These studies show the dangers of making ethical pronouncements in an empirical vacuum. There is a pressing need for more research on how proxy decision makers arrive at their recommendations for treatment. With regard to bone marrow donation, parents have several obligations. Not only do they have to keep the best interests of the two children in mind but they also have to come to a mutually acceptable solution that will at least maintain their partnership. Just as there is now much emphasis on evidence based medical practice, so too ought there to be more interest in evidence based ethical practice.

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Children's views should have been represented in discussion

EDITOR,—I find it odd that in the discussion of bone marrow transplantation the opinion of children was not sought.¹ I therefore turned to my local panel of experts, my children aged 5 to 11. I asked if they would be willing to provide a bone marrow transplant for one of their siblings. I explained the procedure, the discomforts, and the small possibility of death resulting from the anaesthetic. They initially found some of the information confusing, but from their questions it was obvious that the three oldest (aged 7 to 11) understood and agreed to transplantation. My 5 year old was problematic, refusing to donate to his sisters because they would not let him into their room. Try as I might, he could not grasp the issues concerned.

I also explained that some people thought that children should not be allowed to donate bone marrow because donation does not do the donor child any good. My 9 year old summed up the views of the group succinctly: "That's stupid. Why wouldn't you want to save someone's life if you could?" She would have to ask a lawyer for an answer: I could not think of one.

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- 1 Delany L, Month S, Savulescu J, Browett P, Palmer S. Altruism by proxy: volunteering children for bone marrow donation. *BMJ* 1996;312:240-3. (27 January.)

Children may be able to make their own decisions

EDITOR,—The discussion on volunteering children for bone marrow donation makes many important points about proxy decisions affecting children.¹ None of the authors, however, considers the possibility of children making decisions themselves, or even of adults taking account of children's views. Linda Delany refers to the case of Gillick but not to the main conclusion of the case, which was that children can give legally valid consent when "they have sufficient understanding and intelligence to understand fully what is proposed."²

Assumptions about the age at which children are able to make wise decisions tend to be based on ill founded historical prejudices about children's supposed inabilities and on psychological research about their responses to hypothetical questions. Children who have experience of severe illness and treatment tend to give far more informed responses than inexperienced ones. Young siblings of children in need of bone marrow transplants are likely to know a great deal about the implications of offering or withholding this treatment and to have clear views of their own.

We have reviewed the legal obligations of adults to listen to young children and to involve them in decisions that affect them, with the benefits and risks of doing so.³ While supporting high standards of clinical practice and professional ethics we have proposed ways of putting into policy and practice the idea that children can give legally valid consent (as was the judgment in the Gillick case).

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- 1 Delany L, Month S, Savulescu J, Browett P, Palmer S. Altruism by proxy: volunteering children for bone marrow donation. *BMJ* 1996;312:240-43. (27 January.)
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Moving medical malpractice insurance to Medical Insurance Agency may be expensive

EDITOR,—For 15 years I was insured for medical malpractice through a traditional defence union. Then, in 1991, I moved my insurance to the Medical Insurance Agency: the premium was related to the doctor's perceived risk and was half what my payment to the defence union had been. Subsequently I asked for legal advice about a letter to a patient whom I had put off my list. The agency's London based solicitor needed my confirmation that the rules covering this in the red book were the same in Scotland as in England and Wales. This did not inspire my confidence in the company's ability, and in 1994 I moved my insurance back to the traditional defence union. Too late I discovered that the policy that the agency had offered me did not offer retrospective cover unless further unspecified amounts were paid for an undefined number of years. The agency is the only company underwriting this type of policy, and none of the defence unions is prepared to assume my risk. They offer doctors retrospective cover for the years that they were a member. Curiously, the agency does not emphasise this difference prominently in any of its advertising.

The BMA had not heard of this problem but suggested that I wrote to the chairman of the Medical Insurance Agency. After an exchange of correspondence the company said that the item in its brochure on "run off" cover was adequate. I complained to the insurance ombudsman, who was unable to investigate my complaint since the problem was not within his remit.

I am extremely angry at being forced to remain insured with the Medical Insurance Agency or to pay run off cover for the rest of my professional life and my retirement. I am left counting the cost of not seeking clarification of

what exactly run off cover would mean in financial terms. I urge all doctors who may consider changing their indemnity insurance to the Medical Insurance Agency to seek written explanation of run off cover, otherwise it may cost them dear.

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Warfarin should be available as 0.5 mg tablet

EDITOR,—We recently reviewed the pattern of anticoagulant treatment at our hospital before computerisation to absorb the increased workload. We have seen a particular increase in the use of anticoagulants in elderly people. As expected, there was an inverse correlation between the dose of warfarin and age. Most of the elderly people were not treated with a single daily dose: over three fifths required either an alternating daily dose or a more complex regimen over three to seven days to achieve stable therapeutic anticoagulation. These types of regimen are confusing for elderly patients and are difficult to administer and to communicate to patients.

At present, warfarin is available in 1 mg, 3 mg, and 5 mg tablets; these are difficult to divide. We suggest that a 0.5 mg tablet should be introduced, which should be of a nationally agreed colour. Possibly it should be scored to allow the introduction of 0.25 mg doses.

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Advice to authors

We receive more letters than we can publish: we can currently accept only about one third. We prefer short letters that relate to articles published within the past four weeks. Letters received after this deadline stand less chance of acceptance. We also publish some "out of the blue" letters, which usually relate to matters of public policy.

When deciding which letters to publish we favour originality, assertions supported by data or by citation, and a clear prose style. Wit, passion, and personal experience also have their place.

Letters should have fewer than 400 words (please give a word count) and no more than five references (including one to the *BMJ* article to which they relate); references should be in the Vancouver style. We welcome pictures.

Letters should be typed and signed by each author, and each author's current appointment and address should be stated. We encourage you to declare any conflict of interest.

Please enclose a stamped addressed envelope if you would like to know whether your letter has been accepted or rejected.

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