could not be matched to ICMJE criteria. Interestingly, among these 13%, about 56.3% stated that they made a significant contribution, without listing what that contribution was!! [4].

It may not be appropriate to be very flexible in criteria for promotion in India where most of the original and substantial research is limited to only few medical colleges / institutions and rest are just doing "re-search" in the name of research. A recent study in India observed that about 60% of the medical colleges here did not have a single publication in past ten years [5]. With the maximum number of predatory journals being contri-buted from India, 42% of fake single-journal publishers are based in India, and where money is the only criteria for publication, it is not hard to imagine how a single publication could be misused for promotion if every author is allowed to take credit of it for promotion purpose [6].

The authors in the editorial have written that it may even encourage the practice of denying first authorship, and credit, to junior researchers whose contribution is often the maximum and it is not uncommon to find the senior-most author as the first author (even in case reports) due to the premium placed on this position [1]. But the current MCI criteria's are for the promotion of faculty members and not the post graduate students who could easily have been side lined by their Head of the Departments or thesis guide. When the junior most aspirant aspiring for promotion as per new MCI guidelines, in this case an Assistant professor, knows that he must publish two paper with first or second authorship to get promotion, it's hard to believe that he/she will easily give away his/her precious research and first authorship to his seniors, at least for two papers.

Dear Editors, It's a matter of just four papers in a total span of seven years – right from starting the faculty career as Assistant Professor to Professor. MCI is not asking too much of research – just one paper in two years on an average. And if the faculty members are genuinely interested in research, what stops them to conduct several more studies with multiple researchers, and then publish papers by giving equal credit to all. After all, every faculty member should have an opportunity to see his name as first or second author (at least in four research papers) and feel proud, when down the lane, at the time of their retirement; they look back at their career.

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AUTHORS' REPLY

We thank the authors of this communication for their insightful comments on our editorial [1]. The use of indexing in journal databases as a surrogate marker for quality of journals has its own pitfalls, as was acknowledged in our editorial. We agree with the suggestion that the list of databases should be expanded, but suggestion of a specific number of databases is arbitrary. Any index or database that is widely recognized for its quality, should be welcome.

Similarly, we are not sure why they insist on inclusion of a journal in two databases as a specific criterion. There is no doubt that increasing the number of databases to qualify would increase the likelihood of 'acceptable quality' but then why not 3 or 4? The objective is not to make it difficult for good journals to qualify but to try and weed out low-quality or 'predatory' journals. If the included databases are chosen carefully for their quality, inclusion of a journal in one database should be as good as inclusion in two or more. After all, most databases share the criteria they use to evaluate journals for inclusion. These criteria are often based on principles of transparency and best practice that distinguish legitimate journals and publishers from the non-legitimate ones, such as those jointly identified by the Committee on Publication Ethics, the Directory of Open Access Journals, the Open Access Scholarly Publishers Association, and the World Association of Medical Editors [2].

With respect to the limitation on number of authors,

their argument that gift authorship is widely prevalent is valid, and is likely to have been one of the reasons for the Medical Council of India (MCI) recommendations. They however contradict themselves by stating that "it's hard to believe that he/she will easily give away his/her precious research and first authorship to his seniors, at least for two papers", suggesting that juniors in a department can refuse 'gift' authorship to their senior colleagues. If they can decline 'gift' authorship to a senior colleague, one would think that they would also be likely to refuse gift authorship to other colleagues, who are competitors, if all the authors listed on a publication were to get equal credit at the time of promotion. Limiting credit to two authors may paradoxically also increase the risk of gift authorship, if the primary author recognizes that the persons listed at 3rd or 4th position or beyond would not benefit from such authorship in promotions.

Whether research and publications should indeed be criteria for promotion is a wider issue. Most academic medical centers aim for excellence in three areas, namely patient-care, teaching and research. Though contribution in significant measure by faculty members in each of these may be desirable, most are unable to do so and end up contributing to only one or two of the areas [3]. Our medical teaching institutions and regulatory bodies need to engage in a debate on this subject. However, this issue was beyond the scope of our editorial, which, given our affiliation to the Indian Association of Medical Journal Editors, dealt primarily with issues that concern biomedical journals and their editors.

Overall, we accept that what constitutes 'creditable research' that should count towards academic promotions is not easy to define, and the suggestions in our editorial are certainly not infallible. The objective of our editorial was to highlight this very problem. The letters received are heartening, and we hope that these will keep this issue in focus and engender debate that will make the process of academic promotions in our medical colleges more robust.

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The Academy Should take-up the Issue of Off-label Prescriptions

The recent event involving the off-label use of avastin (bivacizumab injection, 100 mg/4mL) should serve as an eye-opener to pediatricians. In an unfortunate incident, a few patients lost vision after an ophthalmological procedure [1]. The regulator, Central Drugs Standard Control Organization (CDSCO) chose to issue a warning pointing out that avastin used in these patients is not approved for use in ophthalmology, and directed that such use be desisted from [1]. The warning was later withdrawn [2], once it was noted that although off-label, its use as an anti-vascular endothelial growth factor (VEGF) for the treatment of age-related macular degeneration (AMD) is endorsed by the WHO [3], International Council of Ophthalmology, National Institutes of Health, and regulatory agencies of France and Italy [2]. However, the event brought the issue of off-label drugs into a sharp focus.

Off-label drug-use is a reality and needs to be resorted to, as the discoveries made after market authorization compel medical practitioners to use the drug for new indications, in new populations using better dosage regimens. As children are usually not enrolled in clinical trials, many drugs continue to be marketed without appropriate pediatric labeling. Pediatricians prescribe drugs on the basis of available evidence (as they should), textbook-material, guidelines or consensus statements. This ensures that children are treated with better therapies as per new evidence. But, if it is used for indications not listed in the license or is administered in a manner (dose, dose regimen, route of administration, *etc*.) not described in the license; the use constitutes off-label drug use. Off-label drug use is highly prevalent in neonates and children [4,5], and while prescribing these drugs, the treating pediatricians have a greater responsibility. If any