

Hanks did not address the profound ethical issues.

The House of Lords Select Committee on Medical Ethics discussed the issue of nutrition and hydration in the terminally ill in relation to the Bland case, but the principles have wider application. They made it clear that it should be unnecessary to consider the withdrawal (or non-introduction) of nutrition or hydration except in circumstances where its administration is in itself a burden to the patient (6). Legal aspects remain unresolved (7). Further debate is needed.

### References

- (1) Craig G M. On withholding nutrition and hydration in the terminally ill: has palliative medicine gone too far? *Journal of medical ethics* 1994; 20: 139-143.
- (2) Waller A, Adunski A, Hershkowitz M. Terminal dehydration and intravenous fluids [letter]. *Lancet* 1991; 337: 745.
- (3) Saunders C. Personal communication 1994 Oct.
- (4) Finlay I. Personal communication 1994 Nov.
- (5) Hanks G W. Personal communication Dec 1994.
- (6) *House of Lords Select Committee on Medical Ethics Report*. London: HMSO, 1994: Paras 251-257: Treatment limiting decisions.
- (7) Craig G M. Is sedation without hydration or nourishment in terminal care lawful? *Medico-legal journal* 1994; 62: 198-201.

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## Medical information

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### Total dissemination of medical information

There is a conflict between the author's wish for total dissemination and the limitation of the print run of journals. Although journals might have 2nd and 3rd readers, the limitations to readership are clear.

The limitation of the audience of the publication the author has chosen makes total dissemination difficult. It is not only in the interest of the author to have his or her opinion, or the results of his or her investigation,

disseminated. It is also in the interest of global health that medical information is transferred to the largest audience possible.

### Free transfer of medical information?

Since 1984 I have been editor of a medical journal directed at general physicians, in former Comecon areas. The journal started with one edition for the former USSR and is financed by subscriptions and advertising. It has a controlled circulation. Strict separation of editorial matters and economic results is guaranteed by a grant from a foundation. The journal is published as a non-profit service to the medical profession.

It is understood that doctors should not charge their colleagues for medical services. Does that include medical information, too? Would it be 'proper' to charge a colleague in another country for medical information?

Normally authors contribute medical scientific articles without any financial compensation. It is understood that the 'publish or perish' obligation makes financial compensation an item that is simply not discussed. Members of our board of consultants accept nomination to the board without any financial compensation. Travel and other outlays might be reimbursed by the publisher. Declaration of interest in pharmaceutical-related investigations is disclosed on request of the publisher. Special relationships with the pharmaceutical industry are not advanced voluntarily.

It is our policy also to select abstracts from major journals and then translate them into foreign languages. In order to avoid any misunderstandings because of difficulties of absolutely exact translation, I include the original abstract too. This serves as a control to prevent mistakes in translation. It also helps the reader to get acquainted with medical English. It is a sort of medical-information journal with, as a side-effect, a medical English course. For a complete original article (most of the time review articles) permission by letter is requested from the author for republication. Sometimes I get no answer, sometimes I am referred to the journal's editor, sometimes I get permission. It is a bit at random that permission is given. The intention of this effort is the free transfer of medical scientific information from the industrialized west to the less industrialized countries of Eastern Europe. Medical scientific information

is not available in its plurality and diversity in Eastern Europe. Reader-reply-card returns of 20 per cent and more indicate the need for, and appreciation of, this publication.

Health information for the developing world seems to be a topic which is gaining the attention of top medical journals. Regularly one finds requests from individuals, hospitals and organizations for medical literature.

A publisher transfers scientific information to a larger audience and is economically rewarded for this. From the economical point of view the decision to publish an original contribution should have enough financial reward to make it economically viable. It forms part of his marketing mix whereby he creates a certain image. This image is then projected towards authors and readers.

Reprints and sale of foreign rights is – and should – not be taken into account by feasibility studies of medical journals. Thus the publication of the *British Medical Journal* as the journal of the British Medical Association (BMA) should not consider the possibility of a foreign edition as an underlying factor for the economic survival and continuity of the journal.

### Re-publication in other languages

The author's wish for the greatest dissemination of the results of his study are in accordance with the interest of global health. The general public and the medical community favour reprints or re-publications of a study in foreign languages. The medical society in 'Foreignland' has little or no access to the top medical journals. Because of the native language being 'foreign', publications do not reach it. Its level of wealth being below the average for the industrialized world deprives the medical community of that country of necessary top-of-the-line information. This will keep Foreignland forever on a lower level of quality care. The financial limitations of Foreignland; the ability to read foreign languages and the availability of top medical journals to the medical community create a class society. Only those with access to international gatherings will be able to keep themselves up to date. The monopoly of medical information is restricted to those who have English as a second language. There remains a feeling that a conflict of interest exists between the need for the free transfer of medical information and copyright.

I understand the legal implications of copyright. But legal does not imply ethical. One has the right to forego legal rights in the interest of a more universal feeling of fairness.

Recently I received a letter from the *New England Journal of Medicine* in which they stated that it was necessary for them to revise their policy with regard to the authorization of translations and reprints. I have up to now not received their new policy, but am afraid that this might negatively influence my re-publication efforts.

### What effect will this have on re-publication rights?

One can assume that the economic structure of a medical journal is based on its 'local' circulation. Re-publication of an original investigation in a foreign language would do no economic harm to the original publication. As long as the source is properly acknowledged it would form a marketing tool. It would help to emphasise the importance of access to international medical literature.

Some physicians are now sending back issues of medical journals to foreign colleagues in order to keep them up-to-date with state-of-the-art medical information. I think this kind of foreign aid is well placed. One could argue that mailing a back copy of a medical journal to a foreign institute deprives the original publisher of the economic profit of an additional subscription. I wonder if that argument – although valid – is not in conflict with the interest of authors and public to have access to state-of-the-art medical information. Maybe publishers could be persuaded to mail review copies of books to foreign hospitals. Most of the time those books are discarded, and have no medical use in the publisher's basement. It would do them no harm but would relieve them of unnecessary paper.

Suppose a study in Canada confirms an inexpensive and safe new method of diagnosis. Would it be correct to withhold the re-publication in Russian? Is the Canadian publisher allowed to withhold consent for re-publication? What if he requests a copyright fee that in his eyes is acceptable but in the eyes of the Russian publisher is exorbitant? Different levels of wealth in the two countries create different understandings of the value of money. Should the Russian publisher be allowed to re-publish with only acknowledgement of the source of publication?

The combination of brilliant editors and ingenious investigators

creates quality in medical publishing. Rigorous peer-review leads to quality control. Author and editor exchange their personal prestige for a higher combined level of opinion-leadership. It is the combination of the two which leads to vision and continuing professional development. But it should not stop there. Both author and editor should actively involve themselves in searching for additional coverage of the information they regard as crucial for state-of-the-art medicine. They should enter into agreements with foreign publishers or make easier the broader dissemination of medical information, thus ensuring the maintenance of certain principles and values in medicine.

Health and illness have no national borders, no nation is isolated anymore. Travellers, fugitives and sick people arrive day in, day out in western nations. They should arrive from territories in which modern medical information is not confined to a few with a monopoly. It is in the interest of global health that co-operation and not separation guides medical publishing.

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## Children's informed consent to treatment: the Scottish dimension

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In response to the recent editorial by Donna Dickenson (1), in which the legal position in England and Wales is discussed, we wish to describe the situation in Scotland.

The statutory basis of the law of informed consent to medical treatment in the case of a person under the age of 16 years, is, in Scots' law, defined in the Age of Legal Capacity (Scotland) Act 1991, Section 2 (4): 'A person under the age of 16 years shall have legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment'.

The key difference between the two legal systems is that the age of consent

in Scotland is 16, while it is 18 in England and Wales, although section 8(1) of the Family Law Reform Act 1969 effectively lowered the age to 16 years when determining capacity to consent to medical treatment.

In complete agreement with Donna Dickenson, the concept of consent to medical treatment must logically encompass the right to refuse the medical treatment, since withholding consent is equivalent to refusal.

Furthermore, the 1991 Act clearly allows children under 16 years to consent to or refuse medical treatment depending on the understanding and maturity of the individual child and also depending on the procedure in question. Thomson (2) gives the examples of a tooth-filling which would be clearly within the understanding of, for example, a 12-year-old, and contrasts this with the donation of non-regenerative tissue, the nature and possible consequences of which a 12-year-old may not be capable of understanding. While English law still concentrates on the child's interest, the Scottish statute – quite deliberately – omits all mention of welfare (3). Wilkinson and Norrie (4) argue convincingly that the Age of Legal Capacity (Scotland) Act 1991 gives the right to consent to some children in such a way that they can exercise it without reference to their parent or parents, thus effectively abolishing this parental right for these children's parents. This will be made explicit in the new Children (Scotland) Bill.

Although the 1991 Act does not explicitly abolish the parents' right to consent to, or refuse medical treatment on behalf of a child, should problems arise when the parent consents and the child refuses, or when the parent refuses and the child consents, the court may become involved. Two major considerations will be (a) whether or not the treatment is in the best interests of the child, and (b) whether or not the child is able to understand the nature and possible consequences of the treatment. Strictly, the latter consideration is whether or not a qualified medical practitioner attending the child believes that the child is capable of understanding the nature and possible consequences of the procedure or treatment. Wilkinson and Norrie (4) point out that the express rejection of the welfare principle by the drafters of the 1991 Act encourages the view that in an application to the court to resolve such a dispute between the