Medical wastes found on coastline are increasing

EDITOR.—Last year we reported, on the basis of data from Norwich Union Coastwatch UK, that in 1991 one item of medical waste was found per 5.4 km of coastline surveyed in England and Wales.¹ In 1992 the findings were similar,² but in both studies unspecified medical items accounted for more than 48% of the waste. Injuries are being sustained—for example, 40 needlestick accidents on bathing beaches were reported between 1988 and 1991 to the Public Health Laboratory Service Communicable Disease Surveillance Centre. At 1992 prices the cost of hepatitis B immunoglobulin used in the management of these incidents was £3720, and in some places sharps containers are now being issued to lifeguards, who are advised not to go barefoot on beaches.³

During two weeks in the autumn of 1993 some 15% of the coastline with a similar range of geographical and population characteristics and similar ease of access to that studied in previous years was surveyed for Norwich Union Coastwatch UK by 6000 supervised volunteers. The quality of the data obtained was better than in previous years because the design of the questionnaire had been improved: only 67 of 1332 (5%) medical items found in 1993 were classified as "unspecified." Nevertheless, it is disturbing that one item of medical waste was reported per 1.3 km of coastline surveyed in England and Wales. This represents a fourfold deterioration in environmental quality compared with that in 1991 and 1992. The table shows the rates of reporting of different medical wastes in 1991-3.

Number of different medical items reported/1000 km of coastline surveyed in England and Wales (and number of kms surveyed each year), 1991-3

Item	1993 (1707 km)	1992 (1703.5 km)	1991 (1658.5 km)
Plaster	145.3	2.3	2.4
Medicine bottle	118.9	6.4	5.4
Syringe	94.3	22.3	25.3
Pill packet	93.5	17.6	0
Inhaler	72.1	5.9	11.5
Tube of cream	45.7	1.8	0
Bandage	31.6	0.6	0.6
Rubber glove	8.8	3.5	4.2
Intravenous drip bags or tubing	8.8	4.1	1.2
Other*	109.5	15.3	12.1
"Unspecified"	39.4	116.3	122.0
Total	769.2	196.1	185.2

*Includes spray bottles, tablets, cotton wool and gauze dressings, eye droppers, ear plugs, toothpaste, razors, disinfectant, false teeth, tweezers, cotton buds, colostomy and blood bags, aspirator, first aid box, measuring cylinder, urine bottle, kidney dish, and laboratory pipette.

The apparent fourfold deterioration in environmental standards is shown by the reporting rates for syringes. The reporting rates for tubes of cream, plasters, medicine bottles, pill packets, asthma inhalers, and bandages suggest, however, that the deterioration in environmental quality from 1991 to 1993 is even greater than fourfold. It may, though, be partly explained by the improved quality of the data. The results of the next survey, to be conducted this autumn, should help to answer this question. Nevertheless, these findings suggest that the quality of the coastline environment is unsatisfactory. To help improve

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it a much greater sense of personal responsibility is needed.

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- 1 Philipp R, Pond K, Rees G. Litter and medical waste on bathing beaches in England and Wales. *BMJ* 1993;306:1042.
- 2 Philipp R, Pond K, Rees G. A study of litter and medical waste on the UK coastline in 1992. *Health and Hygiene* (in press).
- 3 Philipp R. Community needlestick accident data and trends in environmental quality. *Public Health* 1993;107:363-9.

Euthanasia

Present law protects doctors and patients

EDITOR.—A P M Heintz raises important issues in his editorial.¹ He correctly distinguishes euthanasia ("a medical act that deliberately shortens the life of a seriously ill patient at his or her request") from the perfectly legal withdrawal or withholding of burdensome and unavailing treatments which only prolong or add to suffering. The recent recommendations of the Select Committee of the House of Lords² uphold the rights of patients to refuse treatments which they do not wish to undergo, and urge the importance of doctors continuing to balance burdensomeness against benefit when advising on treatment.

The present law protects both doctor and patient. The patient feels that life is no longer worth living, but the moral stance behind the law reflects that a person's life is valuable per se—not because of what the person contributes or does, but because the person is a person. In rejecting legalisation of euthanasia, British society and its doctors are declaring the importance of protecting the weak, the disabled, and the dying—and in so doing declaring the dignity of human life. The Select Committee has pointed out that this demands increasing research and facilities for the care of such people.

Unfortunately the Dutch figures³ confirm that when voluntary euthanasia becomes ethically acceptable to the limited extent that it is in Holland, non-voluntary euthanasia is an inevitable

accompaniment. Van der Wal and Dillmann acknowledge that the 1990 figures report more than 1000 occasions of non-voluntary euthanasia—when someone decided that another person's life was not worth living.⁴ So much for autonomy.

Lord Walton reflected on this in his speech to the House of Lords on 9 May 1994 when he said: "One compelling reason underlying this conclusion was that we do not think it is possible to set secure limits on voluntary euthanasia. As our report shows, we took account of the present situation in the Netherlands; indeed some of us visited that country and talked to doctors, lawyers and others. While we accept the sincerity of those who fervently advocated the present procedures that exist there . . . we returned from our visit feeling uncomfortable, especially in the light of evidence indicating that non-voluntary euthanasia—that is to say, without the specific consent of the individual—was commonly performed in Holland, admittedly in incompetent, terminally ill patients . . . We concluded that it would be virtually impossible to ensure that all acts of euthanasia were truly voluntary and that any liberalisation of the law in the United Kingdom could not be abused. We were also concerned that vulnerable people—the elderly, lonely, sick, or distressed—would feel pressure, whether real or imagined, to request early death."

These were some of the considerations which brought the BMA in recent discussions, the Select Committee, the Lords in debate, and the government to reject legalisation of euthanasia.

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- 2 Select Committee on Medical Ethics. *Report*. London: HMSO 1994.
- 3 Van der Maas PJ, van Delden WM, Pijnenborg L, Looman CWN. Euthanasia and other medical decisions concerning the end of life. *Lancet* 1991;338:669-74.
- 4 Van der Wal G, Dillman RJM. Euthanasia in the Netherlands. *BMJ* 1994;308:1346-9.
- 5 Lord Walton of Detchant. Medical ethics: select committee report. *House of Commons Official Report*. (Hansard) 1994; May 9:1345.

Acquiescence corrupts Dutch doctors

EDITOR.—Will I be the only doctor who considers resigning from the BMA in protest against the blatant pro-euthanasia stance of its main organ in recent weeks? Two articles^{1,2} and one editorial³ about euthanasia have been published in the *BMJ*, yet none mentions the House of Lords Select Committee's *Report on Medical Ethics*, with its unanimous recommendation that there should be no change in the law to permit euthanasia because it is uncontrollable and too open to abuse⁴.

We acknowledge that there are individual cases in which euthanasia may be seen by some to be appropriate. But individual cases cannot reasonably establish the foundation of a policy which would have such serious and widespread repercussions. . . . We believe that the issue of euthanasia is one in which the interest of the individual cannot be separated from the interest of society as a whole.

The pro-euthanasia stance seems even more remarkable in the face of the collective view of the BMA expressed in its recent publication on medical ethics:

The BMA considers that whilst there are many cases