

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

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1. Introduction

Some form of assisted dying (voluntary euthanasia and/or assisted suicide) is lawful in the Netherlands, Belgium, Oregon, and Switzerland. In order for individual instances of assisted dying to be lawful in these jurisdictions, a valid request must precede the provision of assistance to die. Non-adherence to the criteria for valid requests for assisted dying may be a trigger for civil and/or criminal liability, as well as regulatory sanctions where the assistor is a medical professional.

In this article, we review the criteria and evidence in respect of requests for assisted dying in the Netherlands, Belgium, Oregon, and Switzerland.¹ Our aim is to establish whether individuals who receive assisted dying do so on the basis of valid requests.

First, we present the legal and regulatory criteria for requesting lawful assistance to die in each jurisdiction. Second, we use the available evidence to assess adherence to these criteria. At the outset, it is worth noting that prosecutions for non-adherence to the request criteria are extremely rare. However, the absence of criminal or indeed other proceedings may not necessarily indicate that the request criteria are met in all cases. Therefore, we draw on a substantial range and number of sources, including the official reports of the relevant oversight bodies, quantitative and qualitative research studies on aspects of end-of-life decision-making in the four jurisdictions, and articles reviewing the empirical data in order to ascertain whether the law is respected. We group the evidence under the following headings: presence of request, timing of request, capacity, voluntariness, information provision, written request, and age. These headings reflect the basic legal requirements for valid consent to medical treatment generally, as well as additional procedural and substantive factors that may be relevant to the validity of the request for assisted dying.² Finally, we comment on our findings, and draw some conclusions; in particular, we note that the evidence suggests that individuals who receive assisted dying in the four jurisdictions examined make valid requests, and third parties who assist individuals to die do not act unlawfully.³

Before proceeding, we should stipulate that our review relates only to adherence to the request criteria under the legal regimes for assisted dying in these four jurisdictions. We do not consider evidence that relates to termination of life without request.

2. Legal and Regulatory Criteria for Requesting Assistance to Die

In the Netherlands, in order to avoid liability for the offense of termination of life on request or assisted suicide,⁴ the attending physician must meet the requirements of due care set out in article 2 of the Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002.⁵ The physician must be satisfied that “the request by the patient was voluntary and well-considered.”⁶ The patient must have capacity to make the request, and the attending physician must consult a psychiatrist if he or she suspects the patient lacks capacity.⁷ The physician must also provide sufficient information to the patient to make his or her request well informed.⁸ The Act does not require that the request be made in writing, but it is established good practice to obtain a written request.⁹ Patients aged 16 years and over with capacity may also make an advance written request, which will allow an attending physician to carry out euthanasia in the event of incapacity, provided the due care criteria are met.¹⁰ Patients aged 16-17 years with capacity may request euthanasia or assisted suicide, although the Act requires their parent(s) or guardian to be “involved in the decision process.”¹¹ Minors aged 12-16 years with capacity may also request euthanasia or assisted suicide, although their parent(s) or guardian must agree with the request.¹² It is unclear from the Act at which stage parental or guardian involvement must occur — that is, whether the minor may make the request for assistance to die independent of their involvement.

In Belgium, a physician who provides euthanasia or assisted suicide will not commit an offense provided the patient making the request is an adult or emancipated minor, has capacity, and is conscious at the time the request is made.¹³ The request must also be both “voluntary,” “considered,” repeated over a reasonable duration, and “not the product of external pressure.”¹⁴ The physician must inform the patient about “his state of health and life expectancy” and “remaining therapeutic options, as well as the possibility of palliative care and its consequences.”¹⁵ This information assists the patient to make a considered request. The request must be in writing, and

signed and dated by the patient, unless he or she is unable to write, in which case the request may be made by a nominated adult with no material interest in the patient's death.¹⁶ The request made on behalf of a person unable to write must indicate why the patient is unable to write, and be written in the presence of the attending physician, whose name is written on the document.¹⁷ A request for euthanasia may be revoked at any time by any means.¹⁸

The Euthanasia Act (Belgium) 2002 also allows the patient to make an advance request for euthanasia.¹⁹ However, since the triggering condition is irreversible unconsciousness, advance requests will not be applicable to many scenarios of future incompetence, including dementia.²⁰ The advance request may be made at any time when the individual has capacity, although it will only be valid if executed less than five years prior to the loss of consciousness.²¹ The request must be written, dated, and signed in the presence of two adult witnesses (who must also sign the document), one of whom must not have a material interest in the patient's death.²² The provisions of article 3§4 of the Act in respect of requests made by patients unable to write apply *mutatis mutandis*, with the exception that the patient's physical inability to write must be medically certified.²³ An advance request for euthanasia may be withdrawn or modified at any time.²⁴ The Act is silent on the formalities for modification, although it is reasonable to assume that the formalities for new advance requests apply.

The Death With Dignity Act 1997 (DWDA) governs physician assisted dying (PAD) in Oregon,²⁵ inserting 127.800-127.897 into the Oregon Revised Statutes (ORS). ORS 127.805 §2.01 provides:

- (1) An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life [...]

To have capacity, the patient must have “the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.”²⁶ The patient must make both written and oral requests for PAD.²⁷ The patient must make an initial oral request, which must be repeated to

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the attending physician “no less than fifteen (15) days after.”²⁸ At the time the second oral request is made, the attending physician is required to offer the patient an opportunity to rescind the request.²⁹ The written request must be signed and dated by the patient in the presence of two witnesses, who “attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request.”³⁰ ORS 127.810 §2.02(2)-§2.02(4) impose further restrictions on who may witness the request; in particular, one witness may not be a relative, and/or “entitled to any portion of the estate of the qualified patient upon death,” and the patient’s attending physician at the time of the request may not witness the request. The patient’s request may not be granted until 15 days after the initial oral request, and 48 hours after the written request.³¹

The patient’s request must be well informed, insofar as his decision:

is based on an appreciation of the relevant facts and after being fully informed by the attending physician of: (a) his or her medical diagnosis; (b) his or her prognosis; (c) the potential risks associated with taking the medication to be prescribed; (d) the probable result of taking the medication to be prescribed; (e) the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.³²

The attending physician is required to verify whether the patient is making an informed decision “immediately prior to writing a prescription for medication.”³³

The DWDA 1997 allows the patient’s request to be rescinded “at any time and in any manner without regard to his or her mental state.”³⁴ The attending physician must also offer the patient an opportunity to rescind the request prior to issuing the prescription for lethal medication.³⁵

In Switzerland, in principle, any individual may assist the suicide of another, provided that the assistance is not selfishly motivated.³⁶ It might appear, therefore, that no particular criteria in respect of the request for suicide assistance apply. However,

Georg Bosshard notes an implicit condition, that “the individual wanting help to commit suicide must have decisional capacity, since otherwise he would not be “*handlungsfähig*” (have legal capacity) and his act could not be considered suicide.”³⁷ This rules out suicide assistance for minors, although the position of adolescents is unclear.³⁸ The individual’s capacity is assessed according to the test set out in article 16 of the Swiss Civil Code.³⁹ In respect of physician assisted suicide (PAS),⁴⁰ federal

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narcotics law permits physicians to administer, dispense, or prescribe lethal medication only within the limits of accepted professional and scientific practice.⁴¹ This has led the courts to impose criteria related to the patient's request. The physician must personally examine the individual seeking assistance in order to assess their capacity.⁴² This case law has been adopted by the Swiss Academy of Medical Sciences (SAMS), whose guidance for physicians states as a precondition that, "the patient is capable of making the decision, his wish has been well thought out, without external pressure, and he persists in this wish."⁴³ The right to die associations, through which almost all suicide assistance is provided, also have their own criteria. In particular, Exit ADMD has developed its own questionnaire, based on a validated test for capacity to make advance directives, which is designed to determine whether an individual seeking suicide assistance has capacity.⁴⁴

For mentally disordered individuals seeking PAS in Switzerland, recent case law has established a more stringent regime. Those requesting PAS must undergo an extensive psychiatric evaluation, in order to demonstrate that their request is not the product of a treatable mental disorder, but the reasoned and settled decision of an individual with capacity.⁴⁵ In consideration of the onerous nature of the procedure for PAS for individuals with mental disorder, it is likely that very few prescriptions will be issued.

3. Adherence to Request Criteria

3.1. Presence of Request

3.1.1. THE NETHERLANDS

An evaluation of the first five years of legalization of euthanasia and assisted suicide in the Netherlands (September 2002 to December 2007) found the request criterion to have been met in all 10,319 reported cases.⁴⁶ Similarly, in a study of reported cases from 2007 to 2009, the relevant Regional Review Committee (RRC) (the bodies delegated the evaluation of reported cases of euthanasia) found that the physician had met the criteria related to the request in all 7,487 cases.⁴⁷

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RRCs seek further information about the request in only a very small fraction of cases (0-2 percent, depending on the region).⁴⁸

3.1.2.BELGIUM

Researchers found that the request criterion was met in all 2,017 reported cases during the first five years of lawful euthanasia in Belgium (September 2002 to December 2007).⁴⁹ A recent study of death certificates from 2007 in the Flanders region also found that an explicit request was present in all instances of euthanasia or assisted suicide among studied cases (142/3623).⁵⁰

3.1.3.OREGON

From Oregon Division of Public Health (ODPH) (the body responsible for monitoring PAD under the DWDA) data for the 673 prescriptions that resulted in death between 1998 and 2012, we may infer that a request was present in all reported cases, since the mandatory waiting period of 15 days between the first oral request and death was respected for all patients.⁵¹

3.1.4.SWITZERLAND⁵²

It is not known whether a request is present in all instances of suicide assistance in Switzerland, although we note that membership of the right-to-die associations is voluntary, and there is no evidence that they solicit members to take up their services.

3.2. *Timing of Request*

3.2.1.THE NETHERLANDS

All reported instances of euthanasia or assisted suicide between September 2002 and December 2007 followed a contemporaneous request.⁵³ Survey evidence for 2005-2006 suggests that a small proportion of physicians are willing to administer euthanasia to dementia patients with an advance

directive for euthanasia (ADE).⁵⁴ However, in the instances of euthanasia documented in the study, the patients “were competent and able to actively express their wishes,”⁵⁵ thus the ADE was not the legally effective request. Euthanasia has been reported in at least one recent dementia case where an ADE was the effective request.⁵⁶ It is not known how many advance requests for euthanasia are granted. Limited evidence suggests that 3 percent of Dutch physicians potentially have complied with an ADE in the case of dementia, although the issue of whether the individuals retained capacity is unclear.⁵⁷ A large proportion of dementia patients are treated until death and a small number receive euthanasia on the basis of a contemporaneous request.⁵⁸ The Royal Dutch Medical Association (Koninklijke Nederlandse Maatschappij ter Bevordering van de Geneeskunst (KNMG)) has advised doctors that they may not perform euthanasia when they can no longer communicate with the patient at all.⁵⁹ This is a particular problem for the consulting physician who has not previously spoken with the patient.⁶⁰ On this point, the KNMG recognizes that its statement of the professional norm is more stringent than the legal criteria.⁶¹ Most Dutch physicians are reluctant to provide euthanasia on the basis of ADEs, notwithstanding their legality as a means of requesting euthanasia.⁶²

3.2.2.BELGIUM

Among reported instances of euthanasia or assisted suicide between September 2002 and December 2007, 2.1 percent (40/2017) of cases followed an advance request.⁶³ For the five instances of euthanasia detailed by Koen Meeussen et al. as part of the 2005-2006 SENTI-MELC study (a nationwide mortality follow-back study conducted through the Sentinel Network of General Practitioners), it appears that in one case an advance written request was the legally effective request, since the patient was unable fully to communicate during the last week of life and lacked capacity.⁶⁴ The most recent report from the Commission fédérale de contrôle et d'évaluation de l'euthanasie (CFCE – the body responsible for monitoring the operation of the Belgian Euthanasia Act), suggests that the rate of euthanasia performed following advance request is stable at approximately 2 percent of cases (49/2037 during 2010 and 2011).⁶⁵

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3.2.3. OREGON

The mandatory waiting period of 15 days between the first oral request and issue of the prescription has been respected in all reported cases.⁶⁶ In 2010, a physician was referred to the Oregon Board of Medical Examiners for failing to wait 48 hours prior to issuing a prescription for lethal medication.⁶⁷

3.2.4. SWITZERLAND

We are unaware of any instances where an individual has made an advance request for suicide assistance. It is unlikely that such an instrument would be legally effective under the Swiss Civil Code.

3.3. Capacity

3.3.1. THE NETHERLANDS

National data relating to the reasons for ungranted requests for euthanasia provide some indication of the way in which the competence criterion is applied. In 2010, physicians cited a lack of a well-considered request as the reason for the case not proceeding in 16 percent of cases (21 percent in 2005).⁶⁸ A 2005 study of granted and ungranted requests among Dutch GPs found that when the patient lacked full capacity, the GP was 21 times more likely to refuse than to grant the request.⁶⁹ From the most recent annual study of the consultations provided by SCEN (Support and Consultation for Euthanasia in the Netherlands – a network of specially trained euthanasia consultants),⁷⁰ when the SCEN consultant finds that the due care criteria have not been met, the reason given is the lack of a well-considered request in 39.4 percent of cases in which such a finding is made.⁷¹ A recent review of a random representative sample of 273 (of the 3695) dossiers submitted to RRCs in 2011 found that in 76 percent of cases, the doctor used the patient's undoubted competence to support his conviction that the request was well-considered.⁷²

Depression, which may affect competence, is significantly less prevalent in granted requests than in refused requests. Using the 2005 national data, one study examined the presence of

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depressive symptoms during the last 24 hours of life, finding that depressive symptoms were present in 12 percent of cases of ungranted requests for euthanasia, and 2 percent of cases of granted requests for euthanasia,⁷³ a trend also found in other studies.⁷⁴ A recent study into depression and explicit requests for euthanasia or assisted suicide among cancer patients in primary care found that:

[N]one of the patients with an explicit EAS [euthanasia or assisted suicide] request suffered from a definite major depression... Furthermore, no relationship was found between depressed mood and explicitly requesting EAS. This outcome was based on results from the [Hospital Anxiety and Depression Scale] (all scales), as well as the single-item depression screener.⁷⁵

Although guidelines require the attending physician to consult a psychiatrist if he or she suspects the patient is incompetent,⁷⁶ psychiatric consultation is relatively rare, particularly if the patient's primary physician is not a psychiatrist.⁷⁷

The recent review of a random representative sample of dossiers submitted to RRCs in 2011 revealed that in 4 percent of cases a diagnosis (or suspicion thereof) was present that might have influenced the patient's capacity. Roughly half of these cases involved dementia (in such cases, the expert must assess capacity and not simply presume incapacity).⁷⁸ In 12 (out of the 26) cases, the patient had been assessed to be competent by an expert, usually a psychiatrist or geriatrician. In the remaining cases, both the attending and consulting physicians explained how they had reached the decision that the patient's request was both voluntary and well-considered.⁷⁹ In most of these remaining 14 cases, the RRC did not see the failure to have the patient's capacity assessed by an expert as problematic, given the provision of extensive information by the reporting and consulting doctors about their conviction that the request was both voluntary and well-considered. Additional information was sought if the RRC was not satisfied.⁸⁰

3.3.2.BELGIUM

In a study of the CFCE database of all reported cases from 2002 to 2007, Smets et al found that a well-considered request was present in 100 percent of cases.⁸¹ The 2007 Flanders death certificate study found that 100 percent (n=142) of patients who received euthanasia or assisted suicide had

capacity at the time the request was made.⁸² In a small study on adherence to legal safeguards that formed part of the 2005-2006 SENTI-MELC study, all of the patients who received euthanasia whose GP was interviewed (n=9) had made a well-considered request for euthanasia.⁸³ Another interview study from the 2005-2006 SENTI-MELC project found that four of the five patients who received euthanasia at home had capacity during the last week of life.⁸⁴ The sole patient who lacked capacity at the time euthanasia was administered had made a valid advance request for euthanasia.⁸⁵ In all five cases, the legal requirements of due care, which include a well-considered request, were met.⁸⁶

To the extent that depression may be relevant to capacity, a nationwide study of euthanasia requests (n=355) found depression to be cited as a reason for the request in 12.2 percent of cases (n=43). In these cases, the request was significantly less likely to be granted (granted 16.3 percent (n=7), refused 20.9 percent (n=9), still alive (27.9 percent (n=12)).⁸⁷ None of the 19 patients diagnosed with a psychiatric disorder had their euthanasia request granted.⁸⁸ Having a psychiatric disorder (which may include major depressive disorders) was a predictor for a refused request.⁸⁹

3.3.3. OREGON

There is no evidence that ODPH scrutinizes physicians' claims that the individuals prescribed lethal medication have capacity. Therefore, it is not known whether all individuals who have received PAD since 1998 had capacity at the time they made the request. Physicians surveyed about requests under the DWDA between November 1997 and August 1999 reported that 93 percent (144/155) had decisional capacity in respect of medical decisions.⁹⁰ Of the 673 patients who died having ingested lethal medication issued under the DWDA, 6.2 percent (n=42) were referred for psychiatric evaluation.⁹¹ It is possible that individuals who request PAD possess an "unusually strong desire to remain independent and in control," which may indicate a certain concomitancy between capacity and PAD requests.⁹² This may be supported by the reasons given by individuals for requesting PAD in the ODPH data.⁹³

Very little research has been conducted seeking to establish whether individuals in Oregon have received PAD notwithstanding a diagnosis of mental disorder. In one study from 2000, 20 percent (28/143) of individuals who made requests for PAD exhibited symptoms of depression,

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although none were prescribed lethal medication.⁹⁴ In 2005, there were alleged to be three cases where individuals with mental disorder were prescribed lethal medication, although in two of these cases the claims regarding the presence of mental disorder are likely to be unreliable, since the diagnoses appeared to rely on press reports and were refuted by the examining clinicians.⁹⁵ A recent systematic review of the prevalence of depression in granted and refused requests for euthanasia and assisted suicide identified a single high quality study that had been conducted in Oregon.⁹⁶ This was a cross-sectional survey that sought to establish the prevalence of depression and anxiety in terminally ill patients who had requested PAD.⁹⁷ Of the 58 patients who requested PAD, 26 percent (n=15) met the survey criteria for depression.⁹⁸ Of the 18 patients who received a prescription for lethal medication, 17 percent (n=3) met the criteria for depression and ingested lethal medication.⁹⁹ None of the three individuals had been evaluated by a mental health professional at the time of the request, and whether the depressive disorder influenced the judgment of the three individuals who received PAD is unknown.¹⁰⁰ One of the three patients underwent treatment for depression, which was successful, yet nevertheless used the prescription for lethal medication.¹⁰¹

3.3.4.SWITZERLAND

The Swiss authorities have brought prosecutions where an individual has been prescribed lethal medication notwithstanding doubts in respect of mental capacity.¹⁰² However, the cited cases have involved individuals with mental disorder, and physicians who have failed to act with due care. It is not known how many individuals not suffering from mental disorder are refused suicide assistance for lack of capacity. Nor is it known whether individuals who are suspected to lack capacity are referred systematically to a mental health professional for further evaluation, either by their physicians or a right to die association, although this may be practice in acute care hospitals.¹⁰³

In respect of the presence of depression, a study of case records for 331 suicides assisted by Exit Deutsche Schweiz (EDS) between 1990 and 2000 found a depressive disorder to be the motivating diagnosis in 2.4 percent (8/331) of cases. Between 1997 and 2000, among 90 eligible suicides assisted by EDS (total suicides=166), 24 individuals (27 percent) were found by EDS volunteers to have depression.¹⁰⁴ In a study for the period 2001–2004 of all suicides assisted by Exit Deutsche Schweiz (EDS) and Dignitas that were investigated by the Institute of Legal Medicine in

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Zurich (n=421), it was found that mental disorder was the motivating diagnosis for 2 percent (3/147) of EDS deaths (3/147) and 3.3 percent (9/274) of Dignitas deaths.¹⁰⁵ The proportion of major depressive disorders among these deaths is not known. Unfortunately, there is no data on the prevalence of depression in refused requests for assisted suicide in Switzerland. It is not known whether any individuals with major depressive disorders have received a prescription for lethal medication since the *Haas* judgment in 2006 in which the Swiss Federal Supreme Court imposed additional procedural requirements on mentally disordered individuals requesting suicide assistance.¹⁰⁶

3.4. *Voluntariness*

3.4.1. THE NETHERLANDS

National data relating to the reasons for ungranted requests for euthanasia provide some indication of the way in which the voluntariness criterion is applied. In 2010, 45 percent of all requests were carried out (compared to 37 percent in 2005). In 2010 across all medical specialties, an average of 0 percent of physicians cited a lack of voluntary request as the reason for the case not proceeding (1 percent of GPs). This figure was 5 percent across all medical specialties in 2005.¹⁰⁷ SCEN consultants find in a relatively small number of cases (between 3.6–8.5 percent in the period 2008–2011) that the due care criteria have not been met as a result of a lack of voluntary request.¹⁰⁸

The recent review of a random representative sample of dossiers submitted to RRCs in 2011 explored the overlapping reasons why the reporting doctor was satisfied that the request was voluntary. In 45 percent of cases, the fact that the patient had made repeated requests had convinced the doctor of the voluntariness of the request. In 43 percent of cases, personal conversations between the doctor and patient had served this purpose. A lack of indication of any pressure or influence had convinced the doctor in 37 percent of cases. In 20 percent of cases the family had been present during conversations between the doctor and patient; this might in some cases have contributed to the doctor's conviction that no influence or pressure was present, or in others might suggest that the value of the personal conversations as an indicator of voluntariness is lessened. In 15 percent of cases, the doctor cited the patient's independence or autonomy as relevant, and in 7

percent the long-standing relationship between doctor and patient. In 5 percent of cases the report contained no clear information indicating how the doctor came to the conclusion that the request was voluntary. Some of these dossiers contained information on this in other sections, but in 3 percent of cases there was no such information provided. Nonetheless, in these particular cases where the attending physician did not provide information on the voluntariness requirement, the consultant's report gave information on voluntariness. Overall, in 14 percent of all the reviewed cases, the consultant's report provided no such information.¹⁰⁹

3.4.2. BELGIUM

Smets et al found that a voluntary request was present in 100 percent of reported cases in the CFCE database from 2002 to 2007.¹¹⁰ In the interviews on adherence to legal safeguards conducted by Tinne Smets et al. as part of the 2005-2006 SENTI-MELC study, all patients who received euthanasia whose GP was interviewed (n = 9) had made a voluntary request for euthanasia.¹¹¹ In the Meeussen et al. 2005-2006 SENTI-MELC interview study, the legal requirements of due care, which include a voluntary request that is not the product of external pressure, were met in all five granted requests for euthanasia.¹¹²

3.4.3. OREGON

There have been several referrals to the Oregon Board of Medical Examiners for non-compliance with the requirement that two witnesses attest that the request for PAD is being made voluntarily. In 2001, a physician was referred for providing only one signature on the request form, although other witnesses were in attendance.¹¹³ Five more referrals were made between 2002 and 2012.¹¹⁴ In these cases it was not reported by ODPH whether other witnesses were present. It is not known whether non-compliance with the witnessing requirements is indicative of a lack of voluntariness.

3.4.4. SWITZERLAND

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It is not known whether all individuals who receive suicide assistance in Switzerland act voluntarily, although we note that no prosecutions or regulatory proceedings have been engaged against medical professionals who have provided lethal medication to individuals whose request has been found to be the product of “external pressure,” whereas proceedings have taken place in the context of allegedly impaired capacity.

3.5. *Information Provision*

Similar to the voluntariness criterion, there is insufficient evidence to establish that all individuals who receive suicide assistance in Switzerland do so on the basis of sufficient information, although we note that no prosecutions or regulatory proceedings have been engaged against medical professionals who have provided lethal medication to individuals whose request has been found not to be “well thought out.”

3.5.1. THE NETHERLANDS

Since the RRCs began publishing annual reports, in only one case has it been found that the information provision requirement was not met.¹¹⁵ In addition to the recent evidence that the RRCs find no problem with requests generally in reported cases,¹¹⁶ the recent review of a random representative sample of dossiers submitted to RRCs in 2011 examined two questions in relation to information provision, both of which are contained in the model report provided to doctors: (1) *who* informed the patient; and (2) *when* was the patient informed. In 45 percent of the dossiers, more than one doctor provided information to the patient. In 41 percent, the specialist provided the information, and in 4 percent of cases, it was provided by the GP. In 9 percent of cases the report provided no information or unclear information on this issue, and in more than half of those cases (5 percent overall), none of the reporting doctor’s documents contained this information. However, in some of these cases the information was provided in the consultant’s report. Nonetheless, in 3 percent of all reviewed cases, the researchers could find no information in the dossier as to the identity of the doctor providing the information to the patient.¹¹⁷ On the second question, a large

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minority of cases was identified in which no information was found in the dossier on the date of information provision (21 percent).¹¹⁸ The researchers concluded that:

At times it is not clearly reported in a [doctor's] report by whom and when a patient is informed over his situation and prospects. However, this seldom leads the review committee to request further details. The committees appear to presume that patients are in principle well informed and do not explicitly verify whether the doctor actually has determined whether the patient is fully informed and also has understood the information.¹¹⁹

3.5.2.BELGIUM

In the 2005-2006 SENTI-MELC study on adherence to legal safeguards, 100 percent of the patients who received euthanasia whose GP was interviewed (n=9) had been informed about their health condition and life expectancy.¹²⁰

3.5.3.OREGON

It is not known whether physicians in Oregon provide patients with the statutorily mandated information that would allow them to make an “informed decision.”

3.5.4.SWITZERLAND

Similar to the voluntariness criterion, there is insufficient evidence to establish that all individuals who receive suicide assistance in Switzerland do so on the basis of sufficient information, although we note that no prosecutions or regulatory proceedings have been engaged against medical professionals who have provided lethal medication to individuals whose request has been found not to be “well thought out.”

3.6. *Written Request*

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3.6.1. THE NETHERLANDS

The RRCs encourage written requests although the statute does not demand them. They appear to be present in almost all reported cases,¹²¹ with those few cases in which they are not present receiving close attention from the RRCs.¹²²

3.6.2. BELGIUM

The 2007 death certificate study in Flanders found that in cases of euthanasia where physicians stated that they had reported to the CFCE, the required written request was present in conjunction with an oral request in 73.1 percent of cases (95 percent CI [56.8, 84.9]), and alone in an additional 9.3 percent of cases (95 percent CI [2.4, 29.9]). In unreported cases, a written request was present in conjunction with an oral request in only 8.6 percent of cases (95 percent CI [3.9, 18]), and alone in an additional 3.7 percent of cases (95 percent CI [0.9, 14.5]).¹²³ In a study of the CFCE database of all officially reported cases from 2002 to 2007, a written request was present in 100 percent of cases.¹²⁴ The 2002–2007 CFCE study suggests that the rate of written requests in reported cases falls within the upper reaches of the 95 percent confidence intervals associated with the rates of written requests in the 2007 death certificate study: the rate is likely to be close to 100 percent.

In the 2005-2006 SENTI-MELC study on adherence to legal safeguards, 89 percent (8/9) of the patients who received euthanasia whose GP was interviewed had made a written request for euthanasia.¹²⁵ All five patients who received euthanasia whose GP was interviewed in the Meeussen et al. 2005-2006 SENTI-MELC study had made a written request for euthanasia.¹²⁶

3.6.3. OREGON

It is not known whether any individual has been provided with PAD in Oregon without first having executed a written request.

3.6.4. SWITZERLAND

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It is not known how many instances of assisted suicide are preceded by a written request; this requirement is not a feature of the legal regime.

3.7. Age

3.7.1. THE NETHERLANDS

No regional review committee judgments involving patients younger than 30 have been posted on the official website, although only selected judgments are ever posted. The RRC annual reports have only discussed one case of euthanasia involving a minor (a 12-year-old suffering from cancer); the committee determined that the physician had acted in accordance with the due care criteria.¹²⁷

3.7.2. BELGIUM

The reports of the CFCE reveal only four cases involving a patient under the age of 20, with no reported cases involving minors.¹²⁸ The 2007 death certificate study in Flanders reported no cases involving patients under the age of 18.¹²⁹ A recent death certificate study in Flanders (data from 2007 to 2008) revealed a null rate for euthanasia and assisted suicide for patients between the age of 1 and 17.¹³⁰ In the 2005-2006 SENTI-MELC study on adherence to legal safeguards, all patients who received euthanasia whose GP was interviewed (n=9) were adults.¹³¹ Similarly, in the Meeussen et al. 2005-2006 SENTI-MELC interview study, none of the patients who requested euthanasia (n=27) were minors.¹³²

The 2007 Flanders death certificate study revealed that patients under 65 years of age were significantly more likely to request euthanasia or assisted suicide.¹³³ However, multivariate analyses revealed no significant differences between younger and older patients in respect of likelihood that the request would be granted.¹³⁴ These data conflict somewhat with a nationwide survey on euthanasia requests from 2009, in which patients over 80 years of age were significantly less likely to have their euthanasia request granted, and significantly more likely to withdraw the request for euthanasia.¹³⁵

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3.7.3. OREGON

It is not known whether any individual under the age of 18 has received PAD in Oregon.

3.7.4. SWITZERLAND

It is not known whether any individual who would not, by virtue of their age, have benefitted from the (rebuttable) presumption of capacity under Swiss Civil Law has received suicide assistance. Neither is it known whether any minors with capacity have received a prescription for lethal medication.

4. Analysis

4.1. *Presence of Request*

The available data suggest that the requirement that a request precede the provision of lawful assistance to die is respected in all reported cases. Thus, where there is a legal regime for assisted dying, and request is a feature of this regime, it is likely to be followed. Of course, those who terminate life without request are unlikely to report this practice to the competent authorities in the absence of legal and regulatory structures, such as those who apply to neonatal termination of life without request in the Netherlands.¹³⁶

4.2. *Timing of Requests*

The requirements that relate to timing of requests appear to be well respected. In Oregon, there has only been one referral because of failure to respect the 48-hour delay between the written request and issuing the prescription. In no case has a prescription been issued earlier than permitted under the statute. While both the Dutch and Belgian Euthanasia Acts permit euthanasia by advance directive, the Dutch are reluctant to perform euthanasia on patients who have lost capacity but who

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have a potentially legally effective request by virtue of an ADE. Among the dementia population with ADEs, Dutch physicians have reported problems assessing the “hopeless and unbearable suffering” criterion, as well as knowing the moment when to perform euthanasia.¹³⁷ These issues arise when dementia patients lose decisional capacity, and it may be (as the KNMG concurs)¹³⁸ that “patient–physician communication in cases of requests for euthanasia is essential and this cannot be captured in or replaced by an ADE.”¹³⁹ By contrast, in Belgium a small but significant amount of euthanasia (approximately 2 percent of cases annually) is performed following an advance directive. The greater willingness of Belgian physicians to perform euthanasia by advance directive may result from differences in the respective Dutch and Belgian legal regimes. The triggering condition for euthanasia by advance directive in Belgium is irreversible unconsciousness as a result of serious and incurable disorder. This criterion is more susceptible to objective determination by physicians than a subjective criterion based on suffering.¹⁴⁰ However, the price of the relatively straightforward Belgian criterion is that many individuals, most notably dementia patients, are unable to plan for future incompetence by executing an ADE.¹⁴¹ There have been successive attempts to amend the Euthanasia Act (Belgium) 2002 in order to allow an individual to execute an ADE to cover the cases where he “has lost awareness of his person, his mental and physical state, and his social and physical environment,”¹⁴² the most recent of which is under consideration by the Joint Committee on Justice and Social Affairs.¹⁴³

4.3. *Capacity*

Decisional capacity is intrinsic to a legally effective request for assisted dying. As a safeguard, the criterion appears to be effective in ensuring that individuals who lack capacity do not receive assisted dying. The capacity criterion is used by attending and consulting physicians in the Netherlands and Belgium to weed out a significant proportion of requests. The relevant reviewing body determined that the capacity criterion was met in all recent reported cases in both of those jurisdictions.¹⁴⁴ The limited evidence available from Oregon suggests that almost all individuals who request PAD under the DWDA have decisional capacity, although unlike the RRCs in the Netherlands, ODHS does not look behind physician’s claims that prescriptions are issued to individuals who have capacity. No referrals to the Board of Medical Examiners have occurred because PAD was provided to an

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individual who lacked capacity. A small proportion of individuals are also referred for psychiatric evaluation, which suggests that Oregonian physicians are somewhat sensitive to issues around capacity. In Switzerland, prosecutions have occurred in cases where there have been doubts over the individual's capacity, although all of these prosecutions have involved mentally disordered individuals. It is not known whether requests for PAD are refused on the grounds of incapacity in individuals suffering from somatic illnesses. However, this appears likely given the quasi-legislative value attributed to the SAMS guidance.¹⁴⁵

Considerable disagreement exists over the prevalence of mental disorder (in particular depressive disorders) in individuals who request PAD/PAS, and the influence that mental disorder has on capacity to request assisted dying.¹⁴⁶

In the Netherlands, depression is significantly less prevalent in granted requests than in refused requests, and severe depression is not significantly present in requests generally. In Belgium, the data suggest that patients who cite depression as a reason for requesting euthanasia are unlikely to have their request granted. It also appears that individuals with a diagnosis of mental disorder (which may include depressive disorder) have virtually no chance of having a request for euthanasia granted.

In Oregon, Margaret Pabst Battin et al.'s review of the impact of the DWDA on vulnerable groups found that "there is no direct evidence that depressed patients are at higher risk for receiving assistance in dying under the [DWDA]."¹⁴⁷ Ilora Finlay and Robert George have disputed this conclusion,¹⁴⁸ based on their interpretation of the finding by Linda Ganzini et al. that among 18 of 58 individuals who received a prescription for lethal medication under the DWDA, 17 percent (n=3) had undiagnosed depression at the time the request was made.¹⁴⁹ Unfortunately, Finlay and George fail correctly to analyze the data, insofar as they do not consider the prevalence of undiagnosed depression among individuals whose request for PAD was not granted (12/40, 30 percent).¹⁵⁰ Thus the study's findings, which used validated measures for depression,¹⁵¹ in fact support Battin et al.'s initial conclusion, since the prevalence of depression in granted requests for PAD in Oregon appears to be lower than the rate in ungranted requests. Ganzini et al.'s statement that "the current practice of the [DWDA] may not adequately protect all mentally ill patients",¹⁵² therefore does not support the proposition that individuals with depression are exposed to greater risk of receiving suicide

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assistance because of the DWDA. Rather, it may reflect principled opposition to providing suicide assistance to mentally disordered individuals.

In Switzerland, Georg Bosshard et al. found a 27 percent rate of “depression” among individuals who had received suicide assistance at EDS, as rated by EDS volunteers.¹⁵³ Based on these findings, the authors advance that “depression concomitant with a somatic disease [...] is much more common in the individuals assisted by Exit.”¹⁵⁴ They also argue “it could be assumed that the incidence of depression, assessed professionally, would have been higher than the 27 percent identified.”¹⁵⁵ However, these conclusions are questionable. First, even if we assume that the rate of depression among the general Swiss population is lower than 27 percent, Bosshard et al. offer no prevalence rates in relevant comparison groups, such as individuals whose requests for suicide assistance from EDS are refused, or individuals who seek PAS at other right-to-die organizations. Second, the rate of depression is based not on validated metrics for depression, but a single item on a questionnaire graded by non-experts. “Depression” under the EDS checklist, therefore, might reflect anything from appropriate sadness to a major depressive disorder. Because of this significant methodological flaw, the data are not sufficiently robust to support the conclusion that mental health professionals would have uncovered a higher rate of depression among individuals who received suicide assistance at EDS.

In all the jurisdictions examined, it appears that mentally disordered individuals are far more likely to have a request for assistance to die refused than granted. However, with the exception of Switzerland, where the Supreme Court has arguably ruled that mentally disordered individuals seeking PAS must demonstrate that the request is “authentic,”¹⁵⁶ none of the assisted dying regimes examined prescribe additional requirements in order for a mentally disordered individual’s request to be valid. Thus, the fact that some individuals who request assisted dying have a mental disorder or depression does not automatically undermine the validity of the request. On the legal criteria, such conditions would only affect the validity of a request if they hindered capacity.

Principled opposition to assisted dying for the mentally disordered “may be reassuring on the one hand, but may, on the other hand, also be an indication of possible “discrimination” toward certain patient groups in granting euthanasia requests.”¹⁵⁷ In the Netherlands, Belgium, and Switzerland, where suffering caused by mental disorder is a legally valid reason for requested assisted dying, the greater difficulty in understanding a mentally disordered individual’s situation may justify

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procedural measures designed to ensure that the suffering criterion is met. However, such additional procedures are independent of the request criterion, which provides no greater legal barrier to the provision of assisted dying in such cases.

4.4. *Voluntariness*

The voluntariness criterion is used by attending and consulting physicians in the Netherlands and Belgium to weed out a small proportion of requests. Recent reported cases in both of those jurisdictions all met the voluntariness criterion when examined by the relevant reviewing body. In Oregon, by contrast, some cases have raised voluntariness concerns as a result of failures to meet the witnessing requirements designed to ensure voluntariness; however, it is not known whether non-compliance with the witnessing requirements is indicative of a lack of voluntariness. Although the evidence is not overwhelming, it may be the case that discussions between the patient and more than one physician (as required in the Netherlands, Belgium, and Oregon) are more effective at screening out voluntariness problems than simply requiring multiple witnesses to a written request (as in Oregon). This may be because the conversations that occur during consultations are more likely to detect both active pressure on the individual requesting assisted dying, and more subtle factors that potentially undermine the voluntariness of the request, such as the mistaken belief that one is a burden to family and friends.

4.5. *Information Provision*

While there is too little evidence on the effectiveness of this safeguard to draw firm conclusions, the almost total absence of reported problems may indicate that requests for assistance to die are adequately informed.

4.6. *Written Request*

This requirement appears to be well respected where it exists. The Dutch experience indicates that in rare cases it may be difficult to fulfill, so there may be grounds for allowing narrow, principled

exceptions to a general rule. The requirement for a written request has particular instrumental value as an aid to retrospective scrutiny of reported cases.

4.7. Age

Restrictions on the basis of age appear to be well observed in all of the jurisdictions studied although the evidence base is limited. A more principled approach could be to base decisions on capacity rather than age. Such a system exists somewhat in the Netherlands. Successive attempts in Belgium to allow minors with capacity to request euthanasia, and to allow parents or guardians of children who lack capacity to request euthanasia on their behalf have failed.¹⁵⁸

5. Strengths and Limitations

As far as we are aware, this is the first review that assesses adherence to the request criteria for assisted dying using the available evidence from the four jurisdictions where some form of assisted dying has been lawful for some time. We have drawn on a substantial range and number of sources in attempting to answer the research question, including Dutch language materials translated into English for the first time.

Our review has two principal limitations. First, we adopt the inherent limitations of the evidence we study. Not all of the empirical evidence surveyed is susceptible to systematic review; neither would all the evidence susceptible to systematic review necessarily be graded as high quality. However, to omit this evidence might be to lose valuable indications of how the request criterion is applied in jurisdictions that allow assisted dying. Second, we were unable to find data on all request elements in all the jurisdictions, and the amount of evidence available for each element is uneven. Whereas we would expect the most attention to be directed to the capacity element, since this potentially is most likely to render an individual's request for assisted dying invalid, further investigation of, in particular, the voluntariness and information provision requirements may be warranted since these are also important features of a valid request. Moreover, in order to be able to draw robust conclusions on adherence to the request criteria, it is necessary to examine both granted and refused requests, and, in particular, the reasons underlying refusals.

6. Conclusion

The evidence from the four jurisdictions reviewed (the Netherlands, Belgium, Oregon and Switzerland) 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. However, further research on the elements that may undermine the validity of requests for assisted dying is warranted.

References

1. Some form of assisted dying is also lawful in Luxembourg, Montana, Washington State, and Colombia. However, there is insufficient evidence to include these jurisdictions in our review.
2. Given the variation in the legal regimes, not all the headings are used for all the jurisdictions.
3. On this issue, see P. Lewis, "The Empirical Slippery Slope from Voluntary to Non-Voluntary Euthanasia," *Journal of Law, Medicine & Ethics* 35, no. 1 (2007): 197-210; The Royal Society of Canada Expert Panel, *End-of-Life Decision Making* (Ottawa, The Royal Society of Canada, 2011): 63-68; L. Bartels and M. Otlowski, "A Right to Die? Euthanasia and the Law in Australia," *Journal of Law and Medicine* 17, no. 4 (2010): 532-555, at 554.
4. *Penal Code (Netherlands) 1881*, Arts. 293, 294.
5. *Termination of Life on Request and Assisted Suicide (Review Procedures) Act, 2001 [Euthanasia Act (Netherlands) 2001]*.
6. *Id.*, at Article 2(1).
7. Koninklijke Nederlandse Maatschappij ter Bevordering van de Geneeskunst [Royal Dutch Medical Association] (KNMG), *Standpunt Federatiebestuur KNMG inzake euthanasie [Position of the Federal Board of the KNMG concerning euthanasia]* (2003): para 5.1.1; Nederlandse Vereniging voor Psychiatrie [Dutch Association for Psychiatry] (NVP), *Richtlijn omgaan met het verzoek om hulp bij*

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zeldoding door patiënten met een psychiatrische stoornis [Guideline on requests for assisted suicide by patients with psychiatric disorders] (2009): para 5.

8. J. Griffiths, A. Bood, and H. Weyers, *Euthanasia and Law in the Netherlands* (Amsterdam: Amsterdam University Press, 1998): at 86.

9. *Id.*, at 85-86.

10. See *Euthanasia Act (Netherlands) 2001*, *supra* note 5, at Article 2(2).

11. *Id.*, at Article 2(3).

12. *Id.*, at Article 2(4).

13. See *Euthanasia Act (Belgium) 2002*, at Article 3§1.

14. *Id.*

15. *Id.*, at Article 3§2(1).

16. *Id.*, at Article 3§4.

17. *Id.*

18. *Id.*

19. *Id.*, at Article 4§1.

20. *Id.*; P. Lewis, "Euthanasia in Belgium Five Years after Legalisation," *European Journal of Health Law* 16, no. 2 (2009): 125-138.

21. *Euthanasia Act (Belgium) 2002*, at Article 4§1.

22. *Id.*

23. *Id.*

24. *Id.*

25. The *Oregon Death With Dignity Act*, Oregon Revised Statutes 127.800-127.995 (1999), 127.880 §3.14 states that "[a]ctions taken in accordance with ORS 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law." Therefore, the term physician assisted dying (PAD) is used to refer to lawful conduct under the DWDA.

26. *Id.*, at 127.800 §1.01(3).

27. *Id.*, at 127.840 §3.06.

28. *Id.*, at 127.840 §3.06.

29. *Id.*

30. *Id.*, at 127.810 §2.02(1).

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31. *Id.*, at 127.850 §3.08.

32. *Id.*, at 127.800 §1.01(7).

33. *Id.*, at 127.830 §3.04.

34. *Id.*, at 127.845 §3.07.

35. *Id.*

36. Penal Code (Switzerland), at Article 115.

37. G. Bosshard, "Switzerland," in J. Griffiths, H. Weyers, and M. Adams, eds., *Euthanasia and Law in Europe* (Oxford, Portland (OR): Hart, 2008): at 471-472; O. Guillod and A. Schmidt, "Assisted Suicide under Swiss Law," *European Journal of Health Law* 12, no. 1 (2005): 25-38, at 30.

38. *Id.*, at 31.

39. *Id.*, at 30.

40. The term assisted suicide or physician assisted suicide (PAS) is the legally accurate term for facilitated self-killing in The Netherlands, Belgium and Switzerland. This usage is relatively unproblematic in Europe.

41. *Loi fédérale sur les stupéfiants et les substances psychotropes du 3 octobre 1951* [Federal Narcotics Act 1951]; *Loi fédérale sur les médicaments et les dispositifs médicaux du 15 décembre 2000* [Therapeutic Products Act 2000].

42. See Bosshard, *supra* note 37, at 473; *Zurich Case* Entscheid der 3 Kammer VB Nr 99.00145 (1999) (Verwaltungsgericht des Kantons Zürich [Zurich Administrative Court]); *Aargau Case* Entscheid BE 2003.00354-K3 (2005) (Verwaltungsgericht des Kantons Aargau [Aargau Administrative Court]).

43. Swiss Academy of Medical Sciences, *Care of Patients in the End of Life*, at para 4.1, available at <http://www.samw.ch/dms/en/Ethics/Guidelines/Currently-valid-guidelines/e_RL_Lebensende.pdf> (last visited October 18, 2013).

44. J. Sobel, "Capacité de discernement et demande d'assistance au suicide," ["Decisional capacity and requests for suicide assistance"] *Bioethica Forum* 2, no. 1 (2009): 29-30, at 30.

45. *Haas* Entscheid 2A.48/2006, 2006 (November 3, 2006) (Schweizerisches Bundesgericht; *Haas v Switzerland* (2011) 53 EHRR 33 (ECtHR); I. Black, "Suicide Assistance for Mentally Disordered Individuals in Switzerland and the State's Positive Obligation to Facilitate Dignified Suicide: *Haas c. Suisse*, Cour européenne des droits de l'homme, 1re section [European Court of Human Rights, 1st Section] (20 janvier 2011) (Unreported)," *Medical Law Review* 20, no. 1 (2012): 157-166; see Bosshard, *supra* note 37, at 473.

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46. M. L. Rurup, T. Smets, J. Cohen, J. Bilsen, B. D. Onwuteaka-Philipsen, and L. Deliens, "The First Five Years of Euthanasia Legislation in Belgium and The Netherlands: Description and Comparison of Cases," *Palliative Medicine* 26, no. 1 (2012): 43-49, at Table 1.

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48. A. van der Heide, J. Legemaate, B. Onwuteaka-Philipsen, E. Bolt, I. Bolt, H. van Delden, M. Geijteman, M. Snijdwind, D. van Tol, and D. Willems, *Tweede evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding [Second evaluation of the Euthanasia Law]* (Den Haag: ZonMW, 2012): tabel 8.10.

49. See Rurup et al., *supra* note 46, at table 1.

50. K. Chambaere, J. Bilsen, J. Cohen, B. D. Onwuteaka-Philipsen, F. Mortier, and L. Deliens, "Trends in Medical End-of-Life Decision Making in Flanders, Belgium 1998-2001-2007," *Medical Decision Making* 31, no. 3 (2011): 500-510, at table 4, table 1; K. Chambaere, J. A. Rietjens, T. Smets, J. Bilsen, R. Deschepper, H. R. W. Pasman, and L. Deliens, "Age-Based Disparities in End-of-Life Decisions in Belgium: A Population-Based Death Certificate Survey," *BMC Public Health* 12, no. 1 (2012): 447-456, at table 4 and 451.

51. Oregon Public Health Division, *Fifteenth Annual Report on Oregon's Death with Dignity Act Oregon's Death with Dignity Act* (2013), at Table 1, available at

<<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf>> (last visited 14 November 2013). Note that responsibility for monitoring PAD under the DWDA previously vested in the Oregon Department of Human Services, and the Oregon Department of Human Resources (defunct). At the time of writing, all DWDA Annual Reports were available at

<<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx>>.

52. In Switzerland, suicide assistance must be notified as unnatural death to the local police and coroner. There is no national body to which assisted suicides must be reported: G. Bosshard, E. Ulrich, and W. Bar, "748 Cases of Suicide Assisted by a Swiss Right-to-Die Organisation," *Swiss Medical Weekly* 133, nos. 21-22 (2003): 310-317, at 311. Therefore, no national reporting data is available.

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53. See Rurup et al., *supra* note 46, at Table 1.

54. M. E. de Boer, R.-M. Droes, C. Jonker, J. A. Eefsting and C. M. P. M. Hertogh, "Advance Directives for Euthanasia in Dementia: Do Law-Based Opportunities Lead to More Euthanasia?" *Health Policy* 98, no. 2-3 (2010): 256-262, at 258: 0.7% (3/454) respondent geriatricians in nursing homes.

55. See, for example, Regional Review Committees Euthanasia, *Jaarverslag 2012 [Annual Report 2012]* (2013), casus 4.

56. The judgment is published on the RRCs' website <<http://www.euthanasiecommissie.nl>>: 60-69 *jarig vrouw* 2011 123821 (Regionale toetsingscommissie euthanasie) and as casus 7 in Regional Review Committees Euthanasia, *Jaarverslag 2011 [Annual Report 2011]* (2012). It is also summarized in T. Sheldon, "Dementia Patient's Euthanasia Was Lawful, Say Dutch Authorities," *BMJ* 343, (2011): d7510, at 1. It does not appear in the English language version of the RRCs' annual report.

57. M. L. Rurup, B. D. Onwuteaka-Philipsen, A. van der Heide, G. van der Wal, and P. J. van der Maas, "Physicians' Experiences with Demented Patients with Advance Euthanasia Directives in the Netherlands," *Journal of American Geriatrics Society* 53, no. 7 (2005): 1138-44, at Table 1 (n=410, weighted percentage).

58. See de Boer et al., *supra* note 54, at 258. In the 2010 annual report of the RRCs, 25 patients with dementia received euthanasia; all were found competent at that time: Regional Review Committees Euthanasia, *Annual Report 2010* (2011). In the 2011 *Jaarverslag*, *supra* note 56, at 11, a dementia-syndrome played a role in 49 reported cases. All were judged to have met the requirements of careful practice. All of the patients involved were considered competent.

59. KNMG, *Tijdig spreken over het levenseinde [Timely end of life discussions]* (KNMG, 2nd ed, 2012): 19, available at <www.knmg.nl/spreken-over-levenseinde> (last visited October 22, 2013). According to Dr. Lode Wigtersma, KNMG Director of Policy and Advice, this position is based on the patient's change in personality caused by his dementia. Zembla, Als ik dement ben, wil ik dood [When I am demented, I want to die] <[http://zembla.vara.nl/Afleveringen.1973.0.html?&tx_ttnews\[tt_news\]=81415&cHash=de3768ac4ffe8f2414ca102affe457b6](http://zembla.vara.nl/Afleveringen.1973.0.html?&tx_ttnews[tt_news]=81415&cHash=de3768ac4ffe8f2414ca102affe457b6)> (last visited October 22, 2013), first broadcast on February 14, 2013. On this "personal identity problem" and advance decision-making at the end of life, see P. Lewis,

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“Medical Treatment of Dementia Patients at the End of Life: Can the Law Accommodate the Personal Identity and Welfare Problems,” *European Journal of Health Law* 13, 3 (2006): 219-234.

60. E. van Wijlick and A. N. Kruseman, “Geen communicatie, geen euthanasie – reactie KNMG,” [“No communication, no euthanasia – reaction of the KNMG,”] *Medisch Contact* [Medical Contact] 67, no. 10 (2012): 586-587, at 587.

61. See, for example, the finding of the RRCs in 2009 that such a case involving no current communication had met the legal requirements. Regional Review Committees Euthanasia, *Jaarverslag 2009* [Annual Report 2009] (2010) casus 2.

62. See Zemblu, *supra* note 59.

63. See Rurup et al., *supra* note 46, at Table 1; T. Smets, J. Bilsen, J. Cohen, M. L. Rurup and L. Deliens, “Legal Euthanasia in Belgium: Characteristics of All Reported Euthanasia Cases,” *Medical Care* 48, no. 2 (2010): 187-192 at Table 3.

64. K. Meeussen, L. Van den Block, N. Bossuyt, M. Echteld, J. Bilsen, and L. Deliens, “Dealing with Requests for Euthanasia: Interview Study among General Practitioners in Belgium,” *Journal of Pain and Symptom Management* 41, no. 6 (2011): 1060-1072, at Table 2 and Table 3.

65. Commission fédérale de contrôle et d'évaluation de l'euthanasie, *Cinquième rapport aux chambres législatives (2010-2011)*, [Federal commission for monitoring and evaluation of euthanasia, *Fifth report to legislature (2010-2011)*] 2012, at 7.

66. See ODPH, *supra* note 51, at Table 1.

67. Oregon Department of Human Services, *Thirteenth Annual Report on Oregon's Death with Dignity Act* (2011), at 2.

68. A. van der Heide, A. Brinkman-Stoppelenburg, H. van Delden, and B. Onwuteaka-Philipsen, *Euthanasie en andere medische beslissingen rond het levenseinde: Sterfgevallenonderzoek 2010* [Euthanasia and other medical decisions at the end of life: Death certificate study 2010] (Den Haag: ZonMw, 2012): at Tabel 2.6.

69. M. C. Jansen-van der Weide, B. D. Onwuteaka-Philipsen, and G. van der Wal, “Granted, Undecided, Withdrawn, and Refused Requests for Euthanasia and Physician-Assisted Suicide,” *Archives of Internal Medicine* 165, no. 15 (2005): 1698-1704, at Table 4 (95 per cent CI = 4.2-1096).

70. M. C. Jansen-van der Weide, B. D. Onwuteaka-Philipsen, and G. van der Wal, “Implementation of the Project 'Support and Consultation on Euthanasia in The Netherlands' (SCEN),” *Health Policy* 69, no. 3 (2004): 365-373; M. C. Jansen-van der Weide, B. D. Onwuteaka-Philipsen, and G. van der

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Wal, "Quality of Consultation and the Project 'Support and Consultation on Euthanasia in the Netherlands' (SCEN)," *Health Policy* 80, no. 1 (2007): 97-106.

71. KNMG, *Spiegelinformatie SCEN 2011 [SCEN Annual inventory of activities 2011]* (2012): at Table 4.5, available at <<http://knmg.artsennet.nl/Diensten/SCEN/Spiegelinformatie-3.htm>> (last visited October 23, 2013) (31.2 percent in 2008, 29.8 percent in 2009, 22.2 percent in 2010; data from the most recently performed consultation). Note that the consultation intervenes prior to the provision of euthanasia, and where the consultant finds that the due care criteria have not been met, euthanasia will usually not occur.

72. See van der Heide et al., *supra* note 48, p. 182.

73. B. D. Onwuteaka-Philipsen, M. L. Rurup, H. R. W. Pasman, and A. van der Heide, "The Last Phase of Life: Who Requests and Who Receives Euthanasia or Physician-Assisted Suicide?" *Medical Care* 48, no. 7 (2010): 596-603, at Table 4.

74. See Jansen-van der Weide, *supra* note 69, at Table 1 (depression present in 0.01 percent of granted euthanasia requests and 21.3 percent of refused requests); J. H. Groenewoud, A. Van Der Heide, A. J. Tholen, W. J. Schudel, M. W. Hengeveld, B. D. Onwuteaka-Philipsen, P. J. Van Der Maas, and G. Van Der Wal, "Psychiatric Consultation with Regard to Requests for Euthanasia or Physician-Assisted Suicide," *General Hospital Psychiatry* 26, no. 4 (2004): 323-330; I. Haverkate, B. Onwuteaka-Philipsen, A. van Der Heide, P. Kostense, G. van Der Wal, and P. van Der Maas, "Refused and Granted Requests for Euthanasia and Assisted Suicide in The Netherlands: Interview Study with Structured Questionnaire," *BMJ* 321, no. 7265 (2000): 865-866.

75. C. D. Ruijs, A. Kerkhof, G. van der Wal, and B. Onwuteaka-Philipsen, "Depression and Explicit Requests for Euthanasia in End-of-Life Cancer Patients in Primary Care in The Netherlands: A Longitudinal, Prospective Study," *Family Practice* 28, no. 4 (2011): 393-399, at 396.

76. See KNMG, *supra* note 7, at para 5.1.1; NVP, *supra* note 7, at para 5.

77. See NVP, *supra* note 7, at para 5.2 (stating that the rate is only 3 percent); Groenewoud et al., *supra* note 74, at Table 1, p. 328 (estimating that the rate of psychiatric consultation is about 4 percent of all requests for euthanasia and assisted suicide and reporting almost twice as many requests for psychiatric consultation from psychiatrists than from non-psychiatrists).

78. Following a complaint, the regional disciplinary tribunal found that a psychiatrist had erred in deciding that the patient lacked capacity simply because he suffered from dementia: "The dementia

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diagnosis does not automatically mean that a patient is incompetent in relation to [the desire for euthanasia].” Regionaal Tuchtcollege Groningen [Regional Disciplinary Tribunal Groningen], December 6, 2011, LJN: YG1572, discussed in van der Heide et al., *supra* note 48, at 66-67.

79. *Id.*, at 183.

80. *Id.*, at 184.

81. Smets et al., *supra* note 63, at Table 3.

82. See Chamberaere et al., “Trends in Medical End-of Life Decision Making...,” *supra* note 50, at Table 4.

83. T. Smets, J. Bilsen, L. Van den Block, J. Cohen, V. Van Casteren, and L. Deliens, “Euthanasia in Patients Dying at Home in Belgium: Interview Study on Adherence to Legal Safeguards,” *British Journal of General Practice* 60, no. 573 (2010): e163-e170, at e165.

84. See Meeussen et al., *supra* note 64, at Table 3.

85. *Id.*, at Table 2.

86. *Id.*

87. Y. Van Wesemael, J. Cohen, J. Bilsen, T. Smets, B. Onwuteaka-Philipsen, and L. Deliens, “Process and Outcomes of Euthanasia Requests under the Belgian Act on Euthanasia: A Nationwide Survey,” *Journal of Pain and Symptom Management* 42, no. 5 (2011): 721-733, at Table 3 and Table 4.

88. *Id.*, at Table 3.

89. *Id.*, at 726.

90. L. Ganzini, H. Nelson, T. Schmidt, D. Kraemer, M. Delorit, and M. Lee, “Physicians' Experiences with the Oregon Death with Dignity Act,” *New England Journal of Medicine* 342, no. 8 (2000): 557-563, at Table 2.

91. See ODPH, *supra* note 51, at Table 1.

92. L. Ganzini, S. K. Dobscha, R. T. Heintz, and N. Press, “Oregon Physicians' Perceptions of Patients Who Request assisted suicide and their families,” *Journal of Palliative Medicine* 6, no. 3 (2003): 381-390, at 388.

93. See ODHS, *supra* note 51, at Table 1.

94. See Ganzini et al., *supra* note 56, at Table 2. Note that in Table 4 it is reported that 29 patients had depressive symptoms.

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95. N. G. Hamilton and C. A. Hamilton, "Competing Paradigms of Response to Assisted Suicide Requests in Oregon," *American Journal of Psychiatry* 162, no. 6 (2005): 1060-1065; L. Ganzini, "Physician-Assisted Suicide," *American Journal of Psychiatry* 163, no. 6 (2006): 1109-1110.
96. I. Levene and M. Parker, "Prevalence of Depression in Granted and Refused Requests for Euthanasia and Assisted Suicide: A Systematic Review," *Journal of Medical Ethics* 37, no. 4 (2011): 205-211, at Table 1.
97. L. Ganzini, E. R. Goy, and S. K. Dobscha, "Prevalence of Depression and Anxiety in Patients Requesting Physicians' Aid in Dying: Cross Sectional Survey," *BMJ* 337, (2008): a1682.
98. *Id.*, at 973.
99. *Id.*, at 974.
100. *Id.*
101. *Id.*
102. See *Zurich Case*, *supra* note 42; *Aargau Case*, *supra* note 42; *Basel Case* Entscheid 6B_48/2009 (11 Juni 2009) (Schweizerisches Bundesgericht) [Swiss Federal Supreme Court].
103. J.-B. Wasserfallen, R. Chiolerio, and F. Stiefel, "Assisted Suicide in an Acute Care Hospital: 18 Months' Experience," *Swiss Medical Weekly* 138, no. 15-16 (2008): 239-242, at 240.
104. G. Bosshard, E. Ulrich, S. J. Ziegler, and W. Bar, "Assessment of Requests for Assisted Suicide by a Swiss Right-to-Die Society," *Death Studies* 32, no. 7 (2008): 646-657, at Table 1. This evidence is of highly questionable quality, as discussed in the analysis.
105. S. Fischer, C. Huber, L. Imhof, R. Mahrer Imhof, M. Furter, S. Ziegler, and G. Bosshard, "Suicide Assisted by Two Swiss Right-to-Die Organisations," *Journal of Medical Ethics* 34, no. 11 (2008): 810-814, at Table 1.
106. See *Haas*, *supra* note 45; *Black*, *supra* note 45.
107. See van der Heide et al., *supra* note 68, at Table 2.6.
108. See SCEN 2011, *supra* note 71, at Table 4.5.
109. See van der Heide et al., *supra* note 48, at 182.
110. See Smets et al., *supra* note 63, at Table 3.
111. See Smets et al., *supra* note 83, table 2.
112. See Meeussen et al., *supra* note 64, at Table 2.

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113. Oregon Department of Human Services, *Oregon's Death with Dignity Act: Three Years of Legalized Physician-Assisted suicide* (2001): at 4.
114. Oregon Department of Human Services, *Fourth Annual Report on Oregon's Death with Dignity Act* (2002), at 10; Oregon Department of Human Services, *Sixth Annual Report on Oregon's Death with Dignity Act* (2004), at 13; Oregon Department of Human Services, *Seventh Annual Report on Oregon's Death with Dignity Act* (2005), at 14; Oregon Department of Human Services, *Eighth Annual Report on Oregon's Death with Dignity Act* (2006), at 13; Oregon Department of Human Services, *Twelfth Annual Report on Oregon's Death with Dignity Act* (2010), at 2.
115. Regional Review Committees Euthanasia, *Jaarverslag 2004 [Annual Report 2004]* (2005) casus 14.
116. See Griffiths et al., *supra* note 8, at 169.
117. See van der Heide et al., *supra* note 48, at 188.
118. *Id.*, at 189.
119. *Id.*
120. See Smets et al., *supra* note 83, at Table 2.
121. See Griffiths et al., *supra* note 8, at 169.
122. Two such cases appear in the annual report for 2009: RRC, *Jaarverslag 2009*, *supra* note 61: casus 2, 13. In case 2, the patient had developed aphasia which prevented a written request but the RRC was satisfied that the request by means of hand gestures, repeated at a later date in the presence of the patient's daughter, had been competent, and that the physician had paid particular attention to the issue of the patient's competence. In case 13, the patient had made repeated oral requests, but at the time of admission to hospital was no longer able to make a written request. Although this fact alone would not necessarily have resulted in a judgment of "not careful," the fact that the consulted physician had not been able to assess the patient's capacity did result in such a judgment. Only case 2 appears in the English language version of the *Annual Report: Regional Review Committees Euthanasia, Annual Report 2009* (2010): at 9.
123. T. Smets, J. Bilsen, J. Cohen, M. L. Rurup, F. Mortier, and L. Deliens, "Reporting of Euthanasia in Medical Practice in Flanders, Belgium: Cross Sectional Analysis of Reported and Unreported Cases," *BMJ* 341, (2010): c5174, at Table 3. The response rate in this study was only 58 percent so the data should be used cautiously.
124. See Rurup et al., *supra* note 46, at Table 1; Smets et al., *supra* note 63, at Table 3.

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125. See Smets et al., *supra* note 83, at Table 2.
126. See Meeussen et al., *supra* note 64, at Table 2 and Table 3.
127. Regional Review Committees Euthanasia, *Jaarverslag 2005 [Annual Report 2005]* (2006): casus 3.
128. One in 2003; two in 2004; one in 2006.
129. See Smets et al., *supra* note 123, at Table 2.
130. G. Pousset, J. Bilsen, J. Cohen, K. Chambaere, L. Deliens, and F. Mortier, "Medical End-of-Life Decisions in Children in Flanders, Belgium: A Population-Based Postmortem Survey," *Archives of Pediatrics & Adolescent Medicine* 164, no. 6 (2010): 547-553, at Table 1.
131. See Smets et al., *supra* note 83, at Table 1.
132. See Meeussen et al., *supra* note 64, at Table 1.
133. See Chambaere et al., (2012), *supra* note 50, at 458.
134. *Id.*
135. Van Wesemael et al., *supra* note 87, at Table 3.
136. Commissie Late Zwangerschapsafbreking en Levensbeëindiging bij Pasgeborenen [Commission on late abortion and termination of life of neonates] (LZA-LP), *Jaarverslag 2007 [Annual Report 2007]* (2008); LZA-LP, *Jaarverslag 2008 [Annual Report 2008]* (2009); LZA-LP, *Gecombineerd Jaarverslag over de jaren 2009 en 2010 [Combined Annual Report 2009-2010]* (2011); LZA-LP, *Gecombineerd Jaarverslag over de jaren 2011 en 2012 [Combined Annual Report 2011-2012]* (2013).
137. See de Boer et al., *supra* note 54, at 260.
138. See Wijlick and Kruseman, *supra* note 60, at 587.
139. *Id.*, at 261.
140. See Rurup, *supra* note 46, at 47.
141. See Lewis, *supra* note 20, at 127.
142. *Id.*, at 127-128.
143. Sénat de Belgique, *Proposition de loi modifiant la loi du 28 mai 2002 relative à l'euthanasie [Bill to amend the Euthanasia Act (Belgium) 2002]* (S 5-1611) (2012).
144. See Smets et al., *supra* note 63, at Table 3; see RRC, *Jaarverslag 2005, supra* note 127; Regional Review Committees Euthanasia, *Jaarverslag 2006 [Annual Report 2006]* (2007); Regional Review Committees Euthanasia, *Jaarverslag 2007 [Annual Report 2007]* (2008); Regional Review Committees Euthanasia, *Jaarverslag 2008 [Annual Report 2008]* (2009); RRC, *Jaarverslag 2009, supra* note 61;

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Regional Review Committees Euthanasia, *Jaarverslag 2010 [Annual Report 2010]* (2011); RRC, *Jaarverslag 2011*, *supra* note 56.

145. See Bosshard, *supra* note 37, at 464-465.

146. See, e.g., Hamilton and Hamilton, *supra* note 95; L. Ganzini, "Commentary: Assessment of Clinical Depression in Patients Who Request Physician-Assisted Death," *Journal of Pain and Symptom Management* 19, no. 6 (2000): 474-478; I. Finlay and R. George, "Legal Physician-Assisted Suicide in Oregon and The Netherlands: Evidence Concerning the Impact on Patients in Vulnerable Groups - Another Perspective on Oregon's Data," *Journal of Medical Ethics* 37, no. 3 (2011): 171-174.

147. M. P. Battin, A. van der Heide, L. Ganzini, G. van der Wal, and B. D. Onwuteaka-Philipsen, "Legal Physician-Assisted Dying in Oregon and The Netherlands: Evidence Concerning the Impact on Patients in "Vulnerable" Groups," *Journal of Medical Ethics* 33, no. 10 (2007): 591-597, at 596.

148. See Finlay and George, *supra* note 146, at 173.

149. See Ganzini, *supra* note 97, at 974. Note that this study was not available at the time of Battin et al.'s review.

150. *Id.*

151. *Id.*

152. *Id.*, at 975.

153. See Bosshard et al., *supra* note 104, at Table 1.

154. *Id.*, at 652.

155. *Id.*, at 655.

156. See Black, *supra* note 45, at 164-165.

157. See Van Wesemael et al., *supra* note 87, at 731.

158. See Sénat de Belgique, *Proposition de loi complétant, en ce qui concerne les mineurs, la loi du 28 mai 2002 relative à l'euthanasie [Bill to add provisions in respect of minors to the Euthanasia Act (Belgium) 2002]* (S 5-1947) (2013).