

A Reply to John Keown's Criticism of the Effectiveness of the Assisted Dying Regimes in the Netherlands and in Oregon

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A REPLY TO JOHN KEOWN'S CRITICISM OF THE EFFECTIVENESS OF THE ASSISTED DYING REGIMES IN THE NETHERLANDS AND IN OREGON

ABSTRACT: This paper discusses John Keown's argument whereby the available data concerning the practice of assisted dying in the Netherlands and in Oregon proves that the laws and guidelines adopted to prevent unlawful abuses are clearly ineffective. In his opinion, the main issues concern the following safeguards: request; type of suffering; consultation and reporting procedure.

However, a close scrutiny of Keown's empirical remarks will show that his conclusions are erroneous as they rely on a misinterpretation either of specific provisions (e.g. unbearable suffering in the Netherlands) or of the evidence taken into account (e.g. request and consultation in the Netherlands; reporting in Oregon).

A correct understanding of both the regulatory regimes in place and the existing empirical data will demonstrate that in both countries there is a good rate of compliance with most of those safeguards; whilst it cannot be proved that a limited percentage of non-compliance with certain requirements (e.g. psychological consultation both in the Netherlands and in Oregon; and reporting in the Netherlands) has produced unlawful consequences for the patients.

KEYWORDS: Assisted dying; The Netherlands; Oregon; safeguards' effectiveness; empirical evidence

SOMMARIO: 1. Introduction. – 2. Relevant practices. – 3. Relevant provisions. – 4. Keown's general criticism. – 5. A reply to Keown's analysis. – 6. Conclusion.

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1. Introduction

John Keown argues that in the Netherlands and Oregon the safeguards adopted to assure compliance with the provisions regulating assisted dying¹ (AD) are widely disregarded². As a consequence, patients would be exposed to unlawful abuses³. The validity of this argument would be confirmed by the available data concerning the practice of AD in these countries.

It will be argued that Keown's empirical analysis lacks persuasiveness as it hinges on a flawed interpretation either of specific provisions or of the evidence examined. A correct understanding of both the regulatory regimes in place and the empirical data regarding specific safeguards will show that in both countries there is a good rate of compliance with such requirements; whilst it cannot be proved that the limited percentage of non-compliance has produced unlawful consequences for the patients.

It will first be necessary to clarify the scope of the relevant practices of assisted dying in order to determine what are the laws and guidelines that will be discussed hereinafter. It will also be helpful to recall the content of the provisions dealt with.

The subsequent discussion will be divided in two parts: the first one will present Keown's remarks about the empirical evidence concerning the alleged breach of specific requirements; whilst the second one will question the validity of his conclusions.

It must be stressed that this paper will only be concerned with the part of Keown's analysis concerning the empirical evidence that would support his thesis; therefore, it will not examine his claims about the causes of the safeguards' assumed ineffectiveness. Moreover, it will not be investigated whether, as Keown argues⁴, the supposed lack of control and protection has been the inevitable consequence of the legalisation of assisted dying. This issue would require a dedicated examination of the logical⁵ and notably empirical⁶ versions of the slippery slope arguments⁷, which would be out of scope.

2. Relevant practices

The practices of assisted dying whose safeguards are criticised by Keown are physician assisted suicide (PAS) and euthanasia. While the definition of the former⁸ is not controversial, the scope of the latter is often object of controversy. The Dutch use this term to refer to «termination of life on re-

¹ The term is generally used to refer to both voluntary active euthanasia and assisted suicide. See P. LEWIS, *Assisted Dying and Legal Change*, Oxford, 2007, 6.

² J. KEOWN, *Euthanasia, Ethics and Public Policy. An Argument against Legalisation*, Cambridge, 2002, 114 (Netherlands), 180 (Oregon).

³ *Ibidem*, 124 (Netherlands), 180 (Oregon).

⁴ *Ibidem*, 149.

⁵ *Ibidem*, 76, 81.

⁶ *Ibidem*, 72.

⁷ *Ibidem*, 71. See also P. LEWIS, *Assisted Dying and Legal Change*, cit., 161-162.

⁸ For a range of possible definitions see P. LEWIS, *Assisted Dying and Legal Change*, cit., 5.

quest» (also called voluntary active euthanasia (VAE))⁹, though Keown argues that it should encompass any case of «intentional death by medical practitioner»¹⁰. However, this expression is extremely broad and includes a variety of end-of-life procedures. In fact, some of them (e.g. “intentional killing by deliberate omission”) are lawful also in many restrictive jurisdiction; whilst others (e.g. “active termination of life without request” or non-voluntary euthanasia (NVAE) and involuntary euthanasia (IVAE)), except in limited circumstances¹¹, are prohibited also in the Netherlands and Oregon. The following discussion will be limited to the effectiveness of the safeguards relating to those practices of assisted dying that distinguish these two jurisdictions from others in which AD has not been legalised, namely voluntary active euthanasia in the Netherlands¹² and physician assisted suicide in Oregon¹³.

3. Relevant provisions

Since the remarks made by Keown point to specific requirements of these two legal regimes of assisted dying, it is useful to outline their content.

Request: in the Netherlands, the patient’s request must be «voluntary and carefully considered» (s.2(1)(a))¹⁴; in Oregon the patient must be capable and his/her request must be expressed voluntarily (127.805§2.01(1))¹⁵.

Suffering: in the Netherlands, the patient must be suffering unbearably and have no prospect of improvement (s.2(1)(b)); the source of the suffering can be either physiological, though does not have to be a terminal illness, or psychiatric¹⁶. The attending physician must «have come to the conclusion,

⁹ J. GRIFFITHS, H. WEYERS, M. ADAMS, *Euthanasia and Law in Europe: With Special Reference to the Netherlands and Belgium*, Oxford, 2008, 76.

¹⁰ J. KEOWN, *Euthanasia, Ethics and Public Policy. An Argument against Legalisation*, cit., 101.

¹¹ J. GRIFFITHS, H. WEYERS, M. ADAMS, op. cit., 218: «in the Netherlands termination of life of severely defective newborn babies is also legal under narrowly defined circumstances». See also *Ibidem*, 226-241.

¹² In the Netherlands, both PAS and VAE can be lawfully carried out exclusively by physicians and in compliance with the criteria of due care specified in the legislation.

¹³ In Oregon, the Death with Dignity Act has legalised only one form of PAS: self-administration by patients of a lethal medication prescribed by the physician.

¹⁴ All the sections related to the Dutch regime refer to the Termination of Life on Request and Assisted Suicide (Review Procedure) Act 2001.

¹⁵ All the sections related to the Oregon regime refer to the Oregon Death With Dignity Act. Oregon Revised Statutes.

¹⁶ A psychiatrist, Dr Boudewijn Chabot, was approached by a fifty-year old woman with a request for assisted dying. The woman, who suffered from severe depression, had already attempted suicide. Dr Chabot had extensive discussions with her and consulted several other physicians and psychiatrists, who did not, however, interview the patient themselves. Eventually, he came to the conclusion that, in the circumstances, there was no realistic treatment perspective, and that her request for assisted dying was well-considered. Accordingly, he provided the woman with a lethal drug, which she administered to herself. Since no independent physician had interviewed the woman, the Dutch Supreme Court found that the defence of necessity was not applicable to this case, and therefore convicted Dr Chabot (though he was not punished); however, the it «also made clear that the patient’s suffering need not have a somatic origin, so that a psychiatric patient capable of a competent and voluntary request could receive assistance in suicide» in J. GRIFFITHS, H. WEYERS, M. ADAMS, op. cit., 80. For a detailed account of the *Chabot* case, see J. GRIFFITHS, *Assisted Suicide in the Netherlands: The Chabot Case*, in *The Modern Law Review*, 58(2), 1995, 232. See also H. POLS, S. OAK, *Physician-assisted dying and psychiatry: Re-*

together with the patient, that there is no reasonable alternative in light of the patient's situation» (s.2(1)(d)). In Oregon, the only suffering requirement is that the patient is suffering from a terminal disease, which should cause death within six months (127.800§1.01(12), 127.805§2.01(1)).

Consultation: in the Netherlands, the attending physician must consult at least another «independent physician, who must have seen the patient and give a written opinion» on whether the due care criteria are respected (s.2(1)(e)). Moreover the patient must be referred to a psychiatrist if the attending physician suspects that he or she lacks capacity¹⁷. In Oregon, the attending physician must consult another physician «who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease». If either the attending or the consulting physicians suspect that the patient «may be suffering from a psychiatric or psychological disorder, or depression causing impaired judgment [they] shall refer the patient for counselling» (127.800§1.01(4)(5), 127.815§3.01(1)(d)(e), 127.820§3.02, 127.825§3.03).

Reporting: in the Netherlands, the attending physician is required to report the case to the municipal pathologist (s.21). In Oregon, the attending physician has a duty to report «each prescription written under the Act to the Oregon Department of Human Services (ODHS), and report each death resulting from the ingestion of the prescribed medication»¹⁸.

4. Keown's General Criticism

According to Keown, the evidence coming from both the Dutch and the Oregon experiences of assisted dying confirms the lack of control exercised over the practices of voluntary active euthanasia and physician assisted suicide by the safeguards in place. Consequently, patients are subjected to unlawful practices. In his opinion, this failure would be the inevitable consequence of the faults contained in the provisions and ultimately of the impossibility to draft effective safeguards¹⁹. As mentioned above, it would be out of scope to tackle the last claim, the focus therefore will be only on whether the evidence assessed by Keown upholds his concerns²⁰.

The substantial part of Keown's scrutiny of both the Dutch and the Oregon experiences of assisted dying was conducted more than ten years ago²¹. Yet, Keown²² and other commentators²³ who have endorsed his remarks have subsequently reaffirmed the validity of his original conclusions.

cent developments in the Netherlands, in International Journal of Law and Psychiatry, 36, 2013, 508; R. HUXTABLE, M. MÖLLER, "Setting a principled boundary"? Euthanasia as a response to 'life fatigue', in Bioethics, 21(3), 2007, 121.

¹⁷ *Ibidem*, 97. This requirement is not expressively stated in the law, but in recommendations made by the Dutch Association for Psychiatry (NVP).

¹⁸ P. LEWIS, I. BLACK, *Commissioned Briefing Paper. The effectiveness of legal safeguards in jurisdictions that allow assisted dying. Commission on Assisted Dying*, London, 2012, 18.

¹⁹ J. KEOWN, *Euthanasia, Ethics and Public Policy. An Argument against Legalisation*, cit., 74, 80.

²⁰ *Ibidem*, 90, 173.

²¹ *Ibidem*, Ch. 8-13, 15.

²² J. KEOWN, *Debate. Physician-Assisted-Suicide: Lord Joffe's Slippery Bill*, in *Medical Law Review*, 15, 2007, 132.

²³ See W.L. SAUNDERS, J.D. FRAGOSO, M.A. FRAGOSO, *Should we Legalize Voluntary Euthanasia and Physician-Assisted-Suicide?* (date of publication not found), in <http://www.frc.org/infocus/should-we-legalize-voluntary-euthanasia-and-physician-assisted-suicide> (last visited 08.05.2015). See also J. PEREIRA, *Legalizing euthanasia or assisted suicide: the illusion of safeguards and control*, in *Current Oncology*, 18(2), 2011, e40.

4.1 The Netherlands

Keown maintains that the validity of his claim about the flaws contained in the Dutch safeguards²⁴ and their resulting ineffectiveness is upheld by the empirical evidence²⁵.

He assesses the data coming from the first two national surveys²⁶ conducted in the Netherlands regarding not just voluntary active euthanasia, but «all medical decisions affecting the end of life»²⁷.

In Keown's opinion the main issues concern the following requirements foreseen for VAE: request; type of suffering; consultation and reporting procedure. Here are his findings:

Request: the 1,000 cases of non-voluntary euthanasia (0,8% of all deaths in 1990) reported in the first survey represent a blatant breach of this requirement²⁸; and although the second survey showed a decreased in their number (0,7% of all deaths in 1995), it «confirmed that NVAE remained far from uncommon»²⁹.

Unbearable suffering: both the evidence from the survey – in particular the reasons given by patients for requesting voluntary active euthanasia³⁰ – and the lax interpretation of this requirement by the courts – in the *Chabot* case³¹ and by the first instance judge in the *Brongersma* case³² – proved the validity of his concerns about its ineffectiveness. Commenting the findings of the second survey, he states that this requirement was disregarded in all the cases of voluntary active euthanasia in which the patients' requests were not motivated by unbearable and hopeless suffering³³.

Last resort: the first survey demonstrated that voluntary active euthanasia happened to be carried out even when palliative care was available³⁴. This tendency was confirmed by the second survey, which indicated that in almost all the 17% of the cases of VAE-PAS in which «there were treatments alternatives...patients did not want them»³⁵.

Consultation: in 1990, consultation was carried out in 84% of cases of VAE-PAS, but only in the 48% of the cases of non-voluntary euthanasia³⁶; whereas, with regard to the second survey, Keown casts

²⁴ J. KEOWN, *Euthanasia, Ethics and Public Policy. An Argument against Legalisation*, cit., 89: the author extends his criticisms to the guidelines contained in the legislation.

²⁵ *Ibidem*, 90.

²⁶ The first survey was held in 1990; and the second in 1995.

²⁷ J. KEOWN, *Euthanasia, Ethics and Public Policy. An Argument against Legalisation*, cit., 91. The second survey scrutinised the same practices.

²⁸ *Ibidem*, 103, 104, 123.

²⁹ *Ibidem*, 128.

³⁰ *Ibidem*, 109.

³¹ *Ibidem*.

³² *Ibidem*. Keown refers to the decision of the District Court of Haarlem that acquitted the attending physician who had helped a patient to commit suicide, though the latter had no physical or mental illness, but was "tired of living". For a detailed account of this decision, see J. GRIFFITHS, H. WEYERS, M. ADAMS, *op. cit.*, 35. See also, R. HUXTABLE, M. MÖLLER, *op. cit.*, 117.

³³ J. KEOWN, *Euthanasia, Ethics and Public Policy. An Argument against Legalisation*, cit., 127-128.

³⁴ *Ibidem*, 12.

³⁵ *Ibidem*, 127.

³⁶ *Ibidem*, 112-113.

doubt on the interpretation of the data and he concluded that «consultation occurred in only around half of all cases» of voluntary active euthanasia and physician assisted suicide³⁷.

Reporting: in 1990 only 486 out of 2,700 cases of VAE-PAS were reported; therefore, the common widespread failure to report cases of voluntary active euthanasia shows the lack of control over the practices³⁸. The second survey indicated that, despite the improvements (the rate of compliance went from 18% to 41%), most cases were not reported³⁹.

4.2. Oregon

Similarly to Netherlands, Keown starts his examination by arguing that also in Oregon the guidelines in place are neither precise – as the definition of relevant requirements is vague⁴⁰ – nor strict – since the Act lacks important requirements⁴¹. Then, he holds that «the unfolding evidence of the Act's operation is far from reassuring»⁴². This evidence that would confirm their ineffectiveness is provided mainly by two sources: the critical remarks made by the authors of a study on the first reported case of physician assisted suicide⁴³; and the findings of the first three reports⁴⁴ produced by the Oregon Department of Human Services⁴⁵.

According to the first source, the «apparent deficiencies» occurred in the management of the first reported case of PAS «illustrate some of the major inadequacies of the Act»⁴⁶. Such «inadequacies» largely correspond to the abovementioned concerns expressed about the flaws contained in the Act. As far as the ODHS's reports are concerned, Keown maintains that the first one «does not, in any event, prove that all cases of physician assisted suicide in Oregon that year satisfied the Act»⁴⁷. Likewise, in the second one, its authors

«frankly acknowledged: 'Underreporting cannot be assessed, and non-compliance is difficult to assess because of the possible repercussions for noncompliant physicians reporting data' to the OHD'»⁴⁸.

Finally, Keown holds that the third report highlighted disturbing changes in this practice, such as the decreased number of patients who received psychological evaluation compared to the previous report, despite alleged evidence that many requests came from depressed people⁴⁹.

³⁷ *Ibidem*, 131-132. See also J. PEREIRA, *op. cit.*, e30-e40, who argues that the psychiatric counselling requirement is disregarded.

³⁸ J. KEOWN, *Euthanasia, Ethics and Public Policy. An Argument against Legalisation*, cit., 113-114.

³⁹ *Ibidem*, 132.

⁴⁰ *Ibidem*, 171.

⁴¹ *Ibidem*, 171-173.

⁴² *Ibidem*, 173.

⁴³ H. HENDIN, K. FOLEY, M. WHITE, *Physician-Assisted Suicide: Reflections on Oregon's First Case*, in *Issues in Law & Medicine*, 14(3), 1998, 243.

⁴⁴ These reports concern the practice of PAS in 1998, 1999 and 2000 respectively.

⁴⁵ J. KEOWN, *Euthanasia, Ethics and Public Policy. An Argument against Legalisation*, cit., 176-179.

⁴⁶ *Ibidem*, 175.

⁴⁷ *Ibidem*, 177.

⁴⁸ *Ibidem*, 178.

⁴⁹ *Ibidem*, 179.

5. A reply to Keown's analysis

In the second part of this paper, it will be conducted a critical evaluation of Keown's analysis of the empirical findings used to support his conviction about the ineffectiveness of the laws and guidelines employed in the Netherlands and in Oregon.

It will be maintained that, despite the existence of limited issues concerning the functioning of certain safeguards, there is no evidence of either a significant lack of compliance or unlawful abuses. This 'counter analysis' will rely mainly on the review of empirical data contained in official as well as academic sources.

5.1. Theoretical criticism vs empirical evidence

It seems that sometimes Keown instead of providing empirical evidence showing that the laws and guidelines were breached, only criticises the way in which they were drafted or interpreted.

5.1.1. Unbearable suffering in the Netherlands

Keown does not seem to acknowledge or accept either that the type of suffering requested to meet this requirement does not necessarily have to be physical⁵⁰, or that its source can also be psychiatric, though not existential⁵¹. His argument relies only on a negative judgment of the elasticity of this requirement.

Moreover, the available evidence indicates that this criterion is quite effective as it is used by doctors «to weed out a significant proportion of requests. Reported cases ... almost all meet the criterion when examined by the relevant reviewing body»⁵².

5.1.2. Voluntary active euthanasia not used as a last resort in the Netherlands

Similarly to what observed for unbearable suffering, Keown fails to appreciate that the Dutch system of assisted dying does not foresee a palliative filter. In general, only in cases where the source of suffering is psychiatric, «the patient may not reject "a realistic alternative to relieve the suffering"»⁵³.

5.2. Faulty interpretation of the data

5.2.1. Request

With regard to the Netherlands, Keown seems to equate the existence of cases of non-voluntary euthanasia with a breach of the request requirement prescribed for voluntary active euthanasia. How-

⁵⁰ P. LEWIS, I. BLACK, *Commissioned Briefing Paper. The effectiveness of legal safeguards in jurisdictions that allow assisted dying. Commission on Assisted Dying*, cit., 4.

⁵¹ J. GRIFFITHS, H. WEYERS, M. ADAMS, *op. cit.*, 80, 113, 123.

⁵² P. LEWIS, I. BLACK, *Commissioned Briefing Paper. The effectiveness of legal safeguards in jurisdictions that allow assisted dying. Commission on Assisted Dying*, cit., 79-80.

⁵³ *Ibidem*, 5. See also J. GRIFFITHS, H. WEYERS, M. ADAMS, *op. cit.*, 91, 117.

ever, the cases of termination of life without request are not subject to the same regulatory regime⁵⁴ of voluntary active euthanasia. Therefore, it cannot be assumed that all cases of NVAE are the consequence of a breach of the safeguards on VAE. Indeed, the data used by Keown indicated that most of the non-voluntary euthanasia cases concerned clearly incompetent patients⁵⁵ who would have never been eligible for voluntary active euthanasia.

In any case, updated research shows that the number of these cases have constantly decreased since 1990: in 2010 they amounted only to the 0,2% of all deaths⁵⁶.

Finally, a recent study⁵⁷ assessing compliance with this requirement - among other countries –also in the Netherlands and in Oregon, came to the conclusion that

«[t]he evidence ... suggests that the legal criteria that apply to an individual's request for assisted dying are well respected: individuals who receive assisted dying do so on the basis of valid requests; third parties who assist individuals to die do not act unlawfully»⁵⁸.

5.2.2. Consultation and psychiatric referral

By using the data on non-voluntary euthanasia in Netherlands to question the compliance with the consultation requirement, Keown makes the same mistake highlighted above for the request. Moreover, according to recent research from 2005 to 2010 there has been an increase in the percentage of cases (from 87.7% to 93.8%) in which doctors had a «discussion with other physician»⁵⁹.

As for the requirement to refer patients to psychiatric specialists when they are suspected to suffer from mental disorder, the concerns expressed by Keown⁶⁰ are only partially confirmed by the available evidence. In the Netherlands, «psychiatric consultation is relatively rare, particularly if the patient's primary physician is not a psychiatrist»⁶¹. However, there is no evidence to establish whether the patients who were not referred lacked capacity. Moreover, «depression is significantly less

⁵⁴ Cases of NVAE are regulated either by a specific regime (e.g. neonates) or by no regime at all. See P. LEWIS, I. BLACK, *Commissioned Briefing Paper. The effectiveness of legal safeguards in jurisdictions that allow assisted dying. Commission on Assisted Dying*, cit., 21.

⁵⁵ J. KEOWN, *Euthanasia, Ethics and Public Policy. An Argument against Legalisation*, cit., 104, 128.

⁵⁶ B.D. ONWUTEAKA-PHILIPSEN, A. BRINKMAN-STOPPELENBURG, C. PENNING, G.J.F. DE JONG-KRUL, J.J.M. VAN DELDEN, A. VAN DER HEIDE, *Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey*, in *The Lancet*, 380, 2012, 908-909.

⁵⁷ P. LEWIS, I. BLACK, *Adherence to the Request Criterion in Jurisdictions Where Assisted Dying Is Lawful? A Review of the Criteria and Evidence in the Netherlands, Belgium, Oregon, and Switzerland*, in *Journal of Law, Medicine & Ethics*, 41(4), 2013, 885.

⁵⁸ *Ibidem*, 895.

⁵⁹ B.D. ONWUTEAKA-PHILIPSEN, A. BRINKMAN-STOPPELENBURG, C. PENNING, G.J.F. DE JONG-KRUL, J.J.M. VAN DELDEN, A. VAN DER HEIDE, *Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey*, cit., 911, Table 3. See also P. LEWIS, I. BLACK, *Commissioned Briefing Paper. The effectiveness of legal safeguards in jurisdictions that allow assisted dying. Commission on Assisted Dying*, cit., 28-30, 57, 84.

⁶⁰ J. KEOWN, *Euthanasia, Ethics and Public Policy. An Argument against Legalisation*, cit., 7. See also H. POLS, S. OAK, *op. cit.*, 511.

⁶¹ P. LEWIS, I. BLACK, *Adherence to the Request Criterion in Jurisdictions Where Assisted Dying Is Lawful? A Review of the Criteria and Evidence in the Netherlands, Belgium, Oregon, and Switzerland*, cit., 889.

prevalent in granted requests than in refused requests, and severe depression is not significantly present in requests generally»⁶². In Oregon,

«[t]here is a downward trend in the number of counselling referrals in those who do ultimately receive physician assisted suicide, and the (limited) data on the presence of depression in this population suggests that counselling referrals are not taking place as often as the statute requires»⁶³.

Yet, it cannot be established that patients suffering from depression are less protected than other patients requesting PAS⁶⁴.

5.2.3. Reporting

In the Netherlands, since 1995 the number of cases of VAE/PAS reported has increased sensibly as in 2005 it amounted to the 80% of all cases, though in 2010 it went down to the 77%⁶⁵. Moreover, the noncompliance seems to be caused by doctors' failure to classify the unreported cases as voluntary active euthanasia or physician assisted suicide, rather than by reluctance to report⁶⁶.

With regard to Oregon, «[t]here is not data on the reporting rate»⁶⁷; moreover, stating that it is difficult to assess underreporting is not the same as providing evidence that this phenomenon has taken place⁶⁸.

Finally, it must be noted that although a low reporting rate envisages a lack of control of the practices, it does not *per se* constitute evidence of unlawful abuses.

6. Conclusion

The aim of this paper was to establish the soundness of a specific aspect of John Keown's criticism about the ineffectiveness of the regulatory regimes for assisted dying in the Netherlands and in Oregon: whether this assumption can be supported by empirical evidence.

⁶² *Ibidem*, 893.

⁶³ P. LEWIS, I. BLACK, *Commissioned Briefing Paper. The effectiveness of legal safeguards in jurisdictions that allow assisted dying. Commission on Assisted Dying*, cit., 85-86.

⁶⁴ M.P. BATTIN, A. VAN DER HEIDE, L. GANZINI, G. VAN DER WAL, B.D. ONWUTEAKA-PHILIPSEN, *Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in "vulnerable" groups*, in *Journal of Medical Ethics*, 33, 2007, 596. See also P. LEWIS, I. BLACK, *Adherence to the Request Criterion in Jurisdictions Where Assisted Dying Is Lawful? A Review of the Criteria and Evidence in the Netherlands, Belgium, Oregon, and Switzerland*, cit., 893-894.

⁶⁵ B.D. ONWUTEAKA-PHILIPSEN, A. BRINKMAN-STOPPELENBURG, C. PENNING, G.J.F. DE JONG-KRUL, J.J.M. VAN DELDEN, A. VAN DER HEIDE, *Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey*, cit., 913.

⁶⁶ *Ibidem*, 914.

⁶⁷ P. LEWIS, I. BLACK, *Commissioned Briefing Paper. The effectiveness of legal safeguards in jurisdictions that allow assisted dying. Commission on Assisted Dying*, cit., 90.

⁶⁸ F. PAKES, *The legalisation of euthanasia and assisted suicide: A tale of two scenarios*, in *International Journal of the Sociology of Law*, 33, 2005, 79-80 for a comparison between the reporting systems in the Netherlands and in Oregon.

The “counter analysis” conducted in the second part of the paper denies such conclusion, by showing that Keown’s empirical remarks present several flaws. His concern about the Dutch requirement of unbearable and hopeless suffering, does not rely on empirical data, but rather only on his negative opinion about the way in which it was conceived and applied. With regard to the request requirement he wrongly assumes that cases of non-voluntary euthanasia always imply a breach of the safeguards provided for voluntary active euthanasia. Even though there is concern about a lack of compliance with the physicians’ duty to refer potentially mentally ill patients for specific counselling, the available evidence indicates that such patients are not less protected than others. Finally, the current limited noncompliance with the reporting requirement does not constitute evidence of unlawful abuses.