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Canadian Internet Pharmacies: some ethical and economic issues

Introduction

Health care delivery in North America is evolving rapidly. Prescribing and dispensing of prescription drugs via telephone, fax and the Internet are prominent among the many recent developments which are transforming our health care system.[i]

Although distance dispensing [d-dispensing] currently accounts for only a small part of the health care delivery system in either Canada or the United States, it is expanding at an exponential rate and will likely become a major part of the system within the very near future.[ii] In my opinion, neither technophobia nor technophilia is the correct attitude to adopt towards the rapid growth of d-health. Technologically mediated health care, if it is properly regulated, has the potentiality to make a significant and positive contribution to our health care system. On the other hand, if insufficiently or improperly regulated the technology could produce more harm than good. In other words, although there is a danger that *unregulated* or *under-regulated* d-prescribing or dispensing could cause avoidable harm to patients, there also exists an equal but opposite danger, viz., that *over-regulation*, based upon ignorance or misplaced fears, will result in the loss of significant potential benefit to patients.

Opposition to the Canadian International Pharmacy industry may be attributable in significant measure to the medically dangerous and/or commercially corrupt practices adopted by many distance or online pharmacies. [See below, the section of this Report entitled ***Rogue Internet Pharmacies***.] Ethically objectionable practices – such as dispensing drugs to patients for whom no physician has written a prescription - were especially prevalent during the early phases of the industry, before a rigorous licensing and regulatory framework was securely in place. In one sector of the d-dispensing industry such unprofessional practices persist.

This rogue component of the d-health industry is geographically dispersed, typically originating from countries with rudimentary health care controls and little proper regulation. The point which needs to be stressed here is that the ethically disreputable branch of the Internet Pharmacy industry, which makes little or no effort to deliver health care in a professionally responsible manner, offers a model of health care delivery which diverges markedly from the model embodied in the mainstream Canadian International Pharmacy industry. Unfortunately, Canadian International Pharmacies are sometimes "convicted" on the basis of "guilt by association" with their distant e-cousins.[iii]

No one who values responsible medical practice should oppose tight regulation of d-medicine. No one who values pharmacy ethics should oppose legal sanctions, including criminal prosecution and professional de-licensing, of those unethical elements of the industry which employ the Internet or other distance technologies in ways that are unprofessional. It is important, however, for us to take heed of the danger that, in our zeal to curb unethical Internet prescribing, we will react in the direction of over-regulation. For it is also true that ethically inappropriate regulation (whether originating from governments or from misplaced professional zeal) may impede rather than promote responsible and technologically innovative efforts to improve health care delivery.

I will argue that concerns generated by the unregulated, unscrupulous and unprofessional element of the industry should not be allowed to undermine the tightly regulated and generally reputable Canadian International Pharmacy industry. It will also argue that it is ill-advised for provincial pharmacy associations to attempt to impose sanctions on Internet pharmacies and Internet pharmacists whose business consists of filling prescriptions that have been "co-signed" by licensed Canadian doctors [based, in part, on the prescription written for American patients by their American doctors]. My argument will be that discipline and sanctions are ill conceived because the policies adopted by the Canadian International Pharmacy industry are at least as safe for patients as the policies of many traditional bricks-and-mortar pharmacies.

That is, Canadian Internet Pharmacy practice appears to meet or to exceed the professional standards prevailing in many conventional Canadian pharmacies. Real physicians [typically American] write the original prescription after a face to face consultation with the patient; a second physician [licensed to practice in Canada] examines the information provided by the first physician, sometimes seeks additional relevant information, and co-signs the original prescription, which is then filled by a real pharmacist. Additional safeguards are typically in place: for example, patients are required to complete a form listing all medication taken, both prescribed and OTC; patients are also required to assist the co-signing physician by listing any medical conditions they may have. Controlled substances and acute care drugs are not dispensed - the former because of the danger of criminal intent, the latter because of time constraints in delivering medication to the patient. These and other similar measures seem consistent with the standards one would expect of professional pharmacists.

Ethics and the Professional Pharmacist

> *The term [profession] refers to a group … pursuing a learned art as a common calling in the spirit of public service – no less a public service because it may incidentally be a means of livelihood. Pursuit of the learned art in the spirit of public service is the primary purpose. - Roscoe Pound* [iv]

Some pharmacists are salaried employees of a hospital, clinic or other public health care facility. Many, however, work in the commercial marketplace as either employees or

owners of for-profit businesses. That is, many pharmacists are either businesspeople or work for businesspeople.

At the same time, every pharmacist, *qua* pharmacist, is a health care professional and, as such, is bound by the fundamental principle of health care ethics: “The life and health of my patient will be my first consideration.” [Hippocratic Oath: Declaration of Geneva]

Those pharmacists who “wear two different hats” – viz., an entrepreneurial hat and a health care professional hat – may find that these dual roles sometimes come into conflict.[v] The ethos of the marketplace, encapsulated in the phrase *caveat emptor*, will sometimes point in a very different direction from that required by professional ethics, encapsulated in the phrase *primum non nocere*. When a health care professional experiences a conflict between the values of prudence (e.g., personal profit or career self-interest), on the one hand, and professionalism (altruistic commitment to patients/clients), on the other, it is the professional commitment which should prevail. Professional identity in every health care discipline is, or at least should be, constituted by the primacy of the ethical commitment to patients.

It is the true mark of the health care professional that s/he professes knowledge and skill primarily on behalf of patients and the wider society. That is, health care professionals, in common with other professionals, commit themselves to an altruistic orientation. In return for the professional autonomy conferred on them by society, not to mention the prestige and high income that typically accompany professional status, the professional pharmacist accepts a fiduciary responsibility to the patient. This fiduciary responsibility translates, in practice, to the acceptance that the patient’s life and health are values which should trump the pharmacist’s income or career advancement.

This is not to deny that it is legitimate for professionals who are also in business (or employed by people in business) to pursue their own career self-interest and profit. Concern for personal interests, whether career advancement or financial gain, is not improper *per se*. What is not permitted, however, is for health care professionals to use their knowledge and power to exploit patients. High quality patient care must come first. Profit-seeking behaviour should always be subordinated to the health needs of patients.

It is this stringent moral requirement which most strikingly distinguishes professional conduct from the mere provision of a marketplace service in return for payment.

The Rogue Internet Pharmacy Industry

There are rogue Web Sites by means of which drugs are prescribed for patients who have had no face-to-face encounter with a physician but who, instead, have merely filled out a rudimentary online questionnaire or, in some cases, have simply requested the drug in question without even the pretence of a medical examination. There are rogue Web Sites which supply fake drugs or which deliver genuine drugs but in a poor condition, e.g., drugs which have passed their expiry date. Some fraudulent Internet Pharmacies take money from patients and then fail to deliver the promised drugs. Some Sites offer to sell

controlled drugs to people whose intention in purchasing them is to re-sell them for profit to drug addicts. Some Internet Pharmacy Sites have been convicted of criminal activities, including money laundering and credit card fraud. These "pill mills" certainly deserve to be put out of business, and their proprietors deserve, when the offence is serious, to be imprisoned for endangering the public. They bear very little, if any, resemblance to legitimate Internet pharmacies.

In short, careful and well-designed regulations are needed to prevent sub-standard care while not, at the same time, serving to deter or to chill potentially beneficial online health interactions.

The Canadian IPS Pharmacy Industry

Prescription drugs cannot be dispensed from a Canadian pharmacy unless a doctor *licensed to practice in Canada* has written the prescription. The moral justification underlying this policy is not entirely clear. It is easy to recognize that, in the interests of patient safety, one would want to restrict access to potentially dangerous medications, and easy to see that the best way to promote appropriate prescribing might be to require that patients obtain a prescription from a licensed medical practitioner. Typically, that licensed medical practitioner has been a physician though, increasingly, nurse practitioners, psychologists, and pharmacists have been given limited rights to prescribe at least some kinds of medication. It is more difficult, however, to understand the requirement that Canadian pharmacies should only be permitted to fill prescriptions which have been written by licensed *Canadian* physicians.

What is the rationale, one wonders, for Canadian regulations which prohibit Canadian pharmacies from honouring prescriptions written by duly licensed American physicians? Could it reasonably be claimed that American physicians are generally less well qualified to write scripts than Canadian physicians? There is no reputable evidence of which I am aware which would support a claim to Canadian superiority in this domain. Thus, the requirement appears to be unwarranted from the point of view of the best interests of patients, whether Canadian patients who seek medical care in the USA and return with prescriptions written by American doctors or American patients who have obtained prescriptions from American doctors which they wish to fill, for any of a number of reasons, at Canadian pharmacies. Canadian Colleges of Physicians and Surgeons would appear to be in agreement with this point, since they have publicly advocated a change in Canadian regulations which would allow Canadian pharmacists to fill American prescriptions based *solely* on the signature of a licensed American physician.

In this connection, the pertinent ethical question which needs to be considered is: What are the ethics of treating patients based on residency? Should patients be discriminated against because they live outside of Canada? Over a period of more than 2000 years there have been dozens of versions of the Oath of Hippocrates. To my knowledge, none of the versions has ever stipulated that the fundamental principle of the Oath - "The life and health of my patients will be my first consideration." – should be qualified by restricting

the health professional's obligation to patients who share his/her nationality. "The life and health of my Canadian patients will be my first consideration" is not a principle that any Canadian physician or pharmacist should feel comfortable defending.

The Province of Manitoba is home to about one third of Canadian IPS Pharmacies. For reasons which are difficult to understand, Manitoba (like other Canadian provinces) requires that before a Manitoba pharmacist can dispense drugs to any patient that patient's prescription must have been issued by a physician licensed to practice in Canada. Thus, if a patient (whether American or Canadian) has been examined, face to face, by his or her American physician and issued with a prescription, this prescription can be filled by a Manitoba pharmacy only if it has been co-signed by a Canadian physician. Because the Manitoba College of Physicians has taken disciplinary action against Manitoba physicians who co-sign prescriptions for patients (without having personally done a face-to-face examination of the patient) Manitoba IPS Pharmacies have been forced to use Canadian physicians who are licensed out-of-province to perform the task of co-signing.

The Ethics of Co-signing Prescriptions

If the signature of a licensed American physician continues to be judged insufficient or unacceptable by itself, and if the practice of Canadian physicians co-signing prescriptions written by American physicians is judged to be unethical in every circumstance, then the Canadian IPS Pharmacy Industry will find it difficult or impossible to serve its American patients.

It must be noted, however, that it is not uncommon for Canadian physicians to write prescriptions for patients when they (the physicians) have not directly examined the patients prior to writing the prescription. For example, in group medical practice it is not uncommon for a member of the group who is "on call" for absent colleagues to renew by telephone prescriptions for that colleague's patients.[vi] The scenario might look something like this: The on-call doctor takes a call from an asthmatic patient of his/her absent colleague and, in response to the patient's request, the doctor calls the patient's pharmacy to renew the patient's inhalator prescription. Or consider this alternative scenario: a hospital emergency room doctor comes on shift and is presented with a list of prescription orders submitted by various interns and nurses on the ward. The doctor then proceeds, without having personally examined any of these patients face-to-face, to write the requested prescriptions. Many emergency Room doctors claim that is no other way feasibly to manage this kind of situation short of a drastic increase of staffing levels.[vii] A third scenario: A diabetic patient living in some remote rural or northern location, with no easy access to a doctor's office or a hospital, 'phones her physician to request that her prescription for insulin be renewed. The doctor, after asking a few perfunctory questions and establishing both that the patient's condition is chronic and that the patient is doing well on this particular brand of insulin, obliges the patient and 'phones in a renewal of her prescription to a pharmacy geographically accessible to her.[viii]

I suppose that in an ideal world, no doctor would ever issue a prescription (not even a prescription renewal), for any patient, without a direct physical in-person visit first. But our world is very far from ideal – resources are limited, sometimes severely limited, and cost-control measures are difficult to avoid; moreover, patients sometimes live in remote locations and/or suffer from illness or disability which restricts their mobility. Thus, in scenarios similar to those sketched above, it seems unfair to scapegoat doctors who are trying to do the best they can for their patients in sometimes difficult circumstances.

Back to the question with which we started: Could it ever be consistent with medical ethics for a physician to sign (or co-sign) a prescription for patients when the physician has not personally taken that patient's history and done a face-to-face medical examination before writing/co-signing the prescription? The answer seems clearly to be: yes.

The American Medical Association has drafted online-prescribing guidelines which seem sensibly to promote and protect patient safety. These Internet prescribing guidelines include requirements that: the patient must be examined [in person, by a physician] to determine a specific diagnosis; physicians must discuss treatment options with patients; physicians must provide the patient with information about risks and benefits, and physicians must follow-up with the patient.[ix]

Let us suppose, then, that (i) a licensed American physician has examined a patient face to face, (ii) this physician diagnoses the patient as diabetic, say, (iii) discusses with her the benefits and risks of taking medication (insulin) to control blood sugar levels, and (iv) writes a prescription for a new form of insulin which is judged to be appropriate in the circumstances. In this or similar circumstances, there seems to be good reason for judging that it is ethically permissible for a (Canadian) doctor to co-sign this prescription. It is ethically permissible, and some would go further and insist that it is ethically obligatory, because by co-signing the prescription the Canadian physician enables patients with chronic medical conditions to satisfy their medication needs safely, conveniently and affordably via a Canadian IPS Pharmacy.

Imagine, also, that the Canadian IPS Pharmacy imposes further safeguards, such as a requirement that the patient must already, at the time of placement, have been taking the medication for a certain length of time, say for a period of at least one month, and knows both that it is well tolerated and that it effectively controls her chronic medical condition (diabetes) With stringent safeguards in place, of the sort outlined in this section, it seems clear that the Canadian International Pharmacy industry cannot reasonably be accused of slighting its ethical responsibility as a provider of health care .[x]

Patient Safety Comes First

a) Assembly line medical practice

The prevailing practice of Canadian IPS pharmacies requires that Canadian co-signing physicians basically perform a review function. That is, the role of the Canadian co-signing physician is to check the appropriateness of the original (American) prescription for the condition diagnosed; as well, the co-signing physician checks that the prescribed dosage is correct and that the patient instructions are appropriate. Where potential problems are flagged, co-signing physicians are able to 'phone or otherwise contact their American colleagues to ascertain that no mistake has been made in the prescription as originally written. If a mistake has been made, it can then be corrected.

As explained above, there certainly exist rogue Internet Pharmacies, which should, wherever possible, be shut down as quickly as possible because of their unsafe practices. Considerations of patient safety demand no less. By contrast, the Canadian IPS Pharmacy industry has adopted a model for the dispensing of prescription drugs which is, if anything, potentially *safer* overall than the traditional bricks and mortar model, as well as being potentially more economical.

It should also be kept in mind that the realities of present day health care, in both the USA and Canada, are often dramatically different from the classical paradigm to which lip service is paid.

A classical model of doctor-patient (and pharmacist-patient relationship) looks something like this: a thorough and rigorous physical examination in the doctor's office before a diagnosis is made and a prescription written; continuity of care with one's family physician over a long period of one's life; continuity of care with one's bricks-and-mortar traditional neighbourhood pharmacist, who serves as a source of information and advice to patients.

Merely to describe this paradigm is to recognize how far we have moved away from it in much of North American medical practice. Patients not infrequently obtain drug prescriptions from doctors after only the most cursory possible physical exam (or no physical exam at all). Patients are sometimes hustled in and out of their doctor's busy office, and are permitted/encouraged to ask few questions. In consequence, prescriptions are sometimes written by physicians without an adequate conversation (between doctor and patient) concerning the risk-benefit profile of the prescribed medicine let alone possible medical and non-medical alternatives. Patients who ask for specific drugs - because they have seen Direct to Consumer Advertising from the Pharmaceutical industry, advertising which often exaggerates the benefits and minimizes the potential adverse effects of these drugs[xi] – are likely to be given the prescription they request. Some Canadian family physicians see *on average* sixty patients per day.[xii] This inevitably means that each patient is allowed, on average, no more than a few minutes to explain symptoms to and ask questions of the doctor before receiving a diagnosis and treatment

plan. High patient volumes are possible largely because patients accept (or at least tolerate) rushed treatment so long as they emerge with a prescription in their hands.

We are talking here about a problem – excessive patient volumes leading to sub-optimal medical care - which not infrequently afflicts conventional bricks and mortar medicine. It almost goes without saying that the practice of "assembly-line" medicine, when it occurs, can easily lead to dangerous prescribing.

It is simply not realistic, therefore, to portray office visits as a panacea. For example, a study done in 2000 of inappropriate drug use among community-dwelling elderly patients found that between 22.5% and 29% were taking at least one inappropriate medication.[xiii] This is an alarmingly high figure, but it is consistent with other studies of the same problem.

In sum, the theoretical benefits of the face-to-face office visit are often not achieved in practice.

The Distribution of Professional Services

As discussed above, the primary moral commitment of every health care professional should be a commitment to the health care needs of his/her patient. But, more than this, professionalism also entails a public-spirited commitment to distributive justice.[xiv] Pharmacists, for example, as health care professionals, should be committed to the creation of a system that enables all patients who need access to prescription drugs to gain that access.

It goes without saying that, in a health care system that aspires to achieve principles of distributive justice, people lacking financial resources would not have to go without the medication they need; nor would they have to depend upon erratic charity. In Canada, it is widely accepted that governments have the prime responsibility for ensuring that there exists universal access to medically necessary care. However, when state provision of medically necessary care is either absent or inadequate, health care professionals have an obligation to bring to society's attention the ways in which our current system of provision leaves a large number of people with important health care needs either unserved or underserved. Moreover, unless/until the state establishes systems to fulfill everyone's health care needs, health professionals cannot shirk their own moral responsibility to facilitate the provision of needed goods and services to patients, in so far as this is possible.

Money enables many patients to gain access to the pharmaceutical products they need to maintain or restore their health or ameliorate their illnesses. But when a patient lacks both insurance (whether public or private) and private funds, then there is a duty which falls upon the health professions, including professional pharmacists to take reasonable steps to ensure that patients have affordable access to the drugs they need.

Fully a third of Americans surveyed admit that they or a family member has not filled a prescription or has reduced the prescribed dosage for economic reasons. Lacking insurance altogether or lacking adequate insurance, they simply could not afford to pay the high cost of prescription medications in the USA.[xv]

Fears that Canadian Patients Will Experience a Shortfall of Prescription Drugs Because of Retaliation from the US-based Pharmaceutical Industry

Some critics of the Canadian Internet pharmacy industry have argued that the dispensing of prescription drugs from Canadian Internet pharmacies to American patients will lead to a harmful shortage of vital drugs for Canadian patients. The shortage of prescription drugs will come about, it is claimed, because American pharmaceutical manufacturers will reduce or cut off their supply of prescription drugs to Canada in an effort to prevent their re-importation to the United States.

As noted earlier in this Report, something like this problem has already occurred, albeit only to a minor degree. Opponents of the Canadian International Pharmacy industry argue that if this were to happen on a large scale then serious shortages could result for Canadian patients needing prescription drugs. Such shortages might potentially be seriously harmful to Canadian patients. The critics conclude that it would be desirable for the Canadian Pharmacy profession to prevent potential shortages from occurring by imposing sanctions against the Canadian International Pharmacy industry.

Empirical evidence in support of shortage claims is, however, rather weak. Disruptions in the distribution chain, having nothing to do with Internet Pharmacies, occur from time to time. These disruptions can sometimes lead to shortages of several days' duration. Spokespeople for the Internet Pharmacy industry claim that there does is not even a single documented case to date of a Canadian patient who has been denied prescription medication owing to shortages caused by e-businesses.[xvi]

Moreover, if shortages were to arise in the future because of pharmaceutical company tactics, for example, as part of a campaign to shut down the Canadian International Pharmacy industry, the Canadian Government has the power to take remedial action. Health Canada has already made clear that it is monitoring the actions of those drug companies which are attempting to restrict supplies to Canadian pharmacies. The policy of Health Canada is clearly stated by one of their spokeswomen: "If a problem occurs, HC would take appropriate action to ensure an adequate supply of drugs for Canadians".[xvii] Moreover, this is not an idle promise: Under the Patent Act, the Government of Canada possesses the power to declare a national emergency and then, on an emergency basis, to suspend patents on drugs which are in short supply. This last-named measure would enable the government to issue a contract to generic drug companies authorizing them to produce the drug(s) in short supply.

For these reasons, the argument - that the Canadian Internet Pharmacy industry should be shut down because its very existence is already leading or will soon lead to prescription drug shortages for Canadian patients/consumers - is not a strong one.

Moreover, it should be kept in mind that the dispensing of prescription drugs from Canadian pharmacies to American patients is not a new phenomenon. American patients, especially American retirees, have been making forays across the border to conventional Canadian pharmacies for the purpose of stocking up on prescription drugs since well before the advent of Internet dispensing.[xviii] A 2003 U.S. Congressional estimate suggests that an open marketplace between the USA and Canada in pharmaceutical products could save American consumers "at least $635 billion of their own money each year."[xix]

Conclusions

Distance prescribing and dispensing of drugs, like distance/online provision of health information, is a two-edged sword: it has great potentiality for good but, if not properly regulated, could instead produce significant harm to patients/consumers.

It should be kept in mind, however, that what is true of d-prescribing and dispensing is equally true of virtually all medical interventions: Every system of health care provision has weaknesses as well as strengths. Every system of health care provision, whether traditional or technologically-based, has the potentiality to provide significant benefits but at the same time could easily, if not properly regulated, produce significant harms. Just as it might be said of medical practice that no treatment is without risks and side-effects, so it might be said of systems of health care provision, traditional as well as innovative, that it is important to balance potential benefits against potential risks of harm before deciding which is better overall. The risk-benefit ratio of the **rogue** Internet Pharmacy industry is highly unfavourable, for reasons discussed earlier. By contrast, the risk-benefit ratio of the **reputable** Internet Pharmacy industry appears to be highly favourable. It is to be hoped that regulations and restrictions will evolve as additional evidence becomes available concerning the optimal regulatory system for a heterogeneous population which needs a drug supply which is safe, affordable and accessible.

The prime goal of an ethically defensible International Pharmacy regulatory system should be to optimize potential benefits to patients while minimizing potential harms and to distribute the benefits in an equitable manner to all those who need prescription drugs.

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[i] I will be focusing, in this discussion, on Distance dispensing [d-dispensing], including Internet dispensing, by Canadian International Pharmacies, but it should be noted that "d-health" encompasses not only e-dispensing (and prescribing), but also health information Web Sites, online Continuing Medical Education, e-medical records and even surgery done by on site robots under the control of a surgeon in a distant

location. It is reasonably foreseeable that the field of d-health will become an increasingly important component of every advanced health care system. The key factors driving forward this transformation of our health care system include the desire to improve patient safety by reducing medical errors and the desire to lower administrative costs. See: G. Eysenbach, Editorial, "What is e-Health?" 3 J. Med. Internet Res. e20 (2001), http://www.jimr.org/2001/2/e20. Cited in Nicolas P. Terry, "Prescriptions sans Frontieres" *Yale Journal of Health Policy, Law, and Ethics.* IV: 1 (2004).

[ii] Eighteen per cent of U.S. households purchased prescription drugs online in 2003. By 2004 the percentage had increased to twenty-seven percent; figures for 2005 are not yet available, but are almost certain to be much higher still. See: Eric G. Brown, Bradford J. Homes *et als*, *Forrester's Top Ten Healthcare Predictions for 2004*. (December 15, 2003) *at* http://www.forrester.com/ER/Research/Brief/0, 1317, 33444,00 html.

[iii] In the USA a good deal of Internet prescribing and dispensing is driven by patients attempting to obtain drugs which their doctors will not prescribe for them, for example, controlled substances such as the painkiller Oxycontin. Another significant generator of online prescribing in the USA consists of patients seeking "lifestyle" drugs, such as Viagra, that many patients are embarrassed to discuss with their physicians (or even with their pharmacists). Neither controlled substances nor lifestyle drugs are generally available via the Canadian Internet Pharmacy Industry.

[iv] Roscoe Pound, *The Lawyer from Antiquity to Modern Times* (St. Paul: West Publishing, 1953). P.5

[v] Pharmacists who work for hospitals or other public institutions are unlikely to feel the same commercial pressures of their private sector colleagues, but they could easily experience organizational pressures or career pressures which operate, as the profit motive does in the commercial sector, which pose a challenge to professional standards.

[vi] Personal reports made to the author by Canadian physicians working in group practice settings.

[vii] Comments made to the author by ER doctors in a number of Canadian hospitals.

[viii] Comments made to the author by physicians practicing as part of the University of Manitoba's Northern Medical Unit.

[ix] Kristen Wedell, "Cyberpatients and Online Prescription Sales, *Internet Law*. Cited by Beth Cooper & Rebecca Pringle, "Online Prescriptions: A developing Convenience or Emerging Nightmare?" http://gsulaw.gsu.edu/la wandpapers/fa02/cooper_pringle.

[x] It is worth noting that the MPhA itself licenses IPS Pharmacies; and, further, that the fee for an IPS license was $13,200.00 per year, compared to $700.00 for a "regular" pharmacy.

[xi] Abigail Caplovitz. *Turning Medicine Into Snake Oil: How Pharmaceutical Marketers Put Patients at Risk.* NJPIRG Law and Policy Center May 2006.

[xii] The author, for example, was involved in a disciplinary hearing of the Manitoba College of Physicians and Surgeons involving the patient records of a Winnipeg doctor who saw on average 60 patients a day. Evidence adduced at this hearing suggested that this number was on the high side but was by no means unique.

[xiii] J. T. Hanlon *et als*. Inappropriate drug use among community-dwelling elderly. *Pharmacotherapy* 2000: 20:575-582. See also: R. Tamblyn *et als*, "Unnecessary prescribing of NSAIDs and the management of NSAID-related gastropathy in medical practice. *Ann intern Med* 1997; 127:429-438.

[xiv] Beauchamp and Childress, *Principles of Biomedical Ethics*, 3rd Edition; Engelhardt, *The Foundations of Bioethics*. Oxford.

[xv] N. K. Choudhry & A.S. Detsky. "A perspective on US Drug Re-importation", *JAMA*. Vol. 293, No.3, January 19th, 2005.

[xvi] Daren Jorgenson, Canadameds.com, as quoted in the *Globe and Mail*.

[xvii] Diane Gorman, Health Canada's Assistant Deputy Minister, at press conference held on November 18, 2003.

[xviii] Alexander Calhoun, "Get on the bus: Extreme Answers to Prescription Drug Costs.". *Christian Science Monitor*, 2000.

[xix] Pharmaceutical Market Access Act of 2003, H.R. 2427, 108th Congress, 2 (5).