

## Netherlands, first country to legalize euthanasia

Last month, the Netherlands became the first country to decriminalize voluntary euthanasia. Under new legislation a doctor will not be prosecuted for terminating a person's life providing he or she is convinced that the patient's request is voluntary and well considered and that the patient is facing "unremitting and unbearable" suffering.

The doctor must have advised the patient of his or her clinical condition and have reached a firm conclusion with the patient that there is "no reasonable alternative". In addition, at least one other independent physician must have examined the patient and reached the same conclusion.

The legislation reached its final hurdle on 10 April when the Dutch senate voted by 46 votes to 28 to approve the bill. The vote was seen as a formality, after the lower house voted last autumn by 2:1 in favour of decriminalization.

There will be little change in practice, as Dutch doctors have offered euthanasia to terminally ill patients for at least two decades. In 1994, a law was introduced which obliged doctors to report any cases of euthanasia to the authorities, who would then decide not to prosecute if the doctor had followed certain guidelines. Euthanasia still remained a crime, however, carrying a maximum 12-year prison sentence.

The Royal Dutch Medical Association welcomed the move, saying it would resolve the "paradoxical legal situation" and ensure that doctors acting in good faith and with due care would not face criminal proceedings.

Although surveys show that the change in law is supported by 90% of the Dutch population, there were still angry protests outside the parliament building. In the weeks preceding the debate, the senate received over 60 000 letters urging legislators to vote against the bill. The mostly Christian protesters view the measure as an assault on the sanctity of life.

About 3000 cases of voluntary euthanasia are carried out each year in the Netherlands. Mr Rob Jonquierre, managing director of the Dutch Voluntary Euthanasia Society, believes that the new legislation will not lead to a massive increase in the number of cases. He told the *Bulletin*: "We may see more requests, as patients may find it easier to talk to a doctor about euthanasia knowing that the doctor will not now be committing a crime."

But he adds: "One of the main reasons for requesting euthanasia is fear of the dying process. So if patients are confident that a doctor won't refuse euthanasia at a future date this can be very reassuring and can give them the strength to continue."

Belgium could be the next country to change its laws on mercy killing, as a bill to partially decriminalize euthanasia is currently before parliament. In Belgium, 72% of the population is believed to support some sort of death on demand.

The issue of euthanasia is likely to remain high on the medicolegal or ethical agendas of many countries in coming years. One reason, according to some experts, is a growing insistence among patients in many countries on having the final say — in all senses of the word "final" — about their medical treatment.

Another reason is that people are living longer and because of medical advances increasing numbers are surviving with debilitating conditions, such as cancer and heart disease. However, some experts in palliative care argue that advances in palliative medicine mean that more patients should be able to live a pain-free life, thereby reducing the need for euthanasia.

Jonquierre believes it should not be an issue of palliative care vs euthanasia. "The best possible care should be given before the issue of euthanasia arises. However, a discussion of euthanasia should be part of the palliative care package." ■

Jacqui Wise, *London, UK*

## Heated debate likely on plan for EU-wide health coordination

In a vote on 4 April, the European Parliament called for the creation of a European Health Coordination and Monitoring Centre (HCMC) — the cornerstone of a proposed new programme that would coordinate and streamline health policies across the 15 member states of the European Union (EU). At the same session, the Parliament also called for an almost 30% increase in funding — from € (euros) 300 million (US\$ 256 million) to € 380 million (US\$ 336 million) — for the programme, which would run from 2001 to 2006.

Officially termed "programme of community action in the field of public health", the new programme was first proposed last May by the European Commission, the EU's executive body. The Parliament is currently calling for a number of revisions.

The proposed programme would replace eight existing programmes, which each addresses a single public health topic, such as cancer, AIDS and other sexually transmitted diseases, rare diseases, pollution-related diseases, epidemiological surveillance, health education, injuries and accidents, as well as drug abuse.

The Commission's public health proposal, explains Member of Parliament Antonios Trakatellis, "is the first integrated EU venture in this sector. To date, important health topics have been dealt with in a piecemeal fashion, with different problems tackled mainly in isolation from each other". The main goal of the new programme, Trakatellis says, would be to collect and evaluate medical and epidemiological data across the EU, bookmark health-determining factors, including lifestyle, socioeconomic or environmental factors, and elaborate mechanisms by which one could respond rapidly and efficiently to health threats like, say, emerging infectious diseases.

The coordinating centre, the HCMC, that Parliament is calling for would be a clearing house for all types of public health data compiled from across the EU. It would gather data through national health agencies, monitor epidemiological trends and health inequalities, and come up with a catalogue of best health care practices to be provided to all EU citizens. "In order to collect and manage data, you need a functioning coordination centre, which simply wasn't there [in the initial proposal]," Trakatellis says.

In their vote, members of Parliament also included a wish-list of urgent issues the new programme should focus on: they include cardiovascular diseases, mental disorders, age-related neurodegenerative diseases, cancer, respiratory diseases, and AIDS and other sexually transmitted diseases. The Parliament also called for safeguards against exposure to electromagnetic fields and expressed the hope that research under the current WHO programme on magnetic fields would be supported.

The Parliament's revisions, says Trakatellis, would help ensure that this is a sound programme for the entire EU. "Ideally, it would cover just about everything related to public health. I consider it the beginning of a long journey toward the convergence of health policies and services among the member states."

Dr Marc Danzon, the director of the WHO Regional Office for Europe in Copenhagen, welcomes the EU proposal.

The new programme, he says, would be a signal that “the Commission is getting more involved in the sector of public health — and that is good for the work of WHO”. Once up and running, WHO is planning to collaborate closely with the EU networks, among other things in order to avoid any duplication of effort, Danzon says. “It’s neither in their interest, nor in ours. But the risk really is minor. In the field of epidemiology and public health, there are far too few people and too much data. In fact, there is work for 1000 organizations. The [Commission’s] intention is good, the plans are good; now let’s implement them together.”

But Trakatellis’s — and the Parliament’s — vision has still a long way to go. The Council of the EU, composed of the responsible ministers of the member states, has its say on the proposal. Then the Commission, the Parliament and the Council have to settle on a compromise.

“The Commission is not ruling out anything for the future but the first priority right now is to get the new programme up and running — which, given its scope, is a massive effort,” a Commission spokeswoman, who requested anonymity, told the *Bulletin*. Discussions are under way with other health agencies, including WHO, she added, on a broad range of topics, including what has to be done to make sure that there is no duplication of effort when the new programme goes into effect.

The Parliament’s April vote is thus likely to mark the beginning of some heated debate. ■

Michael Hagmann, *Zurich, Switzerland*

## Arsenic in water — how much is too much?

The United States is in the throes of a fractious debate about what the permissible levels of arsenic in water should be.

The current US standard of 50 parts per billion (ppb), in place since 1942, is criticized as dangerous by public health watchdogs, who would like to see the level reduced to 10 ppb, a change proposed by the Clinton administration in January. EPA chief Ms Christine Todd Whitman has asked the US National Academy of Sciences (NAS) to review more data and to consider standards ranging from 3 to 20 ppb and has also asked an advisory council to study the potential costs of lower standards. Meanwhile, the current standard of 50 ppb remains in place.

The arsenic found in drinking-water is primarily from natural sources — it leaches into groundwater from rocks and soil. It can also enter the environment as a by-product

of industrial and agricultural processes. WHO says prolonged exposure to arsenic in drinking-water causes cancer of the skin, lungs, bladder, and kidneys. In particular, the agency notes in a soon-to-be-published fact sheet, lung and bladder cancers have been observed at levels below 50 ppb — the international standard set by WHO in 1963. In 1993, WHO set 10 ppb as a “provisional guideline value” but notes that on health grounds this value “would be less than 0.01 mg/l [or 10 ppb]”.

Countries where arsenic in drinking-water has been detected at concentrations above 10 ppb include Argentina, Australia, Bangladesh, Chile, China, Hungary, India, Mexico, Peru, Thailand, and the US. In at least four of these countries — Bangladesh, China, India, and the US — adverse effects on health have been documented, WHO says. ■

Catherine Dold, *Boulder, Colorado, USA*

## In Brief

### Polio vaccine not HIV source, four studies show

Findings of four studies reported at the end of April — three in the journal *Nature*, one in *Science* — strongly refute a much-publicised theory that the first cases of AIDS resulted from African trials of an oral polio vaccine supposedly contaminated with the chimpanzee variety of HIV (SIVcpz). British writer Edward Hooper elaborated on the theory at length in his 1999 book, *The River*. Three of the new studies found neither chimpanzee DNA nor genetic material from HIV or SIVcpz in samples of the vaccine used in the trials, as would be expected if the theory was correct. The fourth study suggested that HIV was present in humans long before the vaccine field trials. Put together, these new studies show that the oral polio vaccine was not the source of AIDS. For more information see pp. 1045, 1046 and 1047 in *Nature*, 26 April, 2001 and p. 743 in *Science*, 27 April 2001. ■

### And MMR vaccine not a source of autism, US panel says

A 15-member immunization safety review committee convened by the US Institute of Medicine concluded in a report released on 23 April that there is no causal relationship between the measles-mumps-rubella combination vaccine and autism, and “no proven biological mechanisms that would explain such a relationship”. Other leading health groups, including the American Academy of Pediatrics, WHO and British health authorities (see *News* story in the *Bulletin*,

p. 272, vol. 79, March 2001), have come to much the same conclusion. An MMR-autism link was first mooted in a study published in 1998 in *The Lancet*. Details from [www.iom.edu/IOM/IOMHome.nsf/Pages/immunization+safety+review](http://www.iom.edu/IOM/IOMHome.nsf/Pages/immunization+safety+review). ■

### Petroleum funds to fuel malaria research

ExxonMobil announced in mid-April its support for three malaria initiatives — the Harvard Malaria Initiative (HMI), the Medicines for Malaria Venture (MMV) and the WHO-spearheaded Roll Back Malaria (RBM) programme. The petroleum and petrochemical company is donating US\$ 1 million to the HMI, a Harvard School of Public Health initiative focusing on basic research for antimalarial drugs and vaccines, and US\$ 300 000 to the MMV, a non-profit foundation that coordinates antimalarial drug development. A further, as yet unspecified, amount will go to RBM to support its antimalarial activities in five African countries — Angola, Cameroon, Chad, Equatorial Guinea and Nigeria — where ExxonMobil operates. For further information, visit these Web sites: [www.hsph.harvard.edu/malaria](http://www.hsph.harvard.edu/malaria), [www.malariamedicines.org](http://www.malariamedicines.org), [www.who.int/rbm](http://www.who.int/rbm), and [www.exxonmobil.com](http://www.exxonmobil.com) ■

### Malaria researchers note: parasite genome now on Web

PlasmoDB, an Internet-based database allowing genomic analysis of *Plasmodium falciparum*, the cause of the most lethal form of malaria, is now available at <http://plasmodb.org>. Two US research teams at the University of Pennsylvania announced in April. The database owes a lot to sequencing work conducted at two US institutions, the Institute for Genomic Research and the Naval Medical Research Center at Stanford University, and to the UK’s Sanger Centre. ■

### First guidelines out for tackling deadly lung disease

The US National Heart, Lung and Blood Institute, together with WHO, issued in April the first international guidelines on diagnosing, treating and preventing chronic obstructive pulmonary disease (COPD). The guidelines were drawn up by the *Global initiative for chronic obstructive lung disease*, or GOLD, a team of COPD experts from more than 100 countries. Although it is the fourth leading cause of death in the world, COPD has failed to attract the attention it deserves from the international health care community and from governments, says GOLD chair Professor Romain Pauwels. For more information and a copy of the guidelines contact Dr Nikolai Khaltaev ([khaltaevn@who.int](mailto:khaltaevn@who.int)). ■