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.

Lory Laing, PhD
James M. Howell, MB
Department of Public Health Sciences
Faculty of Medicine
and Oral Health Sciences
University of Alberta
Edmonton, Alta.
Received via e-mail

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.

Tamison Doey, MD
Essex, Ont.
Received via e-mail

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

to include additional authors inappropriately. Is it time to create some disincentives to counter the incentives for authorship inflation? In particular, academic institutions could adopt more formal evaluation criteria for authorship.

One possible quantitative measure is a numerical score for each of an author's published articles. A score should have desirable mathematical properties and should be simple to calculate, explicit and widely accepted. As an example, let N be the rank order of the author in question on an article and let M be the total number of authors of that article. The score could be 1/N+1/M. The sole author of an article would receive a score of 2 (1/1+1/1=2). Two authors would share a total score of 2.5 (1/1+1/2=1.5 for the first author, and 1/2+1/2=1 for the second). As more authors are added, the total score to be divided among them would increase slowly, so that the score assigned to each preceding author would decline. A score like this could be summed for all of an author's articles in various publications, perhaps weighted according to the types of publications, and the total score could be converted to a rate by dividing it by the period under consideration (e.g., 3 years, or an entire career). Because scoring methods such as this one emphasize the number of articles published over the substance of those articles, perhaps a factor representing the importance of the articles should be included in the calculation. The number of citations of each article, who cited it and why, could help determine importance.

Clearly, refinements in measuring productivity could provide disincentives to authorship inflation and incentives to make better use of acknowledgements in articles. However, such measures do not address the more fundamental issue: why authors should publish. Perhaps authors should challenge themselves to submit manuscripts only when they have something to share that is unique, mature and important. They should resist the culture of "publish or perish" and should be supported in this by their colleagues, peers and managers.

Glenn Jones, MSc, MD
Hamilton Regional Cancer Centre
Department of Medicine
McMaster University
Hamilton, Ont.

[The authors reply:]

Dr. Jones agrees that we need a uniform and objective means of rating contributions that includes such factors as authorship position and the role of the investigator. He has given a tantalizing scoring method for assigning contributions. Although we agree that some formal method of evaluation is needed, we can identify some problems with his proposal. The person listed last may be the senior author who may (or may not) have been responsible for the intellectual content and overall supervision of the study. Furthermore, the method may not address the authorship styles in which a few authors are listed along with the group or in which members of the group are simply listed in alphabetical order or in the order of total number of patients enrolled. We feel that any scoring method would be more valuable if the investigators were asked to indicate (1) the role they played in the study (principal, coprincipal or co-investigator), (2) the percentage of the overall study they feel they were responsible for and time they put into the study and (3) perhaps (for major promotions) even a formal report of their role in the study. This would allow each author to be more explicit about his or her role in each study and would allow independent confirmation of the stated roles.

Jones raises the separate and complex issue of the challenge to academics to "publish or perish." He suggests that only unique, mature and important information be submitted for publication. Medical progress is generally made in small steps, and even well-designed negative studies may be informative to medical readers. The peer review process employed by most journals should, at least in theory, weed out studies that lack the importance or quality required for publication. As well, the significance of some research is identified only many years after it is reported. This issue continues to pose important challenges and warrants continued discussion. Perhaps it should be a topic for a national consensus conference of academics, scientists, department chairs and deans. Such a conference could be expanded to address the value of participation in symposia, presentations at meetings and educational activities.

H. Dele Davies, MD, MSc
Alberta Children's Hospital
University of Calgary
Calgary, Alta.
Joanne M. Langley, MD, MSc
IWK–Grace Health Centre
Dalhousie University
Halifax, NS
David P. Speert, MD
University of British Columbia
Division of Infectious and Immunological Diseases
British Columbia's Children's Hospital
Vancouver, BC
for the Pediatric Investigators' Collaborative Network on Infections in Canada (PICNIC)

Action long overdue on drug labelling

I would like to add some comments about the letter "Drug packaging," (*Can Med Assoc J* 1997;156:764-5), in which Dr. D. John Doyle made some excellent recommendations. As a family physician who has been in practice