times, this clearly was not intended. What apparently was intended, and achieved in large part, was control of drug distribution at the wholesale level in Iowa, and a substantial interest in drug distribution at the pharmacy level both in Iowa and elsewhere. The Woodland situation makes clear that the physician owners were involved in a substantial conflict of interest in at least the following ways:

(1) Physician owners had the incentive to stimulate moving drug products in the wholesaler's warehouses by prescribing for them.

(2) Physician owners had the incentive to direct patients to Woodland franchised pharmacies paying percentage fees.

(3) Physician owners had the incentive to overprescribe for their patients, thereby increasing sales by the wholesalers and also increasing the percentage fees received from pharmacy franchises.

In addition to these two specific examples involving abuses related to physician ownership, we can also state that percentage leases of the type that would be prohibited by S. 1575 are in force and continue to be demanded of pharmacists who wish to establish pharmacies in physician-owned medical centers, clinics, and even regular commercial buildings.

With your permission, Mr. Roberts would like to present a situation of this type for the record.

Senator Moss. All right. Mr. Roberts.

Mr. ROBERTS. Senator Moss, just a few days ago we received a telephone report from the Iowa Pharmaceutical Association concerning a situation in Ames, Iowa, in which a pharmacist was seeking to establish a pharmacy in a physician-owned medical clinic. The situation in Iowa, the board of pharmacy requires that for any pharmacy which is to be established in a clinic, that the lease must be submitted to the board of pharmacy for review.

At first the physicians and their attorneys were reluctant to submit the lease to the board, but finally acceded to the demand. When reviewed, the lease revealed that it was a percentage lease, that the percentage stated was 14 percent of the total prescription volume up to \$400,000, with a 10-percent override on volumes over \$400,000.

And the board of pharmacy at that point informed the attorneys for this clinic that it would not approve a lease of this type for, among other reasons, that the AMA Council on Judicial Ethics declares percentage leases of this type to be unethical.

At that point, the attorneys for the clinic brought in a new lease. This lease states a flat rental. Under normal circumstances, a flat rental would be found to be acceptable, and certainly not unethical.

However, in this case, the rental amount stated was \$48,000 a year, which figures out on a square foot basis to \$40 a square foot for rental for pharmacy space. The highest amount for similar space that we have ever heard of is \$10.

At this point, the board was itself placed on the horns of a dilemma, because when it expressed disapproval of this lease, the attorneys indicated that that would be fine with them, they would simply not submit an application in the name of the pharmacist for a pharmacist-ownership of the pharmacy, but would simply submit an application on behalf of the physicians themselves, so that it would create another physician-owned pharmacy situation.

At this point, apparently the Iowa Board of Pharmacy has concluded that it would rather have a pharmacy-owned and controlled pharmacy at a flat rental of \$48,000 or \$40 a square foot, rather than create another physician-owned pharmacy. And to the best of our information, the board of pharmacy is being forced in this case, because of the tactics being used by the doctors, to approve the \$48,000 lease.

Senator Moss. Thank you, Mr. Roberts.

Mr. SACKS. It is apparent that mere ethical pronouncements by the AMA's Judicial Council are not and will not be sufficient to remedy the problem we are facing. Legislation is needed.

We emphasize that the failure to legislate with regard to the problem in the drug field has unquestionably, in our view, created the "hands-off" climate in which these abuses can flourish in medicare and medicaid generally. This failure to legislate also has made possible one of the most indefensible decisions made by Government officials in connection with the medicaid program.

The Department of Health, Education, and Welfare's Handbook of Public Assistance Administration entitled "Medical Assistance Programs Under Title 19 of the Social Security Act (Supplement-D)" was issued on May 16, 1967. Section D-5150 originally specified that Federal financial participation with regard to prescribed drugs:

* * * is available in expenditures for drugs dispensed by licensed pharmacists and, when dispensed by legally authorized practitioners, where not adequate pharmacy services exist or are available when needed, and the practitioner dispenses such drugs on his written prescription, and retains records thereof.

On June 28, 1968, the Administrator of HEW's Social and Rehabilitation Service announced a change in this policy which now permits Federal financial participation with respect to prescribed drugs in all cases involving physician dispensing:

Federal financial participation is available in expenditures for drugs dispensed by licensed pharmacists and licensed, authorized practitioners in accordance with the State Medical Practice Act. When dispensing, the practitioner must do so on his written prescription and maintain records thereof.

Since the earlier HEW policy had permitted Federal financial participation relating to physician dispensing where adequate pharmaceutical services were not available from licensed pharmacists, it insured that medicaid patients always would be able to obtain needed medication.

What could have influenced responsible HEW officials to relax their stand? In our opinion, it was physician-backed pressures relating not to health care, but to money. The change in HEW policy did absolutely nothing to increase the availability of pharmaceutical services to medicaid patients.

We are most pleased to see that section 7 of S. 1575 would reinstate HEW's original policy with regard to Federal financial participation in all federally supported programs. This provision is urgently needed to control the escalating costs of these programs by eliminating unwarranted duplication of services.

Finally, we wish to relate the need for S. 1575 to another serious health care related problem. Much recent attention has been given the subject of medical malpractice. The Department of Health, Education, and Welfare has appointed a Special Assistant for Malpractice Research and Prevention in the Health Services and Mental Health Administration of the Public Health Service.

The problem has also been studied by the Senate Subcommittee on Government Reorganization chaired by Senator Ribicoff. A National Conference on Medical Malpractice sponsored by the American Osteopathic Association, with support from the Department of HEW, was held this year on February 7-8 in Chicago, Ill. This significant conference brought together representatives of the health care professions (including APhA), the health insurance industry, Government and consumer representatives, as well as both plaintiffs' and defendants' attorneys with broad experience in malpractice litigation.

Several participants in this conference attributed the escalating malpractice claim experience of physicians in large part to public resentment relating to dehumanization of medical care and also to the belief that doctors are getting rich at the public's expense.

These factors are also cited in the Senate subcommittee's report, "Medical Malpractice: The Patient Versus the Physician."

Financial involvement of physicians in pharmacy and the pharmaceutical industry which has already been brought to light and which will continue to come to the public's attention, can only serve to enflame the malpractice claim and litigation problem. Thus, because of the abuse of a segment of our medical practitioner, the entire medical profession suffers. Congress would go far toward improving the image

of medical practitioners as a group by imposing legislative restrictions on those who are unwilling or unable to keep their own house in order.

Pharmacy is pleading for a fair opportunity to keep its own house in order by preserving control of the practice of pharmacy within our profession. Pharmacists are willing to accept and exercise their responsibility and authority fully. We will accept the benefits when these are fulfilled, and we will accept the penalties when they are not.

We believe firmly that patients should continue to receive the benefit of high quality pharmaceutical services which only a pharmacist provides. We urge that pharmacists be permitted to provide such services as free and independent professionals and not as the servants of the medical profession.

Senator Moss. Thank you very much for that good presentation Mr. Sacks, and the attachments that are on your statement will also be printed in the record so that they will make clear the material you presented to us here today.

I think your statement is very much to the point. Of course, as you indicated, you have appeared previously before the Antitrust Subcommittee. We seem to be still struggling with the same problem we have had for a number of years.

Your reference to the Bonco Co. situation is interesting. I have a recent letter indicating that this company is still engaged in selling its shares to physicians.

The vice of physician ownership of drug packaging companies has long been in evidence. It was brought out in hearings of the Antitrust and Monopoly Subcommittee. What strikes me is that the AMA holds that physician ownership of repackaging companies is unethical. This was brought to the AMA's attention in 1964, 1965, and 1967, and the AMA promised to take action to end physician ownership in them. Yet spot checks by the staff just this last week showed that the same companies are owned by physicians. In 6 years the AMA has done nothing effective to end this blatant form of conflict of interest.

So I think it is clear that we must move on the legislative level, and I hope that we can move promptly in order to overcome this very serious problem.

Mr. ROBERTS. Senator Moss, may I give you another example involving a physician-owned repackaging company? This would involve reading two paragraphs from a letter we received from the State of Washington, State Pharmaceutical Association. It's a copy of a letter addressed to Senator Magnuson, chairman of the Commerce Committee, and I quote:

Not too long ago, the Paramed Company, a drug repackaging concern, sold stock to physicians, particularly in the Pierce County area. Some of those physicians owning stock insisted that the pharmacists thereabouts stock and dispense Paramed products, frequently to the exclusion of better known and better respected products.

When I wrote a letter to the President of the Pierce County Medical Society protesting this situation, I got no answer from him. But I did get a letter from the attorneys for the Paramed Company, threatening suit if I did not stop calling Paramed a repackaging company. Apparently the Pierce County President himself had a financial interest in Paramed.

Senator Moss. Thank you for adding that to the record, as another example of what is going on in various parts of the country.

Yesterday, Dr. Steinfeld, the Surgeon General, testified in qualified support of the bill before us, S. 1575. He agreed with the premise of

the bill that physician ownership of repackaging companies or pharmacies and dispensing by physicians creates a conflict of interest that should be avoided. However, he felt that S. 1575 was too broad in its prohibitions and that the Department of Health, Education, and Welfare should be given power to exempt physicians from the bill's prohibitions. He did not think that the exemptions should be written into the bill as they are now but should be done by regulation by HEW.

I wonder what the reaction of you gentlemen is to this statement by Dr. Steinfeld.

Dr. APPLE. Mr. Chairman, I think our reaction is that we feel definitely that the language ought to be included in the bill as provided, that we ought not leave this to regulation by HEW.

As a Member of the Senate who has considerable expertise in packaging, Senator, you have in front of you the kind of misbranded, mislabeled packaging that goes on in violation of the Food and Drug Act. We know physicians' offices are not checked for these things. We know that the regulations that can be implemented can be changed, as the case of the medicaid program, when pressure is applied to the agency involved.

We would prefer to see this spelled out once and for all and we think that the Congress ought to make its mandate known to the country on this particular issue and not leave it to the executive branch to change it as they wish.

Senator Moss. Thank you, Dr. Apple. This is indeed a dramatic example of failure to comply with the Food and Drug and Cosmetic Act on packaging. What is the mechanism for Federal enforcement, if any, and why hasn't it worked?

Dr. APPLE. Well, I don't think the Food and Drug Administration has adequate personnel to undertake this. Further, as a matter of policy, they have never gone into this type of law enforcement.

You might say it's become an unwritten rule in our society with respect to Federal regulations that the physician is always exempt.

We have the same matter pending before us now on the dangerous drug bill in front of the Congress. There is a blanket exemption for physicians. Now we know there are abuses that originate from the offices of physicians—not necessarily always by the physician himself—but by persons employed in his office. We have the same thing—as we indicated, as Mr. Olson read—it's not atypical in a dispensing physician's office for the physician to be out of the city attending a meeting or on vacation and having the lay person—not even a registered nurse—hand out medication at the request of the individual.

If a pharmacist were to engage in that kind of activity, he would be in direct violation of Federal and State laws, and someone would be on his back pretty hard and pretty fast.

But this can go on constantly in physicians offices, and I think Congress would render the public a great service if Congress moved to pass this legislation and once and for all eliminate the drug inventories that are accumulated all over physicians' offices in this country.

Senator Moss. Are there State laws to deal with this situation that are not being enforced?

Dr. APPLE. Well, California did pass a statute in an effort to ban physician ownership, but it has some loopholes that physicians soon found a way of getting around.

And we feel that Federal legislation is definitely needed across the board on this issue. If we were to attempt to go through 50 States legislatures to enact this type of legislation, it would take us 50 years.

Senator Moss. Are there State laws also against dispensing by the physicians?

Dr. APPLE. No; the State laws, again, at the time they were enacted, provided an exemption to physicians.

Senator Moss. On the packing, the statute is adequate, if it were enforced—is that what you told me on the first question when we asked about these examples?

Dr. APPLE. They are required to label the drug dispensed when a physician does it, the same way a pharmacist is required to put the name of the patient, the name of the prescriber, the date, and other pertinent information required under the act.

Furthermore, of course, if a pharmacist were to dispense a product in those kinds of containers, I think that the Board or Pharmacy would have a right to bring him to task for the kind of practice he is engaged in. Many of those drugs in those envelopes in front of you are in the process of disintegration and have been since the day they were handed out and taken out of the light-resistant containers.

We also have another facet of this situation in terms of the dispensing physician and that is his mere presence encourages what is known as a mail order operator or mail order distributor who caters to the dispensing physician. We have reported to the Food and Drug Administration in the past, we have reported to the Federal Trade Commission, instances where anybody could write to one of these interstate type of drug distributing firms and obtain, on a fictitious physician's letterhead, all the drugs he wanted of any kind. Here we are in the midst of one of the most serious drug abuse problems in the country and at the same time we are being told that more and more these mail order firms are flourishing. It all doesn't make sense, Senator.

Senator Moss. Are the number of physician-owned pharmacies increasing now or have they been increasing since last you testified?

Dr. APPLE. If you define a physician-owned pharmacy as one in which the doctor has the direct controlling interest of stock, I would have to say that perhaps we are about where we were the last 3 or 4 years.

It is far more effective to engage in a type of situation of a percentage lease, or some other type of equity arrangement, which doesn't require the physician to have his name on the license application.

But it boils down to the fact that more and more, as we move toward group practice in medicine, and the more clinics that are established—and we agree with people who believe that pharmaceutical service ought to be available in a clinical environment, that the pharmacist can only get an opportunity in these particular environments to participate in his profession by paying through the nose. Now \$40 a square foot is unconscionable.

Senator Moss. Is there any validity to the argument that the physician can dispense drugs more cheaply than sending his patients to the pharmacy—that the patient gets an advantage, a price savings in that way?

Dr. APPLE. This is a claim that has been made since time immemorial. I don't think that any physician goes into dispensing as a benevo-

lent gesture. If he has a patient who needs—is in dire financial circumstances or he wishes to assist, he can usually make some arrangement with the pharmacist for consideration of that patient's welfare.

The claim, of course, always being that the physician can buy cheaper than the pharmacist. This may be true, but if we are talking about the same quality of drugs, I don't believe it's true. And I think there is ample evidence to indicate that the physician's charges on the average and on the whole are far more in excess to the patient than the pharmacist's would be, when he merely collects the cost of the drug plus a reasonable fee for professional services.

Senator Moss. Well, if this pharmacy had to pay \$40 a square foot for its rent, this would be reflected in the cost—it would have to go into the drugs dispensed; wouldn't it?

Dr. APPLE. There is no question that the pharmacist has to charge the public more than he would if he were paying \$10 a square foot, or \$8, which is even more common.

You might say, why doesn't the public just take their prescriptions somewhere else? Generally, these arrangements are worked out so that the public is held as a captive audience.

Senator Moss. They leave the physician's office and there is a pharmacy right there in the same building.

Dr. APPLE. Even more so, as the patient leaves the physician's office, the nurse says, if you walk across the hall or down the hall, your prescription will be ready for you.

The patient isn't given the physical prescription, the written document and given a choice to go out, because this wouldn't serve the best interest of the physicians that own that building. Especially, on a percentage basis, you can see that the smaller the volume of that pharmacy, the less take the physicians would get.

Senator Moss. Well, thank you, Dr. Apple, and Mr. Roberts, Mr. Sacks, and Mr. Olson. It's good to have you before the committee. We appreciate your testimony and it is rather persuasive, I would say. Thank you very much.

Dr. APPLE. Thank you, Mr. Chairman.
(The statement follows:)

STATEMENT OF THE AMERICAN PHARMACEUTICAL ASSOCIATION

Mr. Chairman and members of the committee, as you know, the American Pharmaceutical Association is the national professional society of pharmacists in the United States. Its approximate 50,000 members are composed of practicing pharmacists, pharmaceutical educators, pharmaceutical scientists and pharmacy students. APhA's objective as a professional organization is the continual improvement of the pharmacy profession as a part of the nation's health care services. I am Philip Sacks of Chicago, Illinois, Vice-Speaker of the APhA House of Delegates. I am a practicing pharmacist, President of the Illinois Pharmaceutical Association and member of the Illinois Board of Pharmacy. I am accompanied by Dr. William S. Apple, Executive Director of APhA, Mr. C. Albert Olson of Bountiful, Utah, President of the APhA Academy of the General Practice of Pharmacy, and Mr. Carl Roberts, Director of the APhA Legal Division.

We are appearing again in support of legislation introduced by Senator Hart, which is designed to rectify serious conditions in the delivery of health care which are harmful to consumers and a threat to both the professions of pharmacy and medicine. In fact, these conditions benefit only a small percentage of physicians throughout the country. We refer, of course, to instances involving physician-owned pharmacies, physician-owned drug companies and physicians who, for their own financial benefit, regularly dispense drugs to patients.

APhA did not endorse Senator Hart's first effort in this area because we did not agree with its basic approach. However, we did support wholeheartedly S. 260, which Senator Hart introduced during the 90th Congress. In our view, S. 260,

represented a major improvement over the earlier bill. We believe that even greater improvements have been made in the bill you are now considering, S. 1575. We offer our full support of this measure as drafted and will do all we can to obtain its enactment.

Since the first hearings on this subject in 1964 by the Senate Antitrust Subcommittee, there has been amassed a substantial and dramatic record of existing and potential abuses which are likely to occur when physicians are engaged in activities which would be prohibited by S. 1575.

In our previous testimony on S. 260, we have detailed pharmacy's total lack of success in attempting to resolve this problem on an interprofessional basis with the medical profession and its chief spokesman—the American Medical Association. We feel that members of the Commerce Committee should have the benefit of this background and we have appended excerpts from our 1967 testimony to this statement. We have not come here today to rehash what is now documented history. Nothing has changed. Rather, our objective today is to place the problem in present day context and to illustrate that, as time goes on without resolution of the problem, its effects become more widespread, more insidious, and a more potent threat to decrease the quality of health care received by the nation's citizens and to increase the price paid for it.

It is hardly overstating the case when we tell you that this nation is in the throes of a health care crisis. Note that we are not saying the nation faces a health care crisis; we are saying that the crisis is upon us and is worsening. Only a few years ago, the nation was concerned about the inability of many to pay for needed health care. Congress responded with the Medicare and Medicaid programs. Today, our citizens are concerned not only for those who find it difficult to pay for health care, but also for those who are financially able to pay for it, but are unable to obtain health care for want of sufficient numbers of health care facilities and health care personnel.

Congress has established as a national policy the development of adequate health care facilities and personnel. Within the past several years, Congress has appropriated hundreds of millions of dollars for hospital construction and modernization, new medical schools, training of physicians, dentists and allied health personnel, including pharmacists. In January, 1969, Dr. Charles W. Bliven, Executive Secretary of the American Association of Colleges of Pharmacy, reported the scope and effect of federal financial support for our profession. Briefly summarized, his report indicates that federal grants for construction of undergraduate teaching facilities and research facilities received or projected from fiscal year 1964 through fiscal year 1972 total 37.5 million dollars. As a result of such construction, approximately 1,000 new first year places for pharmacy students will have been created. In fiscal 1967 and 1968, pharmacy student loan and scholarship funds received from the federal government totaled 6.8 million dollars. These funds were used to provide financial assistance to approximately 7,200 pharmacy students during those two years. Thus, on the one hand, Congress is pouring money into the development of greater numbers of pharmacists, but on the other hand, Congress has to date refused to take one step that would work to ensure the continued existence and stability to the pharmacy profession in this country. That step is the elimination of physicians as professional and economic poachers in pharmacy.

Today's drastic shortage of physicians to provide medical services has been widely documented. We need only point to the American Medical Association's own policy position within the past year which would encourage the training of nurses to serve as so called "physicians assistants." We might also point to expanding interest in the training and development of new types of paramedical personnel. Yes, we could even point to the development of broader roles for the pharmacist, including a primary responsibility as a drug consultant and drug therapy planner for the physician. The point is that we don't have enough physicians in this country to perform those functions for which the physician is trained, namely, the diagnosis and treatment of disease. It is incredible, in the face of this shortage, that a small but significant segment of the medical profession is attempting to perform not only their traditional health care role, but also the health care responsibility traditionally assigned to the pharmacist.

Pharmacists spend an average of six years being trained as experts in the preparation, storage and handling and dispensing of drugs. This training and pharmaceutical practice make the pharmacist the most knowledgeable member of the health care team with regard to pharmaceutical products. This expertise is wasted to a great extent, because the pharmacist is prevented from exercising his knowledge by overly restrictive laws and inhibited by the attitudes of many physicians. The

threat of the physician dispensing hangs over every pharmacist's head. We will make further reference to one aspect of this problem shortly and show how physician's ownership of drug interests can seriously degrade health care.

Another aspect of this waste is attributable to dispensing physicians whose knowledge of drug product quality is limited at best, and whose selection of drug products frequently reflects the salesmanship of drug manufacturers rather than pharmaceutical training and knowledge.

The question which Congress must face squarely at this time is whether or not it is in the public interest to continue the use of pharmacists as members of the health care team.

As we have stated in prior testimony on this problem, the division of functions between the physician and pharmacist were settled by agreement between the professions during the mid 1800's. Since this agreement was reached, however, there has been a serious erosion of the relationship. Most major nations of the world require by law that physicians prescribe and pharmacists dispense.

If pharmacy is guaranteed a professionally independent and economically sound future, the pharmacist will continue to serve the public health needs of the nation. He will, in fact, take on an expanded and far more important role in the delivery of health care services than that performed today. On the other hand, if pharmacists are not guaranteed the freedom to exercise professional judgments within their area of expertise and the freedom to practice their profession with assurance of a reasonable, secure financial future, major incentives to recruit new pharmacists will have been destroyed.

Today's graduating pharmacist is better trained and better motivated than at any time in our history. However, the realities of today's general practice of pharmacy, with a continuing reduction in independent, pharmacist-owned pharmacies and a concurrent growth of corporate-owned chain pharmacies, is creating the most professionally frustrated pharmacists in our history. Those circumstances which frequently force upon the pharmacist little more than the function of a clerk are a major threat. The encroachment of the medical profession in the practice of pharmacy is another major threat.

We have brought with us several examples of the inferior methods of dispensing physicians which are a threat to health care. These samples of drugs dispensed by physicians were provided us by the Michigan State Pharmaceutical Association. Some were gathered in the emergency room of St. Lawrence Hospital in Lansing in connection with accidental poisoning cases. Pharmacists know that similar samples can be obtained in virtually every state. In the office of such physicians, the drug dispensing function is often relegated to a nurse, or worse, a totally untrained assistant.

If you will examine these envelopes you will note that their labeling is totally inadequate, and directions for use are either confusing or non-existent. The name of the patient is not indicated and the date when the drug was dispensed is not given. Moreover, all of these drugs have been dispensed in small envelopes with absolutely no regard for the storage standards which are established to assure the stability and therapeutic value of the drug.

Thus, most of the drugs in these samples are required to be stored in prescription vial type containers according to the standards of the official compendia, which, as you know, have been adopted as the federal standard for drugs under the Federal Food, Drug and Cosmetic Act, as well as state acts. We would point out that under Sections 502 and 503(b) of the Federal act, and also under the state acts, every one of these samples would be deemed to be misbranded and subject to seizure if dispensed by a pharmacist. When federal and state laws require specific dispensing practices to protect public health, how does the public health benefit when drugs are dispensed in this fashion by a physician? The fact is that there is no federal enforcement of these provisions of the FDC Act against physicians who dispense drugs. The further fact is that physicians who dispense are either unaware of the requirements of the law or "too busy" to comply with them.

In stating our full support of S. 1575, we wish to make clear that we do not attribute the abuses the bill would correct or prevent to the vast majority or even the bulk of the medical practitioners in the country. For the most part, relationships between physicians and pharmacists, certainly at the practitioner level, have been and continue to be sound, mutually beneficial and gratifying. However, there always has been an element in medicine which sees financial involvement in the pharmaceutical industry and pharmacy profession as a way of lining its pockets.

Senator Hart's prior hearings on physician ownership of pharmacies and manufacturing and repackaging companies, as well as his hearings concerning

the dispensing practices of the so-called "fat doctors," have dramatically exposed individual practitioners to public view. Unfortunately, there are always some on whom such lessons have little or no effect. Abuses, both real and potential, continue.

At this point, we wish to submit two such instances for the record. Appended to our statement is an article which appeared in the Louisville Kentucky Times on April 16, 1970. The situation described in that article relates to a small Kentucky drug firm, which apparently numbered among its stockholders a substantial number of physicians or members of their immediate families. It illustrates a classic need for S. 1575. While the article speaks for itself, we feel there are several points which should be emphasized. Firstly, the Kentucky and Indiana Pharmaceutical Associations had received inquiries from their members about this company and the sudden change in many physicians' prescribing habits to prescribing products of this firm by brand name. As the article points out, so-called "ant substitution" laws in almost all states prohibit a pharmacist from dispensing the same drug in dosage form manufactured or distributed by a different company if a prescription is written for a particular brand name product. In other words, if a prescription is written for ampicillin under the trade name of one manufacturer, the pharmacist may not legally dispense ampicillin of any other manufacturer.

We seek the repeal of such state laws because they represent an unacceptable encroachment on the professional prerogatives of the pharmacist and specifically his unique ability to exercise professional judgment in selection of quality drug products. Antisubstitution laws, applicable to most pharmacists, prohibit them from selecting a quality product available at the most reasonable cost to the patient and frequently force the pharmacist to dispense a product of lesser quality against his best professional judgment. We point out that the pharmacist is placed on the horns of this dilemma not because he willingly purchases products of lesser quality, but because prescribers are writing prescriptions for them. We would also point out that the patient often pays a premium for such products, certainly in terms of the price paid in relation to the cost of the product. There can be no question but that the physicians in this situation were given or sold stock to increase sales of the company's brand-name products.

Secondly, we would point out that ethical considerations were apparently insufficient to keep the physicians involved with this firm from resisting the temptation of financial gain, even to the point of attempting to disguise their ownership interests by having stock issued in the names of their family members.

Finally, although the Kentucky Medical Association, through its Judicial Council, was quick to advise its members to divest themselves of any interest in this firm, the Association declined to take any disciplinary action against those involved.

A second situation which we would bring to your attention is described in articles appended to our statement which appeared in the Des Moines, Iowa Tribune on October 23, 1969 and F-D-C Reports ("The Pink Sheet") on May 4, 1970. The staff of the Senate Antitrust Subcommittee is intimately familiar with this situation. It involves Woodland Drug Holding Co., a subsidiary of the Woodland Corporation in which physicians own a very substantial interest. Through Woodland Drug Holding Co., the Woodland Corp. owned three wholesale drug companies in Iowa, a distributor of medical and surgical supplies and equipment and a pharmacy franchising firm. Although, as "The Pink Sheet" article describes, the financial fortunes of Woodland Drug Holding Co. have fallen upon hard times, this clearly was not intended. What apparently was intended, and achieved in large part, was control of drug distribution at the wholesale level in Iowa and a substantial interest in drug distribution at the pharmacy level both in Iowa and elsewhere. The Woodland situation makes clear that the physician owners were involved in a substantial conflict of interest in at least the following ways.

- (1) Physician owners had the incentive to stimulate moving drug products in the wholesaler's warehouses by prescribing for them.
- (2) Physician owners had the incentive to direct patients to Woodland franchised pharmacies paying percentage fees.
- (3) Physician owners had the incentive to over-prescribe for their patients, thereby increasing sales by the wholesalers and also increasing the percentage fees received from pharmacy franchises.

In addition to these two specific examples involving abuses related to physician ownership, we can also state that percentage leases of the type that would be prohibited by S. 1575 are in force and continue to be demanded of pharmacists who wish to establish pharmacies in physician-owned medical centers, clinics and even regular commercial buildings.

Section 7 of the American Medical Association's "Principles of Medical Ethics" states specifically: "In the practice of medicine, a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients."

It is interesting to note that the Judicial Council of the American Medical Association, even though it would permit physician ownership of pharmacies if patients are not exploited, declares it unethical for a physician to have a financial interest in a drug repackaging company or for a physician to own stock in a pharmaceutical company which he can control or does control while actively engaged in the practice of medicine. The Judicial Council has also stated that physicians should avoid regular dispensing where adequate pharmaceutical services are available and should recognize and promote the practice of pharmacy as a profession and should receive the cooperation of the pharmacist in educating the public concerning the practice of ethical and scientific medicine.

Copies of Judicial Council opinions on these subjects are appended to our statement for the record.

It is apparent that mere ethical pronouncements by the AMA's Judicial Council are not and will not be sufficient to remedy the problem we are facing. Legislation is needed.

We would point out also, Mr. Chairman, that problems of physician ownership and their financial impact on the public are not limited to pharmacies and pharmaceutical suppliers. These have now carried over to the field of nursing homes and extended care facilities financed in large part by the Medicare and Medicaid programs. This has been the subject of extensive investigation and hearings by the Senate Finance Committee. Preliminary conclusions contained in a committee staff report call for major steps toward eliminating abuses connected with physician ownership of such facilities.

We emphasize that the failure to legislate with regard to the problem in the drug field has unquestionably, in our view, created the "hands off" climate in which these abuses can flourish in Medicare and Medicaid generally. This failure to legislate has also made possible one of the most indefensible decisions made by government officials in connection with the Medicaid program. The Department of Health, Education, and Welfare's Handbook of Public Assistance Administration entitled "Medical Assistance Programs under Title 19 of the Social Security Act (Supplement-D)" was issued on May 16, 1967. Section D-5150 originally specified that federal financial participation with regard to prescribed drugs:

"* * * is available in expenditures for drugs dispensed by licensed pharmacists and, when dispensed by legally authorized practitioners, *where not adequate pharmacy services exist or are available when needed*, and the practitioner dispenses such drugs on his written prescription, and retains records thereof." [emphasis added]

On June 28, 1968, the Administrator of HEW's Social and Rehabilitation Service announced a change in this policy which now permits federal financial participation with respect to prescribed drugs in all cases involving physician dispensing: "Federal financial participation is available in expenditures for drugs dispensed by licensed pharmacists and licensed, authorizee practitioners in accordance with the State Medical Practice Act. When dispensing, the practitioner must do so on his written prescription and maintain records thereof."

Since the earlier HEW policy had permitted federal financial participation relating to physician dispensing where adequate pharmaceutical services were not available from licensed pharmacists, it insured that Medicaid patients always would be able to obtain needed medication. What could have influenced responsible HEW officials to relax their stand? In our opinion, it was physician-backed pressures relating not to health care, but to money. The change in HEW policy did absolutely nothing to increase the availability of pharmaceutical services to Medicaid patients.

We are most pleased to see that Section 7 of S. 1575 would reinstate HEW's original policy with regard to federal financial participation in all federally supported programs. This provision is urgently needed to control the escalating costs of these programs by eliminating unwarranted duplication of services.

Finally, we wish to relate the need for S. 1575 to another serious health care related problem. Much recent attention has been given the subject of medical malpractice. The Department of Health, Education, and Welfare has appointed a Special Assistant for Malpractice Research and Prevention in the Health Services and Mental Health Administration of the Public Health Service. The problem has also been studied by the Senate Subcommittee on Government Reorganization chaired by Senator Ribicoff. A National Conference on Medical Malpractice sponsored by the American Osteopathic Association with support

from the Department of HEW was held this year on February 7-8 in Chicago, Illinois. This significant conference brought together representatives of the health care professions (including APhA, the health insurance industry, government and consumer representatives, as well as both plaintiffs' and defendants' attorneys with broad experience in malpractice litigation. Several participants in this conference attributed the escalating malpractice claim experience of physicians in large part to public resentment relating to dehumanization of medical care and also to the belief that doctors are getting rich at the public's expense. These factors are also cited in the Senate Subcommittee's report, *Medical Malpractice: The Patient Versus the Physician*:

Second, the public image of today's doctor is not what it used to be. Medical societies and associations are often pictured taking unpopular positions that receive great attention.

The "poor image" of the profession may be passed on to the individual physician when he sends a bill the patient thinks is excessive.

Unfortunately there has developed in this Nation in recent years a negative view of the medical community that physicians, ironically, have helped to create.

Consider, for example, the views of two outstanding and nationally respected lawyers in the malpractice field.

Crawford Morris, a Cleveland lawyer who has defended physicians and hospitals in malpractice litigation for many years, stated:

"It is common knowledge today that almost all doctors are making enormous amounts of money, refuse to make house calls, play golf on Wednesdays, drive expensive cars, own yachts, hunting lodges, and apartment houses.

"The doctor's image is sadly tarnished.

"Once thought of as 'the old country doctor driving through the rain all night to sit beside a sick patient,' they are now thought of as 'supersuccessful businessmen.' This, perhaps subconscious, attitude makes patients more willing to sue their doctors and makes patients on juries more willing to return a verdict, and one of considerable size, against doctors."

Financial involvement of physicians in pharmacy and the pharmaceutical industry which has already been brought to light and which will continue to come to the public's attention, can only serve to inflame the malpractice claim and litigation problem. Thus, because of the abuse of a segment of our medical practitioner, the entire medical profession suffers. Congress would go far toward improving the image of medical practitioners as a group by imposing legislative restrictions on those who are unwilling or unable to keep their own house in order.

Pharmacy is pleading for a fair opportunity to keep its own house in order by preserving control of the practice of pharmacy within our profession. Pharmacists are willing to accept and exercise their responsibility and authority fully. We will accept the benefits when these are fulfilled, and we will accept the penalties when they are not. We believe firmly that patients should continue to receive the benefit of high quality pharmaceutical services which only a pharmacist provides. We urge that pharmacists be permitted to provide such services as free and independent professionals and not as the servants of the medical profession.

[From the Louisville Times, April 16, 1970]

KMA COUNCIL URGES DOCTORS TO DISPOSE OF STOCK IN PROSPECT DRUG FIRM

(By Wayne Welch)

The young pharmacist, who works in eastern Jefferson County, was furious as he talked to a reporter.

A regular customer had come in a few days before with a prescription to treat a cold.

The drug specified was from a new and little known firm, Bonco Labs, Inc. of Prospect, Ky., a wholesale firm.

The pharmacist, not having the drug on hand, routinely phoned the physician who had written the prescription and asked if he might substitute something else. (Pharmacists cannot change a prescription without a doctor's permission.)

The doctor became angry, according to the pharmacist, threatened to physically attack the pharmacist, and said he'd find a place to get the prescription filled as written.

The patient wound up waiting two days for his medicine, the pharmacist noted. "I have nothing against the drug," the pharmacist said, "but this is no way for professionals to treat each other."

He indicated there must be some special reason why the physician was so insistent on the Bonco drug.

KMA STEPS IN

The Judicial Council of the Kentucky Medical Association (KMA), after some investigating, announced yesterday it "strongly urges" all physicians who own stock in Bonco to dispose of it. This "urging" extended to stock owned by members of a physician's family.

The KMA council admitted it doesn't know how many physicians actually own stock, and Thomas Bond Jr., president of Bonco, would not say. Talks with some pharmacists indicated it might be 50 to 100, apparently including some doctors in Southern Indiana.

The problem in the past several weeks has come to the attention of medical and pharmaceutical professional organizations concerned with the possibility that some doctors might be changing their prescription-writing habits to help boost their Bonco stock.

Investigations into Bonco already had been held by the Jefferson County Academy of Pharmacy and the Jefferson County Medical Society before the KMA got involved.

FIRM'S LEGALITY NOT QUESTIONED

Dr. N. Lewis Bosworth of Lexington, chairman of the five-member KMA Judicial Council, said there is nothing illegal about the Bonco type offirm.

"It is just unethical for a doctor," he said, referring to a policy of the American Medical Association (AMA) and its affiliate groups against doctors having a financial interest in a drug firm.

The medical societies, increasingly sensitive to public criticism of doctors' finances, apparently have moved swiftly to meet a problem they find sensitive and potentially embarrassing.

The KMA Judicial Council, which ordinarily meets quarterly, has had at least one special meeting on Bonco, and quickly drew up the statement announced yesterday.

The statement is to be read at the next meeting of all county medical societies in Kentucky.

Throughout the talks, no one—not even a few irate pharmacists who talked to a reporter—has questioned the quality of Bonco drugs.

Officers of Bonco, which is incorporated in Delaware, are Thomas Bond, Jr., Ronald R. Cox, vice-president and secretary; and James E. Bond, treasurer. The name, Bonco, apparently comes from a combination of Bond and Cox.

The firm markets under its own label drugs produced by generic drug makers.

Bond, who indicated he might have a statement later on the KMA action, indicated the firm hopes to expand and produce its own drugs.

Bosworth said Bond was invited to talk with the council, but preferred not to come.

Bond disputed this today, saying he told the council he could not come "at that particular time." Bond said he invited the council to visit Bonco, but was told the council members were very busy and couldn't.

"I don't think their time is any more valuable than mine," Bond said.

An early rumor among pharmacists was that Bonco, apparently aware of the AMA directive about direct physician ownership of drug stock they can influence, had offered the stock to physicians' wives.

Bosworth confirmed this to some degree, noting that wives did own stock. In one case it was a daughter, about 22 years old, he said.

"Our concern," the KMA statement says, "lies with the temptation which is bound to be present on the part of a physician-stockholder to prescribe Bonco products in order to further his financial interest (or that of his family) in the company."

The statement said all physicians interviewed by the Judicial Council—eight to 10 were called in—were aware it is unethical for a physician to own stock in a drug-repackaging house.

Each physician was emphatic that Bonco is not a repackaging house, the council asserts, but "we are not so sure."

Even if Bonco is not a repackaging firm, the council says, the fact that doctors could help boost stock of a small drug company by writing prescriptions could hardly escape the attention of the company.

The council, as does the AMA, drew a distinction between the Bonco case and that of a doctor owning stock in a large, national drug firm like Lilly or Abbott.

The council said a single doctor or even several would have no notable effect on a large company by writing prescriptions specifying their products.

Bond did say this was discrimination against small firms. "All of these companies that are major manufacturers today didn't start out big."

The KMA Judicial Council said no disciplinary action is planned against physicians who own stock in Bonco.

One council member indicated, however, there would be checks later to see if physicians actually did dispose of Bonco stock.

[From the Des Moines (Iowa) Tribune, Oct. 23, 1969]

INVOLVEMENT IN WHOLESALE, RETAIL SALES STUDIED—PROBE DOCTOR-DRUGS TIE

(George Anthan)

Involvement of a group of Des Moines and central Iowa medical doctors in the wholesale and retail sale of drugs is being investigated by the U.S. Senate's subcommittee on antitrust and monopoly.

A subcommittee official told The Tribune by telephone from Washington, D.C., Thursday that the object of the investigation is the Woodland Corp., of Des Moines. The firm's records have been subpoenaed by the subcommittee, the official said.

Woodland Corp. officials have reported that medical doctors own a large percentage of the stock in the firm.

TWO WHOLESALE HOUSES

Woodland Corp. now owns and operates two major drug wholesale houses, Des Moines Drug Co. and Iowa Drug Co., believed to be the largest independent drug wholesalers in the state.

Woodland officials also have said the firm is involved in the retail drug store franchise business.

Dorothy Goodwin, assistant counsel for the anti-trust and monopoly subcommittee, said the investigation is aimed at setting up hearings in connection with a bill that would prohibit doctors from selling drugs, except under rare circumstances.

The bill, sponsored by Senator Philip Hart (Dem., Mich.), the subcommittee chairman, currently is pending before the Senate Commerce Committee.

"It is my feeling this bill is aimed at the type of practices (involving drug sales) that the Iowa doctors say they are involved in," Miss Goodwin said.

The measure would, she said, prohibit doctors from selling drugs at wholesale or retail, except in certain rural areas where there was no other supply of medicines.

INTERVIEWS HERE

Miss Goodwin was in Des Moines for several days about two weeks ago, interviewing Woodland officials and gathering information about the firm's activities.

She also met with Robert Gibbs, executive secretary of the Iowa Pharmaceutical Association, who has declared:

"I do not understand why doctors want to invest their money in such fields as drug manufacture and distribution . . . when there are so many other places for them to put their money."

He supports the proposed federal legislation, saying the American Medical Association "has failed to recognize the problem of physician conflict of interest."

Many independent pharmacists in Des Moines and central Iowa have strongly opposed the involvement of doctors in the drug business, especially in the franchising of retail drug stores.

Miss Goodwin said her probe of Woodland's operations "certainly raises questions" about the possibility of conflict of interest on the part of doctor-stockholders.

She said doctor-involvement in Woodland Corp. could make it possible for physician-stockholders to profit from drugs they prescribe to their patients, although she emphasized there is no evidence to indicate this is happening.

But if physician-stockholders did profit from drugs they prescribed to their patients, "that certainly is not right," Miss Goodwin said.

"NOT SURPRISED"

Harold Castle of Des Moines, Woodland Corp. president, said Thursday that "I would not be surprised" if Woodland is included in U.S. Senate hearings into the selling of drugs by doctors.

Castle said a recent check indicated that doctors own some 400,000 shares of Woodland stock, out of a total of 836,000 shares outstanding.

There are four medical doctors on Woodland's nine-member board of directors. Two other doctors resigned from the board earlier this year.

Castle said Woodland Corp. is negotiating to acquire P.D.Q. of America, Inc., which has several franchised drugstores in the Des Moines area, and whose officials have stated will be expanded into a national chain. P.D.Q. of America, Inc., has offices at Des Moines Drug Co., 2511 Bell ave.

LETTER

However, present relationship between Woodland and P.D.Q. of America, Inc., is not entirely clear because Dr. John Gustafson, chairman of Woodland Corp., reported in a letter published in the May-June issue of The Bulletin of the Polk County Medical Society that Woodland "acquired, effective Jan. 1, 1969, the P.D.Q. franchise operation."

Gustafson stated in an interview last summer, "There is no question about it. We have acquired P.D.Q. and we are working together and have been since Jan. 1."

Many independent druggists in Des Moines and throughout the state reportedly have severely limited their purchases from Iowa and Des Moines Drug Companies, contending that entry of Woodland Corp. into the retail drug business as well as the wholesale drug business would give doctors too much financial interest in the sale of drugs.

Senator Hart's bill also would prohibit doctors from owning and operating drug repackaging firms.

[Reprinted with Permission from F-D-C Reports, "The Pink Sheet", May 4, 1970]

**DRUGGISTS BOYCOTT OF DES MOINES WHOLESALE DRUG LEADS TO BANKRUPTCY;
FATE OF PDQ RETAIL DRUG FRANCHISING OPERATIONS LIES WITH TRUSTEES**

A partial boycott of Des Moines Drug Co. by "large numbers of its regular retail drugstore customers," was a major factor in the 73-year-old, full-line wholesale drug firm's recent filing under Chapter 11 of the bankruptcy act.

The move had been expected since early this year when parent corp. Woodland Drug Holding Co. announced that unless it could find a buyer soon, Des Moines Wholesale would be "incapable of continuing in business more than a short time."

Woodland said the "sudden refusal" by these customers to purchase from Des Moines Drug, "or the lessening of such purchases," was brought on by extensive newspaper publicity about Woodland's MD ownership and Des Moines Wholesale's "working relationship" with PDQ of America, a retail drug franchise business which Woodland took effective control of in mid-1969.

Following the publicity, sales of Des Moines Drug—an NWDA member—declined from \$750,000 per month (\$9 mil. annually) to as low as \$200,000 per month, Woodland said. When Woodland bought the wholesaler in Nov. 1966, it was the largest independent drug wholesaler in Iowa, with sales in the \$5 million range. Iowa pharmacy leaders said disenchantment with Des Moines Drug stemmed equally from the firm's cutback both in products and services following its purchase by Woodland.

**IOWA WHOLESALE DRUG, DEFUNCT AFTER 42 YEARS IN BUSINESS, TWO WITH
WOODLAND**

Woodland Drug Holding—also now in bankruptcy—is a 92.5% owned subsidiary of Woodland Corp., a large MD-controlled holding company with interests in real estate development, banks, franchised Holiday Inns and movie houses. The MD control of Woodland Corp. was the spark which touched off the publicity, which in turn prompted an investigation by Sen. Hart's (D-Mich.) antitrust subcommittee.

"Repeated newspaper and TV publicity and Congressional activity," which challenged the "ethics and proprietary" of the MD control—"allegedly allowing physicians to profit indirectly from the wholesale and retail distribution of Rx drugs"—was a major contributing factor to Des Moines Drug's financial plight, Woodland said.

Woodland Corp. said it has been attempting for over a year to sell its interest in Woodland Drug Holding—or presumably any of its subsidiaries individually. Besides Des Moines Drug, the holding company controls by various means:

Iowa Wholesale Drug—Now-defunct Des Moines wholesaler, 87%-owned by Woodland since October 1967. According to Woodland, Iowa Wholesale was facing immediate bankruptcy when it bought the firm, and had been offered for sale repeatedly. Woodland's efforts to revive Iowa Wholesale were described as "too little and too late" and its operations were shut down in the summer of 1969. The company is "beyond rehabilitation" and "should be liquidated," Woodland said.

Iowa Wholesale, formed in 1928, had sales ranging from \$3.5 million to \$4.7 million annually over a ten-year period up to 1965, with small profits and losses. In 1966 it lost \$192,804 and has continued to lose money ever since, according to Woodland, which blamed the firm's problems "in general" on "the market effect of changes in the independent drug wholesale field, as well as lax management practices." The firm had been controlled by the F. W. Fitch family.

Capitol City Wholesale Drug—Mail-order discount wholesaler, serving a five state area, formed by Woodland in April 1968. Sales in the first partial year were under \$200,000 and expanded to about \$2 million in the fiscal year to July 31, 1969. Capitol employees fill orders at night from Des Moines Drug's inventory. It could not be sold or operated apart from Des Moines and therefore is "subject to the same adverse financial influences," Woodland said.

Standard Medical & Surgical Supply—65-year-old Des Moines distributor of medical and surgical supplies and equipment, also now in bankruptcy. Woodland gained control of Standard through a complicated series of financial transactions in 1967 and 1968 involving two holding companies owned by Woodland Corporations Chairman John Gustafson.

Woodland said that through the FY ended April 30, 1965, Standard experienced "modest but steady net profits from operations and a gradually expanding sales volume." However, in each of the subsequent years it lost money on declining sales.

Among the reasons for Standard's problems are the write-off of about \$64,000 in FY 1966 of an investment in a wholly-owned subsidiary, which became insolvent, and installment payments on judgments against it of about \$63,000 from two lawsuits, Woodland said.

PDQ of America—A drug store franchise operation which admitted four Woodland execs to its eight-man board in 1969 after it was unable to pay Des Moines and Iowa Whsle. for merchandise provided during PDQ's 1968 formation. Extent of the debt is highlighted by a now-cancelled agreement which would have given Woodland a 67% equity interest in PDQ as partial settlement.

WOODLAND VIVIDLY DESCRIBES DEMISE OF DES MOINES DRUG FOLLOWING MERGER

PDQ was formed to develop and sell a franchised program for independent druggists. Its first—and still the only—franchisee was Drug Mart Inc., a group of six formerly independent drug stores that united in 1968.

Drug Mart also is heavily in debt to Des Moines Drug for merchandise acquired in 1968. Woodland's equity interest in Drug Mart would have been 75% under the proposed settlement.

Early this year Drug Mart operated 13 PDQ franchise stores, nine in Des Moines, one each in Waterloo and Fort Dodge, Iowa; Lincoln, Neb., and St. Joseph, Mo. PDQ also operated an outlet under its name in Colorado Springs, Colo. It is understood, however, that a number of these outlets since have been closed, including those in Waterloo and Fort Dodge.

In June 1969, PDQ hired Franchises Internatl. (F-I) to establish a nationwide marketing program for PDQ franchises, but marketing plans never got off the ground because PDQ could not meet certain financial requirements or hire the necessary people. PDQ has paid F-I \$50,000 and is required to issue to it 58,275 (7½%) of its stock.

Attempts were made to convert PDQ's debt to equity via a program recommended by F-1, in an effort to qualify PDQ for a Small Business Administration loan, and thus allow F-1 to go ahead with its marketing plans. Such action ended when Woodland Drug Holding filed bankruptcy, and the fate of PDQ now rests largely in the hands of Woodland's receivers.

Woodland's own description of Des Moines Drug's demise reads like the "Problem" section of a business school case study. Woodland said that prior to its acquisition, Des Moines Wholesale "had been managed conservatively by

the same management for many years. It has been continuously profitable, although the return on its capital investment was modest."

Following the purchase "it continued under the same active management for about a year. Eventually, the then president and a number of other management personnel left or were discharged. Continuous problems of maintaining and controlling inventory were experienced," Woodland said.

"Heavy interest charges were required to meet purchase money indebtedness. Gradually sales declined, margins worsened, and operating expenses increased. Large amounts of inventory were found to be unsaleable or excessive and were disposed of in bulk at distress prices or were written down in value on the books," Woodland added.

"Credit was extended without sufficient controls with substantial bad debt experiences. Working capital, the essence of a whsle. operation, became depleted. Maximum loans were obtained, but were still not sufficient," Woodland continued. In the fiscal years ended July 31, 1968 and 1969 and subsequent interim period, Des Moines Drug sustained "large operating losses."

Besides the publicity regarding Woodland's MD ownership and Des Moines Drug's ties with PDQ, Woodland blamed the whsler's problems on "the general decline in numbers and financial health of the independent retail pharmacies which are the firm's principal customers," and "increasing competition of discount stores and natl. and local chain drug outlets."

Woodland said that because of Des Moines Drug's deteriorated credit standing, most suppliers now demand cash with orders, adding that the company can no longer supply many items typically ordered from a whsle. drug company.

EX-WOODLAND PRESIDENT LOUIS MULLER'S REORGANIZATION EFFORT FAILED

J. W. Ederly, 101-year-old full-line wholesaler headquartered in Ottumwa, Iowa, has been the principal force moving into the Des Moines market to fill the void being left by Des Moines Drug. In May 1968 Ederly bought the inventory of Cramer Drug in Des Moines.

Cramer was doing about \$465,000 a year volume at that time. Ederly's big push came last fall, however, when it opened a branch in Adel, right outside Des Moines.

Drug wholesalers outside the Des Moines area also have begun filling orders in the city—including McKesson, which has houses in Burlington, Cedar Rapids and Sioux City, Morphy Drug in Council Bluffs and Torbert Drug in Dubuque.

Rumors have been circulating that Chicago-based wholesaler Louis Zahn is eyeing the Des Moines market, but insiders say that if the company hasn't moved by now it probably won't. Zahn had planned in January to buy Des Moines Drug, but decided against the move.

Woodland Drug Holding's former President Louis Muller had attempted to organize a group of the company's employees and other investors to buy the operation, but this too fell through as a result of the bankruptcy proceeding.

Muller had indicated that he was not interested in the PDQ operation. "The doctors took a beating on this," Muller was quoted as telling the Des Moines Tribune. "Otherwise the employees could never have come up with the money" to buy the firm.

Muller had been president of Woodland Drug Holding—and all its subsidiaries—since the fall of 1967. For one year before that he was sales manager for Abco Dealers Inc., a NY co-op group of mfrs.' representatives for surgical supply companies. From 1964 to 1966 he was a sales manager with J&J.

GILPIN SET TO LAUNCH STORE-LEVEL COMPUTER ORDERING SYSTEM FOR RETAIL AND HOSPITAL CUSTOMERS; TERMINALS ALSO WILL HANDLE THIRD-PARTY CLAIMS

DC-based wholesaler Henry Gilpin is on the brink of launching a fully computerized Rx ordering system designed to speed deliveries, cut pharmacists' paperwork and electronically transmit third-party Rx claims for processing. Gilpin has been quietly working the bugs out of the system in a one-pharmacy test since December, and is expected to expand operations to several other sites in a few weeks.

The system, called Rx-Econ, provides a direct hook-up between pharmacies and Gilpin's central computers via in-store electronic ordering terminals. The terminals, small enough to fit on a counter-top, are geared to virtually eliminate ordering paperwork and speed deliveries to one day.

Other wholesalers, notably McKesson & Robbins through its Economist program, have also been developing computer links with pharmacies, but Gilpin's

system is believed to be the first effort to provide all customers with store-level terminals.

Gilpin forecasts "a fairly good size" Rx-Econ system in operation with six to 12 months, depending on the availability of low-cost terminals. Terminals compatible with the system now rent for about \$140 per month, but the wholesaler expects rates to drop to \$50 soon. Pharmacies using Rx-Econ will be charged a yet-unannounced fee based on terminal use and the amount of central services provided.

The wholesaler will offer Rx-Econ to all of its customers, retailers and hospitals as well as its Sentry pharmacy franchises. In addition to handling orders, the system provides a basic facility which eventually will be expanded to offer pharmacies electronic accounting services such as computerized family record systems, instant drug interaction data and centralized charge account record-keeping, Gilpin said.

START-UP COSTS OF SENTRY AND CARE FRANCHISE PROGRAMS HURT GILPIN'S PROFITS

Rx-Econ is programmed to accept only Rx orders, but could be broadened to include proprietaries and front-end merchandise as well, company officials said. Gilpin handles housewares, toys, notions and other sundries through its recently-acquired Point-of-Purchase rack-jobber subsidiary.

The advantages of computerized ordering, however, may be overshadowed by the system's potential applications in the third-party area. Using Rx-Econ, pharmacies will transmit claim data daily to Gilpin via the terminals, eliminating the need for claim forms except for store-level record-keeping. Gilpin then will channel this data, already translated into computer "language," to third parties for fast reimbursement.

The wholesaler installed new IBM 1130 computers in each of its four wholesale drug divisions last year, a move which contributed to Gilpin's depressed 1969 earnings. Net dropped 28% from \$278,000 in 1968 to \$200,000 in 1969. Sales increased 4.4% to \$33.5 million, from \$32.1 million in 1968.

Other factors adversely affecting 1969 profits were higher interest rates and operating expenses, lower gross profit margins, start-up costs of Gilpin's Sentry and Care drug store franchise systems and expenses incurred due to acquisitions. The company said its Chem-O-Seal institutional housekeeping service business was "unprofitable in terms of the time and management talent required for its administration," and announced plans to dispose of the two-year-old subsidiary. Gilpin's wholly-owned McKenna Surgical Supply subsidiary, however, is "progressing profitably" with over 80% of its volume stemming from sales to hospitals, the company said. Gilpin's acquired the \$1.5 million-sales Va.-based supplier in Jan. 1969.

OPINIONS AND REPORTS OF THE JUDICIAL COUNCIL

(Prepared and approved by the Judicial Council of the American Medical Association)

41. *Physician ownership of drugstores, drug repackaging houses and pharmaceutical companies and dispensing of glasses by physicians*

Section 7 of the Principles of Medical Ethics provides: "Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient." Under this language it cannot be considered unethical for a physician to own or operate a pharmacy provided there is no exploitation of his patient.

It is unethical for a physician to have a financial interest in a drug repackaging company.

It is unethical for a physician to own stock in a pharmaceutical company which he can control or does control while actively engaged in the practice of medicine. These practices are contrary to the best interest of the public and the medical profession.

The Council calls the attention of the House to the following statement concerning the meaning of the words "drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient" which was adopted by the Council on June 26, 1958.

It is the opinion of the Judicial Council that this language was adopted to permit both the practicing physician and the local medical societies to evaluate the many factual situations incident to prescribing and dispensing which are bound to arise in the practice of medicine. Under this language the doctor is

permitted to exercise his own best judgment when caring for his patients. It is known that there will be situations when it is necessary or desirable for a physician to dispense or supply what he has prescribed. The Principles permit this to be done. On the other hand, this broad language provides a means by which a component medical society can inquire into the facts of a particular practice. The profession thus can act to prevent abuse of discretion and protect patients from exploitation. In essence this language means that a physician in the exercise of sound discretion may dispense "in the best interest of his patient"; it does not authorize him to dispense solely for his convenience or for the purpose of supplementing his income.

48. Dispensing drugs

Although there are circumstances in which physicians may ethically engage in the dispensing of drugs, the American Medical Association nevertheless urges physicians to avoid the regular dispensing and the retail sale of drugs to patients wherever the drug needs of patients can be met adequately by local ethical pharmacies.

49. Definition of a drug repackaging company

The term "repackaging company" as used by the Judicial Council and approved by the House of Delegates refers to a drug company which markets under its own label or trade names drug products manufactured by others with the objective that physicians having a financial interest in the drug company will prescribe its drugs to the patient.

CLARION, IOWA, August 20, 1969.

HON. HAROLD HUGHES,
Senate Office Building,
Washington, D.C.

SENATOR HUGHES: Although on numerous other occasions I have wanted to write my Senators I never have. However today I have received information which compels me to write regarding Senate File 1575 which refers to the dispensing of drugs by doctors.

In Clarion we are in a hot bed for dispensing doctors and it has afforded me many insights into the drawbacks of same. I have had some suspicions of some of the doctors billing their patients for "consultation" when either they call or I call about a refill of medication for prescriptions on file at my store. This has been confirmed in 2 conversations today. This \$3.00 fee for "consultation" is quite unjust to the elderly living on retirement funds.

The A.M.A. and doctors hold that their ethical regard for their patients well-being, both physical and financial, dictates their dispensing. I challenge this because I have been able to ascertain that they are charging much more for drugs than they can be purchased for at the local drug store. This pertains to both legend drugs and O.T.C. drugs. Some examples are as follows:

	Doctor price	Drugstore price
50 Equanil, 400 mg.....	\$6.00	\$5.00
50 Diuril, 500 mg.....	5.10	4.55
50 Orinase.....	5.50	5.25
20 Ovulen, 1 mg.....	2.50	2.00
12 oz. Kolantyl Gel.....	2.00	1.83
12 oz. Maalox.....	2.00	1.43

Last fall I had a conference with the doctors about various things and one of them was when they might consider the cessation of dispensing. Their answer was that they could foresee that in the next 5 years either the A.M.A. or the government would legislate them out of it but until then it was more than taking care of their overhead. Is this the answer of men dedicated to saving of men's lives or of a mercenary who practices medicine as a side line?

We also should consider the availability of drugs. Although the local doctors use numerous drugs that there can be no question about the integrity of the manufacturer there are some drugs which would have to be questioned in this manner. Also the variety of dosage forms of drugs is quite limited in the doctors' offices since, as they say, they don't wish to have too much money tied up, they are obviously not using all drugs that could aid the patient and are available at the local drug store.

As you are aware the laws are quite definitive regarding the dispensing of legend drugs. It states that the only persons who can legally do so are doctors and pharmacists. I know, because I have seen them do so, that nurses and office girls dispense medications locally. Here again when the doctors are questioned they fall back on the theory of a doctor doing no wrong.

While the foregoing may sound somewhat like a case of sour apples I am firmly convinced that given the opportunity to serve the public in my capacity as a pharmacist I can do so both at a lower cost to the patient and provide them with a better selection of drugs. For this I ask your favorable consideration of S. F. 1575.

Respectfully,

RICHARD LANDESS, R. PH.

[From the American Medical News, June 1, 1970]

DRUG SUBSTITUTION

WHITTIER, CALIF.

Your issue of April 27, 1970, states that the American Pharmaceutical Assn. is seeking repeal for so-called "anti-substitution drug law." . . .

An excellent case in point on this currently is the patient with an allergic reaction to paraben preservatives in ointment bases. These were and are present in almost all steroid cremes with the exception of Hytone (Dermik) Hydrocortisone. These are traces of merthiolate or other mercurial preservatives in a good many bases, which would be equally harmful to someone allergic to mercury. At any rate, the physician who knew the patient was allergic to parabens and who wrote a prescription for Hytone would not be well served, nor would the patient if pharmacists "reasserted their professional prerogatives" and substituted a different hydrocortisone creme, containing parabens in the base.

If these anti-substitution laws are repealed, there will be "sweetheart" pharmacists, where the doctor will have an unwritten agreement that no substitution will be done and he will refer the patient to this particular pharmacy. Another alternative which will be exercised by many physicians is increased dispensing. Since any physician can buy prednisone and tetracycline for \$1.30 a hundred and since these cost the patient a minimum of \$10.00 a hundred on prescription, the margin for "doing well by doing good" is fairly wide.

MURRAY C. ZIMMERMAN, M.D.

Senator Moss. Dr. Robert L. Brent, chairman of the Department of Pediatrics, and chairman of the Stein Research Center at the Jefferson Medical College of Philadelphia, Pa. Dr. Brent, we will be glad to have you before the committee, sir.

STATEMENT OF DR. ROBERT L. BRENT, PROFESSOR, RADIOLOGY AND PEDIATRICS, DIRECTOR, STEIN RESEARCH CENTER, THE JEFFERSON MEDICAL COLLEGE OF PHILADELPHIA, PHILADELPHIA, PA.

Dr. BRENT. Thank you very much, Senator Moss. I welcome the opportunity to appear before the committee, and I want to extend my appreciation to you and your staff.

Senator Moss. Well, we certainly appreciate your coming to appear before us, Dr. Brent. We look forward to hearing your testimony.

Dr. BRENT. I have a relatively brief statement which I would like to read.

Senator Moss. Very good.

Dr. BRENT. And might I also comment about some of the previous testimony—is that appropriate?

Senator Moss. That would be perfectly acceptable.

Dr. BRENT. The provisions of this bill are consistent with the ethical standards expected from every medical practitioner in the

dispensing of drugs and in his relationship to the pharmaceutical industry.

Some might question the need for this legislation since one would hope that no medical practitioner would ever place himself in the position of directing patients to utilize services or purchase commodities in which the practitioner has a financial interest.

Yet, I welcome the concept of this bill because as a law it says in print what we expect to be true in the practice of medicine, and by innuendo, in other areas of professional and business life. Simply stated, we do not establish relationships, procedures, or practices, either consciously or unconsciously, which will clearly place in conflict the standards of one's profession and culture against pure personal gain.

This bill simply reiterates this concept in one small area, supports the practices of most medical practitioners, and will stand as a warning to those who fail to meet these standards.

I would now like to comment on the bill specifically and indicate:

- (1) where it might be expanded,
- (2) whether it will serve its purpose, namely, reduce the cost of pharmaceuticals to the patient;
- (3) whether it might have some detrimental effects.

If the committee has as one of its goals a reduction in the cost of medical care then I believe that the provisions of the bill should be expanded to include, as mentioned in the bill:

"(1) All medical practitioners unless they are in a geographic area where the pharmaceutical, commodity or service is not available"—and this is mentioned in the asterisk at the bottom—"exception to line 15-17, page 2."

(2) Restriction of the percent-ownership of publicly offered companies—"exception to line 1-5, page 5."

I believe that the bill mentions that if the company stock is offered publicly this would exempt the physician from being covered by the bill, and I feel it should also mention the percentage of the ownership in the publicly offered company, because a small company could be offered with a physician having major ownership, and therefore I suggest that the bill should restrict ownership to less than 1 percent ownership or some similar small figure.

Furthermore, there are several other medical businesses that should be legally incompatible with the primary role of a medical practitioner. I think from the standpoint of the cost of the savings to the country, these areas are much more important, and would actually elevate the level of medical care more significantly than the points mentioned in the bill already. I would restrict partial or sole ownership in (1) laboratory services; (2) hospitals; and (3) nursing homes.

Having a financial interest in these areas of the health care industry places the medical practitioner under an unfair burden of having to consciously or unconsciously choose between the patient's welfare and his own income.

How can a medical practitioner admit a patient to a nursing home or a hospital that he partially owns without being aware of the fact that a higher occupancy directly affects his income? How can a medical practitioner decide rationally on the number of laboratory tests his patient needs, if he has a direct financial interest in that laboratory business?

Even more important, physicians who have multiple financial interests in the health care industry are going to be less willing and less able to change it.

Actually, the physicians should be leading the way. This leadership would be more readily forthcoming if the physician's allegiance to the health care industry was dependent solely on the efficiency and quality of the delivery of health care.

Will this bill, in its present form, if enacted, reduce the cost of drugs and medical commodities? I think it might make a small dent in the total drug bill of this country. Because although you hear a lot of anecdotes about the improper dispensing of drugs, and the number of physicians that own pharmacies or dispense drugs, I think the members of the American Pharmaceutical Association and the committee would recognize that these instances involve a small percentage of physicians, and therefore the savings that would occur is not in the area of hundreds of millions of dollars, as are the savings that could be generated by improvements in other areas of the health care system.

I believe there are other reasons for the present level of drug costs of this country. This bill will not prevent the overutilization of medications by the medical practitioner and the demand for medication by the patient. I would estimate that 75 percent of all the antibiotics used in this country are unnecessarily prescribed, and that in many instances vitamins and medications used for symptomatic treatment are not indicated at all. There are several antibiotics that are used routinely in this country that our pediatric department rarely uses because they are minimally effective or not indicated. There are medical, scientific groups now working on this problem, and hopefully information will be developed that can be utilized by the public, the medical professions, and the FDA to decrease the use of unnecessary drugs.

I do not want this statement to be interpreted as an indictment of the pharmaceutical industry, for it's their job to develop new and useful drugs and they have performed well in their role.

It is the FDA's and the medical profession's job to approve and utilize drugs that are effective and use them only when they are necessary.

I might expand upon the phenomenon in the United States of the demand for drugs by the public, especially in the middle and upper classes; it is not uncommon that a drug is prescribed due to the fact that the patient expects it and most physicians are unable to resist this pressure.

Furthermore, there are numerous anecdotes that could be used to describe the overuse of antibiotics. When the physician diagnoses a virus infection and prescribes antibiotics, this is usually bad medicine and a waste of medicine. The figure of 75 percent of antibiotics is probably low since more than 95 percent of respiratory infections are viral.

Senator Moss. Isn't this partly due to the fact that everybody has been educated to the fact that there is a pill for everything? If you have a little discomfort, you take a pill and right away you feel a hundred percent?

Dr. BRENT. We have become a drug-oriented culture, and I don't know where the input has to go to reverse this, but I think television is partly at fault.

We have a tremendous number of ads on television—Preparation H—and most of these medications are innocuous and ineffective. There is a whole world of television medicine that has to be changed.

But there are other committees that are interested in television's effect on the population, but there is no question about the fact that television plays an important part in the overutilization of drugs in this country.

It is not one single groups fault. The physician is at fault, but the public also is at fault. It's part of our culture, and we have to be constructive and creative in trying to change the direction of our culture and not by attacking one person or one group. This is another problem.

My last point deals with the—in a sense I might put detrimental in quotes—the detrimental aspects of the bill, because as a physician, and one who is very dedicated to the principle of medicine and enjoys the practice of medicine, and one who is also at a medical school and knows the variation in qualities of the applicants to medical school, I am worried about the effect of this bill if it stands alone.

I think the bill is a good bill, and, in fact, I have suggested areas where this bill might broaden the areas where the medical practitioner should be separated by law from some of the business aspects of delivering health care.

I reiterate that this bill only echoes the ethical and moral standards that we expect of medical practitioners.

By the way, I don't think you need anecdotes to support this bill. If the American Pharmaceutical Association's presentation didn't have one anecdote, it wouldn't make any difference. When a bill reflects the ethical standards of a culture, anybody who is honest shouldn't be particularly against it, because when a bill says this the way we expect people to function, anybody who functions that way should welcome the legislation.

I am worried because so much attention is being given to the transgressions of a few in the medical profession and that similar legislation is not enacted for lawyers, congressmen, and businessmen who also have conflicts of interest between their professional, public, and personal activities.

I might point out that the medical profession has suffered through many image-tarnishing years. And much of the tarnish is well-deserved. The loss of image plus restrictive laws singling out the medical practitioner alone might have a detrimental effect on the quality of men who choose medicine as their profession.

Remember, that the quality of the applicants determines the quality of the doctors who take care of you. Remember that the physician's training period is the longest and most expensive. Remember there is no professional or nonprofessional group other than the physician that is subject to service in the Armed Forces until age 35, or that has anywhere near the percentage of its ranks having served under some form of conscription in the Armed Forces. Let me say that these are not attractive aspects of the medical profession.

Remember that 10 years ago, when engineering, physics and space were attracting our best students, there were many medical schools that could not find qualified students to fill their classes. I was speaking to a dean in Philadelphia who reminded me that 10 years ago, in August, they were 30 students short of filling the class. He worked the

whole Labor Day weekend calling students they had thought unqualified to ask them to come and fill the class. This is past history, and it is possible that history may repeat itself. The change in priorities and the Vietnamese war has changed this situation dramatically, namely the number of qualified applicants that apply to medical school, but it could change again.

In summary, I would point out that there are many other methods of reducing the cost of medical care and pharmaceuticals and have so testified before Senator Hart's Subcommittee on Antitrust and Monopoly on May 19, 1970. Again, I state that I support this bill and recommend certain extensions.

Furthermore, I endorse the clear implication of the high ethical standard that this bill reflects. In order that the bill, 1575, which might be labeled the hypocritic bill, not be labeled by some as the hypocritic bill, I would suggest that legislation be enacted to reflect these same high ethical standards with the aim toward eliminating areas of conflict of interest that apply to lawyers, legislators, other professionals and businessmen.

Thank you.

Senator Moss. Thank you very much, Dr. Brent, for your good testimony. I, of course, would agree with you heartily that the same standards of eliminating conflicts of interest and being in a position where one, through his professional activities, can gain or be in a position, anyway, to have personal gain from a sideline such as we are talking about here in the medical profession, ought to be applied to any profession, all the way across.

I don't know that it's practicable to insert, in this bill dealing with this specific problem, lawyers and congressmen and professionals and others in there. But the principle is certainly valid.

Dr. BRENT. That is why I support the bill, because I feel that if you expect individuals to attain this level of standards, it isn't long before the hypocrisy of other areas of our culture becomes well known, if not to the old at least to the young.

I might make some comments on the testimony of our previous representatives, because I think their testimony was good.

I think it was sound. I, for one, on the other hand, never am able to accept anecdotes because they give me no denominator on the instances, and they know perfectly well that when you deliver testimony like that, you create the aura that one profession lacks ethical standards and the others are angels. And we know that people who become doctors come from the United States of America, they reflect a cross section of the people of the United States of America, they reflect the ethical standards of those people. If we have cheats and crooks and disreputables in the medical profession, it only means that we have those same types as plumbers, and pharmacists, and lawyers. There is no reason why a special breed of people go into medicine. In fact, if you could document it, you would find that the ethical standards are a little bit higher. But that's not important.

I don't think anecdotes are necessary to support this bill. I could give you 20 anecdotes on pharmacists and what they have done when I have sent patients with prescriptions. We send out a prescription for a cortizone ointment and the patient comes back and says the prescription ran out, and the pharmacist had given him a sample. That

doesn't damn the pharmaceutical profession because of one dishonest pharmacist, and it is not a cause for legislation.

But the principle of high standards, and that's what we want all people to attain is a basis for this legislation. In fact, the previous presentors bring up a good point with regard to the fact that samples are a problem, and should we allow samples to be distributed. Physicians get tremendous numbers of samples.

Physicians get samples and some sell them as pharmaceuticals, and so do some pharmacists get samples and sell them. I just wonder if this is something the committee ought to look into because one of the reasons why a physician could even think about making a profit is that he does get a substantial number of drugs free, and put that together with a little bit he buys from drug firms we might eliminate the beginnings of a business. This legislation could eliminate the business totally.

But they made a good point about the purchase of pharmaceuticals by physicians from these large—I guess you would call them jobbers—who will sell you drugs at low cost that you aren't certain about the quality of the drugs.

Senator Moss. I suppose those samples are sent out by proprietary drug companies hoping the physician, by handling out the samples, could carry on, and therefore prescribe them thereafter for his patients?

Dr. BRENT. I can be honest with you—being in a pediatric clinic, we depend on samples, but we give them away. There are many patients, because of State laws, who will get complete pharmaceutical support in a certain income group, and as soon as they go \$20 beyond that income group, they have to buy their own drugs. So that group of patients is in a tight spot, and we save them medication costs with samples.

Many physicians give away samples for nothing, but that is not a responsible way, and I am sure the APhA would rather see all patients go to the drugstore and if they can't afford it, they can get proper financial aid from insurance or government.

There are a lot of points that I made and that the APhA made that are peripheral to this legislation, but in order to make this legislation work these other suggestions might be implemented.

Senator Moss. That's a very good point. You indicated, of course, the feeling of physicians that perhaps they are being targeted by this bill. Do you have any estimates of how many of them generally would support the provisions of this bill and how many, perhaps out of resentment or for other reasons, would resist the bill?

Dr. BRENT. I think it would go by age and place. I can't imagine a physician at one of the 100 university medical centers in the United States even thinking about this bill one way or the other.

In fact, most of them would say, I don't understand what you need it for. Most good doctors are so busy reading and trying to be good doctors, they can't get involved in other businesses.

If you talk to the man who is doing it, it is easy to build up a defense mechanism—he's doing good, saving the patient a trip, all kinds of plusses.

But again, I don't like to go on percentages that we guess at, and anecdotes. The bill is good in principle and reflects the ethical standards we expect from the physician. It is impossible to learn all the

things in medicine. I myself stay out of any other businesses. One business is enough, and if medicine was a poorly paid profession, if I were starving and any other physician in the United States were starving, I could understand it, but the fact is that in this country the physician group, dentist group and the medical profession group is very fortunate. They do reasonably well financially, and there is no reason for them to be trying to earn extra money on the health care business. We should be trying to improve it.

Senator Moss. I particularly noted in your testimony that you pointed out the other health care services that also offer a conflict of interest situation, such as ownership in a laboratory or interest in a laboratory, and hospitals, and nursing homes.

Dr. BRENT. Well, the hospital is actually the most treacherous, because it puts the physician in a position he should never allow himself to get into. And I would say the most ethical, moral physician, having been put in the position where solvency is concerned (the hospital has a low occupancy, and the patient comes in and he has to decide wither to work that patient up as an out-patient or put him in the hospital) how can he legitimately make a rational decision at that instance? He can't. And furthermore, if we decided that hospitals should close and we can take care of patients in another fashion, how can he make a decision of closing a hospital he owns?

So if we are going to be innovative and creative in the health care industry, our (physicians) only interest should be in the delivery of health care, and not have an investment in bricks and mortar.

Senator Moss. Dr. Brent, I certainly appreciate your testimony. I think you have given us a very good insight into the view of the physicians and the profession, and I think what you have said is valid.

I think the vast majority of practicing medical doctors are so busy practicing they are not even aware of the kind of thing we are talking about, so we are talking about a rather small segment; but those certainly ought to be, some way or other, compelled to observe the rules of avoidance of conflict of interest.

Dr. BRENT. There are two other points—one is, I would be interested if the representatives from the American Pharmaceutical Association would comment on what type of pharmacist—since he is a registered pharmacist—goes into such an arrangement with the group of physicians as they described, and why haven't they ostracized that pharmacist. In other words, they expect the AMA to put controls on the doctors. I would ask them the same question, why do they support a pharmacist who goes into such an arrangement of paying \$40 a square foot? Is he still a member of their organization?

Secondly, with regard to conflict of interest, you haven't asked me about any other areas of conflict of interest which I think it could affect the medical industry directly.

We have two major areas that involve the health care industry, which involve specifically the legal profession, and these are tragic problems to me because many of our legislators are lawyers, could improve this problem very quickly.

Malpractice insurance will reach about \$500 million soon. And as you know, in malpractice insurance, about 70 to 80 percent of the cost, the premiums of malpractice insurance, go to the legal profession.

A very high percentage of the cost of malpractice insurance goes to the law firms for defending the case. So the fact is that patients in most instances get very little out of the final suit because the cost of litigation is so great.

This is a dramatic area where a tremendous drop in the cost of medical care could be effected. Physicians are paying fantastic fees in malpractice insurance, and on top of that, the patients are not getting the benefit of being paid for some of the things that happen to them.

It's exactly the same with automobile insurance, of which the biggest cost is medical care. About 80 to 90 percent of the premiums for automobile accidents—and the medical care involved—again goes to law firms and yet there are bills in the legislatures throughout the country trying to eliminate the middle man, the lawyer, so that the patient gets paid directly if he is injured.

And the fact is that there is more than enough money to pay the patient, whether the doctor was at fault or not, from that \$500 million, yet they go through years of litigation, the bulk of the money ends up in the hands of the legal profession, and the patient is not getting the money nor is the problem being solved.

So here is an area involving hundreds of millions of dollars, of malpractice insurance and I don't know what the cost of automobile insurance in which there is a major conflict of interest because legislators are sitting on their hands.

Senator Moss. I am glad to have you bring that up. Of course, we have that legislation before this committee. We have been already holding hearings and trying to determine whether there is a way to have insurance repayment situation, particularly in injuries from automobiles—although it does go into malpractice too—without going through the mechanics of finding out fault.

You see, the tort system under which we operate always relates back to who is at fault. You must find out who is at fault, and the one that is at fault has the obligation to pay. And this has become very complex, as you say, and very lucrative to those practitioners of the legal profession who are involved in it.

And, as you say, it's been estimated that we could restore everybody that has an injury or damage out of an accident out of just the premium funds, and never be concerned about this question of who is at fault, trying to put the blame on somebody.

Dr. BRENT. There is one other aspect to your point and that is the total cost of the medical care to the accident victim. Let's say a person is in an automobile accident. If there were two sides or three sides, he has to go to three doctors or four doctors because each insurance firm and each law firm wants to have their own examination. And furthermore, each—the plaintiff—I guess it would be the plaintiff—knows that the more times he goes to the doctor, the more debilitated he appears. Frequently he goes every week and loses wages from his income because he is not at work. And what happens is, in order to prove your point, you have to get five times as much medical care, and the whole thing spirals into a cost that is way out of proportion to the actual problem.

Senator Moss. Well, you have pointed to an area where certainly we have something equally serious, or maybe even more serious, than the problem we are talking about directly, which has to do with the

medical involvement with the dispensing of drugs. And I am glad to have you make this comment, because I feel strongly about that point too, and I hope we can move in that area.

Senator PEARSON. Dr. Brent, I will read your testimony. We had a conflict of committee meetings for me this morning. Let me ask you this question—it may have been covered.

Yesterday I inquired of a physician that was a part of a clinic, in group practice of medicine, whether or not there was any distinction to be made between the case of an individual physician owning an interest in a pharmacy, and the situation where there is a group practice in a clinic that owns a pharmacy as a part of their total group practice of medicine.

Do you see any distinction between those two?

Dr. BRENT. Only quantitatively, not qualitatively. As I mentioned before, I think if you just say to yourself, don't put yourself in the position of being able to be accused of a conflict of interest. Remember that the practice of medicine itself is a very rewarding profession, both financially and from the standpoint of intellectual stimulation. There is no need to own a pharmacy solo or in a group.

There is absolutely no reason to get involved in the dispensing of drugs in any manner or fashion, as was pointed out by the American Pharmaceutical Association. They have people who spend years in training, to learn to mix, store, package and dispense drugs. The physician is not prepared to do this.

Now the group practice-owned drugstore could possibly do it, but there is a conflict of interest there which is perfectly obvious, and there is no reason for it. Of what benefit is it to the patient?

Senator PEARSON. Do you see a valid exception? My State is Kansas. In the western part of our State they have a difficult time getting doctors. There's a conflict as to whether or not it is good to have some of our small county hospitals operate, and so forth.

But out in the high western plains of Kansas, or in the State of Utah, in the rural areas, do you see this as a sensible, feasible approach to offering medical care?

Dr. BRENT. You mean if the physician is way out in the rural area and there is no pharmacy around? I think that is a legitimate reason to dispense drugs. But somebody has to determine whether he knows how to dispense drugs. If he is in that situation, he has to meet the same standards as a pharmacist. He has to be instructed what the laws are, what bottles he has to stock, and the bill doesn't say that.

That is where I pointed out an exception to the bill. If there is a geographic limit, then the physician should be able to dispense or he should consult with the American Pharmaceutical Association. They may be able to decide if a pharmacist could be put in that specific area, if the area might be able to support a pharmacist. You need some interaction between the two to decide if this isn't or is enough business for the pharmacist to make a living in the area. Then, if not, the physician has to do the job, but somebody has to tell him how.

And we don't in medical school. We don't tell a doctor how to be a pharmacist in medical school.

Senator PEARSON. I am glad you touched on that in the statement.

Dr. BRENT. The bill does exempt some people that I don't understand—why ophthalmologists?

Senator Moss. It beats me. I don't know.

Dr. BRENT. Maybe I didn't read the bill correctly, but there is an exemption to a group of people there that I don't understand.

Senator MOSS. Yes. Exclusive of ophthalmologists, optometrists, dentists and veterinarians.

Dr. BRENT. Why ophthalmologists?

Senator MOSS. I can't answer offhand. I am glad it is in the record, and we will find out why that was put in there.

Dr. BRENT. Again, I can understand in a small town if there is nobody who can prescribe lenses, why a physician might also have a service for providing glasses. But in a city, he should be too busy to be involved in selling glasses.

Senator MOSS. I am glad you raised the point, Doctor, and I will have to have some justification for that.

Senator PEARSON. I have no further questions. Thank you.

Senator MOSS. Thank you, Dr. Brent. We appreciate it, sir.

Dr. BRENT. Thank you, Mr. Chairman.

Senator MOSS. Dr. Harry A. Horstman of the American Academy of Allergy will be our next witness. We are glad to have you with us, Dr. Horstman, and look forward to your testimony.

STATEMENT OF DR. HARRY A. HORSTMAN, AMERICAN ACADEMY OF ALLERGY, WASHINGTON, D.C.

Dr. HORSTMAN. Thank you, Mr. Chairman. I regret that the original material sent by the American Academy of Allergy contained an error which has now been corrected. We were seeking an exemption under section 5, where the original material said section 4. This has been corrected in the material which I put out.

Mr. Chairman, I am appearing on a strictly technical matter which I feel is extremely important. My name is Harry A. Horstman, Jr., M.D. I am a physician practicing allergy in Washington, D.C., and a fellow of the American Academy of Allergy. I am appearing before you at the request of Dr. Saul Malkiel, president, the executive committee, and the Medical Services Committee of the Academy, to present a statement relative to bill S. 1575.

The Academy is composed of over 1,900 members representing nationwide interest and expertise in research, teaching, and practice in the field of allergy and immunology.

Thus, allergenic extracts, as therapeutic materials, used in the treatment of patients with allergic diseases, are an integral part of the specific treatment and must be formulated and especially prepared for that particular patient. Such formulated and prepared treatment extract mixture may not be suitable for any other patient.

The concentration of especially formulated and prepared allergy treatment extract has to be varied from patient to patient, depending upon the degree of sensitivity of each case. And should have been added—also the dosage is varied frequently throughout the treatment year.

Systemic constitutional reactions, following injections of such extracts, may occur and may be serious. Such reactions would be more likely if each treatment extract mixture were not "personalized" for each patient in its formulation and preparation.

There is as yet no universal standardization of allergenic extracts, a fact which is giving concern to the Division of Biologic Standards and

the National Institute of Allergy and Infectious Diseases. Extracts of the same substance, supplied by different manufacturers, may vary appreciably in strength, and furthermore, different batches of extracts supplied by the same company may vary in clinical potency. This would preclude the compounding of therapeutic allergenic extracts by pharmacies, upon prescription.

In order to render the best medical care and offer the best clinical results of therapy, as well as to best avoid undesirable effects of ill-formulated and ill-prepared allergenic treatment extracts, the physician, in the practice of allergy, with the knowledge of the degree of sensitivity of the patient, must supervise the formulation and preparation of such treatment extracts for clinical use in the specific treatment of patients with allergic diseases.

It is urged, therefore, that allergenic extracts be made an exception in section 5 of the Hart bill, S-1575.

Senator MOSS. Thank you, Dr. Horstman. Now, an allergy is something—the treatment of something that breaks out the body—do I understand that, as a layman?

Dr. HORSTMAN. Allergenic extracts are used primarily in the treatment of severe hay fever and asthma. They are of relatively little value in other types of allergy, and of almost no value in dermatitis cases, or hives, which you may have implied.

Senator MOSS. I see. So this would be mostly hay fever and asthma that you would be dealing with?

Dr. HORSTMAN. This would cover at least 90 percent of the use of allergenic extracts.

Senator MOSS. Is it your testimony that a doctor—one who practices allergy—could not properly prepare a prescription that could be then filled by a practicing pharmacist, but that it ought to be really prepared in the office of the physician?

Dr. HORSTMAN. That is correct, sir.

Senator MOSS. Is this the common practice now? Is this generally done now?

Dr. HORSTMAN. This is the procedure by which allergenic extracts are prepared and dispensed. These may be given in the doctor's office, and this I believe would be preferable under all circumstances. However, there are many patients who require desensitization who cannot make weekly trips to see a doctor. I might use as an example, Duke University, which has a very large allergy section.

Duke gets its referrals from all over the State of North Carolina, and perhaps from many of the other States. A patient comes there and resides either in some sort of a motel or even in the hospital. He is evaluated and a program is then established which the patient returns with to his family doctor or referring physician.

From this point on, the contact with the allergist is by some form of communication, either phone or mail, to regulate the dosage and follow the progress of the patient.

Senator MOSS. Are these prescriptions—are they fluid or pills?

Dr. HORSTMAN. They are injection materials. Most of them are in solution. However, some of them are precipitates, and the type of vaccine or the type of extract which is chosen would depend upon a number of rather highly technical subjects.

Senator MOSS. Well, a practicing allergist then would have stocked in his office, a number of fluids and drugs out of which he would compound what he was to use for a particular patient?

Dr. HORSTMAN. That is correct, sir.

Senator MOSS. What I am trying to find is the distinction as to why it wouldn't be practical for the physician, in examining the patient, to write down what he thinks should be the combination and have the patient then get it filled and utilize that; then vary that prescription if it did seem to be tailored, as you indicate, to the specific problem of a given patient.

Dr. HORSTMAN. Mr. Chairman, I would like to explain that this is an extremely complex field. Each batch of material which I receive from a manufacturer, I evaluate its potency because, as my statement mentions, there is no standardization for these materials, and they vary from manufacturer to manufacturer and from batch to batch.

Therefore, I evaluate the potency of these materials on patients in whom I know the degree of sensitivity. I use my patients as a standardization for the materials that I then compound into extracts.

I might say, sir, that one would, from determining the degree of sensitivity, by history, by skin test, by physical examination, would decide approximately what dosage this patient might tolerate, where to start and to what level one might, over a period of several years, obtain a satisfactory result.

Having gone through this, a formula is set up, using material which only I understand the potency of. The patient follows a schedule, and this schedule includes a reduction in dosage at a certain time of year; provided that this were a grass case, at the beginning of the grass pollinating season, the dosage of this extract must be reduced appreciably or you will be subjecting the patient to an undue risk of having a serious systemic and possibly fatal reaction.

It would seem extremely difficult for a doctor-pharmacy-patient relationship to be established where such variables could be controlled.

Senator MOSS. Well now, in judging the potency, as you say, of the materials you receive, you do that by giving some dosage to a patient and observing the results? Or, how do you judge the potency?

Dr. HORSTMAN. I make multiple dilutions of the material and use the skin of a known patient to determine its potency.

Senator MOSS. I see. Section 5, subparagraph 2, of the bill provides an exception for the administration of a unit dose of a drug to the patient by or under the supervision of such medical practitioner. Isn't this enough of an exception to meet the situation you are talking about?

Dr. HORSTMAN. Well, this would help somewhat. However, it would extremely complicate the management of the patient as the dosages are frequently as low as one one-hundredth of a cubic centimeter. Now I don't know whether you realize how small a volume that is. But it is almost impossible to dispense one one-hundredth of a cubic centimeter in a sterile vial. Therefore I think that a special exemption is necessary for allergenic extracts.

I might say, sir, I am not sure that this would qualify as a drug, as defined. There was some question in my mind when I read the bill that perhaps these were not drugs in the sense that you were defining them, but they certainly are materials which are used in the desensitization of patients, and the treatment therefore of allergic diseases, and in view of this possibility, the Academy of Allergy felt that a special exemption was necessary.

Senator Moss. The testimony you have given us today is the position of the American Academy of Allergy?

Dr. HORSTMAN. Yes, sir; and I am sure there will be additional testimony from other groups which will include the section on allergy of the American Medical Association, and also the American College of Allergists, which is another national group.

Senator Moss. I am advised that we have a telegram from that group, and it will be included in our record.

Dr. HORSTMAN. Sir, if they mentioned section 4, I do wish that the correction will be made to section 5.

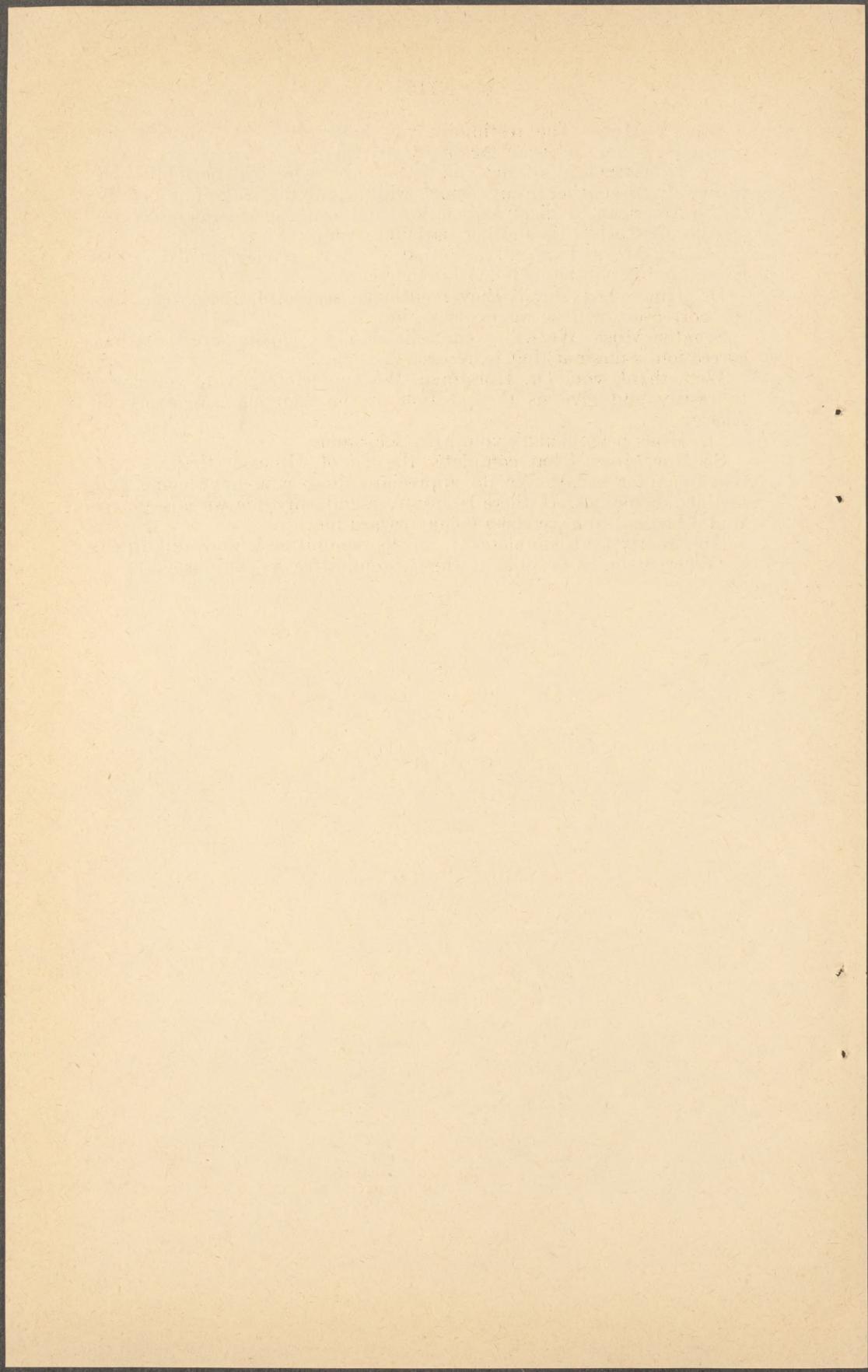
Senator Moss. We will examine it closely to make sure that that correction is made if that is necessary.

Well, thank you, Dr. Horstman. We appreciate having you come to testify and give us the position of the American Academy of Allergy.

Dr. HORSTMAN. Thank you, Mr. Chairman.

Senator Moss. That completes the list of witnesses that we had scheduled for today. We do appreciate those who have come and testified before us. If there is any oversight, any one we missed, we would be glad to have them come forward now.

Apparently that completes it. So the committee is now adjourned. (Whereupon, at 11:30 a.m., the subcommittee was adjourned.)



ADDITIONAL ARTICLES, LETTERS, AND STATEMENTS

[Voice of the Pharmacist vol. 2 No. 29, Apr. 29, 1959 (Supplement)]

IOWA PHYSICIAN-PHARMACIST CODE OF UNDERSTANDING

The purpose of this Code of Understanding is to improve relations between Doctors of Medicine and Pharmacists. Its provisions are intended as guides for physicians and pharmacists in their inter-related practices in the areas covered by it.

This Code of Understanding is not a pronouncement of law, but constitutes suggested rules of conduct for the members of these two health professions subject to the principles of ethics governing the members of the respective organizations and rules of law prescribed for their individual conduct.

This Code constitutes the recognition that Doctors of Medicine and Pharmacists are inter-dependent upon one another in serving the patient.

It is the hope of the parties who have participated in the development of this Code of Understanding that by an improved and closed relationship between the professions of medicine and pharmacy, that the public will be better served.

PHYSICIAN

According to the American Medical Association Code of Ethics "It is not unethical for a physician to prescribe or supply drugs, remedies or appliances as long as there is no exploitation of the patient."

The Iowa Medical Society is cognizant of this provision in medical ethics but believes drug dispensing by physicians should be discouraged if adequate pharmaceutical service is readily available.

Physicians are trained to diagnose and treat disease while pharmacists are trained to compound prescriptions on the precise orders of physicians. Physicians should recognize the specialized training of pharmacists and utilize their services whenever it serves the best interests of the patient. Each of these professions should be respected and their areas of training and practice acknowledged of the fullest extent possible. The free choice of pharmacists should be permitted on the same basis as free choice of physicians.

The physician has a responsibility to make clear to the patient that even though a specific drug may be expensive, it is the best therapeutic agent he feels can be administered in treating the condition of the patient. Physicians should not advise a patient as to the exact price of a prescription, anymore than a pharmacist should attempt to establish a fee for a physician's service.

A physician should cooperate with pharmacists, first, by specifying the number of times a prescription is to be refilled and second, by making himself available to the pharmacist to determine whether or not his original orders should be altered after the original number of refills have been obtained.

Physicians and pharmacists should work together as a team in seeing to it that a patient is properly medicated. Only through this teamwork is the patient properly served.

PHARMACIST

The pharmacist should never diagnose or prescribe even at the insistence of the patient but should refer those needing medical attention to a Doctor of Medicine of the patient's choice.

The sale of proprietary products and home remedies that have been released by the Federal Food and Drug Administration for over-the-counter sale which the patient may request for self-medication shall not be considered counter prescribing by the pharmacist.

In an emergency or preceding arrival of the physician, the pharmacist will render such first-aid treatment as is indicated by scientific knowledge and good judgement.

If there is any question in the pharmacist's mind regarding the ingredients of a prescription, possible error or safety of the drug, he should privately and tactfully

consult the physician before making changes and never discuss it with, or in the presence of, the patient.

There should be no substitution of ingredients by the pharmacist, and he should follow the prescriber's directions in the refilling of prescriptions.

If no refilling instructions are contained on the original prescription, the pharmacist will not, and according to law, can not, refill such prescriptions without the authority of the prescriber.

The pharmacist should never discuss the composition of a prescription or its therapeutic effects with the patient. When such questions arise he should diplomatically suggest the prescriber is the proper person with whom such matters should be discussed.

The pharmacist shall be responsible for providing a complete bank of drugs on which the physician may draw by prescription for the treatment of his patient and serve as a source of information on new drugs and their combinations in order that the physician's patient may have advantage of the latest pharmaceutical developments.

FDC REPORTS—"THE PINK SHEET"®

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Vol. 32, No. 13

March 30, 1970.

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* * *AMHO'S Worldwide Drug Sales Gain \$68 Mil.* to \$632 mil. Pharmaceuticals account for bulk of gain, rising 13% from \$380 mil. to \$429 mil. Proprietaries record 10% sales rise for second straight year, from \$185 mil. to \$203 mil. Anacin and Preparation H "hold leadership positions." Dristan makes gains. Domestic Rx sales advance 12% v. 15% rise overseas. U.S. proprietary sales increase is 8% v. 16% abroad. Profits match sales growth, rising 10.5% to \$127.1 mil. Foreign earnings jump 17.2% to \$27 mil.----- Page 9

* * *Rxs Written Generically Rise, but Brand-Name* products continue to be used by many pharmacists in filling large shares of "generic" Rxs, Gosselin data indicate. Tetracycline prescribed generically in 8.3 mil. Rxs in 1969, but 2.4 mil. are filled with products of brand-name mfr. Gosselin figures indicate \$3 bil. mfrs.-level Rx drug market for 1969. Generics represent 8.8% of 551 mil. new Rxs, up from 1968's 8.2%. Average charge for all new Rxs rises 4.3% to \$3.86, while average for generics jumps 7.5% to \$3.02. Special study in Iowa shows Medicaid Rxs may provide unique prescribing pattern----- Page 6

R&D expenditures, which Searle detailed for the first time, totaled \$18.1 mil. (1% of sales) in 1969, up 12.5% over \$16 mil. (just under 11%) in 1968. The (increase was due to higher spending on potential Rx and animal health products and multiphasic health testing, the company said. Cleared for marketing early this year was Ornitol—a treated reproduction-inhibiting whole kernel corn for "control of vagrant pigeons.")

Profits increased 6.1% to \$28.5 mil. (\$2.08), from \$27.4 mil. (\$1.96) in 1968, but profit margin dropped from 18.5% to 17.4%. The decline resulted from diversification efforts outside of the pharmaceutical field, start-up costs in Puerto Rico and in the United Kingdom, and the addition of exec and management personnel needed to manage a diversified operation, Searle said.

GOSELIN DATA ON TETRACYCLINE, AMPICILLIN, AND OTHER DRUGS SHOWS M.D.S ARE WRITING MORE GENERIC RXS BUT PHARMACISTS FILL THEM WITH BRANDS

Market research data on tetracycline, ampicillin, and four other major drugs indicate that the number of Rxs which M.D.s write generically is on the increase, but pharmacists continue to dispense brand-name products in filling a large share of the generic Rxs.

Tetracycline was prescribed generically in 8.3 mil. Rxs written in 1969, but only 5.9 mil. were filled with a generic. Brands were dispensed by pharmacists in filling 2.4 mil. of the generic Rxs (see table below).

Penicillin G was prescribed generically in 2.8 mil. Rxs, but only 1.2 mil. of them were filled with a generic.

These and other interesting figures were included in a March 19 presentation by R. A. Gosselin to the NYC Pharmaceutical Ad Club (PAC). Gosselin's Natl. Prescription Audit (NPA) provides a nationwide projection of figures on M.D. prescribing patterns, based on an actual count of Rxs in the files of a scientifically selected panel of retail pharmacies. Gosselin also provides mfrs. with the Natl. Hospital Survey, which measures the use of Rx drugs in medical institutions.

Gosselin's data indicated the U.S. Rx drug market for 1969 totaled \$3 bil. at the mfrs.' price level. Other market research figures may show a "somewhat" higher total, Gosselin noted, by including distribution channels in addition to the two main ones—retail pharmacies and hospitals.

No figures were presented by Gosselin to PAC on the use of generics in hospitals, where the volume of non-branded drugs has made greatest gains. Use of Rx drugs in both hospitals and retail pharmacies had "phenomenal growth" during the sixties, Gosselin told PAC. But Gosselin added that the proportional share of the total Rx drug dollar volume represented by each segment has "remained relatively constant" at 75% for retail pharmacies and 25% for hospitals.

The names of at least 80 suppliers of tetracycline registered regularly in the NPA for 1969, but Gosselin explained that six brands were "arbitrarily" selected as the "original" ones. Since only five companies were the original marketers of tetracycline in the U.S., Gosselin has either included a late-comer's brand in his six, or one of the five companies had two brands.

HOW M.D.'s WROTE AND PHARMACISTS DISPENSED Rxs FOR 6 MAJOR "GENERIC" IN 1969

[Based on R. A. Gosselin National Rx audit figures]

Product	New Rxs (millions, rounded)			How generically written Rxs were filled (millions)		Number of manufacturers' products used	
	Total written	Written by brand	Written generically	With branded product	With generic	Brand	Generic
Tetracycline.....	20.6	12.3	8.3	2.4	5.9	6	74
Ampicillin.....	13.9	10.8	3.1	3.1	-----	6	9
Penicillin G.....	8.6	5.8	2.8	1.6	1.2	4	50
Meprobamate.....	4.8	3.1	1.7	.2	1.5	2	71
Digoxin.....	3.2	1.5	1.7	1.0	.7	1	38
Thyroid.....	2.8	1.2	1.6	1.1	.5	3	15

One brand of digoxin accounted for 78.4% of the digoxin Rxs filled in 1969—2.5 mil. out of 3.2 mil. The 2.5 mil. total for this brand apparently included 1 mil. digoxin Rxs, written generically. In all, the names of 39 digoxin suppliers registered regularly in the 1969 NPA.

Ampicillin represents an unusual situation. Six brands accounted for virtually all—99.8%—of the 13.9 mil. Rxs written in 1969 for the leading semi-synthetic penicillin. But the names of 15 suppliers were registered, and nine of them apparently divided a market of about 60,000 Rxs.

Zenith, the first to market a generic ampicillin, started in March 1969 with bulk material from patent-free Italy. The NPA figures indicate that Zenith, if it sold any substantial amount of generic ampicillin in 1969, must have moved it through hospitals.

Beecham, owner of the basic ampicillin product patent, sued Zenith for infringement in May 1969, and the case is now going through various pretrial phases. The Justice Dept., in an apparent effort to open the \$85-mil.-plus U.S. ampicillin market to generics, has filed a civil antitrust suit on March 19 against Beecham and its primary U.S. licensee, Bristol Labs ("The Pink Sheet" March 23, page 20).

The number of new Rxs, written generically, has been increasing at a faster rate than the percentage gains recorded for all new Rxs. In 1969, generics had an 11.9% increase compared to 5.3% for new Rxs as a whole.

Even with a faster rate of increase, generic Rxs in 1969 still accounted for only 8.8% of the 551 mil. plus new Rxs written during the year. In 1968, the generic share of total new Rxs was 8.2%. In numbers, generics gained 5.1 mil. in 1959 to 48.4 mil. from 1968's 43.3 mil.

The Price Argument: Average Charge For Generic Rxs Increasing Faster

Generic Rxs for four major drugs in 1969 increased at a faster percentage rate than the 11.9% gain for all generic Rxs. For tetracycline, generic Rxs rose 23.9%—from 6.5 mil. Rxs in 1968 to 8.3 mil. in 1969; ampicillin had a 73.3% increase—from 1.8 mil. to 3.1 mil. generic Rxs. Prednisone generic Rxs were up 14.3% and digoxin gained 26.1%, according to Gosselin's data.

GOSELIN'S IOWA STUDY OF MEDICAID VERSUS NONMEDICAID NEW RX'S

	Medicaid (13.6 percent)		Nonmedicaid (86.4 percent)	
	Rank	Percent share	Rank	Percent share
Ataraxics.....	1	15.1	5	6.6
Cardiovascular preps.....	2	11.6	7	3.9
Sedatives and hypnotics.....	3	9.9	6	4.4
Analgesics.....	4	7.2	2	9.2
Antibiotics.....	5	7.2	1	23.6
Diuretics.....	6	6.7	10	2.7
Hormones.....	7	4.4	3	8.7
Cough and cold preps.....	8	3.7	4	8.6
Antispasmodics.....	9	3.5	-----	-----
Vitamins and nutrient s.....	10	3.4	-----	-----
Sulfonamides.....	-----	-----	8	3.3
Antiobesity preps.....	-----	-----	9	3.0
Total.....	-----	73.1	-----	74.0
All other.....	-----	26.9	-----	26.0

The importance of price as the major argument used by govt. and other promoters of generics may be diminishing in the face of Gosselin data showing that the average charge for dispensing a generic is increasing faster than the average for all new Rx's.

The average charge for all new Rx's rose from \$3.70 to \$3.86 in 1969—up 4.3%—but the average for all new generics went from \$2.81 to \$3.02, a 7.5% gain and the average for the "Top 10" generics—including tetracycline and the five other important drugs—increased 9.1% in 1969 from \$2.76 to \$3.01.

Even greater percentage and dollar increases in the average price of generic Rx's are evident when 1969 is compared with 1959. The average charge for all new Rx's rose only 22.5% from \$3.15 in 1959 to \$3.86 in 1969. This compares with a 26% increase in the general cost-of-living index during the 10-year period.

But the average price for all generic Rx's jumped 63.2% from \$1.85 in 1959 to \$3.02 in 1969, and the average for the "Top 10" generics went up 99.3% from \$1.51 in 1959 to \$3.01 in 1969.

Contributing to the big increases is a major change in the kind of drugs now in the generic group. Expiration of patents and other developments have placed important drugs in the generic category. Only five of the "Top 10" generics in 1959 were on the same list in 1969—phenobarbital, thyroid, penicillin G, paregoric, and nitroglycerin. The remaining five of the "Top 10" for 1969 are: tetracycline, ampicillin, prednisone, digoxin, and meprobamate. The "Top 10" account for over half of all the Rx's written generically.

Medicaid Rx's may provide a unique prescribing pattern, it was indicated in Gosselin data from a special study of Rx's dispensed in Iowa in 1968. Ataraxics (tranquilizers), with 15.1% of all Iowa Medicaid Rx's, topped the list of therapeutic categories in the govt. program. Antibiotics, which led non-Medicaid Rx's with 23.6% were ranked fifth in Medicaid dispensing at 7.2%.

In Iowa, 13.6% of all Rx's dispensed were through Medicaid, Gosselin noted, but early NPA data indicates a natl. figure of 10% as the Medicaid share of total Rx's dispensed. In some states, Gosselin said, the Medicaid percentage may be higher. Gosselin's NPA is now collecting, on a routine basis, nationwide data on Medicaid Rx's and on other Rx's dispensed under third-party programs, including Blue Cross and private insurance carriers, particularly those involved in handling the United Auto Workers contract. Cardiovascular products ranked as the Number Two therapeutic category in the Iowa Medicaid study; analgesics are Number Two in Iowa non-Medicaid Rx's.

AMHO'S WORLDWIDE DRUG SALES GAIN \$68 MILLION TO \$632 MILLION; U.S. RX VOLUME ACCOUNTS FOR \$31 MILLION OF INCREASE; DOMESTIC PROPRIETARIES FOR \$12 MILLION

AMHO's worldwide drug business jumped \$68 mil. (12%) in 1969 from about \$564 mil. to \$632 mil., increasing from 52% to 53% of the firm's \$1-bil.-plus total sales. Pharmaceuticals accounted for the bulk of the gain, rising from \$380 mil. to \$429 mil. Proprietarys recorded a 10% increase for the second straight year, from \$185 mil. to \$203 mil.

Growth was somewhat better outside the U.S., both in pharmaceuticals and proprietary. Domestic Rx sales advanced 12% from about \$262 mil. to \$293 mil. compared to a 15% increase overseas from \$118 mil. to \$136 mil. U.S. proprietary volume was up about 8% from \$148 mil. to \$160 mil. v. a 16% increase abroad from \$37 mil. to \$43 mil.

AMHO reports its divisional, foreign and domestic breakdown on the basis of gross sales. The figures reported above and in the accompanying table are computed by "The Pink Sheet" by applying to net sales the percentage each group contributed to gross.

Leading AMHO's pharmaceutical sales increase were Wyeth's Omnipen ampicillin, Ovril 1/2-mg. OC, the Tubex line of sterile, disposable, pre-filled needle-cartridge syringe units, and its Serax mid-range tranquilizer. Wyeth's Equagesic tranquilizer also had "appreciable sales gains," and its SMA infant formula "made good progress" aided by the new 32-ounce can of SMA Ready-to-Feed, introduced in April.

CALIFORNIA ATTORNEY GENERAL SAYS PHARMACISTS DON'T DISPENSE LOWEST-COST DRUGS FOR MEDI-CAL; ACQUISITION COST DEFINITION BRINGS CRITICISM OF RETAILERS AND FORMULARY

The Calif. attorney general has charged that many pharmacists are violating the Medi-Cal formulary's rule that "the pharmacist shall, in consultation with the prescriber, dispense the lowest-cost item he has in stock, including generic equivalent, which meets the medical needs of the recipient."

The 74-page report, covering all aspects of the Medi-Cal program, was accompanied by a four-page press release which helped it garner extensive lay-press coverage, including the Wall Street Journal and the New York Times.

The report listed some nine ways "in which pharmacies are engaging in activities which violate the laws and regs governing Medi-Cal." The charges ranged from outright fraud and kickbacks to situations, such as dispensing "excessive" Rx's, where the fault may lie with the MD, not the pharmacist. (See box on next page for text of the violations imputed to pharmacists.)

The criticism about failure to dispense the lowest-cost drug contended that "a brand name is always more expensive than the generic-name drug" and often "is as much as two or three times more expensive." It added that "in situations where an inexpensive generic drug could have been dispensed, the patient has been given an expensive brand-name drug."

COMPULSORY GENERIC PRESCRIBING ON GOVERNMENT PROGRAMS NOT FEASIBLE UNTIL CLINICAL EQUIVALENCY IS PROVEN, H-E-W REPORT MAY TELL WHITE HOUSE

Compulsory generic prescribing on all federal programs is not feasible until it can be demonstrated that generic equivalents actually provide the same therapeutic benefits, the H-E-W Dept. may tell the White House in its report on the costs of medical care.

If reflected in the final report, scheduled to go to President Johnson in a few weeks, this view will be in line with the thinking of FDA Com. Goddard, who arranged a trip for dept. officials to the military drug procurement center in Philadelphia last December ("The Pink Sheet" Jan. 2).

Purpose of the meeting was to learn how the military insures quality drugs for its personnel via a procurement program based largely on generics. Both Goddard and Public Health Service Surgeon General Dr. William Stewart are understood to be interested in getting appropriations to support studies of "clinical equivalence" by their agencies.

Drug prices have not made a major contribution to the increasing costs of medical care, the report might say, quoting Consumer Price Index statistics to show that MDs fees and hospital charges have shot upward.

A statement like this in a prestigious govt. report would support the case which the Pharmaceutical Mfrs. Assn. (PMA) has been preparing and documenting for months in anticipation of attacks on Capitol Hill during this session as part of the drive to enact generic drug legislation. The PMA case was unveiled to closed meetings of members held in NYC and Chicago last week, and was well received as a good start on a "professional job."

White House Report May Call For Competition At Pharmacy As Well As Manufacturing Level

H-E-W, however, may dull the thrust of its "good word" for the industry by pointing out that drug costs are higher than they would be if greater price competition existed, either at the manufacturing or retail pharmacy levels. The Kefauver investigation might be used as a reference to show the role of promotion costs in the prices of branded drugs.

Absence of an official or authoritative source of information for MDs on the effectiveness and safety of drugs, and the need for FDA to do something about this—another Goddard favorite project—also could be discussed in the White House report.

Even when generics are prescribed, the report may say, the pharmacist might not dispense a lower cost drug. Some drafts of the report are critical of the mark-up system in this regard.

While the White House report is being finished, memos also are circulating around the dept. among officials who have to deal directly and immediately with

drugs and their costs as part of on-going programs, such as Medicaid and the use of vendor systems in state welfare programs. Still other officials are preparing the dept.'s position on anticipated generic drug investigations and/or legislation on Capitol Hill.

For example, a Welfare Administration memo takes issue with the so-called Goddard view by recommending a study beamed at the enforcement program used by the military to get good generic drugs. Import as a study of clinical equivalency may be, the H-E-W official contends, this project should not be mixed up with efforts the dept. must make in the area of establishing policy on drug pricing. Included in suggestions is a study on the broad range of mfrs.' prices to various levels of the trade, and the effect of rebates offered by mfrs. to state welfare programs.

CHAINS' AVERAGE PRICE FOR GENERIC RX IS \$2.44 V. \$3.05 FOR INDEPENDENTS, GOSSELIN TELLS NACDS CONFERENCE; AVERAGE FOR ALL RXS IS \$3.38 V. \$3.86

The spread between average chain and independent pharmacy prices is greater for generic Rx's—\$2.44 v. \$3.05—than the average for all Rx's—\$3.38 v. \$3.86.—market researcher Raymond Gosselin told the NACDS Pharmaceutical Conference No. 3.

The study also showed that generic Rx dispensing, while on the increase since 1966, is still far below the proportionate level of the mid-1940's. Generics will account for 8.6% of the 1/4 bil. Rx's dispensed in 1969, Gosselin predicted, up from 6.4% of 1 bil. Rx's in 1966 and 7.1% of 500 mil. during 1956, but well under the 1946 level of 36% of 250 mil. Rx's.

Gosselin's presentation to NACDS represented the first time he has broken down his Natl. Rx Audit figures by size of operation, and the first time he has compared generic and all-Rx figures on a chain v. independent basis. His statistics are based on a survey of more than 1,000 pharmacies.

Generics accounted for a great proportion of Rx chains (11 or more units) than independents, but Gosselin warned against generalizing that the ratio of generics increases as chain size grows. Pharmacy operators with 4-10 units ranked lowest in generic dispensing (5.8%), followed by 2-3 store firms (7.4%), single outlet pharmacies (8.9%), and chains (9.3%).

Comparing new Rx's with refills by size of operation Gosselin said single stores have a 46.5% new-Rx rate, while the figure is 51.3% for 2-to-3-store firms, 49.6% for 4-to-10-unit operations and 50.1% for chains with 11 or more pharmacies.

Total Rx's Will Double in Next 10 Years With or Without Third-Party Programs

The total Rx market, Gosselin predicted, will double again within the next 10 years "with or without third-party programs." He questioned estimates made earlier in the conference by H-E-W's special asst. for pharmaceutical affairs, Dr. Mark Novitch, who said third-party plans would cover 60-to-70% of all Rx's by the mid-1970's.

Gosselin said he had no quarrel with the *number* of pre-paid Rx's being forecast, but he contended the future demand for non-third-party Rx's was being underestimated. "The third-party field hasn't been researched enough, especially by govt.," Gosselin declared.

Retail v. hospital Rx sales is another area riddled with misconceptions, Gosselin said. "Predictions that hospitals will take over the Rx drug business are almost as unfounded now as they were 10 years ago," he said. Between 1958 and 1968 the retail share of the Rx drug market has held even at 75%, and over the next 10 years "at best, hospitals may grow from 25% presently to 28% or 30%," he added.

Some 160 drug chain execs attended the Nov. 2-4 meeting in Chicago, which focused on third-party programs (see next story). Speakers on other subjects were Purdue pharmacy Dean Varro Tyler, and Bruce Bernstein, director, retail drug div., Roth-Young Personnel Services.

NACDS will hold its 1970 Pharmaceutical Conference at Williamsburg, Va., Sept. 9-12. Its Cosmetic Conference will be in NYC June 7-9, the Control & Methods Conference Nov. 3-6 in Dallas, and the assn.'s annual meeting April 12-16 in Bal Harbour, Fla.

GOSSELIN'S BREAKDOWN OF PRESCRIPTION MARKET

	1-store operations	2 to 3 stores	4 to 10 stores	11 or more stores
Number of prescriptions dispensed (millions).....	939	85	97	129
Percent of prescriptions dispensed.....	75.1	6.8	7.8	10.3
Average prescription price (brand name and generic).....	\$3.86	\$3.95	\$3.58	\$3.38
Average generic prescription.....	\$3.05	\$3.29	\$2.74	\$2.44

Professional Fee Boosts Rx Cost Only 2.1%, Virginia Blue Cross reported after a survey of 12 pharmacies in areas ranging in population from under 4,000 to over 500,000. The survey was conducted to determine the feasibility of replacing the acquisition-cost-plus-professional-fee reimbursement system with payment based on usual and customary charges. The Va. Blue Cross Rx prepayment plan now uses a \$1.85 fee.

The survey found that the average Rx price on the usual-and-customary basis is \$3.82—\$2.05 for the ingredients and \$1.77 markup. The average was 8¢ higher, \$3.90, when the \$1.85 fee was used. The study excluded OCs and o-t-c drugs. On the markup basis, the average charge ranged widely, with a high of \$4.61 in one pharmacy in a city of 500,000 to 599,999 persons. The low, \$3.40, was recorded in two pharmacies. One was in a town with 3,000 to 3,999 population, the other in a community of 10,000 to 14,999 persons.

[From the New York Times, Wednesday, June 10, 1970]

OFFICIAL SAYS MILLION GET PILL ILLEGALLY

(By Richard D. Lyons)

WASHINGTON, June 9.—The head of the Food and Drug Administration, Dr. Charles C. Edwards, estimated today that one million American women were obtaining birth control pills illegally.

Testifying before a House committee investigating F.D.A. affairs, Dr. Edwards said it was difficult to control such traffic and that precise figures of illegal oral contraceptive sales were unknown.

Privately, however, he said that his agency had received estimates that between 15 and 50 per cent of the 8.5 million American women getting the pills were doing so without prescriptions.

Dr. Edwards said he considered the 50 per cent estimate far too high and that the more correct figure was closer to the lowest estimate, which would mean about one million.

"We are certain that a tremendous number of women in the United States are getting their drugs through other channels [than prescriptions for themselves]," Dr. Edwards told the House Committee on Government Operations.

OVERUTILIZATION OF PRESCRIPTION

He cited one source of the illegal traffic as "overutilization of one prescription," explaining that some women receive prescriptions for an indefinite number of refills, some of which are given to women for whom they were not intended.

He said college campuses were areas in which illegal birth control pill traffic was high, but that it was almost impossible to stop it because "doctors couldn't conceivably ride herd on all the people taking oral contraceptives."

Representative L. H. Fountain, Democrat of North Carolina, the committee chairman, asked if prescriptions could be written limiting the number of refills. Dr. Edwards said that it was possible, but that doctors themselves were the "controlling factor."

The exchange took place during the first of three days of hearings called to inquire into the deficiencies of the F.D.A. Today's hearing focused on oral contraceptives and whether women were being adequately informed of potential hazards of birth control pills.

Dr. Edwards announced that starting tomorrow his agency would require that each package of oral contraceptives contain a 132-word leaflet warning the purchaser: "Do not take this drug without your doctor's continued supervision."

VARIETY OF SIDE EFFECTS

The leaflet states that the prescribing physician will, upon request, provide a more extensive written statement describing the variety of side effects, some of them fatal, that oral contraceptives can cause.

The two written statements are a compromise between what Dr. Edwards announced March 4 that the F.D.A. might require and what the American Medical Association, the drug industry and higher officials in the Department of Health, Education and Welfare wanted done.

On March 4, Dr. Edwards proposed that a 660-word leaflet giving specific details of side effects be included in each pill package.

Dr. Edwards and William Goodrich, assistant general counsel of H.E.W. for food and drugs, testified today that the original version was opposed by the American Medical Association, the American College of Obstetrics and Gynecology, the Pharmaceutical Manufacturers Association, four drug companies and four state medical societies.

The main argument against the longer version was that it was too complicated for the average woman to understand. Mr. Goodrich said the list of side effects in the shorter version was incomplete and that because of this a woman would be unable to make an accurate judgment as to her own condition.

Then followed a long series of questions from Congressmen and committee staff members as to why Dr. Edwards changed the leaflet that he had originally drafted.

DOCTORS' POSITION

Dr. Edwards said that "pressure was being exerted by the American Medical Association and the American College of Obstetricians and Gynecologists." These groups have taken the position that doctors, not women, are best qualified to determine if birth control pills are harmful to a particular woman and that the leaflet is an intrusion into the "sacred doctor-patient relationship."

Consumer and feminist organizations have contended that women have a right to know as much as possible about the drugs they are taking and thus the shorter version does not contain enough information.

Dr. Edwards would only state for the record that Dr. Roger O. Egeberg, the assistant secretary of H.E.W. for health and scientific affairs, and Robert H. Finch, who is vacating his post as H.E.W. Secretary, were "involved in" the revision.

Both Dr. Egeberg and Mr. Finch have stated that they ordered and approved the shorter version because they felt that most women either would not read or could not understand the longer version.

Dr. Edwards also announced that the F.D.A. would undertake a market survey by the end of the year to determine exactly what type of information about birth control pills was being received by American women.

Goddard's Comments on MD-Dispensing, made during Sen. Hart's diet-pill hearings, put him in the politically awkward position of indirectly opposing the Mich. Demo's bill to limit MD-dispensing. The FDA chief's Feb. 2 remarks were prompted by a question from Jerry Cohen, chief counsel to Hart's Antitrust Subemte. "Doesn't it make sense to say that MDs ought not to be allowed to dispense drugs from their own offices?" Cohen asked.

"I'm torn badly on such a question," Goddard said. "It becomes very difficult (to answer) when you look at the practice of medicine . . . There *is* appropriate dispensing by physicians. I would suggest that remedial action (against bad dispensing practices) could more appropriately be made by (state and local) medical societies, in concert with AMA, rather than by FDA."

Cohen then spoke of possible "conflicts of interest . . . when you give an MD license to act as a businessman . . . selling pills," and asked, "shouldn't we let the pharmacist be the businessman?" Goddard replied that he wished "it were that simple" and questioned if Cohen would "stop the physician from giving an injection?" Goddard recalled his own rural practice in which "I dispensed all the drugs and included (their) cost" in his fee of \$2 per office visit. "I feel that stronger actions are needed by the medical profession itself, but I would find it very difficult to draw the line," Goddard added. "I think this is a subject that the AMA can more properly discuss."

NARD DEMAND FOR GODDARD'S RESIGNATION WILL TEST ASSOCIATION'S POLITICAL STRENGTH; QUALIFICATION IN HIS COMMENT ON CLOSING DRUGSTORES IS OVERLOOKED IN PRESS

NARD's demand for FDA Com. Goddard's resignation, based on his off-the-cuff statement that the "corner drug store should be closed down," will provide a test of whether the organization of retail drug store owners still has the kind of political strength it enjoyed during the 1930s when it secured enactment of the Fair Trade laws.

First reaction from H-E-W's topline indicated that NARD still is respected as a political force, though it has not been able to demonstrate its strength in recent years. H-E-W- Undersecretary. Wilbur Cohen telegraphed NARD Exec Secty. Willard Simmons with assurances that neither the dept. nor FDA favors the closing of drug stores.

APhA Exec Director William Apple held his fire, explaining that he has asked Goddard for a clarification of his impromptu remark. Apple said he would comment after he had heard from Goddard.

Apparently the unusual series of events put Goddard in the middle of the intrapharmacy cross-fire between NARD and APhA.

Goddard concedes he was quoted correctly—but incompletely—in the lay press. But his controversy-provoking comment is understandable against the background of his views, previously expressed publicly and privately, that the march of medical science will change the way pharmacy is practiced. His views in this respect parallel those expressed by Apple on a number of occasions.

Goddard's off-the-cuff comment was made in a meeting with lay-press reporters before the delivery of a speech on drug efficacy before the American Assn. for the Advancement of Science Dec. 30 in NYC. His statement reflected Goddard's feeling that the pharmacist is rapidly emerging as a therapeutic advisor to both the doctor and the patient.

As the patterns of medical practice change to meet increasing demands from the public for the delivery of medical services, Goddard believes, more pharmacists will practice their profession in closer coordination with doctors, either in hospitals or offices. If this comes about, the focal point of pharmacy will move from the retail store to newer settings.

Goddard told the NYC press conference that "the corner drug store should be closed down, although I know that's a radical statement." He advocated instead that drugs be dispensed in medical centers and MDs' offices.

Goddard qualified his statement by predicting that any such development was 20 years away, but this was not reported in the lay press, nor reflected in the Natl. Assn. of Retail Druggists (NARD) demand that the FDA chief resign.

HEW UNDER SECRETARY COHEN'S TELEGRAM TO NARD EXECUTIVE SECRETARY WILLARD SIMMONS

This will confirm my telephone conversation with you in which I stated unequivocally that neither the dept. nor FDA favor or endorse any proposal for closing down drug stores now or in the future.

Blue Cross Rx Prepayment Covers MD-Dispensed Drugs as an option "if the customer demands it," James Goodman, Blue Cross manager of product development, said May 7. He told the American College of Apothecaries in Miami Beach that an MD covered by such an option would have to sign the same sort of participation agreement that a pharmacist does. Goodman commented that the MD-dispensing coverage is something he personally does not like.

At present, Goodman estimated, prepayment covers some 2% of legend drugs' total cost, a figure that is sure to rise with the mushrooming growth of prepayment. He said that although about 28% of the U.S. population has "some form of protection against drug costs (primarily major-medical type of either insurance companies or Blue Cross and Blue Shield), we know by comparing prepayment drug payouts with total legend drug costs that the protection is minimal."

The front-end deductibles of major medical plans block "substantial third party payment for Rx legend drugs where the average overall annual expenditures are only \$15.40 per year," Goodman noted. "If prepayment is to make a significant dent in Rx drug costs, it seems mandatory to us that the whole class of expenditures should be moved from the so-called major medical eligible expense classification, or that of a prolonged illness category, and treated as a separate line item of health-care cost," he added.

AMA ON GENERICS AND DRUG COSTS

Accepting a special report from the Board of Trustees, AMA meeting at Las Vegas (Nov. 28-Dec. 1) adopted resolution reaffirming present policy "that physicians should be free to use either the generic or the brand name in prescribing drugs for their patients." House of Delegates also agreed on policy to "encourage physicians to supplement medical judgements with cost considerations in making this choice." AMA believes MDs should be free to use either the generic or the brand name in prescribing for all their patients—indigent and Medicare, included. Generic prescribing, the Board's report said, delegates the choice of source-of-supply to someone else, and the MD should not do this unless "he is convinced that he can rely upon the quality and purity of the drug that will be dispensed."

Only two other AMA actions were in drug field: (1) Conn. resolution asking for telephone prescribing of Class A narcotics was rejected by reference cmte.; and (2) Ore. resolution, reiterating AMA's opposition to false and misleading advertising of proprietary drugs, was accepted, including newsworthy language in its first whereas: "Ethical promotion of proprietary medicines through recognized and ethical media is reasonable and justifiable in the promulgation of the free enterprise system."

MD ownership and dispensing, a lively issue at recent AMA meetings and one in which pharmacy has a major interest, received no official attention at Las Vegas. The AMA had gone as far as its internal political situation would allow at its meeting last June when it resolved favorably on respecting the profession of pharmacy.

Overriding interest at Las Vegas meeting was on operation of Medicare and Medicaid; many resolutions were on maintaining "separate billing" from MDs to patients, and on "reasonable" or "prevailing" charges under Medicare. After the meeting, top AMA-ers met with H-E-W Undersecretary, Wilbur Cohen in what has been described as the first real dialogue between govt. and the medical profession in almost 30 years.

Though medical judgements must always come first, the AMA Board said in its report on generics and costs, MDs should be encouraged to take cost into consideration in making a choice of the drugs they use. The AMA pointed out that costs vary even among different brands of the same drug. "*Medical considerations must be paramount in the selection of drugs,*" the Board said but the MD "*also has an obligation to be mindful of the economic consequences of the treatment he prescribes.*"

The Trustees' report said an MD who prescribes by brand "should inform his patient of the medical considerations which have led him to the decision . . . and of the cost considerations which have led him to prescribe a particular brand. He should also encourage the patient to be cost-conscious in having the Rx filled."

In choosing the drug, the report noted, "the MD has an opportunity to serve his patient by designating an acceptable brand which can be purchased by his patient at the lowest possible cost." If the MD chooses to prescribe generically, the report added, he "should be assured that whoever actually makes the choice of supplier can and will take into account not only the medical needs of his patient, but will protect the patient's economic interests as well."

OK _____
OK _____



the interstate drug exchange, inc.
ENGINEERS HILL, PLAINVIEW, L.I., NEW YORK 11803

Date _____
Our Order No. _____

Sold _____
To: _____

Dr. Henry H. Naff
965 Bluff View Drive
Knoxville, Tennessee

NAME
STREET ADDRESS
CITY STATE ZIP CODE

Your Order No. _____
Dept. _____
Degree _____

Please Add 75¢ For Orders Under \$15.00 Reg. No.

No. of Pkgs.	Size	Item	Price	Extension
1	100	Valium 5mg (Roche)		\$7.50
2	100	Myadec (Parke Davis)	\$3.75	7.50
				\$15.00

(CHECKS ON MONEY ORDER) MAY BE SAFELY ENCLOSED.

MRS. MYRTLE K. BUSBEE

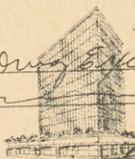
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PAY TO THE ORDER OF

Interstate Drug Exchange \$15.00

Valley Fidelity Bank
AND TRUST COMPANY
Knoxville, Tennessee



June 9 1970
Fifteen & 00/100 DOLLARS

Myrtle K. Busbee

7064 100 2291 105 686 211

"FAIR TRADE ENDANGERS PUBLIC'S HEALTH"

PRESIDENT'S COUNCIL IMPLIES MANY CAN'T PURCHASE DRUGS BECAUSE FAIR TRADE
KEEPS PRICES HIGH

Did you know that the fair trade laws constitute a possible danger to public health?

That's what the Johnson Administration—a hardline opponent of fair trade—would have you believe.

In the just-issued annual report of the President's Council of Economic Advisors, a section dealing with the alleged evils of resale price maintenance declares, among other things, that:

"While resale price maintenance is used for many products, including household appliances, cosmetics, beverages, and many other items, it is most extensively used in the sale of pharmaceutical supplies and proprietary drugs.

"Because of the adoption of Medicare and the growing public concern with improvement in health standards, it is particularly important to evaluate the impact of resale price maintenance for this group of products."

Implication: The suggestion here is that large numbers of needy individuals are unable to purchase drugs because prices of these products are being artificially maintained via resale price maintenance.

What the CEA report fails to make clear is that, in point of fact, not very many drug products are fair traded these days even in the 20 states that still have valid fair trade laws. The practice is rare for legend drugs, and its incidence among o-t-cs is spotty, and is diminishing.

But reading the CEA comments, one is given the impression that virtually all drugs are fair traded in the states.

No Domination: It will be of interest to small retailers besieged by discounters to learn from the CEA report that "protection of inefficient firms is *not* a purpose of the antitrust laws. A small number of very large firms will not dominate retail markets in a competitive environment. For one thing, entry costs in retailing are typically low, so that any attempt to seize and hold the dominating market share in any major retail market would be futile.

"Whatever the case may have been in the 1930s for depression-born modifications of the basic competitive philosophy, that case does not apply in today's and tomorrow's expanding economy," the report concludes.

"In a healthy and viable market economy, effective competition will inevitably see some enterprises fall and go under."

"RX MEN SHOULD SEE TO IT MENTAL PATIENTS TAKE THEIR DRUGS AFTER
LEAVING HOSPITAL"

A system whereby community pharmacists are directly responsible for seeing to it that patients released from mental hospitals continue to take the drugs prescribed for them—and thus remain out of the hospital—has been proposed by the North Carolina Pharmaceutical Assn.

According to William Smith, secretary of the association, over 45% of the patients released from North Carolina's state mental hospitals ultimately return to these institutions. A big reason for this, he said, is that there's no really adequate followup program for these patients—and, in particular, no mechanism to make certain that these patients actually take the tranquilizers that can act as the principal protection against a return to the hospital.

Mandate: The association, he continued, has therefore proposed to the state's Commission of Mental Health that community pharmacists be given the job of dispensing these drugs, and, further, that they be given a mandate to inform mental patients when they're due for a refill.

Under existing procedures, the state provides a week's supply of drugs to released patients, and refers them to a local physician for followup treatment. Patients who are needy enough to qualify for the state's welfare program generally can and do get prescriptions filled for the tranquilizers they need.

Unprotected: Unprotected, said Mr. Smith, are a large percentage of mental patients who, though they aren't poor enough to qualify for welfare aid, nevertheless can't afford the expense of buying tranquilizers.

"It's this group that we think the community pharmacists could help. It's our belief that the state should set up machinery to supply free tranquilizers to this group of patients through community pharmacists, and enlist the aid of community pharmacists to see to it that these patients get the drugs they need."

APHA PLANS STUDENT AWARD

The American Pharmaceutical Assn has decided to establish an annual award for the outstanding student chapter.

The competition will begin this year.

[From Drug Topics, Feb. 6, 1967]

PRICE SUPPORT OPPOSED

WASHINGTON.—Unexpectedly, President Johnson's Council of Economic Advisers is showing new interest in resale price maintenance—which it still opposes.

This interest, dormant for some time, was revived "because of the adoption of Medicare and the growing public concern with improvement in health standards," the Council said in its annual report to the President. The report was sent to Congress by the President, who made no mention of resale price maintenance in his message. The Council noted, however, that "the administration has consistently opposed" resale price maintenance.

The Council also expressed interest in increasing costs of medical care, but the President's message did not discuss this, either. The advisers noted that "prices of drugs and medicines have not risen in recent years," but added "neither have they been reduced."

The discussion of resale price maintenance by the Council followed one on antitrust law activities. This noted that "effective antitrust cannot provide for the protection of individual competitors at the expense of the protection of competition." The Council pointed out that during the early 1930's many states acted to restrict competition in the field of retail distribution "when the pervasive economic distress bankrupted many small firms and threatened countless others with failure."

"Relief was sought, and frequently obtained, in the form of restrictions on the pricing policies of larger and more efficient firms—especially in chain stores and mail order houses," said the advisers' report. "Resale price maintenance is such a device, largely born in the 1930's, which can impair the competitive force of free markets."

The report pointed out that resale price maintenance laws are on the books in 40 states, but that because use of adverse legal decisions they are fully effective in less than 20.

"Resale price maintenance permits manufacturers to guarantee attractive margins to retailers in order to encourage them to promote their products rather than those of competitors," said the report. "But by providing a shield from competition, price maintenance agreements often raise prices to consumers. Moreover, they can induce the development of excess capacity in some branches of retailing, as well as blunt price competition in manufacturing industries dominated by a small number of large firms."

"While resale price maintenance is used for many products, including household appliances, cosmetics, beverages, and many other items, it is most extensively used in the sale of pharmaceutical supplies and proprietary drugs. Because of the adoption of Medicare and the growing public concern with improvement of health standards, it is particularly important to evaluate the impact of price maintenance for these products."

"A basic purpose of the antitrust laws is the maintenance of a market system in which many firms can operate effectively. But protection of inefficient firms is *not* a purpose of the antitrust laws. A small number of very large firms will not dominate retail markets in a competitive environment. For one thing, entry costs in retailing are typically low, so that any attempt to seize and hold a dominating market share would be futile."

"Whatever the case may have been in the 1930's for depression-born modifications of the basic competitive philosophy, that case does not apply in today's and tomorrow's expanding economy."

NO MORE DOUBT RE VALIDITY OF OHIO FT LAW, BASED ON NOTICE: STATE HIGH COURT

Ohio Supreme Court's Feb. 1 opinion, decisively upholding the state's 1959 fair trade (FT) statute supplementing the non-signer approach with the "notice" principle, could revive activity among state pharmaceutical assns. for passage of new laws. It also could lead to increased enforcement efforts in Ohio, a hot discount area. On Jan. 1, GE abandoned FT on its small appliances in Ohio.

Status of Ohio's new-type FT law has been somewhat cloudy, despite a U.S. Supreme Court decision in its favor several years ago in cases involving Lilly and Upjohn against the Revco discounting chain. The uncertainty resulted from an unusual legal situation.

The new case, *Olin v. Ontario Store*, came to the state supreme court on an appeal from a lower court decision *invalidating* the act. The high court, in a 4-to-3 decision, overturned the lower court and validated the law for the entire state.

In the Revco (Hudson Distributors) cases, the 1959 statute had been *upheld* by the lower court. The Supreme Court held, 4-3, that the law was unconstitutional. But the high court's ruling didn't knock the law out because the Ohio supreme court cannot invalidate a law upheld by a lower court if more than one justice votes for the law.

While an appeal in the Revco case was pending in the U.S. Supreme Court, a number of lower Ohio courts followed the four-man state high court majority in ruling against FT in *Olin* and other cases. The relatively brief four-man majority opinion in the *Olin* case was based primarily on a paragraph from former Justice Goldberg's U.S. Supreme Court decision in the Revco cases stating that the wisdom of enacting FT laws is a matter of Congress and the legislatures—not the courts.

FAIR TRADE LAW IN OHIO UPHELD BY STATE TOP COURT

COLUMBUS, O. (FNS).—Ohio's fair trade law was held constitutional last week by the Ohio Supreme Court in a 4-3 ruling.

The ruling stems from a Cincinnati case in which the Common Pleas and Appeals courts there had held the law unconstitutional.

Olin Mathieson Chemical Corp., had sought an injunction to prohibit the Ontario Store of Price Hill from selling firearms manufactured by the company at less than the fair trade price.

Judge Paul W. Brown, who wrote the majority opinion, said:

"This court is not concerned with the wisdom of this type of enactment. Whether the act is wise or unwise is a question not for the courts but for the General Assembly.

"So long as such act does not contravene any constitutional mandate, it is the duty of this court to uphold it."

Agreeing with Judge Brown were Chief Justice Kingsley A. Taft, Judge Paul M. Herbert and Seventh District Appeals Judge Nils Johnson.

They pointed out, "The act under consideration is clearly an expression of the will of the public inasmuch as it was almost unanimously concurred in by the representatives of the people in both Houses of the General Assembly."

ARIZONA HIGH COURT UPHELDS FAIR TRADE

LEGISLATIVE ACTION IS THE ONLY WAY TO CHALLENGE STATUTE, TRIBUNAL SAYS IN SKAGGS CASE

The Arizona Supreme Court has upheld the constitutionality of the state's fair trade law—declaring in blunt terms, that the only way such laws can be altered is through legislative action.

Although the Arizona high court's decision doesn't establish any new concept in support of fair trade, the ruling is noteworthy because of the forcefulness with which it rejects the challenge to the Arizona statute.

Participants in the case were Skaggs Drug Centers and U.S. Time Corp., which was seeking to prevent Skaggs from selling Timex watches below fair trade minimums.

In its ruling, the Arizona high court declared that the fair trade statute. . . .

• Does not, as charged by Skaggs, violate the Arizona law prohibiting price fixing.

- Does not violate the "due process" amendment to the U.S. constitution.
- Does not constitute an illegal delegation of police power to the legislature.

Not Concerned: "This court is not concerned with the wisdom of the fair trade act, nor may we substitute our judgment for that of the legislature in its choice of method of enforcement."

"Our inquiry is limited to the question of whether the act contravenes the state and federal constitutions. Wisdom, necessity, propriety, or expediency of the act are matters exclusively within the province of the legislature.

"Fair trade acts have been enacted in more than 40 states of the union, most of which have been attacked as violating the constitutional rights of 'non-signers'.

"We have found that, in 17 states, in addition to Arizona, the 'non-signer' provision has been held constitutional, whereas in 24 states such provisions have been declared unconstitutional."

NJ anti-Chain Bill Killed in Caucus would have required all pharmacy executive officers, active directors and holders of voting stock in drugstore corporations to be registered pharmacists. Introduced June 3 by NJ Assembly Speaker Albert Smith (R—Atlantic County), the bill had been scheduled for quick floor action without a hearing, but the caucus emte. failed to approve it. The bill said "introduction of nonprofessional ownership has been harmful" and ownership of narcotics and dangerous drugs "should be by pharmacists in pharmacies and should not be left to commercially-oriented lay people."

[From F.D.C. Reports Apr. 22, 1968]

TRADE AND GOVERNMENT MEMOS

APhA Frowns on Rx Advertising in draft of new code of ethics that obviously tries to avoid clash with antitrust laws by aiming at the conduct of the pharmacist rather than advertising of the drug dispensed. The focus on the individual engaged in the practice of a profession is similar to the way the AMA and the bar assn. codes deal with MDs and lawyers advertising their services. The code, proposed by APhA's recently formed Judicial Board, says in the eighth paragraph of a nine-paragraph draft that "a pharmacist should not solicit professional practice by means of advertising."

Another provision in the proposed code, when considered with the language on advertising, could be construed as creating pressure on pharmacists not to work for chains, discounters or even independent community pharmacies which advertise Rx prices, products or services in any way. The provision says, in part, that "a pharmacist should not agree to practice under terms or conditions . . . which require him to consent to unethical conduct."

In its report prepared for the APhA House of Delegates sessions at the Miami Beach convention the week of May 5, the Judicial Board explained the meaning of the provision. "This section establishes that a pharmacist is responsible for the unethical conduct of an employer respecting pharmacy by consenting to that conduct through a continuing employment relationship," the Board said. The proposed code will be submitted to the APhA membership this year for study, with a mail ballot on it probably next year.

RESCO Objects to Ban on Rx Price Advertising being considered by Va. state senate subemte. President Sidney Dworkin, testifying before the subemte., said outlawing advertising of Rx price advertising is "a direct violation of the free enterprise system." He claimed that the bill, which has passed the House, was apparently prompted by the Cleveland discounter's entry to the Va. market through the acquisition of the 17-unit Patterson chain which has about \$4 mil. sales, half in Rx's.

[From FDC REPORTS, Mar. 10, 1969]

* * * *Retail Rx Ads Okayed By Fla. Supreme Court* except for unchallenged law that still outlaws advertising narcotics, CNS stimulants, tarquilizers, barbiturates, and "other hypnotic and somnifacient drugs." Ruling permits law-challenger Webb's City and other discounters to continue to name and price Rx drug ads

aimed at senior citizens and others with chronic diseases. *Some 35 states have laws or regs banning Rx ads* (last paragraph on page 4 is incorrect re this). Fla. decision is first overturning a law, but a number of state pharmacy board anti-ad regs have been rejected by the courts..... (Page 4)

Rx Price Ad Ban Called "Anti-Consumer" Legislation and an "artificial barrier against free and open competition," by a spokesman for the Natl. Newspaper Assn. testifying at FTC's consumer protection hearings. Paul Conrad, the assn.'s general counsel and govt. relations director, criticized state laws banning price advertising of Rx drugs and optometric devices and services as "rendering truthful advertising illegal." Conrad, whose D.C.-based assn. is composed of 7,000 daily and weekly papers in 50 states, added that "an agreement not to advertise, from the viewpoint of a tradesman, is the next best thing to out-and-out price fixing."

Conrad said that if professional assns. "choose to make advertising a violation of their self-imposed code of ethical conduct, that is their privilege." But he insisted that govt. "has no business making truthful advertising by individual practitioners in these professions . . . a violation of the law."

APHA JUDICIAL BOARD SAYS BROAD RANGE OF RX PRICE ADVERTISING PRACTICES VIOLATE ASSOCIATION'S CODE OF ETHICS; SEVERAL CHANGES SUGGESTED IN PROPOSED CODE

A broad range of Rx price advertising practices violate APHA's Code of Ethics because "the pharmacist is not dealing in commodities but is engaged in a professional practice to which the rules of the market-place do not apply," the assn.'s Judicial Board ruled Nov. 25.

In a report to the special meeting of the APHA House of Delegates in Chicago, the Judicial Board termed "unethical" 11 methods of "solicitation of professional practice" questioned by an APHA member. Involved were in-store, window, newspaper, radio, TV, and other forms of advertising.

[EDITORS' NOTE: Reproduced on the next page is the text of the 11 methods of solicitation ruled on by the APHA Judicial Board.]

"Although the practice of the community pharmacist has traditionally existed in a commercial environment, the dispensing of drugs and medications . . . is a professional service . . . and because the pharmacist is engaged in a professional practice, the reasons inherent in the prohibition of solicitation of professional practice by other health professions . . . apply with equal force," the Judicial Board said.

This principle has been recognized by several states which have passed laws to abolish certain methods of solicitation by pharmacists, and by courts which have approved such legislation, the Board noted. It said the legislative recognition "is reinforced by the APHA Code of Ethics which . . . states in its most relevant part: 'The pharmacist holds the health and safety of his patrons to be of first consideration; he makes no attempt . . . to offer for sale any drug or medical device merely for profit.'"

In the case of other health professions, "courts have sustained legislation prohibiting advertising on the ground that a state may go so far as to 'ban practices . . . tending to unseemingly competition and lowering of standard,'" the Judicial Board said.

"There is no less justification for . . . pharmacy to uphold advertising limitations relating solely to the professional services . . . on the grounds of protecting the profession from commercial exploitation, aiding in maintaining a high standard of professional ethics, and protecting the public from deception and imposition," the Board added.

The questioned methods of solicitation "may well be appropriate for ordinary commodities, but they are not appropriate for the professional service provided by the pharmacist," the Judicial Board said. It added that the methods support the inference that those using them "practice pharmacy solely for profit and that the health and safety of patrons are not of first consideration," which is "a discredit to the profession."

The Board's opinion has been in the works since May, when the panel told APHA's annual meeting in Miami Beach that the ruling was being reviewed by

the assn.'s general counsel to determine whether it could be released for publication. The Chicago meeting was told that the lawyers had approved release of the opinion, which was made under APhA's old Code of Ethics, now in the process of being revised.

RX ADVERTISING PRACTICES COVERED BY APHA JUDICIAL BOARD ADVISORY OPINION

In-store advertising over the Rx dept. which reads: "Are you paying high prices for your prescriptions? Bring your next Rx to (pharmacy) and save."

Window advertising which reads: "Let us price and fill your next Rx."

Newspaper advertising which states: "Have (pharmacy) price and fill your next prescription . . . Compare and save."

TV advertising which states: "Price and compare . . . Have (pharmacy) fill your next prescription at a lower price."

Solicitation of Rx's from the MD through the use of price lists, with the suggestion that "You might wish to show this list to your patients when the occasion arises doctor, in the interests of saving them money."

The use of both radio and TV commercials which state: "Are you in the dark about prescription prices? Price and compare, then bring your prescription to (pharmacy) for low, low, prices."

Offering a "free tube of tooth paste or a bottle of shampoo for permitting the pharmacist to price the next prescription."

In-store advertising which presently reads: "Dear senior citizen . . . You don't have to join a plan or carry a card to get your prescription filled for less at (pharmacy). Matter of fact, you don't have to be a senior citizen. Point is, everyone gets (pharmacy's) lowest prescription prices because we believe it is our professional responsibility to provide every customer with the finest pharmaceutical service at lowest possible prices. And . . . our prices . . . we promise . . . are as low or lower than anywhere else including any senior citizen discount plan."

The use of a "get acquainted certificate" upon which is written: "Fine professional pharmacy service, at the lowest prices in the nation. This will entitle the bearer (whose name appears above) or a member of his immediate family to a credit of up to \$1 on his first prescription purchase."

An in-store sign of gigantic proportions which reads: "If we aren't filling your prescriptions, you're paying too much."

An in-store sign on the Rx dept. which reads: "Are you paying too much for free Rx delivery?"

PMA SUGGESTION FOR MORE DETAIL RX DRUG PRICE ADS PRODUCES JOINT NARD-APHA ACTION; WRITE PMA DEMANDING RETRACTION, IDENTICAL LETTER URGES PHARMACISTS

Officers of APhA and NARD, in a joint action, are urging everybody in pharmacy to write "directly to PMA" demanding a retraction of its suggestion that pharmacists advertise Rx prices to the public and that state legal barriers to this practice be removed.

Top officers of both NARD and APhA, meeting in Washington Thursday Oct. 31, drafted a joint letter on the subject. The next day, identical letters were issued by APhA and NARD—only the letter-heads and the signatures at the bottom were different. NARD's was signed by Exec Secty. Willard Simmons; APhA's was signed by Exec Director William Apple (see below for text of letter).

APHA AND NARD NOV. 1 LETTERS TO PHARMACEUTICAL ASSOCIATION EXECs

We were astounded by the recent PMA recommendations that pharmacists advertise Rx prices directly to the general public and that legal barriers to Rx drug price advertising be removed . . . To coordinate the profession's response to these PMA recommendations which disregard the best interest of the individual patient, the public health, the professions of medicine and pharmacy and the pharmaceutical industry, a group of officers of the APhA . . . met with officers of the NARD . . . in Washington Oct. 31.

The leaders of both organizations agreed that consumer advertising of Rx drug prices is detrimental to public health and patient safety. Consumer advertising of Rx drugs and pharmaceutical services places prescription drugs on the same basis as that of commercial goods. There are many important differences between prescription drugs and commercial goods. Historically and traditionally professional practitioners do not solicit professional practice. Pharmacists render

specific, individual services which the general public cannot evaluate or judge either in terms of quality or price.

The profession of pharmacy strongly recommends that every individual or family choose a pharmacist to provide all of their pharmaceutical services, including non-prescribed as well as prescribed drugs. The selection of a personal pharmacist should be based on the same considerations by which MDs and dentists are selected—professional reputation, services and conveniences offered, location and availability of services. Pharmacists, like physicians and dentists, are willing to discuss with individual patients the charges they place on the professional services they render.

The APhA and NARD officers in attendance recommended that every pharmaceutical association, college of pharmacy and board of pharmacy support these views by writing directly to the PMA demanding that PMA retract its recommendations. We urge your prompt action on this matter.

The suggestion for increased advertising of retail prices for Rx's was made by PMA in its critique on the second interim report of the H-E-W Dept. Rx Drug Task Force ("The Pink Sheet" Oct. 21, page T&G 1).

Angered leaders in both pharmacy organizations interpreted the suggestion—rightly or wrongly—as an effort to shift the congressional and govt. heat on drug prices from the mfr. to the pharmacist. The PMA suggestion also was regarded in pharmacy circles as favoring the chains, particularly the discounters who use Rx price ads—where legal—to build volume and traffic.

In a conciliatory statement on the NARD-APhA joint letter, PMA President C. Joseph Stetler said that it was not the purpose of PMA's comments on the Rx task force report "to harass pharmacy nor to diminish its professional status." Text of the NARD-APhA letter became available in Washington at noon Friday Nov. 1; PMA's statement was issued in the afternoon (for full text, see facing page).

PMA PRESIDENT STETLER'S COMMENT ON APhA AND NARD LETTERS

During the past year there has been considerable discussion in the Congress and in govt. agencies about drug prices and profits. In connection with this matter we have commented on several occasions about the need for more price information to be available at both the mfr. and retail level.

Most assuredly our purpose in making these comments and in our critique of the report of the H-E-W Task Force on Rx Drugs is not to harass pharmacy nor to diminish its professional status. Our purpose is to find ways to avoid the intrusion of govt. into the free market, and to alleviate the concern about drug prices that has been expressed on a mounting scale by consumers, the govt., and congressional leaders.

Surely more active price competition at the retail and mfr. level is preferable to legislated price control or maximum reimbursement allowances.

We believe the consumer will continue to select the pharmacy from which to buy based on his assessment of numerous factors, including price. Equal or more important, however, will be professional competence and services.

Stetler raised the specter of govt. controls or interference in the drug market and said that active price competition at both the mfr. and retail level is preferable to govt. price controls or maxin reimbursement allowances. Leaders in pharmacy indicated they did not regard the PMA statement as meeting the request for a retraction and there were hints that the profession might be planning other steps. Execs of pharmaceutical houses can be expected to be questioned about the PMA suggestion at the next meetings of their pharmacy advisory councils.

The PMA suggestion on Rx drug advertising apparently succeeded—obviously without intention—in doing what mounting pressure inside pharmacy, including strong efforts by state assn. execs, had failed to accomplish, i.e., bring NARD and APhA into a joint meeting which produced unified action on an issue which the profession regards as important. Until the Oct. 31 meeting, NARD was widely regarded as leaning more toward the PMA side of the gap between the manufacturing group and APhA.

Attending the meeting for APhA were President Max Eggleston, President-Elect William Hennessy, Board of Trustees Chairman Dr. Lloyd Parks, House of Delegates Chairman Mary Louise Andersen, and Apple. Representing NARD were President Michael Perhach, Exec Cmte. Chairman Nick Avellone, Exec Cmte. members Leonard Rosenstein and John B. Tripeny Jr., and Simmons.

Regardless of who initiated the move for the meeting, or where it was held, the joint session and decision to take joint action indicates that APhA and NARD can get together on an issue—if it is big enough and if both believe that it involves a basic interest of their objectives.

This approach to joint action on individual issues or in specific situations is much more realistic than the usual efforts to force APhA and NARD into a "one voice for pharmacy" mould. The "one voice" concept presupposes joint meetings at which the governing bodies of both organizations bargain away or compromise what they conceive to be the primary orientation of their programs in an effort to hammer out a unified position on all problems confronting pharmacy.

NARD officers made it clear that this approach is not realistic in speeches at the recent NARD convention in which the function of NARD was reaffirmed as protecting the interests of retail pharmacy owners ("The Pink Sheet" Oct. 14, page 9).

APhA has always regarded its primary function as protecting the interests of the profession, regardless where it is practiced. The mutual interest that brought them together for the Oct. 31 meeting apparently was the growing threat of chain competition.

CPhA Seeks To Broaden Calif. Rx Ad Ban in light of the Va. federal court ruling against Revco holding that pharmacy boards can outlaw Rx advertising by retailers ("The Pink Sheet" Nov. 3, page T & G-7). Calif. already prohibits promoting "discounts" or "lower than average" prices for Rx's, but the pharmacy law amendment to be proposed by the Calif. Pharmaceutical Assn. (CPhA) would bar non-price ads as well. In line with the Va. Revco decision, the assn. is not seeking to ban Rx discounting, only Rx advertising, CPhA officials told "The Pink Sheet."

Unlike the Va. statute, which was aimed at curbing discount drug chain advertising, the proposed Calif. legislation is intended to block mail-order Rx promoting, CPhA said. In a parallel effort, the state pharmacy board is now holding hearings on a proposed reg to stop mail order Rx sales altogether. The board's plan has run into heavy consumer opposition, however, and the CHhA-sponsored amendment is regarded by some as a back-up strategy geared to achieve the same end.

RESCO Suit Fails To Overturn Va. Anti-Rx Ad Law but federal court rules that the state's ban on Rx discounting is "invalid." The decision, believed to be the first federal ruling on state Rx advertising laws, was delivered by a three-judge panel in Lynchburg, Va., Oct. 29. Because of the dual nature of the decision, both Revco and the Va. Board of Pharmacy—defendant in the chain's action—claimed victory. The impact of the landmark ruling is expected to be felt in 11 other states with anti-Rx ad laws: Calif., Conn., La., Md., Neb., Nev., NJ, NY, ND, Okla., and Pa.

In upholding the portion of the 1968 Va. law empowering the pharmacy board to revoke the licenses of pharmacists who advertise Rx prices, the panel termed the ad ban "a constitutional exercise of the state's police power." The statute "is not invalidated because Revco's pharmacists, whose licenses are subjected to revocation, do not control the corporation's advertising and pricing policy" as the chain argued, "nor does the fact that pharmacists may advertise free Rx deliveries, or free coffee while awaiting the filling of Rx's render the prohibition of advertising prices invalid," the court said.

Striking down the section of the law banning Rx discounting, the panel said that since "neither the Board of Pharmacy nor any other state agency had determined the retail price of Rx drugs which must be maintained without discount," revocation of a pharmacist's license for price-cutting "would be arbitrary and capricious." The court, however, ruled out price fixing as an argument against anti-Rx discounting laws by adding: "We accept the major premise implicit in the defendant's argument—Rx drugs are so intimately related to the public health that the state can fix the prices at which they are sold without violating the due process clause of the 14th Amendment."

A major link in Revco's unsuccessful argument against the provision was that pharmacists do not rank equally with other professionals, the court said. Charging that the chain sought to sidestep legal precedents "by

urging us to hold that pharmacy is not a profession," the judges cited state educational requirements for pharmacists, and upheld a 1967 Va. legislature declaration stating that: "The practice of pharmacy . . . is a professional practice affecting the public health, safety and welfare and is subject to regulation and control in the public interest."

Revco President Sidney Dworkin said in a press release that "the company's position concerning the professionalism of pharmacy has been grossly distorted" in the court ruling. He added that Revco "has never, and will never, directly or indirectly infer that any pharmacist is anything less than a professional."

NEW HAMPSHIRE BOARD LISTS "NO SELF-SERVICE" O-T-Cs

PURPOSE OF RULING IS TO SEE THAT PHARMACISTS HAVE DIRECT CONTROL OVER SALES OF ITEMS

The New Hampshire Board of Pharmacy has issued a list of more than 50 over-the-counter products which can no longer be sold on a self-service basis in New Hampshire.

According to board secretary Elmer Roentsch, the purpose of the ruling is to see that the pharmacists have direct control over the sale of these items.

Mr. Roentsch explained that the rule does not prohibit the sale of the restricted products by clerks.

No Plans: He said that, at present, the board has no plans to require the sale by Rx Men only of these items.

He said that the action has been taken under a provision of the New Hampshire pharmacy law which defines, in general terms, the conditions under which drugs may be sold in the state.

He noted that, although the section of the law in question was enacted in the 1930s, it has not been enforced.

Late in 1965, the New Hampshire board ruled that the same o-t-cs involved in last fortnight's action could no longer be sold in food stores and other outlets.

Complaints: It is understood that the no self-service regulation resulted from complaints by grocery interests that the barring of o-t-cs in food outlets doesn't make much sense if, in drug stores, patrons can buy these same products without any supervision.

Following is a list of the products involved:

Ammoniated ointment	Hills Cascara Quinine
Alva-Tranquil	Hibitane lozenges
Allerest tablets	Kriptin tablets
Anahist, Super Anahist	Micrin lozenges
Arrestin	Marezine tablets
Bradosol	Novahistine elizir
Bromo Quinine tabs	Nervine tablets
Coricidin-tablets	Nytol
Coricidin-D	Neo-Synephrine tablets
Coricidin medilets	Nodoz tablets
Coricidin cough syrup	Primatene mist
Coricidin nasal mist	Primatene tablets
Cheracol syrup	Perazil tablets
Compoz tablets	Robitussin
Contac capsules	Romilar syrup
C-3 tablets	Sinex
Dristan tablets	Sleep-eze
Doan's pills	Sominex tablets
Dormin capsules	Spectrocin nasal spray
Dondril tablets	Thorexin tablets
Doreal cough syrup	Thorexin syrup
Dozoff capsules	Tetrazets
Endotussin	Tranquil tablets
Excedrin	Thompson sleep capsules
Empirin compound	Tedral tablets
Emagrin tablets	Theracebrin
Fedrazil tablets	Trind tablets
4-Way cold tablets	Vicks Tri-Span

MINNESOTA RX MEN AGAIN ASK DRUG RESTRICTION

STATE ASSOCIATION WILL SEEK COMPROMISE WITH FOOD STORE MEN TO END
10-YEAR BATTLE

Minnesota pharmacists will soon begin still another campaign in their decade-long battle to convince the state legislature that some over-the-counter drugs should be restricted to sale by RxMen.

All previous attempts to gain this objective have been foiled because of strong opposition of Minn food store interests.

Spearheading the new drive will be the Minnesota Pharmaceutical Assn. According to its new secretary, Donald Dee, talks are now going on with the food retailers in an effort to draft a bill which will be acceptable to them, as well as to Pharmacy.

Similar: Mr. Dee said that, in all probability, the bill that is introduced will be similar to the measure considered—but never brought to a vote—during the last Minnesota legislative session.

Essentially, this bill sought to give the Minnesota Board of Health the authority to restrict the sale of o-t-c drugs in any one of 5 different categories. However, the board would not have been able to take such action without holding hearings on each drug to be restricted.

Fed Up: Mr. Dee said that, by now, all the parties on both sides in this legislation are fed up with fighting about it, and that some sort of compromise can probably be worked out in the upcoming session.

Mail-Order Rxs: Massachusetts state court has entered final decree in state pharmaceutical assn.'s case against Federal Rx Service Inc., of Madrid, Iowa. Decree rules that the Iowa mail-order firm's solicitation in Mass.—by direct mailings, salesmen, ads or any other means—of orders to fill Rxs is "illegal under the statutes of Mass." The methods used to implement or enforce the order will be interesting. APhA Legal Div. Director Robert Steeves reports that the Mass. assn. has asked "APhA assistance in the further proceedings in the case."

[From Drug Topics, May 25, 1970]

SIMMONS TELLS AUSSIES OEO HURTS U.S. DRUGSTORES

SYDNEY, AUSTRALIA—Willard B. Simmons, Executive Secretary of The National Association of Retail Druggists, in Chicago, Ill., charged that policies of the U.S. Office of Economic Opportunity are working hardships on the poor and have put privately-owned drugstores out of business.

Mr. Simmons made the statement in an address at the opening of the 1970 International Conference of the Pharmacy Guild of Australia.

Explaining the role of independent retail pharmacies in federal programs, Mr. Simmons said the law has not always been followed in operating the Office of Economic Opportunity's neighborhood health centers. He said that although the law requires the utilization of local pharmacies for medications for the indigent, some of the centers "stock drugs and hire pharmacists to dispense the prescription."

"We have protested this tactic on several counts," Mr. Simmons explained. "First it denies the patients the fundamental right of freedom of choice of their pharmacy. It forces them, in many instances, to travel long distances from their homes to the center to have prescriptions filled, rather than being able to patronize a pharmacy in their neighborhood. Further, it denies them, in most instances, ready access to pharmacists for additional advice, cautions, or for supplementary drug needs. Finally, it deprives local pharmacists, many of them operating in deprived neighborhoods and providing employment for local people of much needed prescription volume.

"These OEO-operated dispensaries already have put some local pharmacies out of business, eliminating a source of employment for local residents and obliterating a source of tax revenue for federal, state and metropolitan governments.

"The towering irony is that private pharmacies' own taxes have been used by an agency of government to put them out of business." Mr. Simmons said The

NARD, the United States' largest organization of retail drugstores, will continue to protest.

"We are determined to reform this bureaucratic attitude that the law can be flouted at will," he said. "We earnestly believe the public interest will best be served, and the government program improved, if local pharmacists are permitted to act as advisors (to the program), their advice heeded, and if they are allowed to dispense drugs and medicines for the people of their communities. We believe the poor are entitled to the same quality and the same availability of service as any one else."

Mr. Simmons noted that pharmacists have an important role to play in all government health programs.

"The broad question as we view these rapidly developing health and welfare programs," he explained, "involves the degree to which independent retail pharmacists will be allowed to apply their professional knowledge and competence to developing and carrying out their objectives. Maximum participation is imperative to assure the fullest benefit from competent pharmaceutical service."

August 12, 1968.

FDC DRUGS AND COSMETICS

F-D-C REPORTS

OEO REPLY TO NARD CHARGES SAYS MEDICAID VENDOR PLANS INFLATE RETAIL DRUG COSTS; NEW NARD LETTER TO CONGRESS AGAIN URGES MOVING OEO CENTERS TO H-E-W

The Office of Economic Opportunity (OEO), replying to NARD's demand that OEO health centers be operated under Medicaid, has charged that vendor plans under Medicaid cause "inflation of retail drug costs."

As retail druggists usually pay "higher acquisition costs . . . Medicaid funds subsidize the mfrs.' differential pricing structure," OEO said in a five-page report sent to senators and representatives visited by NARD members in July ("The Pink Sheet" July 15).

Terming Medicaid's "inflation" of drug costs "an anomaly of the present drug pricing structure," OEO's report told the lawmakers that "Medicaid drug programs vary from state to state; they characteristically pay on a cost plus fee basis, or a cost plus a percentage (sometimes as high as a 50% markup) plus fee."

NARD responded to the OEO report by sending a letter to all members of Congress charging OEO with "working a hardship on the poor people it is designed to serve, and, at the same time, forcing small retail establishments in poverty areas to go out of business."

The NARD letter urged, as the assn. did earlier, that (1) the OEO health centers be transferred to H-E-W and operated under Medicaid; (2) drugs provided to center patients be supplied through a vendor system; (3) *govt. dispensaries in centers should be closed "where private pharmacy services are on hand"*; and (4) drug mfrs.' pricing policies "which discriminate against . . . the independent retail drug store should be ended.

Senate Appropriations Cmte. Report Points to Research On Generic Equivalency

Congress never intended that OEO "use its appropriations to make govt. employees out of the nation's pharmacists and to close drug stores by widespread and unfair govt. competition," NARD Exec Secty. Willard Simmons said in the two-page letter, which was accompanied by a page of complaints from pharmacists in seven cities.

NARD's appeal apparently fell on deaf ears in the Senate Appropriations Cmte., which earmarked \$90 mil. of OEO's \$1.9 bil. for the health centers. In its report on the FY 1969 appropriation for the agency, the Senate cmte. specifically directed it to spend "not less than \$90 mil. for comprehensive health centers."

This would permit OEO to fund more of the centers, approaching LBJ's goal of 50 by the end of 1968. OEO now has 47 centers funded, of which some 34 are in operation, fully or partially. The bill containing the OEO appropriation is the first item of business on the Senate agenda when it returns Sept. 4 from its political convention recess.

The bill also contains \$67.3 mil. for FDA, the same amount as approved by the House, and \$3.7 mil. below the budget request. Of the cut, some \$1.7 mil. was scheduled for drug abuse control, which was shifted to the Justice Dept. after the budget was submitted.

The Senate report said the amount recommended for FDA provides \$1 mil. in program increases which will enable FDA to give "increased emphasis" to clinical studies on the side effects of OCs, and to initiate research on the biological equivalency of generic drugs. The latter research "is a prerequisite to the development of equivalency standards necessary for the resolution of the problem of generic v. brand-name drugs," the report said.

While the Senate cmte. report gave no indication of enthusiasm for NARD's proposal to shift OEO's health functions to H-E-W, there long has been discussion in Washington of giving H-E-W control over all govt. health activities. While the basic philosophy behind such a move has considerable support, the odds appear against it as long as OEO remains an independent agency

OEO has withstood many of the efforts of older-line govt. depts. to cut into the poverty program's operations. Similar success might be achieved by comparing the innovative OEO health programs with the generally recognized bureaucratic lack of creativity in much of the sprawling H-E-W Dept.

The OEO response to NARD's July march on Washington flatly denied many of the assn.'s charges of harm to pharmacists as a result of the OEO centers. "The facts do not support" NARD's charges "that pharmacies are closing, particularly in Denver and Boston, because of Neighborhood Health Centers (NHC) opening in the area," OEO said.

To support its denial, OEO sent the congressmen a copy of a newspaper article attributing Denver drug closings to a price war, and a letter from the city health dept. saying "not one drug store has gone out of business because of the impact of the center."

OEO Says Productive Communication With NARD Members "Difficult To Achieve"

Discussing "the supposition that an on-site dispensary at a NHC will attract the few purchasers of Rx drugs in an area," OEO replied "this is not so . . . the opposite is usually the case." Before a center opens patients usually get drugs at a country or city hospital or "because of the absence of medical care, never seek Rx drugs at all," OEO said.

Opening of a center "generates a greater demand for high quality pharmaceuticals among a population who seldom sought Rx drugs," OEO added, noting that the centers also help thousands of persons eligible for Medicaid or welfare to enroll in those programs. "Thus consumers are enabled to obtain drugs at the pharmacy of their choice, when they had not, because of sheer poverty, been able to do so before," OEO said.

OEO also flatly denied "the allegation that patients are 'directed to govt. dispensaries' or coerced to obtain drugs at health centers." Contending that "the opposite, again, is really the case," the agency said centers "direct patients to several sources of Rx drugs" by telling them of "their right to procure drugs where they wish, by assisting enrollments in the state Medicaid program, and by the outreach work of home health aides and visiting nurses."

In a direct criticism of NARD, OEO pointed to "the difficulties intrinsic to dealing with the diversity of organizations claiming to represent the small pharmacist." OEO reported lengthy discussions with NARD, APHA and at least 12 affiliated and unaffiliated city and state assns.

NARD, the govt. report continued, "claims to 'represent' 40,000 retail drug stores, but it is difficult to obtain their membership rolls. Thus productive communication and program development in coordination with NARD's members in local programs has been most difficult to achieve."

AVELLONE SAYS NARD AND APHA CAN COOPERATE MORE, BUT MUST BE WARY OF ANTITRUST HAZARDS; NARD PRESIDENT WARNS OF GOVERNMENT INTRUSION

NARD and APHA have "ample opportunities for cooperative and coordinated effort," but both "must take into consideration the basic orientation of each assn.," Exec Cmte. Chairman Nick Avellone told the NARD convention in Las Vegas.

He pointed to the two assns.' pledge of unified effort to support Sen. Hart's (D-Mich.) MD-dispensing bill, and the coordinated APhA-NARD criticisms of PMA's call for publicizing Rx prices ("The Pink Sheet" Nov. 4, 1968, page 14).

Although Avellone noted that there "are legal and regulatory hazards to be avoided" when the assns. work in tandem, his comment represented a continuation of the efforts of some pharmacy leaders to heal the breach between APhA and NARD while still recognizing their basic distinctions.

He decried the fact that "a few pharmacists have jumped to the conclusion that NARD and APhA were at loggerheads" because NARD "found it necessary to decline membership in the Natl. Pharmacy Insurance Council." Avellone reiterated NARD's position that it did not join NPIC because assn. counsel Earl Kintner, former FTC chairman, warned of antitrust exposure.

The Bay Village, Ohio, pharmacist said NARD rates "the problems of third-party payment programs . . . the number one concern in pharmacy today." NARD, he said, "is as up-to-date on these developments as well as anyone in the nation."

P-D Chairman Says Third-Party Payments Will Boost Generic-Named Products

Outgoing President Michael Perhach told the Oct. 12-16 convention that one of the major problems facing pharmacists is communications with each other, among assns., with govt. and with the public. He urged "constant and continuing emphasis on the facts . . . to convince some of our bureaucrats and some of our media people that pharmacists indeed contribute to the health and welfare of the public—and that they, in turn, are justified in establishing an equitable profit margin."

The NARD president added that "if we are to keep from being overwhelmed by antagonists on the natl. scene, our congressmen and senators must have the facts about . . . retail pharmacy . . . We must emphasize that the public will be better served . . . through the available pharmaceutical services of community pharmacy, rather than through any institution or govt. dispensary."

Govt. pharmacy programs also drew the attention of NARD Exec Secty. Willard Simmons in his convention report. "Instead of allowing patients to exercise their legal right to have their Rx's filled at the drugstore of their choice, OEO administrators make them travel unnecessary distances, wait for long periods of time, only to receive their medicines—in many cases—without the benefit of personal advisory service available to them in their own community pharmacy," Simmons said.

"These tactics have resulted in closing of a number of retail pharmacies, of loss of jobs to the citizens of the community, and loss of tax revenues," he added. "Yet these things are done under the misnomer of 'economic opportunity'."

Parke, Davis Chairman Austin Smith told the NARD meeting that as third-party payment for drugs grows, generic-named products will probably increase their proportionate share of ethical sales, but brand-name drugs will continue to dominate the market. "The presence of this third party will probably bring a closer pricing between the branded products and generics," Smith added.

Perhaps the purplest prose presented to NARD came from ED Wimmer, VP of the Natl. Federation of Independent Business. Harking back to NARD's support of fair trade, he said "if everyone who stood to benefit . . . had acted as NARD acted, prostitution of name brands by parasite-discount houses now turning the market place into an Egyptian bazaar would never have seen the light of day."

Wimmer also blasted mfrs.'s price discriminations, advocates of generic drugs, and chain stores. He quoted a Kroger ad saying: "Our professional pharmacists don't dirty their hands with other work; they spend their time professionally filling your Rx's."

Wimmer said that "on the other side of this counterfeit coin one finds the statement of a supermarket chain official who said 'it is pure hogwash to say that a pharmacist lends prestige to a supermarket. What a pharmacist brings in is profits, and if he doesn't where is his prestige?'"

Other speakers on NARD's program included House Majority Leader Albert (Okla.), Minority Leader Gerald Ford (Mich.), Rep. Wright Patman (D-Tex.), and President Nixon's consumer advisor, Virginia Knauer (see story, page 10).

Among the 31 resolutions adopted, virtually without debate, at NARD's closing session Oct. 16 were ones:

Urging the H-E-W Dept. to put a pharmacist in a high-level staff position to direct pharmacy services.

Opposing the Nixon Administration's cutback in funds for health research projects.

NARD's Revenues Are \$1,180,603, Up \$48,718 From Previous Year

Continuing opposition to the use or recognition of pharmacy technicians at any level.

Endorsing voluntary continued education for pharmacists.

Supporting BNDD's new regs restricting exempt narcotics to pharmacist-only sales.

Urging continued efforts to obtain passage of a strong federal fair trade law.

Calling for continuation, on an annual basis, of NARD's Washington conference on legislative matters.

Reiterating endorsement of Sen. Hart's MD-dispensing bill, and urging grassroots support for the measure.

Seeking postal and other regulations to restrict mail-order Rx sales.

Urging curbs on OEO-type pharmacy installations, more accurate guidelines for govt. dispensaries, and strict enforcement of such guidelines.

Calling for use of a vendor system in any Medicare out-patient Rx program, and continued free choice of pharmacy in all federal programs.

NARD reported gross revenues of \$1,180,603 for the year ended July 31, up \$48,718 from fiscal 1968. Income in FY '69 exceeded expenses by \$39,245, increasing the NARD general fund to \$1,453,099. The assn.'s 1970 convention will be held Oct. 18-22 in Atlantic City, NJ.

Illinois pharmacists win injunction halting UAW Rx program offered by four Caterpillar plants in the state through Metropolitan Life's Medimet plan. In a ruling that—if upheld—could have implications for the entire health insurance field. Peoria, Ill., state circuit court Judge Robert Hunt said the United Auto Workers' third-party program covering Caterpillar employees since Oct. 1 represents an "illegal restraint of trade" since the standard reimbursement schedule to participating pharmacists—acquisition cost plus \$2.10 professional fee—amounts to price-fixing among competitors.

Walgreen, SuperRx and S&C pharmacies were named along with UAW and Caterpillar in the action, but the temporary injunction, which will be issued today (Oct. 13), applies only to the heavy equipment mfr. The suit, initiated Sept. 26, was formally brought by only one Peoria-area pharmacist, but legal costs were shared by 28 others including Ill. Pharmaceutical Assn. (IPhA) immediate past-President Milton Christy. IPhA officially opposed the suit, though some top Ill assn. leaders, infuriated by UAW's encouragement of Rx discounting, were secretly rooting for the Peoria group.

The effect of the court's action is to turn an anti-trust spotlight on the cost-plus-fee system favored by APhA while giving a clean bill of health to the NARD-preferred usual and customary charge practice. Hunt made it clear that the temporary injunction would outlaw only the fee plan used by participating pharmacies, not the usual and customary reimbursement approach approved for use by non-participants and out of state stores. The court's 12-page, Oct. 8 opinion affects only the portion of the UAW plan offered through four Caterpillar plants but the union is fearful that pharmacists in other areas may press similar suits.

"The probability of a material increase in Rx costs to the public at large resulting from a changeover . . . from the present competitive method to the uniform method of cost-plus-fixed fee . . . is apparent and extensive," the judge wrote. The fee, he added, "is the only reward which the participating (pharmacist) may receive regardless of his volume of business, his ability to buy subject to quantity discounts, or the proportion of the Rx trade to . . . 'front-end' business." For a non-participating pharmacist "to be competitive and to remain solvent" the judge said, he would have to adopt a fee system for all customers or lose a substantial part of his business.

Peoria UAW Rx Plan Injunction Overturned by Ill. Supreme Court in a May 27 decision reversing a state circuit court opinion that the union insurance program's cost-plus-fee reimbursement system promotes "restraint of trade." In lifting the eight-month-old injunction, the high court said the UAW plan offered through Caterpillar Tractor falls within the requirements of Ill. insurance laws and the program's fixed-fee provisions do not involve illegal price-fixing.

The decision, written by Chief Justice Walter Schafer, also upheld arguments of United Auto Workers attorneys that the union's third-party plan is exempt from the state's antitrust statute, which specifically excludes "the activities of any labor organization . . . directed solely to labor objectives which are legitimate under the laws of either the state of Illinois or the United States," ("The Pink Sheet" March 9, page T&G-4). The Peoria pharmacists, who launched the suit immediately after the plan went into effect Oct. 1, had urged the court to uphold the injunction to force UAW, Caterpillar and Metropolitan Life to switch to a patient reimbursement system with fewer "anti-competitive consequences."

Spokesmen for the Peoria pharmacists said they were surprised by the decision and unsure of what their next step will be. They have at least three alternatives: attempt to appeal the ruling to the U.S. Supreme Court; initiate a new price-fixing suit in the federal court system; or drop their battle for "usual and customary" reimbursement. The suit has already cost \$10,000 in legal fees, and the 40 Peoria-area pharmacists who are backing the action have run out of funds. "Without outside financing or direct aid from NARD, it is questionable whether we will be able to move to the federal courts," a spokesman told "The Pink Sheet."

Although the Illinois ruling does not affect the legal status of fixed-fee third-party Rx reimbursement outside of that state, the decision is expected to provide at least moral support to Virginia Blue Cross, which is fighting a similar anti-trust action against its Rx insurance program. Oral arguments on that case, which were not scheduled to be heard until late this summer, are now set for June 9 and 10, and a decision from the state's Supreme Court of Appeals is likely by September.

A 10-YEAR REVIEW OF PHARMACY OPERATIONS

A substantial sales increase during 1968 boosted sales in the average LILLY DIGEST pharmacy to almost \$199,000—a record high. Chart 15 shows the strong pattern of sales growth over the past decade. At the present rate of growth, average sales will pass the \$200,000 mark easily during 1969.

The relationship between sales and expense control is evident in Table 23. When expressed as a percent of sales, the data show a steady uptrend in total expenses and a resultant decline in net profit during the past decade. It is important to note the relative stability of rent and other expenses and the subtle rise in employee wages. This perhaps indicates that pharmacist owners are holding down other expenses in an effort to offset increases in the area of wages.

TABLE 23.—AVERAGES OF PHARMACY OPERATIONS—1959-68 (BASED ON PHARMACIES REPORTING)

[Expressed in dollars]

Year	Sales	Cost of goods sold	Gross margin	Proprietor's or manager's salary	Employees' wages	Rent	Other expenses	Total expenses	Net profit	Value of inventory at cost
1959	134,238	86,431	47,807	10,861	15,045	3,094	11,128	40,128	7,679	22,680
1960	138,342	88,825	49,517	11,377	15,749	3,181	11,909	42,216	7,301	23,700
1961	139,176	89,129	50,047	11,595	15,838	3,324	12,128	42,885	7,162	24,354
1962	146,185	93,493	52,692	12,244	16,758	3,515	13,105	45,622	7,070	25,792
1963	153,262	97,415	55,847	12,610	17,495	3,878	14,305	48,288	7,559	26,952
1964	161,773	103,440	58,333	12,840	18,531	2,960	14,806	50,137	8,196	28,207
1965	167,647	106,894	60,753	13,396	18,602	4,143	14,938	51,079	9,674	28,642
1966	174,646	111,901	62,745	13,604	20,004	4,404	15,911	53,923	8,822	30,542
1967	118,429	120,786	67,643	14,926	21,933	4,662	17,160	58,681	8,962	33,882
1968	198,917	127,872	71,045	15,896	23,383	4,923	18,070	62,272	8,773	35,300

TABLE 23.—AVERAGES OF PHARMACY OPERATIONS—1959-68 (BASED ON PHARMACIES REPORTING)—Con.

[Expressed in percentage of sales]

Year	Sales	Cost of goods sold	Gross margin	Proprietor's or manager's salary	Employees' wages	Rent	Other expenses	Total expenses	Net profit	Annual rate of turnover (times)
1959	100.0	64.4	35.6	8.1	11.2	2.3	8.3	29.9	5.7	3.8
1960	100.0	64.2	35.8	8.2	11.4	2.3	8.6	30.5	5.3	3.7
1961	100.0	64.0	36.0	8.3	11.4	2.4	8.7	30.8	5.2	3.7
1962	100.0	64.0	36.0	8.4	11.5	2.4	8.9	31.2	4.8	3.6
1963	100.0	63.6	36.4	8.2	11.4	2.5	9.4	31.5	4.9	3.6
1964	100.0	63.9	36.1	7.9	11.5	2.5	9.1	31.0	5.1	3.7
1965	100.0	63.8	36.2	8.0	11.1	2.5	8.8	30.4	5.8	3.7
1966	100.0	64.1	35.9	7.8	11.5	2.5	9.1	30.9	5.0	3.7
1967	100.0	64.1	35.9	7.9	11.6	2.5	9.1	31.1	4.8	3.7
1968	100.0	64.3	35.7	8.0	11.7	2.5	9.1	31.3	4.4	3.7

TWENTY YEARS OF PRESCRIPTION DEPARTMENT DATA

LILLY DIGEST data clearly indicate that the prescription department continues to grow at a remarkable rate. Chart 16 graphically illustrates the steady uptrend in ratio of prescription sales to total sales since 1949. The past score of years has witnessed an almost threefold increase in this important statistic. On the basis of this information, it can be concluded that community pharmacists are, indeed, providing essential health services to their patrons.

The average LILLY DIGEST pharmacy gained in all categories listed in Table 24. The number of prescriptions and the prescription revenue rose substantially. A new high in prescription revenue, expressed as a percent of total sales, was recorded in 1968 at 43.2 percent. It is noteworthy that the figure for prescription sales per dollar of prescription inventory once again increased and represents an all-time high at \$7.49. This statistic suggests effective control of the professional inventory, particularly when a comparison is made with the steadily falling sales return per dollar of stock in nonprescription merchandise.

TABLE 24.—PRESCRIPTION TRENDS IN LILLY DIGEST PHARMACIES

[Averages per pharmacy]

Year	Sales			Percentage of prescription sales to total sales	Number of prescriptions	Percent renewals	Prescription charge
	Prescription	Other	Total				
1949	\$14,806	\$63,007	\$77,813	19.0	9,258	41.5	\$1.60
1950	15,987	62,203	78,190	20.4	9,020	42.2	1.77
1951	18,617	66,852	85,469	21.8	9,875	42.5	1.90
1952	21,735	69,799	91,534	23.7	10,436	40.6	2.08
1953	22,546	70,511	93,057	24.2	10,295	40.1	2.19
1954	25,054	75,732	100,786	24.9	11,037	42.3	2.27
1955	27,688	73,905	101,593	27.3	11,273	43.2	2.46
1956	31,430	75,268	106,698	29.5	11,985	44.5	2.62
1957	38,477	86,107	124,584	30.9	13,502	45.7	2.85
1958	40,454	84,403	124,857	32.4	13,693	47.0	2.96
1959	45,319	87,930	133,249	34.0	14,656	48.0	3.09
1960	47,825	90,517	138,342	34.6	14,972	49.3	3.19
1961	49,144	90,032	139,176	35.3	15,135	51.1	3.25
1962	52,578	93,607	146,185	36.0	15,817	52.1	3.32
1963	58,688	94,574	153,262	38.3	17,320	52.0	3.39
1964	63,157	98,616	161,773	39.0	18,532	53.7	3.41
1965	68,587	99,060	167,647	40.9	19,708	53.7	3.48
1966	71,586	103,060	174,646	41.0	19,962	53.6	3.59
1967	78,789	109,640	188,429	41.8	21,544	54.5	3.66
1968	85,953	112,964	198,917	43.2	22,848	54.8	3.76

TABLE 1.—CURRENT TRENDS IN PHARMACY OPERATIONS

Averages per pharmacy	1968, 2,308 pharmacies		1967, 2,312 pharmacies		Amount	Percent of change
	Amount	Percent	Amount	Percent		
Total sales.....	\$198,917	100.0	\$188,429	100.0	+\$10,488	5.6
Cost of goods sold.....	127,872	64.3	120,786	64.1	+\$7,086	5.9
Gross margin.....	71,045	35.7	67,643	35.9	+3,402	5.0
Expenses:						
Proprietor's or manager's salary.....	15,896	8.0	14,926	7.9	+970	6.5
Employees' wages.....	23,383	11.7	21,933	11.6	+1,450	6.6
Rent.....	4,923	2.5	4,662	2.5	+261	5.6
Heat, light, and power.....	1,546	.8	1,530	.8	+16	1.0
Accounting, legal, and other professional fees.....	736	.4	702	.4	+34	4.8
Taxes (except on buildings, income, and profit) and licenses.....	2,538	1.3	2,377	1.2	+161	6.8
Insurance (except on buildings).....	1,430	.7	1,348	.7	+82	6.1
Interest paid.....	784	.4	715	.4	+69	9.6
Repairs.....	643	.3	615	.3	+28	4.5
Delivery.....	851	.4	809	.4	+42	5.2
Advertising.....	2,795	1.4	2,770	1.5	+25	.9
Depreciation (except on buildings).....	2,028	1.0	2,023	1.1	+5	.2
Bad debts charged off.....	343	.2	322	.2	+21	6.5
Telephone.....	612	.3	574	.3	+38	6.6
Miscellaneous.....	3,764	1.9	3,375	1.8	+389	11.5
Total expenses.....	62,272	31.3	58,681	31.1	+3,591	6.1
Net profit (before taxes).....	8,773	4.4	8,962	4.8	-189	2.1
Total income of self-employed proprietor (before taxes on income and profits).....	24,669	12.4	23,888	12.7	+781	3.3
Value of inventory at cost.....	35,300	17.7	33,882	18.0	+1,418	4.2
Annual rate of turnover of inventory.....		3.7 times		3.7 times		No change

Note: These national averages are presented to give a composite picture of the average Lilly Digest pharmacy. Comparisons for analysis should be based on the operations of pharmacies of comparable sales and prescription size which appear in one of the 54 arrangements in the "Heart of the Lilly Digest."

TABLE 2.—CURRENT TRENDS IN PRESCRIPTION DEPARTMENT OPERATIONS

Averages per pharmacy	1968, 2,308 pharmacies		1967, 2,312 pharmacies		Amount	Percent of change
	Amount	Percent	Amount	Percent		
Sales:						
Prescription.....	\$85,953	43.2	\$78,789	41.8	+\$7,164	9.1
Other.....	\$112,964	56.8	\$109,640	58.2	+\$3,324	3.0
Total.....	\$198,917	100.0	\$188,429	100.0	+\$10,488	5.6
Value of inventory at cost and as a percent of sales:						
Prescription.....	\$11,478	13.4	\$10,881	13.8	+\$597	5.5
Other.....	\$23,822	21.1	\$23,001	21.0	+\$821	3.6
Total.....	\$35,300	17.7	\$33,882	18.0	+\$1,418	4.2
Sales per dollar invested in inventory:						
Prescription.....	\$7.49		\$7.24		+\$.25	3.5
Other.....	\$4.74		\$4.77		-\$.03	.6
Size of area (square feet): ¹						
Prescription.....	320	15.0	322	14.9	-2	.6
Other.....	1,814	85.0	1,825	85.1	-11	.6
Total.....	\$2,134	100.0	\$2,147	100.0	-\$13	.6
Sales per square foot: ¹						
Prescription.....	\$265.19		\$240.30		+\$24.89	10.4
Other.....	\$60.15		\$58.97		+\$1.18	2.0
Total.....	\$90.87		\$86.16		+\$4.71	5.5
Number of prescriptions dispensed:						
New.....	10,319	45.2	9,805	45.5	+514	5.2
Renewed.....	12,529	54.8	11,739	54.5	+790	6.7
Total.....	\$22,848	100.0	\$21,544	100.0	+\$1,304	6.1
Prescription charge.....	\$3.76		\$3.66		+\$.10	2.7

¹ Based on averages of pharmacies that reported all data.

A new high in total sales volume was recorded by the average community pharmacy in 1968. The year also witnessed the continuation of several trends. Notably, there was a profit squeeze due to lower gross margins and higher operating expenses. Dollarwise, total income (proprietor's salary plus net profit) reached a record level, but percentage wise, the average community pharmacist's share of each sales dollar was the lowest ever reported.

Table 1 indicates that on the basis of 2,308 reports received, average total sales in pharmacies were almost \$199,000, an increase of 5.6 percent over the prior year. Gross margin was at the lowest level in a decade, 35.7 percent of sales for the year.

Operating expenses were over 6 percent higher than in the preceding year and totaled 31.3 percent of all sales; this confirms a long-term uptrend. Partly as a result of greater sales, employees' wages again increased to a record high of more than \$23,300, or 11.7 percent of sales. The total wage package, proprietor's salary plus employee wages, reached almost 20 percent of sales. Of the remaining expenses, taxes and miscellaneous increased 0.1 percent each, and advertising and depreciation each decreased by the same amount.

Inventory, although slightly higher in terms of dollars, decreased as a percent of sales to 17.7 percent. Table 2 indicates that nonprescription merchandise, which represents over two-thirds of total inventory, increased more than the prescription portion. However, the prescription inventory continued its trend toward greater sales productivity and returned \$7.49 in sales for each dollar invested in stock. On the other hand, the productivity of other-than-prescription merchandise fell to a new low of \$4.74 in sales per inventory dollar. Total inventory turnover remained unchanged at 3.7 times.

Once again the prescription department demonstrated growing strength and was responsible for the bulk of the sales increase. Prescription revenue during 1968 increased more than 9 percent in comparison with the 1967 figure and accounted for 43.2 percent of all sales. This share of total sales is the highest ever recorded and continues an uninterrupted uptrend that began over twenty-five years ago when the prescription department contributed only 12 percent of sales.

Almost 23,000 prescriptions were dispensed during the year—a substantial growth over the 1967 figure. Renewed prescriptions accounted for 54.8 percent of the total, up from 54.5 percent in 1967. This increase confirms a long-term trend in the proportion of renewed prescriptions to total prescriptions. The average prescription charge rose 10 cents, to \$3.76.

The prescription department continues to register remarkable gains in every significant area. The number of prescriptions, the prescription revenue, and the productivity of the prescription department inventory are rising substantially. The productivity of the prescription department floor area is keeping pace. Although the department occupied only 15 percent of the total floor space, it was responsible for more than 43 percent of all sales recorded in the pharmacy. Each square foot of prescription department space yielded over \$265 in sales as opposed to \$60 per square foot for the rest of the pharmacy. The indication is clear that the strength of community pharmacy lies in the area of professional services.

The average size of all Digest pharmacies reporting data on floor space was 2,134 square feet, a figure essentially unchanged from 1967. It is not apparent from these data what the floor-space distribution among pharmacies is; however, it is well known that the long-term trend is toward larger physical layouts.

The economic future of community pharmacy is in the direction of increasing sales and expenses. Gross margins are falling and payroll expenses are rising, with the result that net profit is declining. All trends point to the need for greater managerial effectiveness in expense control to insure profits and, therefore, economic stability.

Average pharmacy owner's income rose 9.2% to \$26,943 in 1969, an increase of \$2,274 over his \$24,669 "take" the year before, according to a preliminary Lilly Digest report. The report covers 1,143 community pharmacies, about half the total Digest sample. It showed that the average proprietor's salary accounted for \$17,401 of his total pre-tax income, up from \$15,896 in 1968. As a percent of sales, however, his income dropped slightly, from 12.4% to 12.3% in 1969.

Gross margins in the average pharmacy rose from 35.7% in 1968 to 36.4% last year. A corresponding decline in the ratio of cost-of-goods to

sales—rather than retail price increases—accounted for the higher margins, the Digest explained.

Net profit remained unchanged at 4.4% of sales despite the better margins, due to spiraling operating expenses which jumped from 31.3% to 32% of sales. Employee wages were the chief factor in the increased expenses, climbing nearly 16% during 1969, from \$23,383 to \$27,089. A recent Digest special supplement indicated that gross margins and operating expenses increase as competition intensifies ("The Pink Sheet" March 23, page T&G-5). The average pharmacy's total sales hit an all-time high of \$219,782, up 10.5% over 1968, the report said. Rx sales paced the increase, climbing 12% v. 9.3% for non-Rx merchandise, continuing "an uninterrupted long-term uptrend in Rx revenue as a percent of sales." Rx volume increased from 43.2% of sales to 43.8% last year. The number of Rx's dispensed rose 9% to an average 24,897 for "a substantial increase of 2,049 Rx's," the Digest said.

Average Rx charges jumped 11¢ in 1969 from \$3.76 to \$3.87, accounting for at least part of the larger margins. New Rx's increased 10.5% to 45.8% of the total while refills posted only a 7.8% gain, reversing the long-term trend toward faster refill Rx growth. R. A. Gosselin's Natl. Rx Audit showed a similar reversal. The final Lilly Digest computations will be completed and distributed to pharmacies in September.

Brand Names Favored 13-to-1 by Indiana Pharmacists who answered a questionnaire for Butler U. College of Pharmacy's Pharmacy Administration Dept. Of 1,300—42% of Ind.'s registered pharmacists living in Ind.—91.5% answered "no," 7% said "yes" and 1.5% had "no opinion" to the question: "Would you be glad to see the end of the 'brand name era'?" The survey also showed:

95.4% lacked "complete confidence" in the therapeutic equivalency of generically equivalent drugs made by "all mfrs."—v. 3.7% "yes" votes.

88.2% were opposed to a federal formulary limiting Rx's that could be dispensed under Medicare & Medicaid programs—v. 10% for.

73.5% against v. 14.8% for price controls in conjunction with a federal formulary at the mfr.'s level, and 75% against v. 13.5% for such controls at the community pharmacy level.

Many of the pharmacists indicated that the demise of the brand-name era would curtail free enterprise in the pharmaceutical industry, according to PhD Pharmacy Administration Prof. Dale Doerr and PhD Pharmaceutical Chemistry Associate Prof. Melvin Weinswig, who conducted the survey.

A number of pharmacists, the professors reported, indicated they would not accept generic equivalents for their own families and questioned whether the lay public would have the opportunity or ability to choose for themselves. A limited number of the pharmacists indicated opposition to differential pricing at the mfr.'s level, the survey revealed, while some favored price controls at the community pharmacy level if the professional fee were utilized.

LOUISIANA STATE ON GENERICS, PERCENT OF WHOLESALE

FDC REPORTS—"THE PINK SHEET"

DRUGS AND COSMETICS

(A specialized weekly for executives in the drug, cosmetic and related industries, Published by FDC Reports, Inc., 1152 Natl. Press Bldg., Washington D.C. 20004, Phone Metropolitan 8-4463.)

U.S. SENATE,
Washington, D.C., November 10, 1966.

Mr. MERLIN R. WILSON,
Executive Secretary, Louisiana State Pharmaceutical Association,
New Orleans, La.

DEAR MR. WILSON: I have received your letter of October 12 in which you included a copy of a resolution stating your association's opposition to "any legislation which would require the use of generic drugs" and directing that a copy

be forwarded to me. I assume that the resolution makes reference to S. 3614, which I introduced July 13 of this year.

Actually, I am surprised to find that the Louisiana State Pharmaceutical Association has formally stated its opposition to this measure, especially in view of the fact that it is my understanding that the American Pharmaceutical Association has been sympathetic to this approach. I am informed that as early as 1955 it supported the use of official drug names and adopted the following resolution:

Whereas it is agreed by all pharmaceutical authorities that generic names need chemical or unregistered names of drugs, or the names recognized by the USP, International Formulary, or Homeopathic Pharmacopoeia of the United States, or the names adopted by the Council on Pharmacies or Chemistry of the American Medical Association; and

Whereas the use of generic names is therefore, in company with the highest ethical standards of the medical and pharmaceutical professions: Be it

Resolved, That the American Pharmaceutical Association, as such, believes in and encourages the use of the generic names for general drug products.

A similar resolution was approved in 1956. It reads in part:

Resolved, That the American Pharmaceutical Association supports and encourages the use of generic names in the prescribing and dispensing of drugs by the medical and pharmaceutical profession.

Other groups, such as the American Public Health Association, have also endorsed the use of official names for drugs.

I suspect that many of your membership are not fully aware of just what my bill would provide; it is in no way deleterious to the integrity of your profession. Basically, it would require that drugs furnished under programs financed by the federal government be provided on an official name basis. I am sure that no one is more aware than you and your colleagues of the tremendous savings which would result not only to the federal government but also to the state and local governments which participate in the federal programs. The bill would not require that the drugs used be purchased from the company offering the lowest price, and I envision that it would be implemented with standards which would ensure the purchase of quality drugs. The success of the armed services and many of our hospitals in securing drugs on an official name basis is a good indication that there are no unsurmountable obstacles to providing drugs elsewhere by official name.

It has been suggested to me that pharmacists are concerned about the furnishing of drugs on the basis of official name because it is common for their markup to be a percentage of wholesale price. It has been further suggested by some of your colleagues that the institution by the profession of a "professional fee" for all prescription fillings, which would be more or less standard regardless of the wholesale price of the drugs, would remove much of the objection to providing drugs by official name, and may actually be preferable to present practice. I certainly have no intentions of sponsoring any legislation which would put our pharmacists out of business, and my bill would certainly permit the type of practice which I have just prescribed.

I would be interested in receiving any suggestions or comments which the Association may care to offer on this matter. I feel confident that if we work together in a spirit of genuine cooperation we can greatly benefit all of our citizens and at the same time preserve the integrity of the pharmaceutical profession.

With every good wish, I am,

Sincerely,

RUSSELL LONG.

TRADE AND GOVERNMENT MEMOS

Chain Inroads into Pharmacy Practice and the retail drug business generally make it imperative for the profession to seek a new and expanded role in the health area, APbA Exec Director William Apple warned the D.C. Pharmaceutical Assn.'s meeting July 18. Noting the "dramatic" growth in chain Rx volume during the past decade, Apple also pointed out that chains enjoy 87.5% of total retail drug dollar volume in the Washington, D.C. metropolitan market.

"Pharmacists who see their future in chain drug stores as owners, managers or even employees have good cause for being optimistic," Apple said. "On the other hand, pharmacists who believe that the independent drug store is an indestructible American institution might

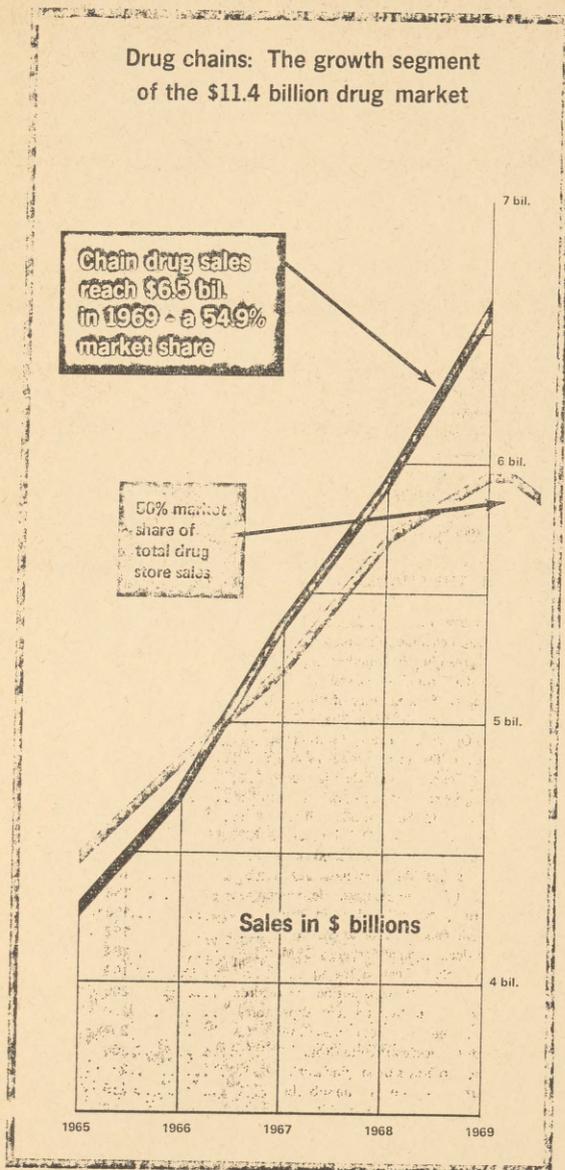
recognize that their future is more precarious than some people would have them believe."

But Apple made it clear that he doesn't believe the future for self-employed pharmacists is in the traditional merchandising type of situation, except perhaps in rural areas which haven't yet attracted chains. In the past, he said, "every new generation of pharmacists has entered into practice with the objective of someday becoming owners of a pharmacy. In the last few years, graduates have started to realize that some awesome obstacles have developed to reaching this ownership objective.

"During the past few decades, there has been a significant shift in the ratio of employed and self-employed pharmacists. Today, employed pharmacists are in the majority. If the trend continues, in the future, we could start the 21st Century with two-thirds and even three-fourths of our professional population in the employee category."

The current "transition period" in health care—marked by manpower shortages and vastly increased involvement of govt. and other third-party paying agencies—provides a "unique opportunity" for pharmacy to establish itself as a health profession, Apple continued. "Pharmacy must be prepared to demonstrate with facts both the content and value of its professional services," he added. "In the past, we have relied on the historical benchmarks of the retail distributive function and the average markup for this function."

"It would be tragic indeed for pharmacy to unshackle itself from the medicine and the mfrs. only to find itself in bondage to chains, institutions and unions," Apple said. "The survival of the self-employed pharmacist is essential to the welfare of the employed pharmacist. As long as there are opportunities to move from employed to self-employed, the salaried professional can maintain his independence and demand that there be no interference with his professional prerogatives."



I—THE GROWTH

Chain volume reaches \$6.54 bil.

Sales gain of 10.6% gives drug chains 54.9% of \$11.9 bil. drug market

The chain drug industry continued to set performance records in 1969. On a 10.6% sales increase, second largest of the decade, the industry's annual volume reached a record \$6.54 billion.

This figure, in turn, gave the chain drug industry a record 54.9% of the \$11.9 billion* retail drug market, up from 51.7% in 1968.

The annual CHAIN STORE AGE survey of 1,500 chain drug stores also revealed the following information:

- Last year, chain drug stores averaged \$88 of annual sales per square foot of selling space, \$4-a-square-foot more than the \$84 recorded in 1968, and \$23 better than the \$65-per-square-foot turned in by the nation's discount houses. The increase, agree most chain people, is due to inflation, trade-up, and the wider selection of higher-priced merchandise available in new stores.
- The typical chain drug outlet's gross margin in 1969 dropped to 33% from 1968 figure of 33.2%. Reason: In another year of rising costs, chains often chose not to pass these costs on to the consumer, choosing instead to remain competitive on price.

