



Trine B. Haugen (born 1955) is Editor of the Journal of the Norwegian Medical Association and Professor of Biomedicine at the Oslo and Akershus University College of Applied Sciences.

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When clinicians and basic researchers collaborate, they cannot always agree on how the different contributions should be valued. Are the Vancouver rules applied negligently?

Who deserves a place on the list of authors?

When meeting clinicians and basic researchers, I frequently hear comments such as «they want to be on the list of authors, even though their only contribution is isolation of DNA» – an example of a lament from a clinician. A similar lament from a basic researcher could be: «They want to be on the list of authors, even though they have only provided some patient information.» A common feature of such comments could be overestimation of one's own efforts or a lack of understanding for those of others, although it is primarily a sign of superficial collaboration.

So when is a contribution crucial enough to qualify for co-authorship in accordance with the Vancouver rules (1, 2)? This is not always very easy to determine, especially if the group of potential authors of an article have no shared understanding of the value inherent in the various contributions. Unwritten rules that have become established in various institutions may also lead to haphazard compliance with the formal criteria. The two laments quoted above categorise contributions as purely technical or purely administrative, provided by the clinician and the basic researcher respectively. This may impinge on part of the core problem – basic researchers and clinicians are given limited assignments, without being included in the scientific discussion. Thus, the basic researcher is assigned a role comparable to that of a technical employee, and the clinician is given an administrative role. As regards technical personnel, practices vary as to whether they are placed on the list of authors or in the acknowledgements. My impression is that they are increasingly included as co-authors. This could be due to a higher level of education and more sophisticated technology, but could also indicate that they are given a voice in the scientific discussion. With regard to academic positions, it has been more a matter of course that a methodological contribution should warrant co-authorship. It is also often taken for granted that listing the clinician as a co-author is a precondition for providing the basic researcher with access to clinical data.

Long publication lists that are either a result of expert status with regard to a favoured method or good skills in re-using patient data can be provocative to those who have no such advantages. Occasionally, an agreement is reached to include a person as co-author of a certain number of articles if the contribution is of such a nature, in order to avoid a disproportionate and unwarranted accolade. However, such a bonus scheme can be difficult to handle if the parties fail to come to agreement, and its ethical quality is questionable.

Ideally, of course, the contributors will have sufficient ability to assess their own contributions, so that unpleasant discussions can be avoided. Occasionally, I have been impressed by authors in collaborative projects who of their own accord have requested to have their name left out of the list of authors or transferred to the acknowledgements, because they did not deem their contribution to be sufficiently material. This has been the case for laboratory results as well as clinical data. But how skilled are researchers in assessing whether they merit a place on the list of authors? International studies indicate that these skills leave something to be desired and that the criteria for authorship are frequently not being fulfilled (3–6).

The Vancouver rules may be well known to most of those who publish articles in medical journals, but perhaps not all of them are aware of the fact that the rules have recently been tightened (7, 8). In a fourth item, it is made clear that authorship implies a responsibility for the *entire* article. A co-author must accept that any problem associated with the article is also his/her problem. This applies regardless of whether the contribution takes the form of patient recruitment or laboratory analysis.

I have found no studies that address co-authorship of joint publications involving basic researchers and clinicians. However, some studies of how paraclinical disciplines assert themselves in clinical research have been published. A study based on the *Canadian Medical Association Journal* concluded that pathologists and radiologists too rarely are found on the lists of authors when data from these specialties are presented (9). Another study showed that in general medical journals with a high impact factor, laboratory medicine professionals are underrepresented on the lists of authors of studies that encompass laboratory medicine (10).

The collaborative climate may deteriorate rapidly if questions are raised as to whether the partner's contribution merits co-authorship, although this may help drive the collaboration in a more fruitful direction. Instead of the basic researcher lamenting that his time-consuming laboratory work fails to be sufficiently recognised, and the clinical researcher lamenting that the laboratory professional fails to understand how much work is required to produce the clinical data, they could invite each other to discussions of their respective fields. A bridge between basic and clinical research is the very foundation of translational research, for which the hospitals are assigned a special responsibility (11).

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