developing countries. This initiative focuses mainly on acute respiratory infections such as viral pneumonias and tuberculosis. The IDRC has recently renewed its commitment to the Essential Health Intervention Project in Tanzania[1] with another disbursement of $1 million and has moved on to the next phase of its support for insecticide-treated bed nets through a grant that will be used to investigate the use of the nets in sub-Saharan Africa.

The claims in the article not only damage the IDRC's hard-earned prestige and credibility in Canada and internationally but are also unfair to dedicated program staff who are struggling to keep the torch burning in times of dwindling resources.

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Reference

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[The authors respond:]

It was not our intention to slight the efforts of Dr. Baris and his (few remaining) colleagues at IDRC who have a strong interest in the health sciences. Indeed, their accomplishments with dwindling resources should be applauded and their continued excellent work encouraged.

However, the description of the latest IDRC reshuffle/renewal/re-organization in no way explains the deplorable situation in which Baris and his colleagues find themselves.

- Federal funding for international development and research is at a 30-year low.
- The number of IDRC employees with a primary interest in health-related issues has dropped by 50% to 75% in recent years.
- Health-related problems of the developing world are certainly not going away.
- The global nature of health-related problems should be obvious to all through examples such as HIV, Hong Kong's avian influenza and the like.

Our "barb" was directed neither at Baris nor even at his counterparts at CIDA (although the latter could invest their funds more wisely by supporting projects like those outlined by Baris). Rather, it was aimed at the wrong-headed parsimony of the federal policy-makers who have set international aid at a shamefully low 0.31% of the gross national product,[1] a level well below the mean for developed countries.

Our prime minister likes to trumpet Canada's recent recognition as the world's best place to live. How can a country that is among the least generous be the best?

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Reference

1. Tomlinson B. Canada. In: Randel J, German T, editors. *The reality of aid 1997/98. An independent review of development cooperation*. London: Earthscan Publications; 1997. p. 42-8.

Physician–patient communication

I am doing research for a book to help improve physician–patient communication and am seeking physicians from across Canada to respond to an electronic survey. A survey form for physicians is posted at

www.storm.ca/~topsey/survey. Respondents will find a number of stories about interactions between physicians and patients collected from patient focus groups, face-to-face interviews with patients and responses to a patient survey posted on the Internet. Survey participants are asked to respond to 2 basic questions pertaining to each of these case studies. Patient interaction stories will be changed bimonthly at the Web site, but all stories will be available in an archive on the same site. Research for this project will end July 30, 1998. Confidentiality will be respected for all participants.

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Rule of thumb: check the dictionary

In the article "MDs have key role in bringing ugly secret of wife abuse out of closet" (*CMAJ* 1997;157[11]: 1579-81), by Nicole Baer, I was most perplexed to read the old chestnut that the expression "rule of thumb" is derived from an American law permitting a husband to thrash his wife with a "rattan no wider than his thumb." Although the derivation seems plausible, your readers can be thankful that this macabre yarn is a fabrication, first published in July 1986 in a letter to *Ms.* magazine from the creative mind of Claire Bride Cozzi. Within only 11 years even that version has evolved: Cozzi cited an undated "English common law" permitting a man to chastise his wife with a "switch" that was to be "no thicker than his thumb."

The true derivation of the term "rule of thumb" has never been in doubt. As the *Shorter Oxford English Dictionary on Historical Principles* indicates, a rule of thumb is "a method or procedure derived entirely from practice or experience, without any basis in scientific knowledge; a roughly practical method." It first appeared in 1692. In his book *Not Guilty*, D. Thomas explored the origins and significance of this persistent urban myth.[1] As Georges Braque has observed, "Truth exists — only falsehood has to be invented."

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1. Thomas D. *Not guilty: the case in defence of men*. New York: Morrow; 1993.

Questions about donepezil

After the recent release of donepezil, a new drug for treating Alzheimer's disease, many of our patients and their families began to enquire about it. Their questions often focused on the drug's efficacy, in view of its high cost (about $150 a month).

A review of the literature for this product yielded only one published randomized controlled trial,[1] which involved 161 patients with mild to moderate Alzheimer's disease followed for 12 weeks. The benefits of treatment were modest,[2] and the authors stated that because of the short length of the study "in the majority of patients the condition was unchanged."[1]

Another randomized controlled trial, lasting for 24 weeks (plus a 6-week placebo washout) and involving 473 patients, is cited in the product's prescribing information (e.g., *CMAJ* 1997;157[6]:809-11). One of us tried unsuccessfully to obtain a copy of this promising study from the manufacturer and from Health Canada. At the time of writing this letter, in December 1997, the product had been on the market for 3 months in Canada and 11 months in the United States, but clinical decisions have had to be based on limited data.

When a product has been accepted by Health Canada and marketed, should not all information be made available to treating physicians, who have the responsibility to inform and guide patients and their families?

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2. Donepezil (Aricept) for Alzheimer's disease. *Med Lett Drugs Ther* 1997;39 (1002):53-4.

[Dr. Bernard M. Prigent, Pfizer Canada, responds:]

The clinical evidence supporting the efficacy and safety of donepezil in patients with mild to moderate dementia of the Alzheimer's type shows a strong and consistent pattern of favourable results.

Three well-controlled clinical trials provide the core evidence. Two of these trials are phase III pivotal trials, one a 12-week study and the other a 24-week study; the third is a 14-week phase II supportive dose-finding study.

Two of the studies have now been published: the 24-week pivotal trial in January 1998[1] and the 14-week dose-finding trial in 1996.[2] (An analysis at 98 weeks of the open-label extension of the latter study has also been published.[3])

There is often a gap between the time a drug is approved and the publication of the data on which the approval is based. In the case of donepezil, the prompt acceptance of