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.

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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