Letter of 12 October 2016 from the Minister of Health, Welfare and Sport and the Minister of Security and Justice to the House of Representatives on the government position on 'completed life'

For some time now, there has been public debate on the issue of whether people who consider their life as completed should be given help in ending their life in a dignified manner and at a time of their own choosing. In 1991, former justice Huib Drion wrote an article entitled 'Het zelfgewilde einde van oudere mensen' ('A self-determined end for elderly people'), but there has been a lot of interest in the subject since then too, witness for instance the citizens' initiative on 'completed life', launched by the civil society organisation 'Uit Vrije Wil' ('Of one's own free will').

The debate concerns people for whom life has lost its meaning and become too great a burden for them to continue living. These are generally people of an advanced age, who no longer see any way to make their lives meaningful, who have difficulty coping with their loss of independence and loss of mobility, who feel lonely, partly due to the loss of loved ones, and who suffer from general fatigue, physical decline and loss of personal dignity. It is about people who no longer want to live, despite receiving attention and help from others, as well as good quality care. To be in control of the end of their lives, they will generally need assistance from others. If a person does not have a serious medical condition, however, there is no medical dimension to their unbearable suffering without prospect of improvement. This means they are not eligible for euthanasia or assisted suicide as referred to in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act ('the Act'). For someone to provide them with assistance in this respect would therefore be a criminal offence. The question is how we can respond to this group of people who are suffering unbearably 'from life' without prospect of improvement, but whose suffering does not have a medical dimension, and who wish to have more control over the end of their lives.

During the debate on the 2014 budget for the Ministry of Health, Welfare and Sport, the parliamentary party of the People's Party for Freedom and Democracy (VVD) asked the health minister to commission a study to establish the legal scope for assisted suicide for people who regard their life as completed, and to identify the social dilemmas that surround this issue (Proceedings of the House of Representatives, 2013/14, no. 16, p. 6). They suggested establishing a committee that would look into the scope for assisted suicide for people who

regard their life as completed. The government then set up a committee, chaired by Professor Paul Schnabel. Its task was:

'to issue an advisory report on the legal scope for assisted suicide for people who regard their life as completed, and on the social dilemmas that surround this issue.'

We submitted the Schnabel committee's report, entitled 'Voltooid leven'('Completed life') to the House by letter of 4 February (Parliamentary Papers, House of Representatives, 2015/16, 32 647, no. 51). The committee investigated and provided insight into the broad social debate and the legal issues. In order to formulate recommendations, it looked at the concept of completed life, the applicable legal framework, the size and characteristics of the group of people who want to end their life because they consider it completed, ethical aspects, ways to prevent a situation in which people see no prospect of living a meaningful life, and the legal scope for and limits on responding to their desire for more autonomy in this respect.

We are grateful to the committee for its work and for the insight it has provided into the issue of completed life. In its report, the committee weighed all the arguments for and against amendment of the current legislation and concluded that it was not desirable to widen the current legal scope for assisted suicide. In the committee's opinion, the current legal framework provides sufficient scope for the majority of people whose suffering relates to feeling that their life is 'completed', because it often has a medical dimension. These people fall within the scope of the current legislation and would therefore be eligible for euthanasia or physician-assisted suicide. As regards people who are not eligible, the committee noted that it did not have the impression that requests for assisted suicide are commonly made in these situations.

We are pleased with the conclusion that the current legislation functions well and that it serves its purpose. The great caution exercised in practice and broad public support mean that physicians and patients are able to make use of the options provided by the law. There is therefore an adequate solution available for people who fulfil the statutory criteria. We support the conclusion that there is no reason to change the system for these people.

However, the current system offers no options for people who regard their life as completed and whose desire to die cannot be met within the scope of the Act. To provide a solution for this

group of people, we have to answer the question of how we can respond to the growing wish among people in the Netherlands to have more autonomy in end-of-life decisions.

To better understand how the committee reached its conclusions and their implications for the question posed above, we will first briefly discuss the committee's report. Then we will address the recommendations it contains. Taking account of the scope discussed in the report, the government will then give its own views on assisted suicide for people who regard their life as completed.

Report on completed life

The committee first provides an overview of the definitions of 'completed life' it encountered in the course of the study. It argues that completed life is an umbrella term that can be interpreted in different ways. The definition which the committee distilled from the various interpretations and used in its report is as follows:

'It is about people who are *generally of an advanced age*, who in their own opinion no longer have any *life prospects* and have as a result developed a *persistent, active desire to die*.'

Adopting this definition means that certain situations are already covered by the Act, i.e. those in which the person's suffering has a mainly medical dimension. According to the committee these situations fall outside its mandate. Other situations that fall under this definition generally concern multiple geriatric syndromes, which can lead to people experiencing (existential) suffering and having an active wish to end their life, according to the committee.

The committee then studied the following legal options with regard to assisted suicide for people who regard their life as completed:

1. Repealing article 294 (2) of the Criminal Code (i.e. no longer classifying assisting a person to commit suicide as an offence).
2. Allowing non-physicians to assist in suicide under certain conditions.
3. No longer classifying euthanasia and physician-assisted suicide as offences.
4. Making a 'last will' pill available.
5. Explicitly bringing 'completed life' without a medical dimension under the scope of the Act.
6. Maintaining the current legal framework.

7. Allowing self-determined termination of life as an alternative to euthanasia performed by a physician.

After studying the current legal framework, the committee concluded that the Act functions well, that due care is exercised in individual cases, which can be assessed and reviewed. As a result there is public confidence in the system governed by the Act, and this has a positive effect on people who want euthanasia, their families, the physicians involved, government and society as a whole.

Looking at what options are currently provided by the Act, the committee concluded that it provides scope for the majority of people with a completed life according to the definition used by the committee, in view of the open wording of the due care criteria. This is mainly because many people who regard their life as completed also often suffer from multiple geriatric syndromes which contribute to unbearable suffering without prospect of improvement. This meets the norm formulated in case law that suffering must, to a large extent, have a medical dimension. The committee therefore concluded that many people whose life is completed also experience a form of suffering that has a medical dimension, so that their request can in principle be granted. In practice, however, the scope provided by the Act is not always used.

The committee also established that there are four important values in our society that play a role in the euthanasia debate and are thus important to the debate on completed life as well. They are: safety, due care, assessability and reviewability and transparency. The committee argued that these values could be at risk if the legal scope for assisted suicide for people who regard their life as completed were to be widened. It was concerned that if the decision is made to change current practice, it will not be clear whether the same degree of due care can be guaranteed. This could cause alarm and uncertainty, which would have a negative effect on current practice.

The committee listed the options currently provided by the law and weighed up various arguments for and against. The basis for its considerations was current legislation. Having established that the present system functions well, that the Act could apply to a large proportion of the people who feel their life is completed and that the group to whom it does not apply is probably small, the committee saw no reason to amend the legal scope for assisted suicide for people who regard their life as completed.

Besides the conclusion that grounds for legislative changes are lacking, the report contained a number of recommendations. First, the committee recommended providing better information to patients, their families and physicians about the existing scope of the Act. The committee established that the current legislation provides scope for termination of life in the event of completed life if the person is also suffering from multiple geriatric syndromes, but that not all physicians are aware of this. We agree with the committee that the due care criteria are worded openly and that completed life in combination with multiple geriatric syndromes falls within the scope of the current Act. The regional euthanasia review committees (RTEs) have also described this clearly in their Code of Practice, which can be found on the committees' website. Improved knowledge of the options provided by the Act will make it possible to grant requests from some of the people who regard their life as completed and want assisted suicide. This does not apply, however, to the group of people who regard their life as completed but who do not suffer from multiple geriatric syndromes, or to those whose suffering has no medical dimension at all but who are suffering unbearably from life, without prospect of improvement, and therefore actively wish to die.

The committee also established that people's knowledge of the Act is often lacking or not up to date. Various initiatives have been taken over the past few years to remedy this. To provide more clarity on the options for euthanasia on the basis of an advance directive, we recently published a guideline on advance directives, aimed at both physicians and the public. Information is also available via the central government website, the website of the Royal Dutch Medical Association (KNMG) and a brochure for patients entitled 'Spreek op tijd over uw levenseinde' ('Discuss the end of your life in time'), which was drafted in cooperation with various pensioners' and patients' organisations. The websites of these organisations also give information about euthanasia and assisted suicide. We will consult with the KNMG on how to further increase physicians' awareness of the options and conditions with regard to euthanasia. We will also look at how more attention could be given to this subject in their training, for instance.

The committee's next recommendation was to establish in a guideline that an extra independent physician must be consulted in complex cases involving completed life. In practice, an expert in the appropriate discipline is often already consulted in complex cases. For instance, the medical profession has drawn up a guideline for cases involving patients with psychiatric conditions. It is

currently under review, and in future will also explicitly apply to physicians other than psychiatrists. The importance of consulting an independent physician who has expertise in a particular medical field is also clear from the Code of Practice, which states that '[w]here the physician lacks the expertise to assess whether reasonable alternatives exist, he should ascertain whether other physicians who do have that expertise have been involved in the patient's treatment, or he should consult a specialist in the medical field in question'. It is reasonable to leave it up to the physicians to decide whether extra expertise is needed.

As regards the – timely – referral by a physician who objects as a matter of principle to considering requests for euthanasia or assisted suicide, the committee recommends making more arrangements for such situations. We would refer in this respect to the KMNG's position paper entitled 'The role of the physician in the voluntary termination of life', which states that physicians have a moral and professional responsibility to provide timely assistance to patients in finding another physician. Since the second evaluation of the Act, the KNMG has highlighted this responsibility in various ways. The third evaluation of the Act, which is currently under way, is expected to establish whether this has had any effect. We would also point out that if the government were to impose an obligation to refer patients, it might give people the idea that physicians are obliged to consider performing euthanasia. This is not the case.

Views on completed life

The report's recommendations and considerations on the current legal framework provide useful insights into what is possible and how to make use of the scope already available. There is a well-defined framework for active termination of life on request for people who are suffering unbearably and without prospect of improvement, if their suffering clearly has a medical dimension. However, the legislation offers no solutions for people who wish to die because they are suffering as a result of, for instance, the loss of their partner and loved ones, loss of meaningful contact, fatigue and apathy, without there being a medical dimension to their suffering.

The question is how to respond to the growing number of people who want to be able to end their lives with dignity and at a time of their own choosing if life has become unbearable for them. The government takes the view that a request for help made by an individual belonging to this group is legitimate. Thanks to the many technological developments in medicine, people are living longer. This is a good thing for many people, but not for everyone. There are individuals

who feel they have had enough, for whom every day is another day of waiting for death. These people are asking for a way to end their life in a dignified manner.

Compassionate grounds

The purpose of the Act, which came into effect in 2002, was to enable physicians who receive a request for active termination of life to help people who are suffering unbearably, on compassionate grounds. When they do so, they invoke the defence of necessity, arising from a conflict of duties. The physician's duty to protect life comes into conflict with his duty to relieve suffering. This assumes that there is no reasonable way of alleviating the patient's suffering other than terminating their life. And of course it is conditional upon the patient having made a voluntary, well-considered and persistent request. By recognising that necessity may be invoked and by including a ground for immunity from criminal liability, the Act creates legitimate grounds for euthanasia. This means that if a person is suffering unbearably and without prospect of improvement, the need to protect human life may yield to the need to act on compassionate grounds, and that the physician is not criminally liable if he fulfils the due care criteria set out in the Act. The Act also provides scope for people of advanced age who wish to die and who suffer from multiple geriatric syndromes, who are suffering unbearably and without prospect of improvement, and in whose situation the physician has come to the conclusion that there is no way to relieve their suffering other than by active termination of their life. The government agrees with the committee that it is important for the scope already provided by the Act to be fully used.

However, the Act has its limitations. Basically, it adopts the point of view of the physician, who has concluded that the only way he can provide proper care to the patient is to grant the patient's request for euthanasia. The physician is under no obligation to perform euthanasia and the patient has no right to euthanasia. If a physician decides to perform euthanasia, it is first and foremost an act of compassion in view of the medical suffering of his patient. That suffering must be demonstrably unbearable and without prospect of improvement. In order to demonstrate this, due care criteria have been drawn up which must be fulfilled and which are used for prior assessment and review. The assessment is carried out beforehand by the physician and an independent expert, and the review is conducted afterwards by a review committee. The focal point of the Act is the physician's situation of necessity due to a conflict of duties arising from the patient's unbearable suffering without prospect of improvement, which has a medical dimension, and the patient's request for active termination of his life.

It would be undesirable to widen the scope of the Act to respond to the wishes of people who are suffering from life, but whose suffering does not have a medical dimension, because the basic motivation for their wish to die is fundamentally different. The unbearable suffering without prospect of improvement of people who regard their life as completed and as a result wish to die does not have a medical dimension. Although these people's lives can be equally unbearable, without prospect of improvement, the medical factor plays a minor role, if any. Here, neither the physician's medical opinion nor the resulting conflict of duties that justifies the physician's conduct is at play.

Autonomy

The guiding principle in the government's search for a solution is the question to what degree we can respond to the desire for greater autonomy among people who wish to die. Autonomy is a fundamental value and an important element in ethics and law. It is a basic principle that expresses the ideal of shaping one's own life and the right to do so. In the thematic evaluation of the legislation, entitled 'Zelfbeschikking in de zorg' ('Self-determination in care') (annexe to Parliamentary Papers, House of Representatives, 2013/14, 31 765, no. 86), autonomy is referred to as a moral and legal foundation of much of our legislation. It is also one of the guiding principles of the current government's coalition agreement.

Of course, autonomy is not an absolute value and should always be viewed in conjunction with other values, in order to assess how these values and the underlying interests relate to one another. That human life deserves protection is one of the values that play an important role in the debate on active termination of life in general, including assisted suicide for people who consider their life as completed. The intrinsic value of life entails a duty to protect it. Naturally, as emphasised in the coalition agreement, the government considers the protection of human life a great good. The government feels responsible for that protection and makes every effort to ensure that vulnerable members of society feel safe and protected.

However, if people no longer have any life prospects and as a result have developed a persistent, active desire to die, the rationale underlying the protection of human life comes under pressure, because life no longer has any value for them. People who have come to a well-considered decision that their life is completed and who are suffering from life, without prospect of improvement, must be allowed to end their life with dignity. This does not mean that

human life is any less worthy of protection, but puts the perspective of the person who wishes to die first.

Autonomy means being allowed to shape your own life and make your own choices, but also having space for those choices to take effect in your life. In the case of people who regard their life as completed and as a result now have a wish to die, autonomy also means being able to decide when and how to die. From the point of view of personal interest, an individual has the right to decide how and at what point in their life they want to die, according to the European Court of Human Rights. As described in the report on completed life, the Court has acknowledged the right to commit suicide since 2011. This stems from the individual's right to respect for their private life as laid down in article 8 of the European Convention on Human Rights. And although the Court did not derive from this right any positive obligations on the part of the State to adopt measures to facilitate assisted suicide, it raises the question of the extent to which people who are capable of making a well-considered decision in this respect should be allowed to ask other people for help in ending their life if they regard it as completed.

Autonomy is at risk of becoming a hollow concept if an individual who regards their life as completed cannot end their life without the help of other people while at the same time those other people are prohibited from offering help. Respecting people's autonomy implies establishing parameters that allow people to shape their own lives, and that includes their deaths.

Providing scope for that kind of choice does not focus on the help that is given, but on a well-considered choice on the part of the individual. As the consequences are irreversible, it must be established clearly that it is the person's entirely inherent will to die, a well-considered and persistent wish that came into being without outside pressure. A wish to die that arises on impulse, for instance because a person breaks up with their partner or has a serious accident, cannot be considered competent and persistent. It is important that the wish develops voluntarily and without pressure from others, including family members. It is therefore essential to establish objective criteria to prevent the substances for committing suicide being made available to people who have not made a well-considered decision. Their wish must not only be palpable, it must be something that can be assessed and reviewed. The concept of compassion also plays a role in that respect. When assessing whether a person has a well-considered wish to die because they are suffering unbearably from life, and is decisionally competent in this

respect, a designated professional will establish from an objective point of view and on the basis of the relevant criteria, whether the wish can be granted. The government's task is to set strict conditions that express the principles of due care, assessability and reviewability, and transparency, so that the safety of all members of society is guaranteed, as discussed in greater detail below.

Separate legal framework

The question at the heart of the debate on assisted suicide for people who regard their life as completed is therefore whether it is desirable to continue to prevent the necessary help from being given. In the government's view, it is not only the physician's duty to act with compassion, but also the government's duty to show compassion when it comes to creating scope for people to make their own choice if they regard their life as completed, are suffering from life, without prospect of improvement, and have come to the well-considered decision that they want to end their life.

The government aspires not only to acknowledge that right to autonomy, but also to give it practical form so that we can do justice to a legitimate and growing wish that deserves our attention.

In 2011, 'Uit Vrije Wil', referred to earlier, produced draft legislation based on its citizens' initiative on completed life: the Assisted Suicide for Elderly People (Review Procedures) Bill. At the time, a majority in the House of Representatives held the view that there should first be a broad social debate on this complex subject. On the basis of debate over the past few years, the present government believes that in cases where a person has a consistent, well-considered and active wish to end their life because they are suffering unbearably from life, without prospect of improvement, but their suffering does not have a medical dimension, scope should be created for autonomy by removing the obstacles in the current legislation for those cases.

Specifically, this means creating an extra immunity from criminal liability for anyone assisting another person's suicide on the basis of the right to autonomy and not, as in the current Act, of an act of compassion by a physician. This requires a separate legal framework, with different basic principles from the current Act, and aimed at a different group of people in society, thus safeguarding the achievements of the current Act. Like the Act, this new legal framework will

have to ensure a maximum degree of due care, assessability and reviewability, and transparency, so that all members of society can feel safe. Stringent requirements will have to be set. We will discuss below the contours we think such a legal framework should have and what elements should certainly be a part of it. It should be noted that the precise details of the conditions require further work.

New criteria for the legal framework

It is important for any new legal framework to contain very clear and specific criteria that will determine under what conditions assisting suicide would cease to be an offence in the case of a consistent, well-considered and voluntary wish to die on the part of an individual who regards their life as completed. The criteria must lead to a system of due care, safety, expertise and assessability and reviewability in this area, in the same way as the Act created a similar system for euthanasia. The criteria will have to make it clear that giving scope for assisted suicide for people who regard their life as completed is based on different values and basic principles than the current system under the Act, although the procedure laid down by the Act can largely be taken over.

The request

Naturally, the starting point is that a request must be consistent, voluntary and well-considered. The request can only be made by the individual in question and it must not have been influenced by others. The person's decisional competence in relation to their choice to end their life forms the basis for being able to grant a request for assisted suicide. The context in which that person lives is also important. The unbearable nature of the suffering and the lack of prospect of improvement, as assessed beforehand, play a decisive role.

Prior assessment

It is important that people receive careful guidance in making their choice. The primary role of the health professional who is given this task will be to assess the request for assistance. A specially trained end-of-life counsellor is the most logical option. This new profession could draw from disciplines with experience in existential and psychosocial problems and in counselling people at the end of life, such as nurses, psychologists or physicians. New training will have to be developed that end-of-life counsellors must complete (a top-up course in addition to their medical training), in order to be allowed to practise. The reason we have opted for a medical top-up course is to ensure that the counsellor can establish that the person's wish to die is not

the result of a medical condition such as depression. Using objective criteria, the counsellor will have to ascertain that the person's suffering is without prospect of improvement and cannot be relieved by treatment, medical or otherwise.

The end-of-life counsellor will have to assess beforehand whether a request fulfils the criteria. Establishing strict norms in this respect is not easy. The same applies to the euthanasia system, when the physician has to be satisfied that the patient is suffering unbearably and without prospect of improvement and that the suffering has a medical dimension. Although autonomy, and thus the scope for people to make their own, well-considered decision, is the basic principle it must also be possible to assess and review requests, in order to ensure that due care is exercised when making the required substances available. It is important to establish that, according to objective criteria, the wish to die is voluntary, well-considered and persistent, that the person is suffering unbearably from life, without prospect of improvement, and that there is no doubt about the person's decisional competence in this respect.

To assess the voluntary and persistent nature of the request, the end-of-life counsellor will talk with the person concerned several times. At least one of these will be an individual interview, without their partner, family or friends. Combined with a waiting period after the final interview, this approach will guarantee as far as possible that the request is persistent and consistent, as well as voluntary and well-considered. Possible medical or social causes that can be remedied must be ruled out and alternatives must be considered. Finally, a second assessment by an independent expert would seem reasonable, in view of the impact of the decision to provide assistance with suicide.

Part of the assessment will involve determining the source of the wish to die, i.e. whether it is an inherent wish and not one that has arisen from problems that can be solved or treated. If it is suspected that the wish is not well-considered, it cannot be granted. If treatment could possibly change the person's mind about wanting to die, they will have to be referred to the appropriate health professional. The importance of due care in assessing a person's autonomous wish to die is underscored by the irreversibility of the consequences of such a decision. When the end-of-life counsellor makes the assessment, on the basis of experience and expertise, he must be convinced that there are no reasonable alternatives.

Process after assent

If it is clear from the assessment that the request for assisted suicide fulfils the criteria, the required substances can be made available through a pharmacist. The end-of-life counsellor could be given special authorisation to prescribe such substances. Another option is for a number of physicians willing to take on this task to prescribe the substances, taking into account the specific situation of the person who wishes to die and which substances can best be used in a particular case. The actual dispensing of the substances could be limited to shortly before the intended use.

Family members may of course be present when the person dies. The details of this will need to be worked out. It is important that their role remain limited to prevent them from becoming criminally liable for assisting with a suicide.

Documentation
Recording the request and the assessments in writing provides important guarantees for the due care that is to be exercised throughout the process. This means that the person will have to fill in and sign a written declaration. As is the case under the current Act, the end-of-life counsellor and the independent expert will be expected to create a file in which they record and substantiate the process they followed and what the result was.

Rreview
A review of each case by an independent committee will be necessary to ensure that the requirements were indeed fulfilled and to take action in situations where this was not the case. The criteria on which review is based must also be clear.

Potential criminal prosecution is a key part of the system under the current Act in the event that a person's actions cross the boundaries set. The Public Prosecution Service has a fundamental duty to enforce the law in order to protect human life, and assesses possible grounds for immunity from criminal liability in light of the Act. To establish a similar approach for the legal framework for assisted suicide for people who regard their life as completed, we are considering a system similar to that of the regional euthanasia review committees.

Although in principle everyone is entitled to autonomy, it is an absolute precondition that steps have been taken to ensure that the person who wishes to end their life has made a careful choice. Autonomy in that choice is therefore not limited to people of advanced age. However,

because the growing number of people who want to choose when they end their life are mostly elderly, it would be logical to limit any new system to people who have reached a certain age.

Preventing 'completed life' situations

Creating scope for allowing people who have an autonomous wish to end their life since they regard it as completed to do so in a dignified manner does not mean that we should not do everything possible to prevent such situations from arising. The committee addressed this in its report, by making recommendations on the social context in which the feeling of one's life being completed arises and pointing out the importance of preventing this. It called for efforts to increase older people's sense of their own worth, by means of a revaluation of old age and of the contribution they can still make to society. This is an important task for us all, as a society, and one that the government supports. The government has taken various measures to initiate and encourage public debate on this subject. For instance, we encourage people to think about old age and the end of their lives, by providing financial support to the activities of the 'Van betekenis tot einde' ('Meaningful until the end') coalition. With the aim of improving end-of-life care and support, the government funds the National Palliative Care Programme. One of the programme's aims is to increase awareness among professionals and the public that care does not stop if a patient's condition is untreatable. Physical, mental, social and spiritual care and support can still be provided in a palliative approach.

Attention for and appreciation of older people will continue to be necessary and valuable in the future. It goes without saying that we, both government and society, will make that effort. The government aims to ensure that people in this age group feel appreciated and do not become isolated. This requires a broad approach, including measures to prevent loneliness and support carers. Society itself has an important part to play here, too. We expect people to look out for one another and help each other give meaning to life, even in times when this is no longer taken for granted.

Conclusion

It is important for the government, society and individuals to make efforts to prevent 'completed life' situations. At the same time it is important to realise that suffering unbearably from life itself, without prospect of improvement, cannot be prevented in all cases. Moreover, too narrow a focus on preventing such feelings does not do justice to the wishes of people who are suffering from life, who regard their life as completed and request help in ending it.

The government holds the view that, for people who regard their life as completed, the basic principle underlying their request is their right to autonomy. We believe it is important for people to be able to exercise that right, even in the context of assisted suicide. In our opinion this can only be done in a careful process that is transparent and can be assessed and reviewed, thus guaranteeing safety.

We welcome the committee's conclusion that the current Act functions well. The recently published 2015 annual report of the regional euthanasia review committees confirms this view. The government agrees with the committee's conclusion that it is important to preserve such a well-functioning system and to make use of the scope it provides. In the government's view, therefore, scope for assisted suicide for people who regard their life as completed should supplement and function alongside the current system. The government intends to consult with various parties in order to develop a new legal framework.