(1) Opinion and order of the Court entered on March 21, 1974, is reported at 373 F. Supp. 683, and is also reproduced in the Appendix to the Jurisdictional Statement, App. 1-9.

(2) The Motion to Amend Findings or Judgment or in the Alternative for a New Trial and the Memorandum in Support is reproduced in the Appendix to Appellees' Motion to Dismiss, A. 2-A. 10.

DOCKET ENTRIES

1973

July 11—Complaint filed and summonses issued to defts.

July 11—Pltfs' Preliminary Interrogatories, filed.

July 13—Marshal's return on summons executed as to all defts., except Thomas F. Marshall, Jr., filed.

July 16—Notification and Request of Court for Designation of Three-Judge Court ent 7-16-73 & filed. Copies mailed as directed.

July 20—Order designating Judge Albert V. Bryan, Sr., United States Circuit Judge and John A. MacKenzie, United States District Judge, to sit with Robert R. Merhige, Jr., in the hearing and determination of this case, ent. 7-18-73. Copy mailed James Banton. (copies of pleadings mailed Judges)

July 31—Motion to dismiss filed by defts. (copies mailed Judges)

Aug. 24—Order soliciting response to motion to dismiss, entered, filed. Copies mailed as directed.

Aug. 27—Defts' Memorandum in Support of Motion to Dismiss filed. Copies mailed judges.

Sept. 7—Plfts' Opposition to defts' motion to dismiss filed.

Sept. 20—Pre-Trial Order directing: 1. answers in 14 days; pltf. replies 10 days after receipt of answers; stipulations due 15 days; discovery cut-off 60 days; exhibits' lists 20 days before trial; exhibits due 15 days before trial, pre-marked; witnesses' lists 20 days before trial; pltf. brief 10-22-73; defts' 11-22-73; pltfs' reply 7 days thereafter; action to be heard 9-17-73, 10:00 a.m. at Alexandria; ent 9-20-73 & filed. Copies mailed judges and counsel.

Sept. 21—Defts' Reply Memorandum in support of Motion to Dismiss, filed. copies mailed judges.

Oct. 2—Pltf's motion to compel answers to interrogatories, rec'd, filed.

Oct. 3—Deft's answers to pltf's preliminary interrogatories rec'd, filed.

Oct. 3—Answer of defts. filed.

Oct. 5—Response of Defts to Pltf's motion to compel answers to Interrogatories filed.

Oct. 5—Plaintiffs' Interrogatories filed.

Oct. 5—Motion to shorten time for Defts to answer Pltf's Interrogatories filed.

Oct. 5—Order directing each deft to answer Plaintiffs' Interrogatories dated 10-5-73 no later than 5 P.M. on 10-19-73 entered 10-5-73, filed. Copies to counsel.

Oct. 5—In Open Court: Merhige, J. Halasz, OCR Appearances: Parties by counsel. Matter came on for hearing on Pltfs' motion to compel answers to interrogatories. Motion heard. Court ruled as follows: Answers to Interrogatories 1-5 are unresponsive except for affirmative

answers; each to be answered in form. Interrogatories 6, 7, 8, 9 are unresponsive and are to be answered. Interrogatory 10(a)(b)(c) and (d) to be answered in 14 days. Pltfs' counsel to prepare sketch for order.

Oct. 5—Order directing defts to file complete and specific answers to Pltfs' Preliminary Interrogatories filed July 11, 1973 no later than 5 P.M. on 10-19-73 entered 10-5-73, filed. Copies mailed to counsel.

Oct. 5—Order directing deft State Board of Pharmacy to provide answers which are more complete than the answers filed on 9-28-73 no later than 5 P.M. on 10-19-73 entered 10-5-73, filed. Copies mailed to counsel.

Oct. 5—Plaintiffs' Proposed Stipulation of Facts filed.

Oct. 17—Defts' List of Controverted Stipulations filed.

Oct. 19—Defts' Second Answer to Plfs' Preliminary Interrogatories filed.

Oct. 19—Answer to plfs' interrogatories submitted on Oct. 5, 1973 filed by defts, with Pharmacy File attached. (copies of pleadings mailed three judges by counsel for defts.)

Oct. 19—Pltfs' Response to defts' proposed stipulations of facts, filed.

Oct. 23—Plfs' Opening Brief on the Merits filed. (copies to judges by plf.)

Nov. 6—Motion to shorten time for defts to answer plfs' interrogatories, filed.

Nov. 6—Plfs' Interrogatories filed.

Nov. 23—Defts' Opening Brief filed.

Nov. 28—Pltfs' List of Exhibits & Witnesses, filed.

Nov. 29—Defts' List of Exhibits and Witnesses, filed.

Nov. 30—Plfs' Reply Brief filed.

Dec. 3—Defts' Answers to Interrogatories filed.

Dec. 3—Pltfs' Exhibits 1-10 recd.

Dec. 4—Order setting hearing at Richmond Division, 12-17-73, 10:00 a.m. ent 12-4-73 & filed. Copies to counsel & judges.

Dec. 5—Exhibits, Part I and Exhibits, Part II, filed by defts.

Dec. 7—Defts' Memorandum in support of motion to re-open discovery filed.

Dec. 7—Motion to reopen discovery filed by defts; "Denied" 12-7-73 & filed. Copies mailed counsel.

Dec. 11—Testimony of pltfs' witnesses filed.

Dec. 12—Stipulation of Facts filed.

Dec. 12—Defts' Objections to Pltfs' witnesses testimony, filed.

Dec. 13—Defts' Additional Authorities filed.

Dec. 12—Statement of Pltfs' Position, filed.

Dec. 18—In Open Court: Bryan, Sr., Mackenzie, and Merhige, Judges, Halasz, OCR, Appearances: Parties by counsel. Matter came on for hearing of oral arguments on merits. Defts' motion to admit into evidence Defts' Exhibits 14, 15, 17, 18 and 20 which have been objected to by the Pltfs heard; motion taken under advisement by the Court. Argument of counsel heard. Case taken under advisement by the Court. (1 Hr. 8 Mins)

1974

Mar. 21—Opinion of Three-Judge Court, filed.

Mar. 21—Final Order of Declaratory Judgment and Injunction restraining defts from enforcement of statute portions declared void; costs awarded to pltfs; ent. 3-21-74, filed. Copies to counsel and judges.

Apr. 1—Defts' Motion to Amend Findings or Judgment or in alternative for a New Trial, filed. Copies to Judges.

Apr. 8—Bill of Costs filed by plfs.

Apr. 8—Affidavit of Raymond T. Bonner filed.

Apr. 17—Transcript of Colloquy at hearing 12-18-73, filed.

Aug. 30—Deft's Supporting Memorandum to amend judgment or for new trial, filed.

Sept. 6—Pltfs' Opposition Memorandum filed.

Oct. 4—Order of Three-Judge Court denying defts' motion to amend findings or judgment and denying motion for new trial ent 10-4-74, filed. Copies mailed.

Nov. 4—Notice of Appeal to Supreme Court of U.S. filed by deft.

Nov. 8—Order directing Clerk to transmit entire case record to U.S. Supreme Court, and requesting that record be returned to this Court at finality of action, ent'd, filed.

Nov. 8—Case record, in 5 vols, del'd to Clerk, U.S. Supreme Court, by Certified Mail.

1975

Mar. 27—Certified copy of order of U.S. Supreme Court noting probable jurisdiction rec'd, filed.

* * *

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

Filed July 11, 1973

1. This is an action pursuant to 42 U.S.C. § 1983 seeking to convene a three-judge court to enjoin defendants from enforcing the provisions of Section 54-524.35 of the Code of Virginia (1972 Supplement) which prohibits the publication, advertisment or promotion of the prices of prescription drugs, and to have the same declared unconstitutional.

2. The value of the amount in controversy exceeds $10,000.

3. This court has jurisdiction pursuant to 28 U.S.C. §§ 1331 and 1343(3).

4. Plaintiff Virginia Citizens Consumer Council, Inc. ("VCCC") is a non-profit, non-partisan, volunteer organization incorporated in Virginia, with a membership of approximately 150,000, many of whom are users of prescription drugs. Among its activities are the promotion and protection of the rights and welfare of its members and all consumers throughout Virginia.

5. Plaintiff Virginia State AFL-CIO is a non-profit labor organization with approximately 69,000 members who are residents of Virginia, and many of whom are users of prescription drugs. It actively promotes the interests of its members as consumers.

6. Plaintiff Lynn B. Jordan is a resident of the state of Virginia. She suffers from certain diseases which require her to take prescription drugs on a daily basis.

7. Defendant State Board of Pharmacy is charged by Section 54-524.16 of the Code of Virginia (1972 Supple-

ment) with the regulation of the practice of pharmacy in the state of Virginia.

8. Defendants Thomas F. Marshall, Jr., Charles F. Kingery, Wallace B. Thacker, Linwood S. Leavitt and William R. Maynard, Jr. are registered pharmacists and are the sole members of the defendant State Board of Pharmacy.

9. The Code of Virginia (1972 Supplement) provides in relevant part:

> A. Section 54-524.22:1: "The Board of Pharmacy may refuse to issue, revoke, suspend, refuse to renew any license . . . if it finds that:
>
> > (c) He has been guilty of unprofessional conduct as prescribed in § 54-524.35."
>
> B. Section 54-524.35: "A pharmacist shall be considered guilty of unprofessional conduct who . . . (4) publishes, advertises or promotes, directly or indirectly, in any manner whatsoever, any amount, price, fee, premium, discount, rebate or credit terms . . . for drugs which may be dispensed only by prescription."

10. As a result of Sections 54-524.22:1 and 54-254.35(4) there is in Virginia no publication, advertising or promotion of the prices of prescription drugs.

11. Because of the prohibition of the publication, advertisement and promotion of the prices of prescription drugs imposed by Sections 54-524.22:1 and 54-524.35(4), plaintiff Jordan and the members of plaintiffs VCCC and Virginia State AFL-CIO are economically harmed:

> A. by being deprived of information as to where the least expensive prescription drugs might be purchased; and

B. by having to pay higher prices for prescription drugs than they would have to pay if the publishing, advertising and promotion of prescription drug rices were permitted.

12. The prohibition of the publication, advertisement, and promotion of prescription drug prices imposed by Sections 54-524.22:1 and 54-524.35(4) and enforced by defendants deprives plaintiff Jordan and the members of plaintiff VCCC and Virginia State AFL-CIO of their right to receive vital information in violation of the First Amendment to the United States Constitution and 42 U.S.C. § 1983.

13. The prohibition of the publication, advertisement, and promotion of prescription drug prices imposed by said Sections and enforced by defendants bears no reasonable relationship to the health, safety, and welfare of the citizens of Virginia, but rather serves only to maintain unnecessarily inflated prices for prescription drugs and to deprive plaintiff Jordan and the members of plaintiffs VCCC and Virginia State AFL-CIO and others of vital information, thus violating the due process provisions of the Fourteenth Amendment to the United States Constitution and 42 U.S.C. § 1983.

Wherefore, plaintiffs pray for an order

(1) convening a three-judge court pursuant to 28 U.S.C. § 2284;

(2) declaring that Section 54.524.35(4) of the Code of Virginia is unconstitutional in violation of the First and Fourteenth Amendments;

(3) declaring that Sections 54-524.22:1 and 54-524.35 (4) violate 42 U.S.C. § 1983;

(4) enjoining defendants from enforcing the provisions of said Section 54-524.35(4) which prohibit the publication, advertisement or promotion of the prices of prescription drugs;

(5) granting plaintiffs such other and further relief as may be just and proper; and

(6) awarding plaintiffs their costs and disbursements in this action, including a reasonable attorney's fee.

* * *

STIPULATION OF FACTS

Filed December 5, 1973

Plaintiffs and defendants hereby stipulate to the following facts, without conceding the materiality of such facts or their relevancy to the issues in this case.

I. Parties

1. Virginia Citizens Consumer Council, Inc. ("VCCC") is a non-profit, non-partisan, volunteer organization incorporated in Virginia, with a membership of approximately 150,000, many of whom are users of prescription drugs.

2. Virginia State AFL-CIO is an unincorporated, non-profit labor organization with approximately 69,000 members who are residents of Virginia and many of whom are users of prescription drugs.

3. Lynn B. Jordan is a resident of Virginia. She suffers from certain diseases which require her to take prescription drugs on a daily basis.

4. The Virginia State Board of Pharmacy regulates the practice of pharmacy in Virginia.

5. Thomas W. Rorer, Jr., Charles F. Kingery, Wallace B. Thacker, Linwood S. Leavitt, and William R. Maynard, Jr. are registered pharmacists and are the sole members of the Virginia State Board of Pharmacy.

II. Practice Of Pharmacy

A. *Education*

6. The School of Pharmacy of the Medical College of Virginia, Health Science Division of the Virginia Commonwealth University requires in its curriculum a course on the history of pharmacy and the background of pharmacy as a professon, orienting students with the practice of pharmacy and telling them something of the traditions of the profession. This course also describes some of the current practices of the profession and opportunities that are available to students once they complete the program in pharmacy.

In the orientation course there are lectures relating to the profession, qualifications of the profession, and ethics of a fundamental nature, as well as a professional nature.

7. The curriculum in the School of Pharmacy is based upon two academic years of college before the student enters into the pharmacy school. The student then completes three years in the School of Pharmacy for a total of five academic years.

The student who enters pharmacy school has qualified himself in pre-pharmacy work—liberal arts, biology, chemistry, physics, English, and mathematics—a total of 63 semester hours of work. In the School of Pharmacy he takes a professional sequence of courses that is designated as pharmacy that runs through his first professional year that would be equivalent to the third college year—organic chemistry, comparative anatomy, quantitative analysis.

The pharmacy sequence continues on into the second and third professional years. He takes biochemistry, physiology, micro-biology, pharmacology, and principles of law and jurisprudence relating to the practice of pharmacy.

And in the final year, he has the opportunity to take elective sequences—blocks of coursework, work that would prepare him for his major interests, such as institutional practice of the profession or the community practice of the profession.

8. The pharmacy student is involved with a rigid, demanding curriculum in terms of what the pharmacy student is expected to know about drugs.

9. The pharmacy students receive their instruction during their final year in pharmacy school in the institution's hospital pharmacies and also make ward rounds with medical and nursing students at the Medical College of Virginia (MCV). They are involved in the whole medical center complex of MCV.

10. Instructors in the School of Pharmacy also hold appointments in the Schools of Medicine, Nursing and Dentistry.

The Virginia Pharmacy school has a tradition that goes back many, many years in utilizing the hospital pharmacies in the instruction of its students in pharmacy so that the students are in the midst of patient care activity.

B. *Professional Aspects*

11. Pharmacy is a profession.

12. Licensure is a requirement to practice pharmacy in the Commonwealth of Virginia and has been a requirement since 1866.

13. Pharmacy is a profession and the individual pharmacist is a professional because (a) there is some particular education or training that is involved, (b) there is a discrete group, by licensure, (c) there is a service to the public.

14. Pharmacists are considered to be one of an important group of health professionals who are concerned with the health and welfare of the citizens they serve. Physicians are one group of professionals who are involved in this team; dentists are a part of the team; pharmacists are; and nurses are part of the team. They are individuals who are competent to make individual professional judgments about their areas of expertise as it relates to the welfare of the patient, and this team should work together to promote the health of the public.

15. The pharmacist today is dealing with drugs of much greater effectiveness (drugs that are designed to do a therapeutic job more effectively) than they were a few years back. The drugs not only have the promise of doing great therapeutic good, but they also have the danger of harm through side effects, misuse, and mishandling. Accordingly, the pharmacist should be in a position to advise and assist the physician in the selection of drugs and to alert the physician to problems such as overdosage, abuse, incompatibility or sensitivities relating to a particular individual.

16. Medication today is more effective in actually curing illness than it was years ago when many medicines only provided for relief from the discomforts caused by the illness.

C. *Retail Aspects*

17. In 1970, total prescription drug expenditures for all Americans were estimated at $9.14 billion.

18. About 95% of all prescriptions are filled by the pharmacist dispensing pre-manufactured dosage forms as opposed to compounding individual prescriptions.

19. The Treasury Department, pursuant to the Economic Stabilization Act, required pharmacists to adhere to the same posting requirements as other retailers. In so doing, the Department stated:

> The dispensing of prescription drugs is considered to be a retail activity, and therefore, it is covered by Price Commission regulations requiring that base prices be posted. The fact that a professional pharmacist is employed to dispense drugs is incidental to the sale of those drugs and does not alter the retail nature of the transaction.

As explained by other Price Commissions rulings:

> The requirement that pharmacists post base prices is in no way inconsistent with their recognized professional standing, but is considered by the Price Commission to be necessary to achievement of stabilization objectives.

20. The acquisition cost to the pharmacist of a particular drug varies depending on the manufacturer and the quantity of the drug purchased.

21. There is no prohibition on the advertising of non-prescription drugs and, in fact, many pharmacies and other retail outlets of such drugs engage in promotion and price advertising of non-prescription drugs. The prices of non-prescription drugs, however, vary between pharmacies throughout the state and in particular localities within the state. For example, in the City of Richmond, the price of Maalox liquid, 12 ounces, an antacid, varies from $1.69

to $0.88, a 92% variance Mylanta liquid, 12 ounces, varies from $2.19 to $1.19, a variance of 84%.

22. (a) In Northern Virginia the price of 25 Darvon capsules (standard dosage) ranges from $2.35 to $3.65, a difference of 55%; the price of 40 Achromycin tablets (standard dosage) from $2.50 to $4.70, a difference of 90%; of 40 Tetracycline tablets (standard dosage) from $1.68 to $3.90, a difference of 132%.

(b) In Richmond, the cost of 40 Achromycin tablets ranges from $2.59 to $6.00, a difference of 140%.

(c) In the Newport News-Hampton, Virginia peninsula area the following variations exist:

(1) Tetracycline: $1.20 to $9.00, a 650% difference;

(2) Achromycin: $2.20 to $7.80, a 241% difference;

(3) Darvon: $1.90 to $4.70, a 147% difference.

(d) A survey conducted by the American Medical Association in Chicago showed price differentials in pharmacies throughout the city of up to 1200% for the same amount of an identical drug.

(e) A study conducted in New York by Consumers Union found that prices for the same amount of one drug ranges from $0.79 to $7.45, and for another drug from $1.25 to $11.50.

III. *Effect Of The Law*

23. As a result of the operation of Sections 54-524.22:1 and 54-524.35(3) of the Virginia Code, there is in Virginia no publication, advertisement, and/or promotion of price information regarding prescription drugs.

24. The State Board of Pharmacy interprets Section 54-524.35(3) as prohibiting a business with pharmaceutical operations in Virginia and outside of Virginia from advertising, publishing, or promoting, directly or indirectly, the prices of prescriptions in the Virginia operations by utlizing advertising media published without the state but which is circulated in Virginia. For example, Peoples Drug Store may not advertise in the *Washington Post* that it has discounts on some prescription drugs if the advertisement directly or indirectly applies to the Virginia operations.

25. Some pharmacies in Virginia refuse to quote prescription drug prices over the telephone for several reasons, one being the mistaken belief that Section 54-524.35(3) prohibits it and another being that consumers may misread prescriptions, thereby leading to misquoted prices. It is the Board's position, however, that the statute does not prevent a pharmacist from quoting the price of prescription drugs to a person orally or by phone upon request.

26. In the absence of Section 54-524.35(3), some pharmacies in Virginia would advertise, publish and promote price information regarding prescription drugs.

27. A significant portion of income of elderly persons is spent on medicine. For some elderly persons it may be more difficult to compare prices between pharmacies than it is for younger persons.

28. Because of the prohibition on the dissemination of information regarding prescription drug prices, Jordan and members of plaintiffs VCCC and Virginia State AFL-CIO are without information from advertisements, publications or promotions as to where the prescription drugs they are required to take might be purchased least expensively. They may, however, attempt to acquire such information by going

from store to store and asking the pharmacist, or by having the physician who prescribes the medication call pharmacists in order to determine the price, or by calling various pharmacies themselves.

29. People who are concerned about the prices of pharmaceutical services, including prescription drugs may discuss them with their pharmacist just as they would discuss the cost of medical services with their physicians.

IV. *Monitoring*

30. Monitoring is the practice pursuant to which the pharmacist maintains a record which includes the customer's age, name, and address; the family unit, if applicable, allergies and drug sensitivities where they are known; the name, quantity, and strength of the drug dispensed; date dispensed and the price to the customer. This information is maintained on "family prescription records" or "profiles."

31. These profiles enable the pharmacist to determine and to advise the patient and/or the physician the type and quantity of such drugs dispensed and how the patient may be affected by such use.

32. Maintaining "family prescription records" involves some additional expense, but they also (a) provide the pharmacy with a patron list for direct mail advertising; (b) cut paperwork and work hours in making charge statements and notations for welfare recipients, special fees for indigents and third-party payments; (c) save time in permitting the pharmacist to furnish quick documentation of prescriptions for tax or insurance purposes. Some pharmacists who do not maintain family prescription records do not do so because of the expense of maintaining them.

33. Some over-the-counter drugs—*i.e.,* drugs sold without the need for a prescription—including aspirin, are an-

tagonistic to prescription drugs. Family prescription records maintained by Virginia pharmacists generally do not list the over-the-counter drugs that customers are taking.

34. Some foods and drinks are antagonistic to prescription drugs. Family prescription records do not list the foods and drinks which a customer consumes.

35. Physicians should maintain a complete medical history on each patient which includes a list of all drugs being taken, even if prescribed by another physician. This is complicated by the mobility of patients, the possibility that they are being treated by more than one prescriber as, for example, an internist, a family practitioner, a gynecologist or obstetrician, ophthalmologist, or dentist. Elderly and poor persons may fall into this pattern of physician use more often that other classes of persons.

36. It is primarily the physician's obligation to ensure that a patient does not take antagonistic drugs and to advise the patient what foods, drinks, over-the-counter drugs and other prescription drugs should not be consumed with the medication which such physician is prescribing. Those pharmacists who maintain family prescription records or who are otherwise familiar with the person's condition and pattern of drug use should advise the customer and/or the physician regarding possible adverse reactions from taking antagonistic drugs, overdosages, and overuse, regardless of which doctor precribes the drug, and some phamacists may also advise their customers which foods, drinks, and other over-the-counter drugs to avoid while taking the particular prescribed drug regardless of which doctor prescribes the drug.

37. According to the U.S. Bureau of Census, of the 4,258,000 persons five years of age or older living in Vir-

ginia in 1970, 1,119,000 were living in a different county or abroad in 1965.

38. Those pharmacies which do monitor do not have the customer's prescription drug history prior to the time he or she moved into the area and began patronizing that particular pharmacy. An interview of the customer to gain such information may be made by some pharmacists.

39. Those pharmacies which do maintain family prescription records do not usually give them to the customer when he or she moves away from the area.

40. Many people patronize more than one pharmacy for a variety of reasons: (a) one may be close to work, another more convenient to home; (b) emergency needs may arise when the customer's usual pharmacy is not open; (c) location in relationship to the doctor's office; (d) free delivery service; (e) non-pharmaceutical items sold in the store may induce the customer to shop there.

41. Section 54-524.35(3) does not prohibit a pharmacy from advertising (a) that it provides delivery service; (b) non-pharmaceutical items; (c) that the customer may have a free coke or cup of coffee while waiting for the prescription to be filled. Any of these advertisings may induce a customer to patronize a pharmacy other than his usual pharmacy.

42. Neither the Code of Ethics of the American Pharmaceutical Association nor of the Virginia Pharmaceutical Association require a pharmacist to maintain family prescription records.

43. The Board of Pharmacy has never promulgated a regulation requiring pharmacists to maintain family prescription records but is considering various proposals.

44. Neither the Virginia Pharmaceutical Association nor the Board of Pharmacy has ever urged legislation requiring pharmacists to maintain family prescription records. The Virginia Pharmaceutical Association with the Virginia Board of Pharmacy has conducted 6 or 7 seminars throughout the Commonwealth explaining and urging the use of medical profile records and the Virginia Pharmaceutical Association does support use of such records.

45. When the customer is aware of the availability of quantity discounts on prescription drugs or that drugs may be obtained at cheaper prices, he may attempt to pressure his physician to prescribe larger quantities of drugs than he would normally prescribe.

The professional integrity of the physician, however, should prevent him from prescribing a larger quantity of medication than is medically necessary in order to allow the patient to take advantage of a quantity discount.

46. Where there is a close physician-patient-pharmacist relationship, the need for family prescription records is diminished by the pharmacist's familiarity wth the patient, his condition, the drugs taken, the frequency with which they are taken, the sensitivity to drugs, prescriber's prescribing habits, all of which he may evaluate to determine whether the dispensing of a particular prescription is in the interests of the patient's health, safety and welfare.

47. Advertising of prescription drug prices encourages the public to shop for their prescription orders when they wish to get them filled, moving from pharmacist to pharmacist. To the extent that customers patronize more than one pharmacy, the ability of pharmacists to formally or informally monitor and maintain a close physician-pharmacist-patient relationship is diminished.

48. In 1958 the Legislature enacted Section 54-426.1 which described it as unprofessional conduct by a pharmacist if he

> "(3) Issues, publishes, broadcasts by radio or otherwise, or distributes or uses in any way whatsoever advertising matter in which grossly improbable or extravagant statements are made about his professional service which have a tendency to deceive or defraud the public, contrary to the public health and welfare.

The Legislature in 1968 amended this section by adding subsection (4) which stated:

> "issue, publishes, advertises or promotes, directly or indirectly, in any manner whatsoever, any amount, price, fee, premium, discount, rebate, or credit terms for professional service or for drugs containing narcotics or for any drugs which may be dispensed only by prescription."

Acting on the report of a committee appointed by the Governor to study the Virginia drug laws Section 54-426.1 was repealed and reenacted as Section 54-524.35 deleting the word "issue" from subsection 4 but otherwise retaining the language quoted in (3) and (4) *supra.*

In 1971 the Legislature established a committee to again review the drug laws. This committee's report recommended amendment of Section 54-524.35 to its present form. This was adopted by the Legislature in 1972.

49. The Virginia Pharmaceutical Association actively lobbied for enactment of the predecessor to subparagraph (3) of Section 54-524.35.

VI. *Stale Or Adulterated Drugs*

50. It would be unethical, unprofessional and illegal for a pharmacist to dispense a drug which is adulterated or which has become dangerous or ineffective because of age or conditions of storage.

VII. *Position Of United States Government*

51. The statements described below and attached as Exhibits A, B, and C are the positions regarding prescription drugs of the persons and/or agencies who authored them.

A. *Task Force on Prescription Drugs, Reports and Recommendations,* prepared by the U.S. Department of Health, Education, and Welfare;

B. *Research Paper and Policy Statement of the United States Department of Justice Regarding State Restrictions on the Advertising of Retail Prescription Drugs,* 1971.

C. *Remarks By Virginia H. Knauer,* Special Assistant to the President for Consumer Affairs, September, 1972.

* * *

EXHIBIT B

Filed December 5, 1973

Research Paper and Policy Statement of the
United States Department of Justice Regarding
State Restrictions on the Advertising of
Retail Prescription Drugs

The Department of Justice, as the executive agency responsible for the enforcement of the antitrust laws, has received complaints relating to state legislative or administrative restrictions on the advertising of prescripion drugs. Our

experience in analyzing market practices, and our role as advocates for competitive policy, cause us to be particularly concerned over two types of restrictions relating to retail drug advertising: (1) state restrictions prohibiting the advertising or promotion of prescription dugs by name or price, and (2) state provisions restricting the type of drug price advertising which may be used, i.e., preventing the use of terms such as "cut rate" or "discount." Competition is our basic national policy. It has proven to be the most effective spur to business efficiency, innovation, and low prices. Prohibitions on drug advertising represent departures from this national economic policy. Such inconsistencies should be countenanced only when clearly justified in terms of public need.

Twenty-eight states,[1] either by statute or regulation, generally prevent the advertising of prescription drugs by name or price,[2] and 10 states prohibit the use of terms such as "discount" with respect to the advertising of prescription drugs.[3] These restrictions on information have dramatic effects. A survey conducted by the American Medical Association in Chicago, and reported in the New York Times on May 28, 1967, showed price differentials in pharmacies throughout the city of up to 1200% for the same amount of an identical drug. A recent study conducted in New York by Consumers Union found that prices for the same amount

[1] Fletcher, *Market Restraints in the Retail Drug Industry,* (University of Pennsylvania Press, 1967).

[2] *Advertising by Name or Price Prohibited by Statute In:* Florida, Maryland, Michigan, New Jersey, New York, Oklahoma and Texas; *—and by Regulation In:* Arkansas, Colorado, Connecticut, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Massachusetts Minnesota, Nevada, Oregon, Rhode Island, South Dakota, Virginia, Washington, West Virginia, and Wisconsin.

[3] Discount Advertising Prohibited by Statute In: California, Maryland and New Jersey;—*and by Regulation* In: Colorado, Louisiana, Maine, Massachusetts, Mississippi, New York and Pennsylvania.

of one drug ranged from $.79 to $7.45, and for another drug from $1.25 to $11.50.[4] Differentials such as these can only exist when they are unknown to potential consumers, for given a choice, most consumers would refuse to pay 10 or 12 times the going price for a drug available elsewhere. The cost to the public of the lack of price competition is enormous. In 1969, $4.0 billion was spent for out-of-hospital prescription drugs.[5]

The Department of Justice believes that the major effect of legislation or regulations prohibiting price advertising of prescription drugs is to reduce retailer incentives to engage in price competiton with resulting higher costs to the public. We submit that sound economic and social policy dictate that any restrictions which have the effect of raising drug costs should be kept to the minimum required by considerations of public safety. Thus the Department urges that the states, which will bear a portion of the burden of high drug prices under the Medicaid program, re-examine the essential premise upon which the advertising restrictions are based;—i.e., that the advertising of prescription drugs will endanger the public health. It is the Department's view that such a premise is largely erroneous and that, to the extent that public health dangers might pose problems, they can be met by methods which stop short of the absolute prohibition of price advertising. The *Final Report* of the HEW Task Force states the problem concisely:

> The present patchwork of State pharmacy laws, regulations, and codes of ethics obviously reflects attempts to cope with a variety of pharmacy problems on a piecemeal basis. Whether they are aimed at the pro-

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[4] "What's the Price of an Rx Drug?" 35 *Consumer Reports* 279 (1970).

[5] United States Department of Health, Education, and Welfare, *Prescription Drug Data Summary*, at p. 7 (1971).

> tection of the public health, or the prevention of competition—fair or unfair—is not clear in all cases.

This analysis is supported by a very recent decision of the Pennsylvania Supreme Court invalidating that state's statutory restrictions on drug advertising. *Pennsylvania State Board of Pharmacy* v. *Pastor*, 441 Pa. 186, 272 A.2d 487 (1971). In an extremely cogent opinion, the court dealt with—and rejected—the traditional justifications generally used to support these restrictions.

The first argument was that advertising would encourage excessive use of drugs. The Pennsylvania Supreme Court rejected a trial court finding that, "[T]he promotion and advertising of dangerous drugs and narcotics would certainly to a degree titillate an aberrant person and create an atmosphere of easy availableness." The court noted that this finding appeared to assume either unethical or illegal conduct by doctors and/or pharmacists, an assumption which the court refused to make. The court noted that the sale of prescription drugs was closely supervised and that other statutes, both state and federal, prohibited sales except by prescription. The court concluded that the highly regulated structure of the pharmaceutical profession, together with the fact that the consumer cannot choose his purchases, made it "most unlikely that advertising the prices of retail prescription drugs would, or could, have any impact on the demand or consumption of such drugs."

The second justification argued was that price advertising would make it more difficult for a pharmacist to "monitor" prescriptions of individuals because it would encourage price shopping. The court found that the evidence did not establish the extent, if any, to which monitoring took place, and that, although some courts had accepted this as a justification for restrictions on advertising, even those courts had

admitted that monitoring is "infrequent" and "not completely effective." In addition, the court noted that more direct methods were available to protect against the prescription of antagonistic drugs.

The third and final justification argued was that price advertising might encourage pharmacists to purchase unusually large quantities of drugs, so as to obtain a lesser price, thus creating the possibility that drugs may stay on the pharmacist's shelf for an extended period of time during which they might deteriorate. The court noted that the sale of adulterated drugs was prohibited, and could subject a pharmacist to criminal liability as well as the loss of his license. The court reasoned, "With such stringent provisions, the additional prohibition on price advertsing would certainly appear to be 'patently beyond the necessities of the case.' "

Even after undertaking this analysis, the court expressed reluctance to overrule the statute by "judicial fiat." The final factor which led to its decision was what the court described as "the dampening of price competition in the retail sale of prescription drugs" and its effect on consumers, especially the elderly. After citing the New York study described earlier, the court quoted from the Second Interim Report and Recommendations of the Task Force on Prescription Drugs of the United States Department of Health, Education, and Welfare, a quotation which deserves partial repetition here:

> "There is an obvious need for patients to be able to determine readily the prices charged by the various pharmacies in their community. This appears to be particularly important in the case of long-term maintenance drugs.

> The task force recognizes the difficulties in making such information easily available . . . .
> Nevertheless, if the patient is to maintain the right to select a pharmacy, he also has a right to know the prices it charges and to campare these with other prices."

We believe that the Court's analysis is persuasive and that it should be carefully considered by other states in forming their policies in this area.[6]

Moreover, the Comprehensive Drug Abuse Prevention and Control Act of 1970[7] illustrates that competitive policy can in fact be incorporated into statutory regulations in this area. The Act specifically recognizes the importance of competition; in both the registration of domestic manufacturers and the issuance of import licenses, the statute requires regulatory action to be consistent with the maintenance of "adequate competition." Section 303(a)(1) of the Act directs the Attorney General, in registering manufacturers, to consider the maintenance of effective controls "by limiting the importation and bulk manufacture of such controlled substances to a number of establishments which can produce an adequate and uninterrupted supply of these substances *under adequately competitive conditions* . . ." Section 1002(a)(2) of the Act authorizes the Attorney General to allow additional imports where necessary to insure adequate competition. Regulations adopted by the Bureau of Narcotics and Dangerous Drugs pursuant to the statute set out specific standards by which competitive determinations can be made, including price rigidity, the extent of service and quality competition, and whether or not

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[6] At least one other similar state restriction has been invalidated by a state court. *See* Florida Board of Pharmacy v. Webb's City, Inc., 219 So. 2d 681 (Fla. 1969).

[7] Public Law 91-513 (Oct. 27, 1970).

substantial differences exist between domestic prices and foreign prices.[8] The primary thrust of the 1970 Act is of course to develop effective controls against the diversion of legitimate drugs into illicit channels. However, it seems clear that the American public should not be denied the benefits of competition in the provision of these substances except as is necessary to carry out the purposes of the Act. Thus, the Act recognizes and coordinates control and competition. Such coordination should be sought by the states in their attempts to supervise the provision of drugs to the public.

Accordingly, it is the Department's view that existing state legislation or regulations which prohibit or restrict price advertising of prescripton drugs may well be adverse to the publc interest. Since such restrictions appear to be unnecessary to protection of the public and result in unjustifiable expenditures by consumers, the Department feels they should be eliminated.

* * *

TESTIMONY OF DEFENDANT'S WITNESSES

Pursuant to the pre-trial conference of December 7, 1973, defendants submit for filing the testimony of the following individuals anticipated to be called as witnesses:

1. Dr. Harold I. Nemuth

2. Dr. Waren E. Weaver

2(a). If Dr. Weaver is not available then Dr. John Andrako will testify—his VITA sheet is attached.

3. Carl F. Emswiller, Jr.

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[8] 21 C.F.R. 311.42.

3(a). If Mr. Emswiller is not available then Eugene White will testify.

4. J. Curtis Nottingham

5. Keith D. Kellum

6. Wallace B. Thacker

7. Thomas E. Rorrer

Though joint stipulations cover the subject matter of some testimony it is in a broad general sense only. Counsel for defendants feel that with the specifics from testimony of the above individuals, either by further stipulations or *ore tenus* the general stipulations will have greater significance. Additionally, the testimony of such individuals covers subject matter to which the parties are unable to stpiulate.

Counsel for defendant, however, submits that as to the first four individuals, *ore tenus* testimony is not necessary if their prior testimony in the case of *Patterson* v. *Kingery,* 305 F.Supp. 821 (W.D. Va. 1969) is received.* Such prior testimony is admissible as an exception to the hearsay rule. Its reliability is satisfied since 1) it was given under oath; 2) the identity of issues (1st and 14th Amendment questions) are the same; and 3) there was an opportunity for, and in fact was, extensive cross examination by individuals who had like motives to cross examine about the same matters as would plaintiffs. See *McCormick on Evidence,* 2nd Edition, 1972, Secs. 254-257, pp. 614-621.

* * *

* To that end defendants attach hereto the prior testimony of Dr. Harold I. Nemuth and move for its admission.

PROPOSED TESTIMONY OF WALLACE B. THACKER

Defendants submit that if called to testify in the trial of the aforesaid matter, Wallace B. Thacker would testify substantially as follows:

I am a graduate of the Medical College of Virginia School of Pharmacy, and am licensed to practice pharmacy in the State of Virginia. Presently, I am a member of the Board of Pharmacy and I am a defendant in this suit.

I practice pharmacy in a hospital as opposed to a community setting. However, as a result of my service on the Board, my reading of professional journals and my contract with community pharmacists, it is my opinion that the pharmacists is the one health professional who is best informed and knowledgeable as regards drugs. Of course, the physician who uses a limited number of drugs is generally more familiar with the clinical response and reaction to these drugs than would be the pharmacist. However, most physicians are not that familiar with the other vast number of drugs which they do not specifically use in their practices.

In my practice, I am constantly asked questions concerning drug dosages, the stability of various drugs and their forms, the compatibilities of these drugs with other chemicals, the therapeutic compatibilities of drugs, uses for a particular drug, and the appropriate method of administration for the drug.

As examples, I was asked each of the following questions by physicians during only one day.

1. Can oxytetracycline HC1 be administered in the same intravenous solution as tubocurraine without loss of potency?

2. A warning to a physician that syrup of Hycodan which contains homatropine methyl bromide should not be

given together with tricyclic-anti-depressants, due to excessive anti-cholenergic action.

3. How long is ampicillin sodium stable when mixed with 5% dextrose in water with a PH of 4?

4. Does the color loss of oxytetracycline hydrochloride when mixed with lactated Ringer solution (ph 6.5) indicate loss of potency?

5. May I administer five—fluro uracil by mouth?

6. A caution to a physician on the use of chloral hydrate concomitantly with warfarim sodium because of the possibility of excessive bleeding.

7. Could you suggest a non-alcoholic anti-tussive liquid that may be given to a psychiatric patent?

8. How many milliequivalents of potassium are in twenty million units of potassium penicillium—G and is this enough to cause hyper-alkemia in an aged cardiac patient?

9. A reminder to a physician that the administration of oral contraceptives will result in a "false positive" increase in PPI values for that laboratory test?

10. Reminded physician that administration of cephalo sporins will cause "false positive" urine test for sugar. (Clinitest).

Such questions are not at all unusual and are typical questions that are presented to us daily.

PROPOSED TESTIMONY OF THOMAS E. RORRER

Defendants submit that if called as a witness at the hearing of the above case, Thomas E. Rorrer would testify substantially as follows:

I am Thomas E. Rorrer, a licensed pharmacist in the Commonwealth of Virginia and I am the pharmacist-in-charge at The People's Pharmacy in Waynesboro, Virginia. I am the proprietor of this pharmacy and have practiced there for several years. During the year 1972-73, I served as President of the Virginia Pharmaceutical Association and in July of 1973, I was appointed by the Governor to serve as a member of the State Board of Pharmacy.

During my tenure in office and in serving in various capacities in the Virginia Pharmaceutical Association, I have had an opportunity to travel and discuss professional and economic aspects of pharmacy with practicing pharmacists in all parts of the Commonwealth, consequently, I am quite familiar with pharmaceutical practice in Virginia.

It is my opinion that at the present time there is aggressive price competition between pharmacists throughout the State of Virginia. Because of my familiarity with the economics of pharmacy practice, I am of the opinion that the advertising of prescription prices would not lead to a reduction in those prices to the consumer. My conclusion is based on the premise that obviously, the cost of the advertising must be passed on to the consumer, and it is my opinion that prescription prices such advertising might not result in sufficient increase volume to offset the added cost and thereby result in a savings to any consumer. On the contrary, this practice might result in an increase in some prices.

It is my further opinion that the advertising of prescription drug prices would isolate pharmacy from the other

professions in that pharmacy would be the only profession whereby its professional services were commercialized and advertised.

As a result of this distinction between pharmacy and other professions, our stature as professionals would be diminished in that we would be considered tradesmen as opposed to professionals. This is a ludicrous result in that the product we sell is not a commodity, rather like the lawyer, the physician, the dentist, the architect, we provide the public with a professional service. That service is our knowledge and professional judgment in making several critical judgments and decisions with regard to each prescription that we fill.

Not only would this illogical distinction adversely affect pharmacists who are now in practice, it would have a detrimental effect on the ability of the professions to attract to its ranks capable young men and women who have little interest in being tradesmen though a high interest in a career as a person considered by the community as a professional.

I have utilized the family prescription record system in my pharmacy for several years. In my opinion it is an essential part of the practice of pharmacy and its effectiveness would be severely diminished if members of the public were encouraged to use many different pharmacies.

TESTIMONY OF DR. HAROLD I. NEMUTH

Dr. Harold I. Nemuth would testify that he is a physician with degrees from Columbia University in the City of New York (Bachelor of Arts) and Doctor of Medicine, Medical College of Virginia, Richmond, Virginia. He practices medicine in Richmond, Virginia and has been since 1947. He is a member of the American Medical Association,

the Medical Society of Virginia, the Richmond Academy of Medicine, the Association of Teachers of Preventive Medicine, the American Association of Medical Colleges, the Pan-American Medical Society, the International Gerontological Society, and others. He teaches at the Medical College of Virginia in the School of Pharmacy, the School of Dentistry, the School of Medicine, and the School of Nursing. In the School of Pharmacy he teaches preventive medicine—the relationship of pharmacy and the pharmacist to public health or the health of the public. He has taught that course at the School of Pharmacy for over ten years.

He would testify that the pharmacist has a relation to public health; that the pharmacist is an important member of the health team in relation to the individual's and society's search for assistance with health problems—(Health team includes everyone who has anything to do with the health of a patient—doctors, dentists, nurses, social workers, psychiatric social workers, physiotherapists, technologists, X-ray technologists.)

The pharmacist is the most accessible professional person to the public. The public does not need to call the pharmacist for an appointment. The pharmacist is available during the entire period that he is on duty, and indeed, on occasion when he is not officially on duty, for consultation by any individual who wants advice in regard to his medical problem, his health or a particular illness. And as such, the pharmacist functions as a professional member of the health team. In short, though the pharmacist does not practice medicine, he advises.

Besides practicing medicine, the witness has lectured to pharmacists and has worked in pharmacies. As a physician the witness would testify that he relies on pharmacists con-

stantly and frequently. For example, the witness relies on pharmacists in correcting minor errors in dosage that may be on prescriptions, thus enabling him to correct the dosage. Pharmacists have called him to advise: that a prescription is not exact as to dosage; that dosage may be too little or too much; that a dosage is antagonistic in relation to other drugs that the patient may be taking about which the doctor had no previous knowledge; that the patient is receiving medications from other physicians about which the doctor had no knowledge. This occurs to any physician. Further, as a physician the witness will testify that he on occasion calls a pharmacist to inquire about a drug before writing a prescription. The witness will also testify that he has a Physicians' Desk Reference (PDR) which lists drugs but that he still has to rely on the pharmacist because (1) the PDR does not delineate information that he seeks in terms of the practical applications of a particular drug; (2) the PDR contains information in such a minute detail that it would take an unnecessary amount of time to glean information that he can get from a pharmacist who knows more and should know more about a particular drug than a doctor might know about a particular drug.

Lastly, the witness would testify that on many occasions the pharmacist aids in combating drug abuse by assisting him in insuring that one of his patients has his prescriptions refilled timely or is not refilling them too frequently.

A physician attempts to learn a patient's background but cannot always keep complete records. The pharmacist is of much more importance today because many pharmacists keep professional records of allergies, sensitivities, and reactions that patients may have had to drugs. Doctors therefore may obtain information from pharmacists in this regard. The PDR naturally does not tell which patient is allergic to what drug. This is a clinical determination, in

which the pharmacist assists. All new patients fill out a form which asks whether the patient has ever been treated by another doctor and whether the patient has been taking any medication during the previous six months. These forms are checked periodically by the physician. The physician is responsible for the medication prescribed, and it is the physician who is responsible for adverse reactions which the consumer may suffer from taking antagonistic drugs. It is possible that a pharmacist is also responsible for such adverse reactions.

Summary

In general Dr. Nemuth's testimony would revolve around two points: (1) how a physician relies upon pharmacists in the dispensing of medications for patients and (2) that such reliance is needed and must be continued since physicians, though attempting to get a medical background on each patient, cannot always be sure that their records are complete nor do they always know what drugs are being prescribed by other physicians.

TESTIMONY OF DR. WARREN E. WEAVER

In case of the possible unavailability of Dr. Weaver, Dr. John Andrako would provide the following testimony. Dr. Andrako is presently Assistant Vice President of the Medical College of Virginia, Health Sciences Division of Virginia Commonwealth University. He holds Bachelor and Master degrees from Rutgers University and a PhD in Pharmaceutical Chemistry from the University of North Carolina. He had previously served as a professor of pharmacy as well as Assistant Dean, School of Pharmacy, MCV. He is or has served on various state and national committees on phar-

macy and pharmacy education; he has served or serves on twenty different university committee and is a member of such organization as the USAN council—the official body which designates names of new drugs; he is a member of the American Pharmaceutical Association, the Virginia Pharmaceutical Association, the American Chemical Society, the American Association of Colleges of Pharmacy, the Medical Chemistry Section of the Academy of Pharmaceutical Sciences, the Virginia Section of the American Chemical Society, the National Clinical Pharmacy Conference Ad Hoc Steering Committee.

Dr. Warren E. Weaver would testify that he is Dean of the Virginia Pharmacy School and has been since 1956. He holds the following degrees: a B.S. in Pharmacy from the University of Maryland, awarded in 1942, and a Ph.D. with a major in Pharmaceutical Chemistry, awarded in 1947. He is a member of the American Chemical Society and has been since 1942, a member of the American Pharmaceutical Association, a member of the Virginia Pharmaceutical Association, the Virginia Society of Pharmacists. Friends of Historical Pharmacy, American College of Apothecaries, among others. In the American Chemical Society, Virginia Section, he has been Secretary, Treasurer, Vice Chairman and Chairman of the Section. He has been Editor of the publication of the Virginia Section of the American Chemical Society, Treasurer of the Virginia Pharmaceutical Association, Secretary-Treasurer of Friends of Historical Pharmacy and President of Friends of Historical Pharmacy. As Dean of the School of Pharmacy he belongs to the American Association of Colleges of Pharmacy and is past President of that organization and a member of the Executive Committee of that organization as well as having held several committee posts and chairmanships of committees

for the Association. He is also a member of the Board of Directors of the American Foundation for Pharmaceutical Education, which is not a membership organization but is an organization that operates in the field of education in pharmacy. In addition, the School is very much interested in programs such as the Regional Medical Program and he holds posts with respect to the Virginia Regional Medical Program.

In the School of Pharmacy he teaches ethics, which is a discussion course for senior students in the School of Pharmacy.

Either Dr. Weaver or Dr. Andrako would testify that pharmacy is a profession. One of the requirements to practice pharmacy in the State of Virginia is licensure. Licensure has been a requirement in Virginia since 1886. Secondly, there is a particular education or training that is involved; there is a discreet group, and thirdly, there is a service to the public. The witness would testify about the curriculum at the School of Pharmacy. That in terms of what the pharmacy student is expected to know about drugs (their chemical composition and reactions of such chemicals as opposed to clinical reactions) the curriculum is certainly more rigid than the education required of the physician. This is indicative of their background and their role on the health team. Though a very small percentage of drugs today are compounded the pharmacist's role is not decreasing. The pharmacist today deals with drugs of much greater effectiveness and which are designed to do a therapeutic job more effectively. The drugs not only have the promise of doing great therapeutic good, but they also have the danger of harm through side effects, misuse, and mishandling. Consequently, though the pharmacist is doing less compounding on the premises, the pharmacist is working more with his

head and is much more concerned with how this drug is working with the patient in terms of controlling the safety of the dose of the medication as the physician has ordered it on his prescription order. In 1942, for example, much of the medication that was prescribed was medication that was only palliative. In short, there was previously more art to the profession than science.

Ethics of the profession of pharmacy formally goes back, in terms of the written word, to the Middle Ages, back into the 1220's.

In the witnesses' opinion, it is not in the best interest of public health to permit advertising of prescriptions. First, advertising of prescription drug prices encourages the public to shop for their prescription orders when they wish to get them filled, moving from pharmacist to pharmacist. This defeats the public in that they no longer have available one of the most important services that pharmacists are able to deliver for their patrons, the service that can be provided by the pharmacist who utilizes prescription records or pharmacists who, through long years of experience and knowledge of a particular individual and his family, have come to know many of the pharmaceutical idiocyncrasies in terms of drug allergies and diseases such as diabetes and the like that might conceivably be involved whenever a patient procures a drug or has a prescription order completed.

Secondly, advertising of prescription drug prices puts pharmacy, the profession directly in the commercial market place in a way that demeans the profession in the eyes of the public and other professionals. The idea that the product is the sum and substance of the only professional service that is related to the pharmacy and to the pharmacist is incorrect. The pharmacist does much besides deliver a drug

product. And commercial advertising that would indicate that all that is involved is the delivery of a product is demeaning to the profession.

In fact, it would be harmful to the public if they shop for prices in this kind of commercial atmosphere, taking what appears to them to be the least price for a product, and they have unknowingly bought something less than they could have purchased elsewhere. This does not mean that if pharmacy were put in the commercial market place, pharmacists would dispense inferior drugs.

People who are concerned about the prices of pharmaceutical services should discuss it with their pharmacist just as they would discuss medical services with their physicians, and the cost of them. Finally, as an educator the witness would testify he has a real concern about prescription pricing, because the more the image is projected to the public that all there is in pharmacy is a prescription product that is counted and poured and sold like tires or any product that does not involve any service other than counting, pouring, and delivering to the individual, the more it means that those in pharmacy education are not going to get the share of those individuals who enter the health professions with the ideal of serving mankind through helping them in their illnesses and difficulties associated with illnesses. If one appeals only to the commercially oriented, inevitably the public will be hurt; because one will not get the kind of individuals who should be entering the profession capable of providing the quality of health care that the citizens of the United States are entitled to receive, and particularly in the Commonwealth of Virginia. The witness would state, however, that naturally pharmacists intend to make a profit.

TESTIMONY OF KEITH D. KELLUM

Defendants state that if called as a witness in the trial of the above matter, Keith D. Kellum would testify substantially as follows:

That I graduated from the University of Houston Pharmacy School with a Bachelor of Science in Pharmacy in 1967 and in that year was licensed as a pharmacist in the State of Texas. For the three years preceeding my graduation, I worked in the Pharmacy Department of a community pharmacy. For the last three years I have been the Executive Secretary of the Virginia Pharmaceutical Association. I am an active member of the National Association of State Pharmaceutical Association Executives, a member of the American Pharmaceutical Association, the National Association of Retail Druggists, the Virginia Society of Hospital Pharmacists and several other professional and civic organizations.

In my capacity as Executive Secretary of the Virginia Pharmaceutical Association, I have extensively traveled over the entire state of Virginia visiting pharmacists, pharmacies and pharmaceutical association meetings, and performed other duties with offices of the Association as would be expected of an executive officer of such an organization. As a result of my contact with pharmacists around the state, my participation in national pharmaceutical association meetings and extensive readings of professional journals, I am quite familiar with the practice of pharmacy on a national scale and am particularly familiar with the practice of pharmacy in the state of Virginia.

In my capacity as Executive Secretary of the Virginia Pharmaceutical Association during the year 1971-1972, I organized and attended six regional continuing education seminars which were conducted throughout the State of

Virginia. All pharmacists licensed in this state, whether members of the Virginia Pharmaceutical Association or not, were invited to attend the seminars. The theme of the seminars conducted during the year 1971-72 was the use of family prescription records. Several persons spoke at each of these seminars and the purpose was to educate pharmacists as to the use and benefits of family prescription records and to encourage pharmacists to utilize family prescription record systems. About four hundred pharmacists attended the seminars. From responses obtained from the 400 plus attendees at these seminars, it was determined that at least fifty percent utilized family prescription records in their practices. Although specific figures are not available, I have determined from my discussions with pharmacists throughout the state, from information given to me by way of the officers of the various district associations throughout the state that not less than thirty percent of the pharmacies in the state of Virginia utilize family prescription record system at this time.

It is also my opinion that if the advertising of prescription prices were allowed, the advantages of family prescription record systems would certainly be minimized, as a tool to protect the public health. I draw this conclusion because the effectiveness of the family prescription record system is dependent upon the patient utilizing one pharmacy as opposed to many pharmacies. I have sufficient respect for the effectiveness of advertising and advertising techniques to realize that their sole effect is to cause consumers to utilize a particular product or business. As pharmacies begin to compete on the basis of price advertising, the natural result would be that consumer would shop from store to store.

It is also my opinion that prescription drug prices would not be reduced if advertising were allowed. I draw this

conclusion for several reasons. First, advertising of any type is expensive. Whatever cost is incurred in advertising would be, of necessity, passed on to the consumer. Secondly, that persons who responded to an advertisement for a particular prescription drug by going to a pharmacy different from his regular supply for a refill prescription would result in requiring the pharmacist to call the original pharmacy for a copy of the prescription and also call the physician for refill authorization. This is much more time consuming than the regular pharmacists, filling of a prescription which the physician has previously authorized to be refilled. A pharmacist is not authorized to refill copied prescriptions. This would result in extra man power and extra costs to the pharmacy. Of course, increased volume might offset this added expense, but in my opinion, such volume would not be generated.

Thirdly, it is my opinion that at the present time competition is very keen between pharmacies, both independent and chain, and the addition of price advertising would not result in driving these prices lower. My support for this comes from figures in the 1973 Lilly Digest which reveals that the net profit for the prescription section of a pharmacy is much lower than it has been in several years. In fact, these figures reveal that on a national basis the net profit of pharmacies is only 3.6 of the total sales. Lilly Digest also reveals that the national average for prescription drugs is $4.38 as opposed to the average price in the state of Virginia which is $4.09. U.S. Department of Labor statistics reveal that as opposed to the cost of other goods and services, the unit cost of prescriptions has, in the last thirteen years, decreased by thirteen percent.

In my position, I am also in constant contact with the officers and members of many other business and professional groups. From the attitudes that I have discerned

from these people, if pharmacy were singled out as the only profession which was allowed to advertise the prices of its services, the stature of the profession would be lowered.

I also unequivocably oppose the notion that the dispensing of a prescription drug is the sale of a commodity and is the same as selling automobiles, aspirin, chewing gum or any other such commodity. When the patient received his bottle of medication he is not receiving simply twelve capsules of an antibiotic, he also is receiving the benefit of the professional judgment of the pharmacist. Irrespective of how simple the particular prescription may be, the pharmacist must apply his professional judgment and skill to the interpretation of the prescription, the interpretation and in many cases, the evaluation of the dosage stated on the prescription, the communication of that dosage instruction, in an intelligible way, to the patient, the selection of the appropriate drug, including the strength, the ability to distinguish between dosage forms which appear similar, the selection of appropriate containers for dispensing to assure that the product does not deteriorate as a result of exposure to light, moisture, temperature, etc., and, possibly, where the physician has prescribed a generic drug— which is less than 20% of the time, selecting a specific brand so as to assure that the patient receives a high quality, effective product. The steps that I have just enumerated are ingredients which are necessary for the filling of even the simplest prescription and I have not attempted to delve into situations which are complicated by, refilling, possible drug abuse, possible improper instructions for use, etc. In dispensing this prescription, the product received is no more a commodity than is a deed or will prepared by an attorney, a denture supplied by a dentist or sketches supplied by an architect.

TESTIMONY OF CARL F. EMSWILLER, JR.

Carl F. Emswiller, Jr. would testify that he has been a pharmacist since 1962 and has a pharmacy located in Leesburg, Virginia at 3 South King Street. He attended the Medical College of Virginia, Pharmacy School and has previously worked in Berryville, Virginia for Eugene V. White from 1962-1968. Eugene White was a pioneer in establishing medical profile records.

When he fills a prescription the witness would testify that he looks at it to determine what it is and the patient's name, then types out a label and fills it with the appproppriate medication. First, however, the receptionist pulls the patient's family record card. This is surveyed with the prescribed medicine in mind, to see that there are no contraindications and that there are no reasons the patient cannot take this medicine for one reason or another. The family record card contains the husband's name, the wife's name, their address, their phone number (for an emergency—the husband's place of employment) any known drug sensitivities or allergies or idiosyncracies the children's names and ages and nicknames (in case the proscription is written in the nickname). The date the prescription is filled is recorded and the prescription number, and each time it is refilled, the amount of medication dispensed, what the medication was, the strength of it, and the fee that was charged. Mr. Emswiller also records medication dispensed for family pets.

The witness would testify that the family record card is valuable from a pharmacist's point of view, from the physician's point of view and the patient's point of view. First, the card provides the pharmacist, with a complete drug history of the patient. This enables him to ensure when he fills the prescription, that there are no known contraindications occurring—allergies, etc. If the patient forgets a prescrip-

tion number or throws a bottle away, the pharmacist can check back, thus aiding the patient and for example, saving them a drive back home. Lastly, physicians often use the card e.g., if they are on a house call and they don't have a patient's chart before them, they will call in and ask the Pharmacist about allergies. A specific example* is a hospital anesthetist called and said that he had a patient who was getting ready for surgery. The patient was taking blood pressure tablets but he didn't know what the name of the medicine was. All the patient knew was that he was taking little green tablets. He didn't have a prescription or anything to refer to. So, the anesthetist called and was told, in a matter of seconds, what the medicine was Salutensin which contains Reserpine. (Reserpine will potentiate anesthetics). The anesthetist commented "That is a good way for me to look up and see no blood pressure at all." Emswiller feels therefore that it is really worthwhile to have his family record system. Though one of the purposes of the record is to provide the patient records for income tax purposes, the whole thing in reality is geared for the safety of the patient. Information from the patients as to the sensitivities and allergies is obtained when the patient comes into the pharmacy for the first time. The receptionist goes out and shows the patient the blank card and expains what the record is and how it is used. Then the appropriate information is obtained by interview. Other specific examples are where one physician has prescribed something and then the patient goes to another physician. One example* is where a patient has been taking Tofranil and was prescribed Parnate by another physician. Both drugs are in the tranquilizing field—one is a potent monoamine oxidase inhibitor and they are contraindicated drugs.

* These incidents occurred in approximately 1968 or 1969 as testified to by Mr. Emswiller in a deposition on June 26, 1969 in the case of *Patterson* v. *Kingery*.

Tranylcypromine would be the generic name. When the patient came in with a prescription for the Parnate, Emswiller knew that there should be a two-week period between taking one after the other. So, he called the physician and told him what the patient had been taking—that just a couple of days before there had been a refill. The doctor changed the medication.

Additionally, a pharmacist is always asked to recommend what patients should take for a cold, or sniffles, etc. There are many over-the-counter preparations (OTC) containing antihistamines or decongestants which should not be taken with certain legend drugs. Any of the monoamine oxidase inhibitors are prime examples. His medical record system assists him in recommending OTC drugs, e.g. "Can you take Coricidin with any of the medicine you are taking?"

In short, when patients ask for an over-the-counter recommendation, he pulls their record and takes a look at it before the determination of what to recommend. If the patient is taking Thyroid, then the witness would not recommend something with a decongestant or antihistamine in it since these things are contraindicated. True, a patient can purchase OTC drugs not only at a drug store, but also at food chains and everywhere else. You cannot be one hundred per cent accurate in such instances, but as a professional you should do all that is possible. The family record card is a giant step in the right direction. The family record system is also helpful in drug recalls. There is no reason why the lot number can not be recorded. The bottle the drug comes in has a lot number from the manufacturer. For control purposes with the lot number recorded one could trace down every tablet on a drug recall that was dispensed through a particular pharmacy. For example, in drug recall incidents, if all the pharmacies in the United States

maintained profile records and recorded the lot numbers thereon, all of the defective drug could be recalled.

Mr. Emswiller has spoken on the medical record system at Rutgers University at the New Jersey Pharmaceutical Association and the New Jersey Society of Hospital Pharmacists. Also at a convention of the American Pharmaceutical Association he helped staff a pharmacy that was built by McKesson & Robbins on the order of the pharmaceutical center, in which the patient record was used, and explained the patient record and how it could be of advantage to pharmacists in their practice.

The witness belongs to the Virginia Pharmaceutical Association, the American Pharmaceutical Association, The Academy of General Practice of the American Pharmaceutical Association and the Virginia Association of Professions.

The family record system also aids in the taking of maintenance drugs and even birth control pills. The card is a drug history. Thus, if a patient doesn't take medication, the pharmacists knows, if he keeps a "tickler" system, that they don't take the medication. The witness would testify that he does not keep a tickler system nor does he know of any pharmacist who does. He, however, attempts by instinct and memory to use the cards in assisting people in drug maintenance. If it is a patient, for example, who was in a mental institution and is home for a tryout period and they suddenly didn't get their medication, the pharmacist could phone the physician or the family and let somebody know that the patient wasn't taking his medication. The card assists a patient by keeping them on a steady maintenance.

In conclusion, the pharmacist can be an effective aid in using the patient record in determining patients are taking their medicine and are receiving proper medicine. The card

system is not going to be one hundred per cent effective. But there is nothing one hundred percent effective. The system, to the extent it helps promote the safety and well-being of the public, is a valuable tool. The system is becoming more and more in use and among the pharmacists the witness knows it is on the increase in usage.

TESTIMONY OF MR. J. CURTIS NOTTINGHAM

Mr. J. Curtis Nottingham would testify that he is a practicing pharmacist in Williamsburg, Virginia. He is a member of the Chesapeake Pharmaceutical Association, Virginia Pharmaceutical Association and the American Pharmaceutical Association, and has served as President in each. He has two pharmacies in Williamsburg, Virginia—Nottingham, Pharmacy, Incorporated, Williamsburg, and Nottingham Terrace Pharmacy, Incorporated, Williamsburg. He employs the family record system in both drug stores. The system is used for income tax purposes and to enable patients to identify drugs in case they have lost their prescriptions and where a patient is under the care of more than one physician, the local physician can call to find out the nature of the medication that may be prescribed by a specialist in a nearby city. He also has occasions to call the physician because of a question that arises as to the appropriateness of medication that may have been prescribed either by the local physician, or the out-of-town specialist, the medication being in conflict, possibly with something already previously prescribed. The card system is what causes such questions to arise and enables the pharmacist to perform his true professional service. The witness would consider it a gross handicap to attempt to carry on his professional services without this record.

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TESTIMONY OF PLAINTIFFS' WITNESSES

Pursuant to the pre-trial conference on December 7, 1973, submitted herewith for filing are the testimonies of those persons whom plaintiffs anticipate calling as witnesses.

* * *

TESTIMONY OF MYRON D. WINKELMAN

If Myron D. Winkelman were called as a witness he would testify substantially as follows:

1. I have been a registered pharmacist for 14 years, during which time I have worked in and with both independent and chain pharmacies. I am currently Vice President for Professional Services for Revco D.S., Inc., a publicly held company with headquarters in Cleveland and pharmacies throughout the United States, including 40 pharmacies in Virginia.

2. Of the more than 20 million prescriptions which Revco pharmacies fill annually, over 99% require no extemporaneous compounding, rather the pharmacist selects the prescribed pre-manufactured dosage form.

3. Since there is no legal, professional or ethical requirement to maintain family prescription records, Revco pharmacies do not maintain them. During the past eleven years, Revco pharmacies have filled over 75 million prescriptions and to my knowledge there has never been a claim by any customer against any Revco pharmacy for having dispensed antagonistic drugs.

4. Although pharmacy is a profession, it is somewhat unique in that pharmacists are not directly compensated for the professional services they render, but rather for the products they sell; therefore when we advertise the

availability of lower prices for prescriptions at Revco we are not referring to the professional services the pharmacist renders but to the price of a commodity. We pay our pharmacists among the highest salaries in the profession in order to attract the best pharmacists. But the salary doesn't vary with the price of the prescription, nor with the number of prescriptions dispensed.

5. Revco has a discount plan for persons over 60 and under 5 years of age, who are entitled to a 10% discount on all of their rescription drugs purchased at Revco. Revco is prohibited from disseminating information about these plans in Virginia. It is my opinion that if the advertising and promoton of these plans were permitted—as for example with promotions similar to those displayed in plaintiffs' exhibits 11(B) & (D)—the number of persons utilizing them would increase significantly. My opinion is based in part upon the fact that where after a prohibition on advertising such programs was eliminated, there was a 300% increase in program utilization at Revco within a six month period.

6. One of my primary responsibilities during my 11 years with Revco has been establishing the prices which Revco pharmacies charge for prescription drugs. When Revco enters a market area, it conducts a thorough study to determine what the prevailing prescription drug prices are, and it conducts regular periodic studies thereafter.

7. Our studies have revealed that in those geographic areas where Revco is permitted to advertise information about the variances in prescription drug prices, such prices in that area generally decline. On the other hand, in those geographic areas, such as Richmond, Virginia where Revco is prohibited from disseminating information about its pre-

scription drug prices, such prices do not decline as significantly, if at all, as in those areas where Revco advertises.

8. It is my opinion that if advertising of prescription drug price information were permitted in Virginia, the prices for many presription drugs would be lower.

* * *

TESTIMONY OF DR. SIDNEY WOLFE

If Dr. Sidney Wolfe were called as a witness he would testify substantially as follows:

1. I am a licensed physician, a former staff member of the National Institutes of Health, and currently the director of the Health Research Group, a non-profit organization concerned about health and safety matters.

2. It is primarily the physician's responsibility to insure that patients do not take drugs which in combination with other drugs produce adverse reactions. Consequently, physicians maintain complete medical histories on each patient, which history includes the names of other doctors who are treating the patient as well as all drugs which the patient is taking. The doctor should also advise the patient what foods, drinks, and non-prescription medicine should not be consumed with the medication which the doctor is prescribing.

Many persons patronize more than one pharmacy for a variety of reasons—one may be closer to home, another more convenient to work, and a third in the building where the doctor has his office; one may provide free delivery; and emergency needs may arise when the customer's regular pharmacy is closed. Consequently, it is necessary for physicians to have a complete medical history on each patient.

4. Physicians do have occasion to consult pharmacists for advice. However, it is my opinion that allowing phar-

macists to advertise will not interfere with the physician-pharmacist relationship. Physicians will continue to consult pharmacists as they do today.

* * *

DEFENDANTS' OBJECTIONS TO TESTIMONY OF PLAINTIFFS' WITNESSES

Filed December 11, 1973

Pursuant to the pretrial conference of December 7, 1973, defendants herewith submit their objections to the proposed testimony of plaintiffs' witnesses.

1. *Testimony of Myron D. Winkleman*

Defendants concede that if called as a witness Winkleman would testify substantially as indicated. However:

A) Such testimony which treats the dispensing of drugs as a product only (Winkleman test. ¶¶ 3 and 4) is directly refuted by the testimony of defendants' witnesses. See e.g. Nemuth, Emswiller, Weaver, Nottingham. All testify 1) the pharmacist delivers a service not a mere product and 2) family prescription records are needed.

B) The testimony that Revco discount plans are not implemented in Virginia (Winkleman test. ¶ 5) is in direct conflict with the decision in *Patterson* v. *Kingery,* 305 F. Supp. 821 (W.D. Va. 1969) allowing implementation of such plans and Board of Pharmacy regulations allowing in pharmacy advertising. See Reg. 14 c(1) and (2). That an increase in utilization of such plans would occur with advertising has no basis; demonstrated no knowledge of Virginia economy and is merely an overt attempt to relitigate *Patterson* v. *Kingery.*

C) The testimony that with advertising drug prices would lower (Winkleman test. ¶¶ 7 and 8) is directly refuted by defendants' witnesses—Kellum and Rorrer.

Defendants object to any inability to cross examine. See *Louisiana* v. *National Ass'n for Adv. of Col. People,* 366 U.S. 293 (1961) at 298.

2. *Testimony of Dr. Sidney Wolfe*

Defendants concede that if called to testify Wolfe's testimony would be substantially as indicated.

However, defendants point out:

A) Testimony as outlined in ¶ 2 of Wolfe testimony is directly refuted by defendants' witnesses Nemuth, and Emswiller as well as by common sense. A physician does not and cannot keep all inclusive records; a pharmacist plays a key important role in the dispensing of drug medication.

B) Testimony as outlined in ¶ 4 is also refuted for example by Emswiller. It is the physician-patient-pharmacist that must be maintained. This aspect is ignored by the Wolfe testimony.

C) There is no foundation that the witness is at all familiar with Virginia practice. As outlined his testimony has no reliability. Defendants object to any lack of opportunty for proper cross examination. See *Louisiana* v. *National Ass'n for Adv. of Col. People, supra.*

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