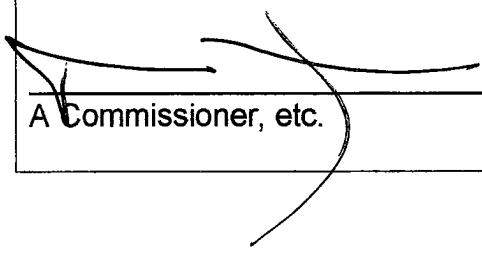


This is **Exhibit B** referred to in the Affidavit of **Stephen Walter** sworn before me this 29 day of May, 2007.



A Commissioner, etc.

consult their physician or their belief that they needed a diagnostic test or a medicine, or as an information source they used (adjusted odds ratio [OR] 2.6, 95% confidence interval [CI] 1.5–4.3). More patients in Sacramento also said that they had conditions that could be treated by an advertised drug (29.4% v. 21.9%: adjusted OR 1.4, 95% CI 1.1–1.8). Patients particularly identified their allergies as conditions that could be treated by an advertised drug: 88 (12.9%) in Sacramento compared with 42 (5.6%) in Vancouver.

Prescription drug requests

Sacramento patients were twice as likely to request medicines as patients in Vancouver and over twice as likely to request advertised drugs (Table 3). After eliminating 12 consultations in which requested drugs were prescription-only drugs in 1 country and OTC drugs in the other, request rates remained substantially different: 14.2% in Sacramento versus 8.8% in Vancouver ($p < 0.01$) (data not shown).

Advertising exposure was measured through the number of listed products a person had seen advertised, identification with an advertised condition and use of advertising as an information source. In Sacramento, all 3 measures were associated with a higher probability of DTCA drug requests. In Vancouver, only the use of ad-

vertising as an information source (3.5% of patients) was significantly associated with DTCA drug requests (Table 3). Fig. 2 compares the number of listed drugs patients had seen advertised with their request rates (χ^2 for linear trend = 18.5, $p < 0.001$).

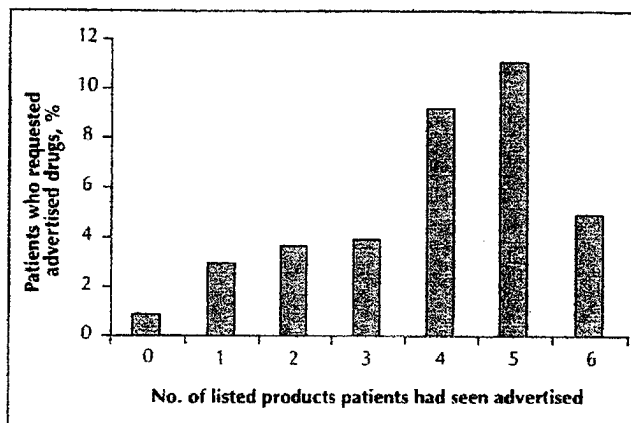


Fig. 2: Proportion of patients who requested DTCA drugs by the number of listed products they remembered having seen advertised. Loratadine (Claritin) was omitted from this analysis, because it had over-the-counter status in Canada. DTCA = direct-to-consumer advertising.

Table 2: Patients' self-reported exposure to advertising

Advertisements seen in previous year	No. (and %) of patients		OR (95% CI)†	Adjusted OR (95% CI)‡
	Sacramento <i>n</i> = 683	Vancouver <i>n</i> = 748		
No. of products*				
0	13 (1.9)	72 (9.6)	0.2 (0.1–0.4)	0.2 (0.1–0.4)
1–5	171 (25.0)	295 (39.4)	0.5 (0.4–0.6)	0.5 (0.4–0.6)
≥ 6	469 (68.7)	359 (48.0)	2.5 (1.9–3.2)	2.7 (2.1–3.6)
Specific product advertisements				
Viagra (sildenafil citrate)	611 (89.5)	592 (79.1)	2.2 (1.6–3.2)	2.0 (1.4–2.9)
Prozac (fluoxetine hydrochloride)	487 (71.3)	426 (57.0)	1.9 (1.5–2.3)	1.8 (1.4–2.3)
Zyban (bupropion hydrochloride)	487 (71.3)	334 (44.7)	3.1 (2.4–3.9)	3.5 (2.7–4.7)
Propecia (finasteride)	357 (52.3)	105 (14.0)	6.7 (5.1–8.8)	7.0 (5.1–9.6)
Depo-Provera (medroxyprogesterone acetate)	210 (30.7)	118 (15.8)	2.3 (1.7–3.2)	2.6 (1.8–3.6)
Evista (raloxifene hydrochloride)	83 (12.2)	27 (3.6)	3.7 (2.3–5.8)	4.6 (2.8–7.5)
Claritin (loratadine)	586 (85.8)	625 (83.6)	1.2 (0.9–1.6)	1.2 (0.8–1.7)
Patients who had seen advertisements for > 3 of 6 listed products§	321 (47.0)	118 (15.8)	4.7 (3.6–6.2)	5.9 (4.5–7.7)
Patients who identified themselves as having a condition treatable by an advertised drug	201 (29.4)	164 (21.9)	1.5 (1.2–1.9)	1.4 (1.1–1.8)
Patients who reported using advertising as an information source	56 (8.2)	26 (3.5)	2.5 (1.5–4.3)	2.6 (1.5–4.3)

Note: OR = odds ratio, CI = confidence interval.

*Percentages do not add up to 100%; 4.4% of values are missing for the Sacramento sample and 3% for the Vancouver sample.

†Odds ratios based on a general estimation equation (GEE) analysis.

‡Adjusted odds ratios based on a GEE analysis controlling for age, sex, health status, income, education and drug payment.

§Excludes Claritin (over-the-counter status in Canada).

We tested the robustness of city of residence as an independent factor that might influence request rates by including it in the same model as these 3 measures of individual advertising exposure. The coefficient for city of residence became smaller and marginally nonsignificant when adjusted for advertising exposure (OR 1.5, 95% CI 0.9–2.6; $p = 0.06$); advertising exposure remained highly significant (Table 4).

Patients requested 37 different DTCA drugs, 7 of which were requested by ≥ 3 patients. One-quarter of Vancouver DTCA drug requests were for products advertised in Canada.⁶ The most commonly requested nonadvertised drugs were antibiotics, anxiolytic or hypnotic drugs, and cardiovascular drugs.

Prescribing

More patients in Sacramento than in Vancouver received 1 or more new prescriptions: 41.3% versus 24.9% (adjusted OR 2.1, 95% CI 1.6–2.8; $p < 0.01$) (Table 5). The prescribing rate was higher overall in Sacramento, but

more Vancouver patients received 1 or more refills: 25% versus 18% (data not shown).

Physicians fulfilled most requests for prescriptions in both settings. In Sacramento 80% of patients who requested prescriptions received them, as compared with 63% in Vancouver (Table 5). The main difference was in the prescribing rate for requested *nonadvertised* drugs (81.4% v. 57.1%), although this difference was no longer statistically significant after adjusting for patient and physician characteristics (adjusted OR 2.2, 95% CI 0.8–6.2). Prescribing rates for advertised drugs differed less (77.6% v. 72.0%: adjusted OR 2.1, 95% CI 0.5–9.6).

Patients who requested medicines were very likely to receive 1 or more new prescriptions, either for the drugs they requested or alternatives. Indeed, for patients requesting DTCA drugs, the odds of receiving a prescription (for any drug) were 16.9 times those of patients who did not request a medicine (adjusted OR 16.9, 95% CI 7.5–38.2) (Table 5).

In order to judge physician confidence in treatment choice for each new prescription, we asked, "If you were treating another similar patient with the same condition,

Table 3: Patients' requests for prescriptions during surveyed consultations

Patients' requests for prescriptions	No. (and %) of patients		OR (95% CI)*	Adjusted OR (95% CI)†
	Sacramento	Vancouver		
<i>Prescriptions requested</i>				<i>Sacramento v. Vancouver</i>
≥ 1 new prescriptions requested (any drug)	108/683 (15.8)	67/748 (9.0)	1.9 (1.3–2.8)	2.0 (1.3–3.1)
≥ 1 DTCA drugs requested	49/683 (7.2)	25/748 (3.3)	2.2 (1.3–3.8)	2.2 (1.2–4.1)
<i>Had the patient seen advertisements for > 3 of 6 listed drugs?‡</i>	Yes	No		<i>Higher v. lower exposure level</i>
≥ 1 DTCA drugs requested, Sacramento	34/321 (10.6)	15/362 (4.1)	2.7 (1.6–4.7)	2.8 (1.6–4.9)
≥ 1 DTCA drugs requested, Vancouver	7/118 (5.9)	18/630 (2.9)	2.1 (0.8–5.9)	1.8 (0.6–5.1)
<i>Did the patient identify himself or herself as having a condition treatable by an advertised drug?‡</i>	Yes	No		<i>Condition v. no condition</i>
≥ 1 DTCA drugs requested, Sacramento	30/201 (14.9)	19/482 (3.9)	4.2 (2.5–7.3)	4.6 (2.5–8.5)
≥ 1 DTCA drugs requested, Vancouver	8/164 (4.9)	17/584 (2.9)	1.7 (0.8–3.5)	1.9 (0.9–3.9)
<i>Did the patient report using advertising as an information source?‡</i>	Yes	No		<i>Advertising used v. not used</i>
≥ 1 DTCA drugs requested, Sacramento	10/56 (17.9)	39/627 (6.2)	3.3 (1.8–6.1)	3.9 (2.2–7.0)
≥ 1 DTCA drugs requested, Vancouver	3/26 (11.5)	22/722 (3.0)	4.0 (1.2–13.4)	4.1 (1.3–13.6)

Note: DTCA = direct-to-consumer advertising

*Odds ratios based on a GEE analysis

†Adjusted odds ratios based on a GEE analysis controlling for age, sex, health status, income, education and drug payment

‡Denominator derived from data in Table 2.

would you prescribe this drug?" We judged an answer of "very likely" to indicate confidence in treatment choice, whereas "possibly" or "unlikely" would indicate some degree of ambivalence. In both settings, physicians were more

likely to express ambivalence about drugs patients had requested, particularly advertised drugs, than nonrequested drugs (adjusted OR for requested DTCA drugs 7.1 in Sacramento [95% CI 2.5–19.8], 14.5 in Vancouver [95%

Table 4: DTCA drug requests as a function of location and individual advertising exposure*

Factors associated with drug requests	No. (and %) of patients who requested DTCA drugs <i>n</i> = 74	Adjusted OR (95% CI)
Patient lives in Sacramento	49 (66.2)	1.5 (0.9–2.6)
Has seen advertisements for > 3 listed drugs	41 (55.4)	2.1 (1.3–3.3)
Has a condition treated by an advertised drug	38 (51.4)	2.7 (1.8–4.2)
Uses advertising as an information source	13 (17.6)	2.9 (1.7–5.1)

*GEE model with city of residence and 3 advertising exposure variables entered, as well as potential confounders (age, sex, health status, income, education, drug payment, physician's sex and graduation year); backward stepwise regression analysis with removal of potential confounders if *p* > 0.1.

Table 5: Prescribing rates during surveyed consultations

Prescriptions requested and received	No. (and %) of patients		OR (95% CI)*	Adjusted OR (95% CI)†
	Sacramento	Vancouver		
Patient received ≥ 1 prescriptions (new and refill prescriptions)	390/683 (57.1)	350/748 (46.8)	1.5 (1.1–2.0)	1.4 (1.0–2.0)
Patient received ≥ 1 new prescriptions	282/683 (41.3)	186/748 (24.9)	2.1 (1.6–2.7)	2.1 (1.6–2.8)
Patient requested ≥ 1 new prescriptions and received the requested prescription(s) (any drug requested)	86/683 (12.6)	42/748 (5.6)	2.4 (1.5–3.7)	2.5 (1.6–3.9)
Patients described above as a proportion of patients who requested any drugs‡	86/108 (79.6)	42/67 (62.6)	2.0 (0.9–4.6)	2.1 (0.9–5.3)
Patient requested ≥ 1 new prescriptions for a DTCA drug and received the requested prescription	38/683 (5.6)	18/748 (2.4)	2.4 (1.3–4.3)	2.3 (1.3–4.3)
Patients described above as a proportion of patients who requested DTCA drugs‡	38/49 (77.6)	18/25 (72.0)	1.4 (0.4–4.8)	2.1 (0.5–9.6)
Patient requested ≥ 1 new prescriptions for a non-DTCA drug and received the requested prescription	48/683 (7.0)	24/748 (3.2)	2.2 (1.3–3.9)	2.0 (1.1–3.7)
Patients described above as a proportion of patients who requested non-DTCA drugs‡	48/59 (81.4)	24/42 (57.1)	3.0 (1.2–7.8)	2.2 (0.8–6.2)
Patient requested DTCA drugs and received ≥ 1 new prescriptions (any prescription) as a proportion of patients who requested DTCA drugs‡	42/49 (85.7)	22/25 (88.0)	0.9 (0.2–4.1)	0.8 (0.1–5.7)
Patient requested non-DTCA drugs and received ≥ 1 new prescriptions (any prescription)	47/59 (79.7)	28/42 (66.7)	1.6 (0.6–4.5)	1.2 (0.4–3.4)
<i>Probability of receiving ≥ 1 new prescriptions among drug requesters v. nonrequesters (combined Sacramento and Vancouver samples)</i>				
<i>Prescription</i>	<i>Drug request</i>	<i>No drug request</i>	<i>Request v. no request</i>	
DTCA drug	64/74 (86.5)	329/1256 (26.2)	17.5 (8.1–37.7)	16.9 (7.5–38.2)
Non-DTCA drug	75/101 (74.3)	329/1256 (26.2)	7.8 (4.8–12.9)	7.9 (4.8–13.2)

*Odds ratios based on a general estimation equation (GEE) analysis.

†Adjusted odds ratios based on a GEE analysis controlling for age, sex, health status, income, education, drug payment, doctor's sex and graduation year.

‡Denominators derived from data in Table 3.

CI 2.6–81.4) (Table 6). Physicians were also more likely to judge patients to be knowledgeable about a drug if they had requested it.

Interpretation

We found that Sacramento patients reported more advertising exposure and requested more advertised drugs than patients in Vancouver and, in both settings, patients with higher exposure to advertising requested more advertised drugs. The prescribing rate for requested advertised drugs was similar, being about 75%.

Physicians judged 50% of prescriptions for requested DTCA drugs to be a "possible" or "unlikely" choice for similar patients. A key argument made in favour of DTCA is that patients are protected because, ultimately, the physician decides whether or not to prescribe.¹⁶ We could not evaluate treatment appropriateness, but if physicians prescribe products that they would not have chosen otherwise, the protection offered by prescription-only status is questionable. In some cases, patients may be right and physicians wrong; however, patients do not obtain sufficient information from advertising to accurately self-diagnose or to choose the best available treatment.¹⁷ If physicians are less familiar with a product, they may also be less aware of contraindications, interactions and adverse effects.

DTCA appears to affect prescribing volume as well as product choice. Patients who requested DTCA drugs were nearly 17 times as likely to receive 1 or more new prescriptions as patients who did not request medicines. Nearly 9 of 10 such patients received prescriptions, either for the

drug they had requested or an alternative.

Patients' requests for advertised medicines could lead to important health benefits if patients seek and obtain appropriate care, perhaps at an earlier stage, and thus avoid disease complications and admissions to hospital. However, many requested advertised products were "lifestyle drugs"¹⁸ or symptomatic treatments. Such therapies may relieve distress or discomfort but are unlikely to prevent admission to hospital or serious morbidity. With a trend toward treatment of milder conditions, a shift may also occur in the balance between expected benefit and potential harm.

We linked self-reported patient exposure to DTCA to patient requests for medicines and prescriptions within surveyed primary care consultations. Other consumer surveys on DTCA have relied on recall of past behaviours over long or indeterminate time periods, introducing a potential for recall bias. We also compared otherwise similar consultations and prescribing decisions that were or were not directly affected by DTCA. This internal comparison group allowed for an examination of the direction of effect of DTCA on prescribing volume and on physicians' confidence in treatment choice. In contrast, the claim made by Weissman and colleagues that DTCA leads to important new diagnoses¹⁹ has been criticized because their survey lacked a control group, making it impossible to know whether DTCA leads to fewer or more such diagnoses than occur in other patient visits.²⁰ A physician survey carried out by the US Food and Drug Administration on consultations influenced by DTCA has been subject to similar critique.²¹

This was a cross-sectional survey based on cluster sam-

Table 6: New prescriptions: physicians' opinions of treatment choice and patient knowledge*

Patients	No. (and %) of prescriptions		OR (95% CI)‡	Adjusted OR (95% CI)§	
	Prescribed drug was not requested by the patient	Prescribed drug was requested by the patient †			
<i>Physician judged the medicine to be a "possible" or "unlikely" choice (v. a very likely choice) for similar patients</i>					
Sacramento	39/322 (12.1)	Any drug	45/98 (45.9)¶	5.0 (2.6–9.5)	5.4 (2.7–11.0)
		DTCA drug	20/42 (47.6)	5.7 (2.3–14.3)	7.1 (2.5–19.8)
Vancouver	23/178 (12.9)	Any drug	17/45 (37.8)	4.1 (1.8–9.0)	6.3 (1.8–22.3)
		DTCA drug	10/18 (55.6)	8.3 (2.7–25.1)	14.5 (2.6–81.4)
Total†	62/500 (12.4)	Any drug	62/143 (43.4)	4.7 (2.8–7.7)	5.3 (3.1–9.2)
		DTCA drug	30/60 (50.0)	6.4 (3.1–13.0)	8.4 (3.8–14.7)
<i>Physician judged the patient to be knowledgeable about the medicine</i>					
Sacramento	81/322 (25.2)	Any drug	70/98 (71.4)	8.5 (4.5–15.9)	9.4 (4.8–18.6)
		DTCA drug	28/42 (66.6)	6.5 (3.1–13.5)	8.0 (3.7–13.0)
Vancouver	37/178 (20.8)	Any drug	24/45 (53.3)	3.8 (1.8–8.1)	4.0 (1.9–8.6)
		DTCA drug	11/18 (61.1)	6.0 (2.1–17.0)	6.3 (2.1–18.9)
Total	118/500 (23.6)	Any drug	94/143 (65.7)	6.3 (3.9–10.4)	6.5 (3.9–10.8)
		DTCA drug	39/60 (65.0)	6.3 (3.4–11.5)	6.9 (3.7–13.0)

*The unit of analysis is each single newly initiated prescription (n = 643; 420 in Sacramento and 223 in Vancouver), not each patient, because physicians recorded their opinion separately for each newly prescribed drug. Some patients requested more than 1 medicine: in total, 143 were requested, 60 of which were DTCA drugs.

†The prescriber was for the specific brand the patient requested.

‡Unadjusted GEE analysis.

§Adjusted ORs based on a GEE analysis controlling for age, sex, health status, income, education, drug payment, and physician's sex and graduation year.

¶The "any drug" denominator includes both DTCA and non-DTCA drugs.

pling, and the results are therefore exploratory. Participating physicians may not be broadly representative because of a possible volunteer bias and their links to medical faculties, and the patient population was relatively affluent. In addition, whereas most Sacramento physicians were salaried, Vancouver physicians mainly worked on a fee-for-service basis. This difference is unlikely to explain the higher prescribing rates in Sacramento, because incentives to prescribe are greater under a fee-for-service system.²² The Sacramento survey took place 10 months later than the Vancouver survey, which may have marginally exaggerated observed exposure differences. However, the relation between individual exposure and requests for medicines would not have been affected.

In a comparison of 2 countries, there is a risk of "confounding by culture," that is, mistakenly attributing cultural differences in behaviour to differences in the advertising environment. However, this cannot account for the finding in both settings that individuals who reported greater advertising exposure had higher request rates for advertised drugs. The most plausible explanation for this consistent relation is an advertising effect. Only the rate at which patients asked for advertised drugs, not physicians' response to requests, differed between the 2 settings.

This survey opens an intriguing window on the effects of DTCA on patient-physician interactions in primary care. Our results are consistent both with a dose-response to advertising at 2 different population exposure levels and, most importantly, with increasing industry investment in this marketing technique.²³ If DTCA opens a conversation between patients and physicians, that conversation is likely to end with a prescription, despite frequent physician ambivalence about treatment choice. And the greater the patient's exposure to advertising, the more likely such a conversation will occur.

This article has been peer reviewed.

From the Centre for Health Services and Policy Research (Mintzes, Barer, Bassett, Evans), the Department of Pharmacology and Therapeutics (Mintzes, Bassett), the Department of Health Care and Epidemiology (Barer, Bassett, Kazanjian, Marion), the Department of Family Practice (Bassett) and the Department of Economics (Evans), University of British Columbia, Vancouver, BC; the Center for Health Services Research in Primary Care (Kravitz) and the Department of Pediatrics (Pan), University of California, Davis, Los Angeles, Calif.; the School of Health Policy and Management, York University (Lexchin), Toronto, Ont.; and the Department of Family and Community Medicine, University of Toronto (Lexchin), Toronto, Ont.

Competing interests: Dr. Pan has received speaker fees from Merck Frosst to produce a public service announcement on varicella immunization. None declared for the remaining authors.

Contributors: Drs. Mintzes and Barer contributed to study plan, design, analysis and reporting. Drs. Kravitz, Bassett and Lexchin contributed to data interpretation, review of drafts of the manuscript and, to a lesser extent, study plan, questionnaire and data collection. Drs. Kazanjian and Evans contributed to study design, interpretation and review of the manuscript. Dr. Pan contributed to US components of study design and organized and supervised data collection and entry in Sacramento. He also reviewed the manuscript. Dr. Marion contributed to the analysis plan and

interpretation and to subsequent discussion of these components and reviewed the manuscript. All authors gave final approval of the version to be published.

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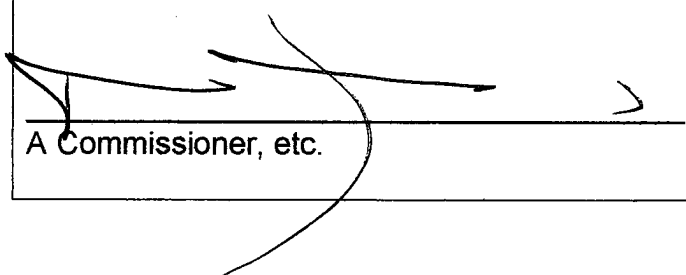
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Correspondence to: Dr. Barbara Mintzes, Centre for Health Services and Policy Research, #429-2194 Health Sciences Mall, University of British Columbia, Vancouver BC V6T 1Z3; fax 604 822-5690; bmintzes@chspr.ubc.ca

This is **Exhibit C** referred to in the Affidavit of **Stephen Walter** sworn before me this 29 day of May, 2007.

A handwritten signature in black ink, consisting of several sweeping strokes, is written over a horizontal line. The signature is partially obscured by a large, curved scribble that extends from the bottom of the signature area.

A Commissioner, etc.

**Appendix C: Copy of transcript from FDA heading
(interchange between Drs Temple and Mintzes)**

1 approved by our IRB with an expedited review. And
2 looking into patient financial records probably would
3 have slowed down that process immensely.

4 DR. PITTS: But what percent of the
5 overall care is indigent are?

6 DR. SCHULTZ: I would estimate greater
7 than 50 percent, probably less than 70. And it's
8 changed a lot from 1999 until now although I'm not
9 still there.

10 DR. TEMPLE: This is for Dr. Mintzes. The
11 -- your slides aren't numbered -- the critical slide,
12 it seemed to me, that led to one of your conclusions
13 was the one that gave physician confidence in
14 treatment choice. Can you say a little bit more about
15 what was asked there?

16 The heading says the medicine was judged
17 to be a possible or unlikely choice versus a likely
18 choice for other similar patients. And in both
19 Sacramento and Vancouver, even where the patient
20 didn't request the treatment, they thought 12 to 13
21 percent of their treatments were in that category,
22 which makes you ask why did they prescribe it.

23 And then what did they -- do you have any
24 idea what they meant when they said it wasn't a good
25 choice? Was that a cost consideration or did they

1 actually give a person a drug they shouldn't have
2 gotten? And admitted it? What was going on there?

3 DR. MINTZES: Okay, what we were -- I mean
4 the question that they answered was how likely would
5 you be to prescribe the same drug to another similar
6 patient with the same health condition. And they
7 could check off very likely, probably, or unlikely.

8 So we were -- and that was predetermined
9 that we wanted to look at the proportions that were
10 very likely versus the possibly and unlikely. And
11 what we were trying to get at was the confidence in
12 treatment choice. Or whether the fact that the
13 patient had requested the drug would have shifted the
14 product that the physician prescribed as compared to
15 what they might normally prescribe.

16 You couldn't -- you know if you asked the
17 physician directly was, you know, how necessary was
18 this prescription, they are legally responsible for
19 the prescription. They're not going to answer that
20 question -- or they're not likely to answer that
21 question honestly. So it was trying to get at it.

22 And, of course, in some cases, you know,
23 so in terms of the drugs that the patient did not
24 request, in some cases clearly the physician felt that
25 there was something different about the situation with

1 this patient that they would not have prescribed the
2 same thing to another patient.

3 DR. TEMPLE: Okay, so no implied
4 inappropriateness. It was just this was an unusual
5 patient.

6 DR. MINTZES: So, yes, this was an unusual
7 -- well, who knows.

8 DR. TEMPLE: Okay.

9 DR. MINTZES: I mean this is my guess that
10 this was an unusual patient and so I mean what we were
11 interested in, on its own, if we just looked at the
12 requested advertised drugs and just looked at the
13 answer to that question, it would have said nothing.

14 I mean what we were interested in was
15 looking at how it compared for those particular
16 prescriptions compared to other newly initiated
17 prescriptions by the same physicians.

18 DR. TEMPLE: But you have no sense whether
19 they meant I gave him an ace inhibitor because he
20 asked for it but I would have used a diuretic or I
21 gave him something expensive and branded whereas
22 ordinarily I would said use a generic? Or just what
23 was it that they were saying was different about this
24 from what they would usually give?

25 My presumption is they are not telling you

1 I gave the person a drug the person didn't need.

2 DR. MINTZES: Yes, they're not saying
3 that.

4 DR. TEMPLE: So they must have meant
5 something else by that.

6 DR. MINTZES: I think it was the choice of
7 treatments really. So sometimes, I mean there was --
8 the questionnaire did have a place for comments on the
9 bottom. But the physicians tended to comment more
10 when they had refused a requested medicine. And had
11 prescribed something else.

12 And there were the occasional comments
13 that say Allegra was on formulary, Claritin wasn't,
14 for instance as a reason. Or that -- I mean some --
15 they also stated what they had prescribed, what else
16 they had done if somebody had requested a drug and
17 they had refused.

18 And sometimes they had prescribed
19 something else that was in the same class. Sometimes
20 they had prescribed, you know, in some cases, a person
21 would come in for a -- had requested hormone
22 replacement therapy. And the doctor had prescribed an
23 antidepressant, for instance. So it was quite a
24 different -- a shift in terms of classes.

25 DR. TEMPLE: I guess for the next survey,

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1 that one should have a why after it.

2 DR. MINTZES: A why? Yes.

3 MR. TROY: Dr. Dubois, I thought you did a
4 -- your study did a really good job of showing where
5 there was, as you put it, consensus how DTC
6 advertising reduced the variability. And you
7 portrayed that as a good thing.

8 Then towards the end, you said, "Well, it
9 looks like we have to go class by class," and you
10 suggested that where there is evidence of sort of a
11 lack of consensus, then maybe we need to treat that or
12 we, if we could, somewhat differently.

13 And I was wondering what the basis was for
14 your conclusions about drugs in which there is sort of
15 less consensus, is it only the bar with respect to
16 COX-2 inhibitors because that's the only one that
17 there seems to be a fair amount of variation. And you
18 said that was a new product.

19 Was there something else that I'm missing
20 about what the different classes of drugs were that
21 lead you to the conclusion that you need two different
22 sort of approaches?

23 DR. DUBOIS: Let me answer the question by
24 sort of taking a side step. It wasn't that the COX-2
25 inhibitors was the linchpin that told me what to do

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