

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 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

parent and child, the welfare principle would not be determinative.

Now it may occasionally happen that a child who is mature enough to understand the nature and possible consequences of the treatment may reach a decision which is objectively (as judged by the reasonable person) thought to be against the child's best interests, but which that child wishes to implement. There are two logical possibilities: either this decision is the right decision for that particular child or that child has made a mistake. If that child is not allowed to reach a decision which is objectively

unreasonable, then it can be argued that there is no real right of consent. Without the freedom to be wrong, there is no freedom.

References

- (1) Dickenson D. Children's informed consent to treatment: is the law an ass? *Journal of medical ethics* 1994; 20: 205-206, 222.
- (2) Thomson, J M. *Family law in Scotland* [2nd ed]. Edinburgh: Butterworths/Law Society of Scotland, 1991: 190.
- (3) Norrie K M. Medical treatment of children and young persons in constituting families. In: Morgan D,

Douglas G, eds. *Archiv für Recht- und Sozialphilosophie: Beihaft 57*. Stuttgart: Franz Steiner Verlag, 1994: 109-117.

- (4) Wilkinson A R, Norrie K M. *The law relating to parent and child in Scotland*. Edinburgh: W Green/Sweet and Maxwell, 1993: 184-188.

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