with his wife Lois and the emerging Fallis family, which was, for me, always special.

Working with Fred was always fun. We would have a heck of a time kibitzing and throwing around the gaff. Always a wink and a spurt of jocularity accompanied Fred as we went about our practice. He was the penultimate conversationalist and friend. With a smile, he could disarm you and get to the quick of the problem while seemingly having all the time in the world to listen.

I regret not keeping more in contact with Fred and nurse Joan Reeve as I have traveled my medical path. Yet Fred was a man, mentor, and special human being with whom time and distance melted as soon as you saw him. He had the knack of kindling the inner fire of comradeship in a split second.

In the early meetings of forming the Department of Family Medicine at the Toronto General Hospital, I believe it was Fred's energy and keenness that kept us on track. Thank you, Fred, for being there and for always sharing a part of yourself.

We will miss you.

—Leonard Levine, MD, CCFP
Ottawa, Ont
by mail

Reference

1. Perkin RL. Fred B. Fallis, MD, CCFP, FCFP. March 28, 1921-August 5, 2000 [news]. *Can Fam Physician* 2000;46:2142-5.

Housecalls are where it's at

I loved your article[1] on housecalls. Amen.

Another advantage of making housecalls is being able to check medications—often Aunt Mabel's drugs from 10 years ago are still around.

Some other tricks I have used are to do housecalls only on Friday mornings to treat myself after a long, hard week. I also talk to family and patients and tell them I cannot rush out from a busy office for emergencies. This avoids unfulfilled expectations.

—John W. Crosby, MD, FRCPC, MCFP(EM)
Cambridge, Ont
by mail

Reference

1. Eaton B. Why we do not make housecalls [editorial]. *Can Fam Physician* 2000;46:1945-7 (Eng), 1957-9 (Fr).

Time to fess up, authors!

As an expatriate Certificant (1969) and Fellow (1978) of the College

of Family Physicians of Canada, I religiously read my *Canadian Family Physician* as soon as I get it. The August 2000 issue contains a thorough, comprehensive, and interesting article[1] on management of genital herpes by Drs Tétrault and Boivin.

Drug costs in America are escalating at an incredible rate. Last year the average increase in drug costs was reported to be 17%, more than four times the background rate of inflation. The cost of drugs was recently shown to have exceeded the cost of hospitalization in America.

The retail ethical drug market is a fascinating antithesis to the famous "economics 101" concept of the "efficient market." An efficient market, of course, is where informed buyers occupying all points of the economic scale are free to buy an object in a market with a variety of suppliers. This is widely believed to produce the most efficient result: all buyers are generally able to find products that suit their needs and price range. For example, in America automobile buyers are able to pay $275 000 for a Rolls Royce or Ferrari or $500 for a 15-year-old junkyard special. All participants receive value for the transaction, and there is no need for government intervention in these markets.

In the retail drug market, although articles about specific drugs fill the pages of medical journals published all over the world and virtually the only advertising in these journals is highly sophisticated and technically high-quality advertisements for various drugs, nowhere does one ever see an allusion to price. The drug industry successfully keeps both patients and doctors completely in the dark about drug prices. I have been the object of many thousands of drug retailing experiences, and I have never heard the cost of a drug ever mentioned unless I ask for it.

Every article ever written about a specific drug is financed by the company that makes the drug. The studies that underlie these issues are financed by the drug company (and at significant cost for expenses associated with arranging the study and for a handsome premium to the physician or physician group carrying out the study). In America, this has become a lucrative sideline in many physicians' practices as a way to cope with the income compression associated with managed care. Doctors who write the articles to expand on these studies are virtually always under contract or have some other financial arrangement with the company, such as the speaker's bureaus.

Finally, the studies are always written in such a way as to completely ignore cost issues and avoid head-to-head comparisons with similar drugs in that class. The only studies that objectively compare drugs are studies subsidized by some national objective body, such as the National Institutes of Health.

Table 1 shows the comparative cost of the drugs touted in the article[1] for treatment regimen for genital herpes (their **Table 4**). I have included the cost at our local pharmacy of the course of therapy identified in the article. For example, treatment of the acute herpes episode will range from about $33 for generic acyclovir to $263 for valacyclovir. There is no evidence that one of these drugs offers any advantage over the other, except for a change in frequency from five times a day for acyclovir versus twice a day for valacyclovir. How many people do you think would pay $263 rather than $33 if they were using their own money?

Another issue is what sense does it make to treat one episode of recurrent herpes that, in general, lasts 6 days, for which treatment reduces the duration of illness by about a day, and where for most people the symptoms are just a local irritation?

Canadian Family Physician already has one of the best, objective, and readable drug evaluations in the North American primary care literature with "Prescrire." *Canadian Family Physician* could improve on an already great journal by requesting that every author of a drug-related article declare all pharmaceutical company relationships in detail and that these be identified at the beginning of the article. Of course, that would not solve the problem of specific reference to drug-related papers in the bibliography, but one can assume that they are all written under drug company sponsorship.

Table 1. Treatment regimens for genital herpes

TREATMENT REGIMEN	NO. OF PILLS	COST (US$)
TREATMENT OF PRIMARY INFECTION		
Acyclovir 200 mg 5 times daily for 10 days	50	33.00
Acyclovir (Zovirax) 200 mg 5 times daily for 10 days	50	71.59
Valacyclovir 500 mg twice daily for 10 days*	80	263.00
Famciclovir 250 mg 3 times daily for 5 to 10 days*	30	110.00
EPISODIC TREATMENT OF RECURRENCES		
Acyclovir 200 mg 5 times daily for 5 days	25	16.00
Acyclovir (Zovirax) 200 mg 5 times daily for 5 days	25	35.00
Valacyclovir 500 mg twice daily for 5 days	20	65.00
Famciclovir 125 mg twice daily for 5 days	10	38.00
SUPPRESSIVE TREATMENT		
Acyclovir 400 mg twice daily	60	51.09
Acyclovir (Zovirax) 400 mg twice daily	60	154.00
Valacyclovir 500 mg daily†	30	98.70
Famciclovir 250 mg twice daily	30	110.00

** Not approved for this indication in Canada.*
† For subjects with 10 or more recurrences yearly, dosage should be 1000 mg daily or 250 mg twice daily.

—*L.B. McNally, MD*
Dallas, Tex
by mail

Reference

1. Tétrault I, Boivin G. Recent advances in management of genital herpes. *Can Fam Physician* 2000;46:1622-9.