shelved by the Ministry of Health. It appears that funds are available for the questionable screening mammography of asymptomatic women 40 to 49 years of age, but not for timely radiation therapy for all of the women with breast cancer who could benefit from it.

The larger question remains: What are the best ways to incorporate recommendations based on new scientific knowledge into medical practice?

**Timothy Johnstone, MB, BS**
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**[The authors respond:]**

We agree with Dr. Johnstone that randomized trials have shown that breast-conserving surgery (BCS) followed by timely radiation therapy (RT) is equivalent to total mastectomy for most patients with early-stage breast cancer. BCS alone, however, results in higher rates of local recurrence[1–5] and higher rates of distant metastatic cancer.[1–3]

As described in our article and in a more detailed investigation of variation in the use of BCS within British Columbia,[6] access to RT services was one of several factors influencing the rate of BCS. Women living more than a 2-hour drive from an RT facility had lower rates of BCS in both BC and Ontario. In 1991, the period of the study, 30% of patients in BC lived more than a 2-hour drive from an RT facility, whereas only 6% of patients in Ontario lived this far from an RT facility. Only 4% of patients were treated with BCS alone in BC, as compared with 17% in Ontario. This finding reflects the closer compliance with international[7] and provincial cancer treatment guidelines in BC. To improve access to RT in BC, a new cancer centre with 4 machines opened in the Fraser valley in 1991, another is under construction in Kelowna, 2 new machines are being commissioned in Vancouver and the capacity in Victoria is being doubled.

There was also a strong surgeon effect influencing BCS use in BC. This could not be explained by the surgeon's sex, volume of patients treated, academic affiliation or year of graduation from medical school.[6] Our study could not determine whether women faced with the need to travel for RT were not offered or did not choose BCS.

It has been shown that patients who participate in the choice of treatment, independent of the choice selected, have less long-term anxiety and depression than women directed to either mastectomy or BCS.[8] Women should be informed of the equivalence of BCS plus RT and total mastectomy in a nonjudgemental way, be assisted to obtain additional information about the advantages and disadvantages of each option and given the time and respect to make the decision for themselves.

The issue of resource allocation among treatment, prevention and screening programs is important and must be addressed by society as a whole. Studies such as ours can describe the distribution of resources but cannot answer the question of how to allocate available resources most appropriately. Such questions require evaluation of the efficacy, effectiveness and costs of different interventions and the preferences of individuals and society toward different outcomes.

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## Introducing students to community health

In the article "Creating community agency placements for undergraduate medical education: a program description" (*Can Med Assoc J* 1997;156:379-83), Drs. Donald Wasylenki and Carole Cohen and Ms. Barbara McRobb describe how it is possible to provide medical students with relevant experience in community agencies by choosing agencies carefully and maintaining good working relationships. We recognize the formidable logistics they overcame in offering 354 students stimulating learning experiences, including allowing students to observe health care in the community, to appreciate the concepts of barriers to health and to

recognize opportunities for gains in health.

These objectives are difficult to measure but, with so much class time involved, evaluation is extremely important.

We have shown how small groups of students can be introduced to community health within limited curriculum time.[1] The groups are assigned specific problems of widely varying nature. They present verbal and written reports for which they share responsibility. Since our article was published, "mini-public health meetings" have been held annually and are appreciated by students, faculty, community practitioners and agencies. They often serve to stimulate further research or response.

We support Dr. Brian Hennen's call ("Demonstrating social accountability in medical education" *Can Med Assoc J* 1997;156:365-7) for a comprehensive approach to community-based education.

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**Reference**

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## Keeping cash flowing

I read Dr. Paul Leger's letter ("Different views on privatization," *Can Med Assoc J* 1997;156:770-1) with great interest. I fail to understand why we do not institute patient copayments in Canada, since nearly every patient I speak with is in favour of them. I do not believe that they will significantly restrict supply or cut down on unnecessary visits, but they would provide some cash flow. If we do not ask for copayments, why not ask patients to pay the GST? That would actually generate income and allow us to do what every other business in Canada is allowed to do — write off the GST on purchases we make while running a business.

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## Back to the grind and back on your feet

The CMA policy summary "The physician's role in helping patients return to work after an illness or injury" (*Can Med Assoc J* 1997;156:680A-C) is an excellent document and should be widely distributed to physicians, employers and entitling adjudicating organizations (i.e., provincial Workers Compensation Boards and disability insurance carriers). I encourage all physicians to read, understand and keep this policy summary in their desks for easy reference.

I have been practising occupational medicine for 23 years, long before it became a distinct medical discipline. This summary reflects many of the long-held beliefs about work and health. A fundamental belief in occupational medicine is that work is healthy. Indeed, epidemiologists have discounted for the "healthy worker effect" for a long time. Work is often part of a rehabilitation health plan, rather than a barrier to regaining health.

Almost all return-to-work plans are appropriate and well managed. In cases where there is a conflict concerning the appropriateness of a return-to-work recommendation, there are almost always other complicating factors. Attending physicians should follow this policy and use clear, scientific reasoning to advise employers, insurers or occupational health personnel about the return to work of their patients.

Confidentiality is a key component of any occupational health program. Employers, insurers and health advisers to industry need only know the information relevant to the successful rehabilitation of the employee. Fitness to work is often independent of diagnosis. Employee consent is thus useful in managing return-to-work plans, as noted in the policy summary. Employers do not, however, need employee (patient) consent to inquire about return to work and whether work restrictions or job modifications will be required. Employers need this information to manage their workplace and their workforce. No diagnosis or medical information is necessary to make these determinations. While respecting patient confidentiality, physicians should speak to employers if asked about these issues.

The principles relevant to return-to-work plans remain risk to self and other.

**James D. McDougall, MD**
Calgary, Alta.

## Publish or perish

I was pleased to see the 2 articles on authorship, "Rating authors' contributions to collaborative research: the PICNIC survey of university departments of pediatrics" (*Can Med Assoc J* 1996;155:877-82), by Drs. H. Dele Davies, Joanne M. Langley and David P. Speert, and "Authors: Who contributes what?" (*Can Med Assoc J* 1996;155:897-8), by Dr. Bruce P. Squires. The definition of genuine authorship given by the International Committee of Medical Journal Editors is clear. Although multiple authorship is appropriate for reports of collaborative research, multicentre trials and so on, in other types of articles main authors may be influenced