abuse of illicit ones. Many argue that criminalization of drug addiction has helped create the social deviant subculture[3] as well as the endemic system of violence[4,5] that regulates it. In some cases a market is created because there is a lack of accessible addiction treatment. If we ignore or do not respond to such systemic factors in the creation of a market, the economics of necessity will prevail to maintain the status quo.

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2. Goldman B. The news on the street: prescription drugs on the black market [editorial]. *CMAJ* 1998;159(2):149-50.
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In the article on the street value of prescription drugs,[1] the authors mention that "an estimated 2.6 million people in the United States use prescription drugs … for 'nonmedical reasons,' " but it is not clear if they are implying a similar level of use in Canada. They do seem to imply that the drugs in question are prescribed by doctors and then diverted. This would be quite a commentary on prescribing habits in Vancouver, unless drugs are getting to the street from other sources. Is anybody assessing this possibility?

The article also suggests that welfare cheques make a significant difference. No doubt many people who use street drugs receive welfare payments, but is there any real evidence that welfare recipients end up on street drugs or that their incomes from welfare will support a drug habit?

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In his editorial[1] Brian Goldman expresses interest in the finding in an accompanying article[2] that the street value for prescription opioid analgesics is currently relatively low compared with previous anecdotal reports. This should come as no surprise, given that Vancouver has been flooded with cheap, highly potent heroin that costs $10 to $20 a hit; it makes sense that the street value of prescription drugs must be adjusted accordingly to remain competitive.

Goldman also worries about the chilling effect that prescribing regulations exert on legitimate access to some medications, citing the triplicate prescription programs in New York State and British Columbia as examples. I challenge his conclusion that these programs either deny access to effective drug therapies or lead to excessive prescribing of less desirable drugs.

When New York added benzodiazepines to its triplicate program, there was a negligible absolute increase in the prescribing of less-safe alternatives but the prescribing of benzodiazepines declined significantly.[3] In BC, physicians who had written excessive numbers of prescriptions for narcotic analgesics, at a rate 10 times greater than the mean rate of their peers, were notified by the College of Physicians and Surgeons of British Columbia.[4] Although this notification resulted in a 25% reduction in the number of prescriptions for these drugs, the prescribing rates within this cohort remained significantly higher than average. One of the most frequently prescribed analgesics was propoxyphene, which has limited proven effectiveness in pain management. It is difficult to accept Goldman's assertion that triplicate prescription programs exert a chilling effect on prescribers and unduly limit patient access to pain control.

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[The authors respond:]

We agree with Dr. Latowsky's comments. The roots of the robust street market in prescription drugs are systemic, and there are no simple solutions. There is a huge need for increased addiction treatment services across Canada. Further research may result in the setting of priorities and support better community planning.

Dr. Fern cogently targets the estimate of the use of prescription drugs for nonmedical reasons; however, the accuracy of the estimate we quoted — taken from a newspaper source — is questionable, and its relevance to the Canadian population is unknown.

In our study we found a surprisingly open and thriving marketplace. However, we did not study the quantity of drugs being bought and sold. Although it is likely that most of the drugs sold on the street are diverted from prescriptions written by physicians, it is unlikely that Vancouver doctors are any more guilty of being

duped and manipulated than their colleagues elsewhere. Other sources include robberies involving pharmacies and dental and even veterinary clinics, as well as fraudulent prescriptions.[1,2]

Fern goes well beyond our study when he comments on the association between street drugs and welfare payments. "Welfare Wednesday" involves the infusion of a substantial amount of disposable income into the downtown core with measurable social consequences.[3] Our limited sample suggested that there was a relation between the street prices of pharmaceuticals and this socioeconomic event.

Through our study we tried to increase understanding of the underground economy for at least some prescription drugs and the ways physicians may be enabling the very addictions they are trying to treat and prevent. There is an urgent need for further research into the extent of diversion of prescription drugs and the significance of this trade in other very valuable classes of drugs, such as antiretroviral products.

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Dr. Latowsky is correct when he links the abuse of prescription and illicit drugs, and he is right to frame the problem of drug abuse in the wider social and psychological context. Although decriminalization is an issue best left to public discourse, there is no doubt that the simple application of laws and regulations cannot and will not solve the problem of drug abuse.

Dr. Anderson's observations do not challenge the premise that his study amply demonstrated. Mere notification of prescribers whose prescribing practices were more than 2 standard deviations above the mean was sufficient to result in a 25% drop in the prescribing of opioid analgesics. This kind of observation has been replicated in many US jurisdictions with multiple-copy prescription programs.[1–4] Although Anderson is rightly concerned about the prescribing of propoxyphene in the cohort of physicians notified, it would have been far more effective to have told the physicians prescribing it that the drug is of limited proven value in treating chronic pain. Of greater concern is the lack of data on the effect of decreased prescribing of opioid analgesics. In the absence of such data, it is impossible to say whether such notification helped or harmed the physicians' patients.

Brian Goldman, MD
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Correction

In an article on the annual meeting of the Royal College of Physicians and Surgeons of Canada,[1] the first name of Dr. Irvin Wolkoff was spelled incorrectly. We apologize for this error. — Ed.

Reference
1. Harrison P. Royal College debates whether MDs should promote moderate consumption of alcohol. *CMAJ* 1998; 159(10):1289-90.

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