

*Presidenza del Consiglio dei Ministri*



**BIOETHICAL REFLECTIONS ON  
PHYSICIAN-ASSISTED SUICIDE**

**18 July 2019**

## CONTENTS

Presentation.....	3
1. Premise: the reason for the opinion and the attention placed on assisted suicide .	6
2. The relationship between euthanasia and assisted suicide.....	9
3..Ethical-juridical framework on the end of life in our legal system.....	11
3.1 Law code and jurisprudential reading .....	11
3.2 Continuous deep palliative sedation .....	12
3.3 Suicide .....	13
4. Issues under discussion in assisted suicide.....	13
4.1 The value to be attributed to the expressed will of individuals .....	13
4.2 Respect for the professional values of the doctor and health care workers .	15
4.3 The slippery slope argument .....	17
4.4 The importance of palliative care and pain therapy .....	18
5. Ethical and legal opinions within the ICB.....	20
6. Recommendations.....	25
Personal Remarks.....	26
A personal remark by Prof. Francesco D'Agostino.....	26
A personal remark by Prof. Assunta Morresi.....	28
A personal remark by Prof. Maurizio Mori.....	30

## Presentation

The Italian Committee for Bioethics (ICB), as a follow up to its mandate to encourage public discussion on ethical issues and provide political decision-makers with consultancy, deems it necessary with this opinion to carry out a reflection on assisted suicide following the ordinance n. 207/2018 of the Constitutional Court, which intervened on the issue, raised by the Milan Court of Assizes (ordinance dated February 14, 2018), regarding the case of Marco Cappato and the suspected constitutional illegitimacy of art. 580 of Italy's penal code.

The Committee has sought to address the issue of assisted suicide in the awareness of detecting different positions both within the Committee itself and in society.

The guidelines of the ICB (02/26/2015) art. 13, with regard to the drafting of opinions, predisposes that these be "constituted first of all by a descriptive part of the *status quaestionis*. In the evaluative part, when divergent orientations emerge, the plurality of the topics and the emerged positions are to be taken into account, in an open form that is compatible with the economy of the document".

The diversity of opinions, on the other hand, gives the opportunity to provide elements of reflection at the service of the choices of a society which intends to tackle an issue, such as assisted suicide, which presents a series of problems and questions to which it is not possible to give a unified response. An issue which is considered among the most controversial of the current bioethical debate in our country. It should also be considered that personal elements and specific situations play an important role when questioning what the right to life consists of, whether the right to death exists and which ethical values to draw inspiration from as well as the dimension in which to place the intervention of a third party, in particular the doctor, called upon to respond to the patient's request.

The public debate concerning assisted suicide illustrates the great difficulty in managing to reconcile two bioethically important principles, such as the safeguarding of life on the one hand and individual self-determination on the other.

The opinion sought to draw the attention of society and the political world, which will have to discuss this issue following the invitation of the Constitutional Court, to what it considered to be the conceptual clarifications and the most relevant and delicate ethical issues arising from such requests: the difference between physician-assisted suicide and euthanasia; the expressed will of the individual; the professional values of the doctor and health care workers; the slippery slope argument; palliative care.

Different opinions can be found within this Committee.

Some members of the ICB are against legitimating physician-assisted suicide, both ethically and legally, and converge in believing that the defence of human life must be affirmed as an essential principle in bioethics, whatever the philosophical and/or religious foundation of this value, that the mandatory duty of the physician is absolute respect for the life of patients and that "facilitating death" marks an unacceptable transformation of the paradigm of "curing and caring".

Other members of the ICB are, on the moral and juridical level, in favour of legalizing medically assisted suicide on the assumption that the value of the protection of life must be balanced with other constitutionally relevant good, such as patient self-determination and personal dignity. Such a balance must take

particular account of conditions and procedures that are a real guarantee for the sick person and for the doctor.

Still others point out that, there is no immediate transmutability from the moral sphere to the legal sphere. Moreover, they highlight that, decriminalization or legalization of so-called physician-assisted suicide along the lines of those carried out by some European countries, would lead to the concrete risks of the start of a slippery slope in the present reality of Italian healthcare.

Despite these divergent positions, the Committee has reached the formulation of some shared recommendations, first and foremost hoping that wherever discussion on this issue may take place – including Parliament - debate on physician-assisted suicide will develop in full respect of all opinions on this matter, but also with due attention to the moral, deontological and juridical-constitutional problems that it raises and with the due in-depth study required of such a lacerating issue for the human conscience.

The Committee also recommends a commitment to provide adequate care for those suffering from incurable illness; it requests that adequate information be given to the patient regarding the possibilities of treatment and palliative care which are to be documented within the care report; it considers essential that every effort be made to implement the information for citizens and health professionals on the regulatory provisions concerning access to palliative care; it hopes for promotion of the broadest public participation in the ethical and legal discussion on the topic and that biomedical and psychosocial scientific research and the bioethical training of health workers in this field will be promoted.

This text was drawn up by Professors: Stefano Canestrari, Carlo Casonato, Antonio Da Re, Lorenzo d'Avack and Laura Palazzani, with the written contributions of Profs: Marianna Gensabella, Maurizio Mori, Tamar Pitch, Lucio Romano, Luca Savarino, Monica Toraldo di Francia and Grazia Zuffa.

The document was discussed at numerous plenary sessions held by the Committee, drawing on a debate in which all of the Colleagues participated, giving an important contribution to its drafting.

There was an audition with the President of the National Federation of MDs and Dentists Colleges, Dr. Filippo Anelli, during the plenary session on May 24, 2019.

The document was approved, by a large majority of those present, at the session on July 18, 2019, Profs: Salvatore Amato, Luisella Battaglia, Stefano Canestrari, Cinzia Caporale, Bruno Dallapiccola, Antonio Da Re, Mario De Curtis, Riccardo Di Segni, Gian Paolo Donzelli, Carlo Casonato, Lorenzo d'Avack, Silvio Garattini, Maria Pia Garavaglia, Marianna Gensabella, Maurizio Mori, Assunta Morresi, Laura Palazzani, Massimo Sargiacomo, Luca Savarino, Monica Toraldo di Francia and Grazia Zuffa.

Prof. Francesco D'Agostino voted against.

Profs. Carlo Caltagirone, Lucio Romano, Lucetta Scaraffia, Tamar Pitch, absent from the session, subsequently assented.

Despite their not having the right to vote assent was given by: Prof. Carlo Petrini, the delegate for the President of the National Institute of Health; Dr. Paola Di Giulio, the delegate for the President of the Superior Health Council; Dr. Maurizio Benato, the delegate for the President of the National Federation of MDs and Dentists Colleges, and Dr. Amedeo Cesta, the delegate for the President of the National Research Council.

Three personal remarks were drawn up and published together with the opinion; the first by Prof. Francesco D'Agostino confirming the negative vote he

gave to the opinion; the other two were by Prof. Assunta Morresi and Prof. Maurizio Mori who, despite their having approved the document, wanted to clarify the reasons for their dissenting positions on certain topics that were dealt with.

The President  
Prof Lorenzo d'Avack

## **1. Premise: the reason for the opinion and the attention placed on assisted suicide**

**1.1** The enormous development of technologies in medicine, on the one hand, makes it possible to treat patients who until a few years ago would have had no chance of survival, and on the other, in some cases it also leads to prolonging life in precarious conditions and great suffering.

Alongside technological transformations, social sensitivity to suffering has also changed. For these reasons too, dying today gives rise to a series of reflections on ethical, juridical, social and economic issues. In this situation some fundamental questions are at stake such as the value of human life, the dignity of the human person with his fundamental rights (the right to freedom, equality, health, etc.), the values of medicine and the role of the doctor, the value of the legal options adopted by public policies.

In end-of-life decisions it is essential to take into account the specific nature of the questions put forward by the patients, which can be very different. In many cases, in fact, patients ask to be accompanied "in" dying with ethical and juridical consequences that do not fall within the scope of either euthanasia or assisted suicide (so-called "accompaniment in dying"). In other cases there may be a request to be helped in dying without suffering, which transmutes into a request for palliative care; in others the request to avoid forms of clinical obstinacy emerges; or even a refusal and renunciation of life-saving medical treatment as provided for by Law 219/2017.

The Italian Committee for Bioethics (ICB), as a follow up to its mandate to encourage public discussion on ethical issues and provide political decision-makers with counselling, deems it necessary with this opinion to carry out a reflection on assisted suicide following the ordinance n. 207/2018 of the Constitutional Court, which intervened on the issue, raised by the Milan Court of Assizes (ordinance dated February 14, 2018), regarding the case of Marco Cappato and the suspected constitutional illegitimacy of art. 580 of the Italian penal code. We will give a description of the contents of this ordinance later.

The Committee has sought to address the issue of assisted suicide in full awareness of detecting different positions both within the Committee itself and in society. The diversity of opinions gives the opportunity to provide elements of reflection at the service of the choices of a society which intends to tackle an issue, such as assisted suicide, which presents a series of problems and questions to which it is not possible to give a unified response. It should also be considered that the personal element and specific situations play an important role when questioning what the right to life consists of, whether the right to death exists and which ethical values to draw inspiration from in these situations, as well as the dimension in which to place the intervention of a third party, in particular the doctor, called upon to respond to the patient's request. The public debate concerning assisted suicide or euthanasia illustrate the great difficulty in managing to reconcile two principles, of great bioethical importance, the protection of human life on the one hand and individual autonomy and self-determination on the other.

The different way of interpreting the balance between these principles or assigning priority to one rather than to the other gives rise to a series of bioethical implications which in turn raise questions that are not easily solved in the sphere of law especially with regard to the end of life.

This question, in fact, does not only have an ethical and juridical dimension, but calls into question much more general existential, psychological, philosophical and anthropological questions. The Committee, although not able to be exhaustive on the topic on an anthropological-philosophical level, proposes an ethical and juridical reflection to provide a framework of physician-assisted suicide as an issue that arises and develops in technologically advanced contemporary societies.

From the ethical point of view, a fundamental question about the end of life is whether there is an intrinsically morally relevant difference between euthanasia or assisted suicide on the one hand, and the withholding or withdrawing of health treatments at the patient's request, on the other. Some dispute this difference on the basis that the expected result, the patient's death, is identical in both cases and they speak of *passive euthanasia*, in the case of withholding or withdrawing of health treatments by request. Others believe, instead, that this difference lies in the distinction between killing and letting die, and they think that there is a radically different moral responsibility between *being the cause of* an event and *allowing* an event to happen. Starting from this conceptual distinction, it is believed that euthanasia and assisted suicide are always and in any case illicit, while the withholding or withdrawing of a treatment at the request of the patient, in the situations envisaged, is always lawful. Finally, there are intermediate positions, according to which the distinction between killing and letting die is generally valid, with the inclusion of some exceptions. In this way it would not be an absolute ethical principle, but *prima facie*, that is to say, a generally valid principle, but not *always* valid: just as there are cases in which it is morally illicit to let die, there are exceptional cases in which it would be morally licit to comply with request of a patient to be killed or to be helped to kill himself.

However, whatever the *moral* evaluation of the licitness or illicitness of assisted suicide may be, it should be considered that the moral discourse and juridical discourse do not necessarily need to coincide nor be radically separated. According to some positions the moral illicitness of suicide must be followed by the legal prohibition of the practice; according to other positions the moral licitness of suicide must be followed by the legalization of the practice. Other positions still claim that in specific medical circumstances and to some extent exceptional circumstances the request and assisting of suicide are not morally reprehensible acts, but that this does not automatically imply that physician-assisted suicide should be legalized or decriminalized. If it is assumed, in fact, that in extreme cases it is morally licit to help an individual to kill himself in order to avoid suffering that he considers unbearable, a series of questions arise that render the expression in legal terms of this situation far from easy: from the compatibility of such practices with medical deontology, to the difficulty of ensuring that some essential conditions are fulfilled in clinical practice (from the autonomy of the patient's request to the uselessness of all possible forms of alternative care and assistance), to the impossibility of finding legally unambiguous formulas capable of preventing dangerous future forms of slippery slope.

In general, therefore, it must always be considered that, on such delicate issues as those under consideration, faced with the widespread moral pluralism present in our society, ethics and law do not always converge, and that the choices of the legislator in this regard must mediate and balance the different values at stake, in order to be able to represent the various requests from society.

**1.2** The subject of this Opinion is the question raised by the Court of Assizes of Milan (ordinance on February 14, 2018), which questions the legitimacy of art. 580 (a) " in the part in which it incriminates the conduct of the aiding of suicide as an alternative to the conduct of instigation and, therefore, regardless of their contribution to the determination or strengthening of the suicidal intent"; and (b) in the part in which it does not make a distinction between the conduct of simple facilitation and that of instigation.

In response to these questions, ordinance n. 207/2018 of the Constitutional Court first observed that art. 580 of the criminal code is "functional to the protection of interests worthy of protection by the legal system", and therefore that "the indictment of assisted suicide cannot be considered incompatible with the Constitution". Furthermore, the Court claims that "the indictment of incitement to suicide and assisted suicide is (...) functional to the protection of the right to life, especially of the weakest and most vulnerable". The ethical principle of protection of life is, therefore, manifested in art. 2 of the Constitution and in art. 2 of the European Convention on Human Rights; from it derives the duty of the State to prepare all measures so that life is adequately protected, "not the – exact opposite - of recognizing to the individual the possibility of obtaining aid in dying from the State or from third parties". The fact, then, that the legislature in 1930 conceived the crime of aiding suicide as a form of protection of human life on the basis of the interest of the Community, does not exclude that, subsequently and still today, the rationale behind art. 580 of the Italian penal code can find its most appropriate justification in the personalistic value of the Republican Constitution.

However, the Constitutional Court also points out that the current regulatory framework concerning the end of life leaves certain situations equally worthy of protection and respect lacking in adequate protection, situations in which the value of protecting human life must be balanced with other constitutionally relevant good. These are situations that were not in the least predictable in the 1930s (but also in the following decades) and that are determined by the extraordinary possibilities of medicine and its technical-scientific apparatus to save patients in seriously compromised conditions from death; however, these patients find themselves living in an irreversibly debilitated state, sometimes even of technological dependence and in suffering, which can lead patients to consider their lives to be undignified.

In particular, the Court has identified four requisites that can justify third-party assistance in ending the life of a sick person: when the person is a) affected by an incurable disease b) that it causes him severe and subjectively intolerable physical or psychological pain and distress, c) is kept alive thanks to life-sustaining treatments and remains at the same time d) capable of making free voluntary and informed decisions. One wonders if these requirements indicated by the Court have a general value or whether they have been formulated with reference to the specific case (the situation of Fabiano Antoniani, aka Dj. Fabo) brought to its attention.

The Court draws an analogy between the refusal of medical treatment permitted by Law 219/2017 on *Informed consent and advance treatment directives* and correlated palliative care, which can extend to deep sedation on the one hand, and the request for assisted suicide on the part of the patient in order to put an end to his existence on the other. This analogy is one of the profiles used to justify the legitimacy of assisted suicide in the extreme situations described above. "If indeed - the Court writes – the cardinal saliency of the value of life does not exclude the obligation to respect the decision of the patient to put



an end to his own life by interrupting medical treatments - also when this requires active conduct, at least on the material level, by a third party (such as the disconnection or shutdown of a machine, accompanied by the administration of continuous deep sedation and pain therapy) - there is no reason why the same value should result in an absolute obstacle, juridically guarded, to acceptance of the patient's request for help serving to deliver him from the slower course – perceived as contrary to his own idea of a dignified death - consequent to the aforesaid withdrawal of life-sustaining treatments”.

For this reason, in addition to respecting the dignity and self-determination of the sick person, the Court deems the intervention of the legislator to be appropriate in order to define the ways and conditions of assisting suicide and the subject's right to receive a end-of-life treatment. Therefore, while recognizing even now that Article. 580 of the Criminal code needs to be supplemented by a provision able to meet the requests coming from those extreme situations mentioned earlier (a person suffering from an incurable disease, the cause of intolerable physical or psychological suffering, kept alive through life-sustaining treatments, capable of making free and informed decisions), the Court defers to a future date (24 September 2019) the public hearing in which the question of constitutional legitimacy will be dealt with. For this reason, given the uncertainty on the issue, the ICB deems it appropriate to intervene, trying to outline the terms of the problem and the values at stake.

## **2. The relationship between euthanasia and assisted suicide**

In specialized language and in common language, the terms "euthanasia" and "assisted suicide" are often used in different ways. It is therefore essential, before an ethical and legal analysis of the topic, to clarify the semantic use of these expressions. It is also necessary to draw a distinction on the procedures that characterize the case of euthanasia and that of the assisted suicide.

*Euthanasia* is a polysemic term, that is, it has different meanings, even if etymologically related. In general, here it is understood as the act whereby a doctor or other person administers drugs at the free voluntary request of the subject, who is fully informed and aware of the implications, with the purpose of intentionally causing the immediate death of the requestor. The aim of the act is the hastening of death on demand in order to remove suffering; in this sense, it is framed within the more general case of consensual homicide (Article 579 of the Italian penal code).

The specific circumstances of legal legitimacy of these practices are variable: generally the legislations provide conditions of serious incurable pathologies and of physical and mental suffering perceived as unbearable and explicitly repeated (e.g. Dutch, Belgian and Luxembourgish legislation). The possibility of extending euthanasia to conditions of depression, severe existential distress, loneliness, negative economic impact on the family, or even to the incapacitated, as in the case of minors or persons affected by dementia, is the subject of discussion.

Another case is suicide, which is distinguished from euthanasia because in this case it is the person concerned who performs the final act that causes death, an act made possible thanks to the decisive collaboration of a third party, which can also be a doctor, who prescribes and gives the lethal product in the period of a certain space of time and in compliance with strict conditions foreseen by the legislator. There is no shortage of cases in which the procedure uses machines that can help the patient with reduced physical capacity to take the lethal product

prepared (by the doctor or by others). Most of the time, assisted suicide is achieved with the assistance of a doctor, pharmacist or nurse and takes place within health facilities (physician-assisted suicide or medicide).

However, another hypothesis can also be considered, that of deeming it unjustified to assign only to doctors and health professions involved at different levels (nurses, pharmacists, psychologists) the task of practicing assisted suicide. Interdisciplinary commissions may also be established at health or social-health facilities, at the expense of the National Health Service (NHS), where the role of doctors may be limited to the mere observation of the existence or absence of clinical conditions for assisted suicide, excluding collaboration with predisposing and administration of the lethal drug<sup>1</sup>.

There is sometimes, even on the part of the person concerned, the fear of a bureaucratized death and an excess of technologies or over-medicalization and so other solutions are envisaged: the recourse to family, friends, or associations that offer help to commit suicide in social-healthcare institutions or at home. In these cases, when carried out outside hospitals, the "assisted suicide" is completed with "pharmacological assistance": the presence of a doctor may be requested only at the initial moment of the procedure, in which in compliance with strict conditions the doctor prescribes the product, which is then distributed by the pharmacist. The person who comes into possession of the lethal product remains, however, free to decide whether or not to use it at a later time. There is no lack of statistical data on people who, despite having obtained the compound, do not carry out their suicidal program.

In dealing with the topic in question, the Constitutional Court makes clear reference to physician-assisted suicide, believing that in this situation the requirements and criteria of foresight of the practice are better respected and guaranteed to any person "an ex ante control of the actual existence, for example, of their capacity for self-determination, of the free and informed character of their expressed choice and of the irreversibility of the pathology from which they are affected."

In all cases of request for assisted suicide described above, at the origin and the realization of the lethal act there was always the will of the person who wanted to put an end to his life through suicide and the presence of a third or third parties, who complied with the request for reasons of solidarity and pity. The laws that allow the assisted suicide consider as a primary condition the conscious, free, clearly affirmed and verified will of the subject, and do not tolerate that, for personal gain, a third party may affect or exert pressure on the autonomy of the person (the case in point of instigation to commit suicide).

It is now appropriate to discuss whether the notion of assisted suicide, in its various modalities, can be included in the notion of euthanasia, since the two cases are in fact often linked together from an ethical or legal point of view.

For some orientations, distinguishing assisted suicide from euthanasia can be an inconsistent and specious operation, given the substantial equivalence

---

<sup>1</sup> This is a hypothesis presented in the audition of May 24, 2019 at the Italian Committee for Bioethics (ICB) by Dr. Filippo Anelli, National President of the National Federation of MDs and Dentists Colleges (FNOMCeO). During his speech, Dr. Anelli presented this residual possibility; the hearing was in fact based, first of all, on the value of care in the medical profession and the paradigm shift that would be involved with assisted suicide in this context. This position is confirmed by the concluding document on the work of the National Deontological Consultative Committee of the FNOMCeO, called on to express its opinion on assisted suicide regarding ordinance n. 207/2018 of the Constitutional Court, 14 March 2019.

between helping a person who wants to take his own life and actually does, and being the person who takes the other person's life. Suicide, which by definition is an individual act when the subject does everything by himself, ceases to be such in the case in which there is assistance, that is, when others provide for the preparation of the aids required to give death, and the person is left only with the final act. In this sense, structural elements of euthanasia can be found in the assisting of suicide: the willingness of the subject, the making of a fully free and conscious choice to receive the treatment necessary to die as a result of circumstances promptly determined by the subject on the spot or provided for in advance; a third party's commitment to meet this request; the public interest to verify that appropriate precautions are respected; the obligation of health facilities to assist the patient and offer concrete opportunities to access palliative care and sedation.

For other orientations, instead, from the philosophical and symbolic point of view there is a significant difference on the level of the principles with which these two actions can be justified. In the case of assisting suicide, it is to be noted that suicide remains a personal act, while euthanasia provides for the intervention of a third party to give death. A distinction that highlights the idea that allowing a person to take his own life is not the same as bringing about someone's death as a result of his request. It is emphasized that killing a person upon his request contrasts with the widespread opinion that the death of a human being should not be intentionally provoked by others. Euthanasia involves people who express a desire to end life, but who prefer or need it to be done by a third party.

### **3. Ethical-juridical framework on the end of life in our legal system**

#### **3.1 Law code and jurisprudential reading**

Apart from the moral debates underlying the various positions, in the Italian legal system a specific discipline of the two practices examined above (euthanasia and assisted suicide) is absent as they are treated as aspects of the general legal forms applicable to crimes against life. One effect of this situation is that such practices give rise to very high criminal penalties, a punishment so harsh as to appear, according to some, to be censurable in terms of reasonable proportionality. This aspect clearly emerges when one considers that cases of euthanasia similar to those described are classified as cases of consensual homicide (Article 579 of the Italian penal code, from six to fifteen years imprisonment) or as voluntary common homicide (Article 575 of the Italian penal code, not less than twenty-one years imprisonment). It seems obvious that a similar framing of the tragic events related to *mercy killing* is incongruous.

Also assisted suicide is considered a criminal offense, regulated jointly with incitement to suicide ex art. 580 of the Italian penal code, a crime which is constituted each time the victim maintains control of his actions, despite the presence of decisive conduct by a third party or aid to carry out his intent, accomplishes it, even of his own hand.

The dividing line between the two different criminal provisions ex art. 579 and pursuant to art. 580 of the Italian penal code consists, therefore, in the fact that the final act causative of death is performed by a third party or instead by the patient, and this is of crucial importance as it determines in terms of criminal liability a reduction of the sentence.

It should also be emphasized that the law, which protects life as a good and other fundamental principle (freedom, dignity, equality, etc.), in the course of time has already found in our legal system a balance between values. The same Constitutional Court (for example in sentence n. 27/1975) has admitted a weighting in the matter of voluntary interruption of pregnancy, even in reference to whoever "has yet to become a person", and we can quote the Court of Cassation in the Englaro affair that established that "it must be excluded that the right to therapeutic self-determination of the patient encounters a limit when it leads to the sacrifice of life as a good" (Cassation Section I civ., No. 21748/2007).

This line is also consistent with the current legislation on informed consent and advance treatment directives (Law 219/2017), where, on the basis of the constitutional jurisprudence intervening pursuant to articles 2, 13 and 32 of the Constitution, the legislator has considered legitimate the refusal and renunciation of healthcare by the fully informed patient, expressed also through advance treatment directives, and shared planning, to *any* health treatment, including life-saving treatment.

It is to be noted that the Constitutional Court in the ordinance in question makes a juxtaposition between the refusal to receive medical treatment pursuant to Law 219/2017 and medically assisted suicide, in order to justify the legitimacy of the latter in some cases. In addition, in recommending in its ordinance a series of limits, cautions and conditions for medical assistance with suicide (incurability of the disease, severe suffering, the multiple profiles in which a person can seek help, administration of such treatments exclusively reserved to the NHS, the possibility for the doctor to appeal to conscientious objection, etc.) it hypothesizes that the legislator may regulate the legitimacy of assisted suicide, not through an autonomous discipline or "a mere modification of the penal provision referred to in art 580 of the criminal code", but rather "by inserting the same regulation in the context of Law 219/2017 and its spirit".

This legislative hypothesis is not shared by the ICB, given that there remains a clear *de facto* difference, with effects on an ethical and juridical level, between the patient who is free to refuse or accept a therapeutic treatment and the patient who asks to be helped to die (assisted suicide). It is one thing to suspend or refuse therapeutic treatments to let the disease take its course; but it is another matter to ask a third party, for example a doctor, for intervention in order to help with suicide. It is a question of facing two juridically different situations: one admissible under the art. 32, paragraph 2 of the Constitutional Charter and of Law 219/2017; the other, prohibited on the basis of the principle "not to kill", which is the foundation of life in society whose possible exceptions cannot be invoked by analogy, but with regard to their possible lawfulness, being if anything, the subject of a specific decision by the Constitutional court or the legislator.

### **3.2 Continuous deep palliative sedation**

With regard to so-called "continuous deep palliative sedation", to use an expression proposed by the Italian Committee for Bioethics in the 2016 Opinion, it affirms the thesis, argued within the same Opinion and in line with what is asserted by the scientific societies of palliative care that continuous deep palliative sedation is not equivalent to euthanasia, because one is an act aimed at relieving suffering, the other an act aimed at bringing on death. A similar difference then finds its justification also in other elements: for example, in the different drugs that are administered in the two different procedures, sedative

procedure or euthanasia procedure, and also in the different outcome of the act, since in the sedation procedure the patient moves, without consciousness, towards a natural death while in euthanasia death is caused immediately. In this regard it has been specified that the Code of medical deontology 2014, "in compliance with the patient's self-determination on the one hand and in compliance with the doctor's conscience clause on the other, underlines how the implementation of the patient's will in refusing cures, places the use of medically induced deep sedation, as an activity allowed to the doctor in coherence and in the respect of deontological precepts. All this in respect of the dignity of the dying"<sup>2</sup>.

### **3.3 Suicide**

From a legal point of view, today suicide is not prohibited. However, it does not constitute the exercise of a constitutionally guaranteed right, but it is understood simply as a possibility or a mere exercise of a de facto freedom.

Normally suicide prevention is an important and shared purpose, in harmony with the personalistic conception of our Constitution which appropriately emphasizes a solidarity perspective. The majority of studies, which have dealt with suicide from different perspectives (sociological, psychological, psychiatric, etc.), have also been conducted in order to gather information useful for preventing suicidal behaviour.

Moreover, it appears evident that, in the hypotheses of assisted suicide outlined by the Constitutional Court, we are faced with a request for assistance to die put forward in existential conditions very different from those that characterize the many different types of suicide, induced by the "suffering of the soul". In this opinion the Italian Committee for Bioethics uses the term *suicide* in full awareness of the difficulty of bringing the situations indicated by the Constitutional Court into the traditional category of suicide. In any case, faced with the request to be helped to die, the approach that inspires the ethics of accompaniment in dying is that of listening, of interpretation of the request: to each subject who, in conditions of particular physical and psychological vulnerability, manifests the will to die, the doctor must employ specific listening skills in order to fully understand the meaning of the patient's request.

## **4. Issues under discussion in assisted suicide**

### **4.1 The value to be attributed to the expressed will of individuals**

The indispensable requirement for the request for assisted suicide to be legitimate is its being an informed, conscious and free decision.

In the legislations that allow assisted suicide, it is always necessary for the person to determine in an explicit free and informed manner the will to end his life through the collaboration of others, who prepare the material means through which the subject brings about his own death, and that it is not a presumed decision or a passive acquiescence or a mere acceptance of the suggestions of others. A conscious, free and informed request that in these circumstances some consider appropriate for it to be addressed to a doctor whom the person trusts.

---

<sup>2</sup> Letter from the President of the FNOMCeO, Dr. Filippo Anelli, to the President of the ICB, Prof. Lorenzo d'Avack, dated March 14, 2019.

The communication between doctor and patient must take place as appropriately as possible and it is up to the doctor, in the first instance, to ascertain that the request meets the safeguarding conditions provided for by law. From the documentation, generally given in the medical records, it must be demonstrated that the patient has been clearly informed about the nature of his illness, on the possible developments of multidisciplinary care and also of products being tested and targeted on those pathologies affecting the patient and on the actual possibility of participating in a pathway of effective and continuous palliative care. For these reasons the decision to provide physician-assisted suicide, while respecting pre-established conditions and criteria, cannot become an automatism, but must always be taken keeping in mind the actual person making this request and the specific situation.

For some currents of thought the self-determination of the individual is a necessary and sufficient condition to legitimize every medical act: in this sense informed consent becomes an expression of autonomy of the capable subject who claims control over his own life and death.

The notions of "informed consent", "legal capacity" and "*compos mentis*" are, however, sometimes criticized by others because of their static and formalistic nature, with a strong reference to patrimonial disposition acts. These privilege, therefore, a notion of "ability to express one's will or identity", which would be more dynamic and adherent to the personal nature of the decision to be taken in the context in question. And in this sense, it may be noted how the same Constitutional Court, in its ordinance no. 207/2018, does not deal with "being *compos mentis*", but sets one of the conditions for assisting suicide in more substantial concepts such as the "capacity for self-determination" or the ability "to make free and informed decisions".

For other currents of thought, however, the request for assisted suicide under certain circumstances is the expression of a space of personal freedom, to be respected also because it is based on ethical and constitutional principles.

Recognizing the decision-making capacity of those in a state of serious suffering does not mean denying the influence of emotions in choices. It is in the character of humans to be guided in their actions by emotional solicitations that interact with rationality. But this does not invalidate self-determination, nor can it, in itself, justify limiting the freedom of persons that are suffering, or there is the risk of adding new suffering.

For other currents of thought informed consent is not at all sufficient to legitimize an act that involves the disposing of one's own life. A possible disposing of one's own life can be justified only by adhering to higher values, as for example occurs in sacrificing oneself to save the lives of others. Therefore, there is a fundamentally different way of understanding the relationship between freedom and life.

Lastly, those who consider assisted suicide to be illicit believe instead that the existential conditions of serious illness and unbearable suffering make these subjects particularly vulnerable. In these cases it is difficult to presuppose clear judgment and the free will of the patient, that is, the will of a true *esprit fort*. The reality is also that such a hypothesis moves in a chiaroscuro atmosphere, dominated by anguish and uncertainty and is anything but unambiguously enlightened. The attitude of those seriously ill and near to death can be ambivalent and inconstant. They are generally frail people, anguished by the fear of suffering and lack of autonomy, sometimes afflicted by economic and family problems, uncertain of their future, needing to be lightened by the weight of

burdensome decisions, often in a state of confusion or depression. These are the prevailing conditions of those who find themselves at the end of life, and they must be taken seriously on a bioethical level to avoid the risk that, in the name of the claimed and supposed autonomous and informed will of the patient, this will open a space for abandoning those subjects considered to be 'marginal', because they are unproductive, dependent and costly, in need of solid support.

#### **4.2 Respect for the professional values of the doctor and health care workers**

A major problem with medically assisted suicide or euthanasia concerns the professional values of the doctor and the health personnel involved in this practice. In this regard there are various positions, but basically they can be traced back to two different perspectives that turn out to be in contrast with each other.

One is historically the most widespread, and states that the professional task of the doctor and health care personnel is directed at healing and care, and does not contemplate acts that directly cause death. An eventual involvement in practices aimed at bringing about death (assisted suicide or euthanasia) would involve a profound change (or even a distortion) of the figure of the doctor and his role in health care facilities as well as in the health care facilities themselves. In fact, instead of being directed to *end-of-life care*, that is to say, accompaniment in dying through palliative care and pain therapy, they would be directed at *aid in dying* by collaborating in (or performing) acts that directly cause death. Excluding assistance to suicide allows doctors to preserve the ethical-deontological significance of their profession and allows patients to maintain a stronger and more solid confidence in their doctor. It is also noted that medicine is not merely a technical and neutral activity, but is a practice based on ethics and deontology that places the protection of life, curing and caring for the patient at its core.

These are the principles expressed by the World Medical Association which, in its most recent document on assisted suicide (2017), reiterated what had already been stated in previous years (1992, 2002, 2005, 2013 and 2015): “The World Medical Association reaffirms its strong belief that euthanasia is in conflict with basic ethical principles of medical practice, and The World Medical Association strongly encourages all National Medical Associations and physicians to refrain from participating in euthanasia, even if national law allows it or decriminalizes it under certain conditions”<sup>3</sup>. The same argument may be applicable to assisted suicide.

This perspective is reaffirmed by the Code of medical ethics (2014), which in art. 3 points out that “the doctor's duties are the protection of life, psycho-physical health, the treatment of pain and the relief of suffering, in respect of the freedom and dignity of the person, without any discrimination, whatever the institutional

---

<sup>3</sup> See *WMA Statement on Physician Assisted Suicide* (Adopted by the 44th World Medical Assembly, Marbella, Spain, September 1992 and editorially revised by the 170th Council Session, Divonne-les-Bains, France, May 2005, reaffirmed by the 200th WMA Council Session, Oslo, Norway, April 2015 and reiterated on October 2017)”. The full text of the document is: “Physician-assisted suicide, like euthanasia is unethical and must be condemned by the medical profession. Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life, the physician acts unethically. However the right to decline medical treatment is a basic right of the patient and the physician does not act unethically even if respecting such a wish results in the death of the patient”.

conditions or in which it operates". And art. 17 states that "the doctor, even at the request of the patient, must not perform or favour acts aimed at causing death". The position is also confirmed by the final document of the works of the National Deontological Council of the National Federation of MDs and Dentists Colleges (FNOMCeO) March 2019, whose accompanying report, also, acknowledges that professional values must be "experienced in an age of overwhelming evolution in science and medical technology and they influence the process of dying, modifying it; at the same time, society transforms the social and individual perception of death"<sup>4</sup>.

Even the National Federation of Italian Pharmacists in its Deontological Code (2018), art. 8 (*Dispensing and supply of medicines*) provides that: "the dispensing of medicine is a sanitary act, to protect the health and psychophysical integrity of the patient". Furthermore, in the oath (text approved by the National Council on December 15th 2005) the pharmacist pledges "to defend the value of life by protection of the physical and mental health of persons for the relief of suffering as the sole purpose of the profession, inspiring all my professional actions with responsibility and constant scientific, cultural and social commitment, affirming the ethical principle of human solidarity".

The new Code for Italian Nurses (April 2019) art. 24 underlines that the nurse "provides nursing care until the end of the life of the patient. It recognizes the importance of providing assistance, shared care planning, palliative care, environmental, physical, psychological, relational and spiritual comfort".

The other position is historically more recent and less widespread, and states that aid in dying can be included among the professional duties of the doctor and health personnel. This is because today not only have the conditions of dying profoundly changed compared to the past, but also because people want to assert self-determination over their own life and death. In some cases, the process of dying is prolonged by medical interventions that involve suffering and anguish in people, so that not only are palliative care and advance care planning programs required, but there is also an explicit request for help to die to overcome an inevitable situation of suffering. In these cases, the willingness of the doctor to comply with the request to die stems from *primum non nocere*, or rather from the duty imposing not to cause harm and to relieve pain.

In other cases, moreover, rather than avoiding suffering, the request to be helped to die arises from the autonomous choice of a person who wants to avoid the loss of dignity that the evolution of the disease can entail.

Even in this perspective it is observed that medicine is not a mere technical and neutral activity, but it is a practice informed by an ethic that prioritizes both respect of the autonomy of the person concerned, and the fight against suffering, as well as the protection of a life that for the person concerned has lost its dignity. The deontological codes of Holland, Belgium and Canada have adopted this perspective which is proposed as an alternative.

It should also be kept in mind that, in the event of legislation legitimizing providing physician-assisted suicide, in some cases there may be a concordance between the will of the patient who asks to end his life, and the will of the doctor or health care worker who supports the patient's request. But in other cases there may be discordance, because the doctor or the health care worker may not want to provide assistance with suicide, appealing to multiple reasons of conscience:

---

<sup>4</sup> FNOMCeO, Concluding Document of the National Deontological Consultative Committee, March 2019, p. 3.



the protection of life, the identity of the medical profession, the duty of care, social risks, etc.

The Committee has examined this position and believes that, in the event of legislation legitimizing physician-assisted suicide, it should specify the possibility of conscientious objection for the doctor, should this act be considered profoundly contrary to personal convictions. This means that the implementation of physician-assisted suicide can take place only in cases of a concordance between the will of the patient asking to be helped to end his life and the willingness of the doctor to comply with the patient's request.

Moreover, even the legislation which, in various countries, has legalized physician-assisted suicide or euthanasia, generally provides for the possibility of conscientious objection of the health personnel involved. As the ICB stated in its 2012 opinion<sup>5</sup> "conscientious objection in bioethics is constitutionally founded (with reference to inviolable human rights) and must be exercised in a sustainable manner"; therefore "the protection of conscientious objection, due to its sustainability in the legal system, should not restrict or make more difficult the exercise of rights conferred by law nor weaken the bonds of solidarity deriving from common membership to the social body". In the same opinion the ICB reiterates that "when conscientious objection is permitted there must be organization of a service that nevertheless allows the exercise of legally recognized rights despite the non-participation of the objector" (p.17).

### **4.3 The slippery slope argument**

Applied to the case of physician-assisted suicide, the metaphor of the "slippery slope" draws attention to the danger or risk that possible legislation, permitting physician-assisted suicide in particular and clearly delimited circumstances, may, go beyond the initial intention, and inevitably then considerably loosen its grip extending to include in practice cases which, in the initial situation, were not foreseen at all.

According to some, the approval of physician-assisted suicide in certain tragic and sporadic cases, would see it also slipping into anticipation of death modalities and situations involving dementia and disability for which the capacity for explicit consent is more uncertain. It would then become difficult to distinguish between physical and psychological suffering, resulting in extending the initially restricted conditions from incurable pathologies and unbearable suffering, even to persons with psychological problems such as depression or "existential suffering". In a society characterized by a constant and progressive aging of the population and the need to contain the costs of health care, the legalization of physician-assisted suicide, which initially could be envisaged today for a few pitiful and exceptional cases, could push society to catch sight of the economic benefits in return for abandoning the care that would be necessary and indispensable to guarantee a dignified existence to those directly involved. The underlying concern is that the legitimization of assisted suicide in certain existential conditions can lead to the start of a "slippery slope" of considering such conditions unworthy of life in general, to the point of determining almost a sort of "duty to die" as quickly as possible, as an implicit request, a situation that would weigh more heavily on the less well-off and/or those without any family ties.

---

<sup>5</sup> Italian Committee for Bioethics, *Conscientious Objection and Bioethics*, 12 July 2012

Even some of those who morally approve assisted suicide in very limited cases support the slippery slope argument, believing that this may especially concern the juridical sphere insofar as it is not possible to regulate the exception, nor is it possible to set a clear dividing line between physical suffering and mental suffering, being tired of life and the rejection of life. According to this approach justifying a single act is something quite different from justifying a practice or a policy. In other words, one can imagine that a single act, for example of assisted suicide, addressed to that patient, in that particular extreme condition, could be *morally* justified and could even not be subject to criminal prosecution; however, the *legalization in juridical terms* of a practice involving acts of this kind would assign a very different meaning. According to this analysis, the professional practice and the legalization of acts allowing doctors to assist or "bring about death", even under very specific conditions, presumably leave open to serious abuse, with the risk that these acts may increase more and more over time.

Others, however, observe that the slippery slope argument can be of value if taken as an invitation to caution in identifying stringent conditions for the admissibility of assisted suicide, but oppose its forced rhetoric according to which there would be no break with regard to other morally unacceptable forms of anticipation of death, but rather a necessary continuity from physician-assisted suicide based on the conscious request of the patient (necessary albeit insufficient condition): a continuity that tends to eliminate the differences that distinguish morally admissible situations from those considered inadmissible.

Experience shows that there are forms of control that prevent slipping. For example, specific commissions have been created, which carry out periodic reviews, monitoring the new practices in order to ensure compliance with the clauses envisaged and report any problems or abuses. Experience shows that these measures are able to prevent sliding down the slippery slope.

On the other hand, any future modification of the grip initially envisaged by the law (loosening or tightening) should be understood as a possible and reasonable response to new social and cultural needs and changes in common feeling. If there were to be a loosening of the law, it should not be interpreted a priori as undue yielding to the logic of the slippery slope. This can happen when the experience gained in the meantime justifies this solution, revealing aspects and problems that were not previously perceived.

In this sense, they argue that even in the case of physician-assisted suicide it is possible to have a legislative measure capable of reconciling the different needs in the field. Such a provision should, therefore, on the one hand hold firm the symbolic value and the deterrent force of the prohibition to kill and, moreover, enhance social responsibility together with the constitutional duty to provide adequate care towards all the sick; on the other hand, it should determine the morally qualifying elements in order to consider as legal an act (medicide) which, at least in certain cases and under certain conditions, a part of society is willing to deem licit and therefore worthy of being brought to the attention of the legislator.

#### **4.4. The importance of palliative care and pain therapy**

The last topic considered here regarding medical assistance with suicide concerns the use of palliative care: this is a theme often reiterated in national and international documents and always present in discussions regarding the end of

life and the respective rights and obligations of the patient and the doctor, in the context of the care relationship.

A first aspect to remember is that the goal of palliative care is neither to hinder nor to hasten death, but to take charge of the patient's physical and mental pain. The philosophy that inspires and permeates palliative care is to accompany the patient "in" the transition to death, refraining from providing help "to" die.

When physical and psychic symptoms are refractory, in incurable conditions and terminal illness or imminence of the patient's death, continuous deep palliative sedation becomes a possible option in the sphere of palliative care. As clarified in the ICB Opinion on deep palliative sedation<sup>6</sup> it is not comparable to euthanasia and must be administered on the basis of well-defined criteria of medical appropriateness and cannot be considered a pathway which, due to its characteristics, should always be associated with the withdrawing of life-sustaining treatments, regardless of the person's condition at the end of their life.

In this sector of palliative care, the Italian law 38/2010, *Provisions to ensure access to palliative care and pain therapy*, is considered at the forefront of Western medicine. A text that is acting as a driving force in Italy, in considering palliative care and pain therapy within the entire patient care pathway, and not only limited to the end of the patient's life.

Unfortunately, the development and consolidation of the culture of palliative care in our country still encounter many obstacles and difficulties, especially with the absence of territorial homogeneity in the variety of services provided by the NHS, and in the lack of specific training in the field of health professions. This is not the place to adequately address this issue, for which we refer first of all to the Italian Parliament's annual reports on the application of Law 38/2010 and to the dedicated portal by the Ministry of Health<sup>7</sup> as well as to the fact-finding investigation into the implementation of the law of the Social Affairs Committee of the Chamber<sup>8</sup>.

However the ICB unanimously hopes that the NHS will always be able to truly offer palliative care and pain therapy in the terms established by Law 38/2010, to every person who needs it<sup>9</sup>, without inequalities in terms of scale and quality of services, throughout the national territory. This should be a top priority for health policies.

In the context of the debate, some standpoints highlighted the need to set as a pre-condition, a mandatory proposal, to be made to those who intend to seek physician-assisted suicide, for the network of palliative care facilities to take charge of them. It is therefore believed that specific palliative care pathways should be offered, indicating concretely the available health facilities and access

---

<sup>6</sup> Italian Committee for Bioethics, *Deep and continuous palliative sedation in the imminence of death*, 29 January 2016

<sup>7</sup>[http://www.salute.gov.it/portale/temi/p2\\_6.jsp?id=3766&area=curePalliativeTerapiaDolore&menu=cure](http://www.salute.gov.it/portale/temi/p2_6.jsp?id=3766&area=curePalliativeTerapiaDolore&menu=cure). Essential for the verification of the state of implementation of the legislation on palliative care should be the monitoring mechanisms and the periodic report to Parliament provided for by Law n. 38/2010 (Article 8) and Law 219/2017 (Article 11).

<sup>8</sup> See *Investigation on the implementation of the law of 15 March 2010, n. 38, concerning access to palliative care and pain therapy, with particular reference to the pediatric field*, adopted by the Social Affairs Commission of the Chamber on 10 April 2019.

<sup>9</sup> In this regard, we recall what was stated by art. 2, c. 1 of Law 219/2017: "The doctor, using appropriate means for the patient's condition, must work to alleviate his suffering, even in the event of refusal or revocation of consent to medical treatment indicated by the doctor. To this end, appropriate pain therapy is always guaranteed, with the involvement of the general practitioner and the provision of palliative care referred to in the law of 15 March 2010, n. 38".

methods: pathways which each patient may accept or refuse, wholly or in part. In this way it is also believed to be possible to prevent physician-assisted death being chosen as the consequence of abandonment or in any case inadequate health care, especially with regard to the relief of suffering.

It is therefore believed following this train of thought that the request for suicide or "to" die, may be reformulated together with the patient, through the pathway of palliative care, as a request for help not to suffer, to be accompanied "in" the process of dying, so that the answer must not be the provision of the pharmacological or technological means to implement the intent to kill oneself. In this sense, palliative care is an *alternative* to the request for physician-assisted suicide and an effective response to suffering persons who do not really want to kill themselves, but only want a way out of the situation of intolerable pain.

According to other points of view it is believed that palliative care is a valid practice responding to many situations of suffering and that its spread is certainly appropriate and desirable; however, according to their thinking, it is illusory to believe that palliative care is able to respond effectively to all the situations facing the patient at the end of his life. In some cases the suffering is uncontrollable and continuous deep sedation itself proves to be not practicable for some patients who consider it contrary to their dignity, preferring a more rapid pathway when dying. In this sense palliative care is not an alternative, but preliminary and synergistic to physician-assisted suicide. The values patients attribute to the practice of palliative care are different from those they want to affirm by requesting help to die. These values consist in the enhancement of one's own autonomy, in the personal attitude that each individual has when faced with the end of life, in the re-appropriation of one's own death, in the certainty of preserving one's dignity in death. The patient claims the freedom to decide on the manner and circumstances of the path to be taken towards the end of his life.

## **5. Ethical and legal opinions within the ICB**

The issues examined above show the complex nature of the ethical, bioethical and bio-juridical problems raised by physician-assisted suicide. As we have seen, different perspectives exist in this regard, and different opinions are also found within this Committee, which in some way reflect the different trains of thought in the public debate set out above. There are many positions, with subtleties, nuances and shades of differences among them: in this document they have been grouped into three perspectives in order to make the cultural picture more explicit.

**A)** Some members of the ICB oppose physician-assisted suicide both ethically and legally, and converge in believing that the defense of human life must be affirmed as an essential principle in bioethics, whatever the philosophical and/or religious foundation of this value. On this basis it is believed that any legitimization of physician-assisted suicide:

a) activates an irreparable *vulnus* to the principle according to which the primary and mandatory duty of the doctor (and, more generally, of each operator and every legally recognized and guaranteed health system) is absolute respect for the life of patients, even in cases in which they themselves may make explicit requests for assisted suicide or more generally requests for euthanasia; in this context the moral principle of the non-availability of human life is recalled as each

person has an intrinsic dignity even in conditions of serious disability or impairment of health;

b) cannot be justified starting from the possibility of rigorously ascertaining, beyond any reasonable doubt, the patient's alleged suicidal desire, as being the fully informed, conscious will of the patient, free from psychological, family, social, economic, or religious conditioning;

c) inevitably provokes or favours the progressive exceeding of any intended stated limits, as appears absolutely evident in those ordinances, which, having legalized physician-assisted suicide, have in fact extended it unduly to minors, the psychologically and/or psychiatrically frail, to the elderly who are not self-sufficient, so providing clear evidence of the difficulty - once the principle of the most rigid respect for life has been weakened - in putting the brakes on the slippery slope in favour of the practice of euthanasia or practices in any case similar to euthanasia that are increasingly widespread.

However humanly understandable the extreme and dramatic conditions of some concrete cases and certain clinical conditions that lead patients to ask the doctor for help to die, the paths already outlined by the legislator and by consolidated bioethical reflection are deemed to be sufficient: the non-justification of the unreasonable obstinacy of care (considering it a duty that the doctor wisely balances the objective therapeutic proportionality and the subjective requests of the patient with reference to the perception of suffering) and the justification of "letting die", with palliative accompaniment in dying (even with continuous deep palliative sedation), in conditions of awareness of rejection and renunciation of care and in the context of a patient-doctor relationship centred on mutual trust.

The patient's conscious choice regarding the non-initiation or suspension of treatments, i.e. the possibility of refusing or renouncing treatment, must always be guaranteed, since it is attributable to personal conscience which is not and cannot be compressible; similarly the doctor must be free in science and conscience to accept or not any requests. The conscious request of refusal or renunciation of treatment can therefore be respected by implementing full freedom of care, allowing patients to always choose their own doctor, for free and mutual decision making in care pathways.

The sliding from "letting die" (which recognizes the limit of medical intervention on the patient's body, providing that there is full awareness of the consequences) to "facilitating death" (which legitimizes the patient's request to the doctor to help him commit suicide) in addition to marking an unacceptable transformation of the paradigm of "curing and caring", on which the medical profession has always been based, does not adequately take into account the particular vulnerability of the sick person living conditions of life which, due to technologies but also without technologies, are considered subjectively, and perhaps even socially, not worth living. Faced with such requests, which must be heard and understood, the response must not be the proposal or making available of the pharmacological or technological means to implement the intent to kill oneself; it should rather be the offer of help to face the suffering and pain, in the logic of solidarity and also psychological support. In this sense, what needs to be implemented is effective and equitable access to palliative care and pain therapies, as well as the appropriate training of doctors, health professionals and psychologists to communicate with patients in extreme conditions. Palliative care, pain therapies and medical-psychological assistance at the end of life (hopefully in addition to human solidarity and closeness) are able to effectively prevent suicidal requests and guarantee the fundamental and priority right of every patient

to be treated and taken into care, even in the context of very serious pathological situations or at the end of life.

(Amato, D'Agostino, Dallapiccola, Di Segni, Garavaglia, Gensabella, Morresi, Romano, Palazzani, Scaraffia, Sargiacomo)

**B)** Other members of the ICB are in favour of the legalization of physician-assisted suicide, both on the ethical and bioethical level as well as on the juridical level, in the presence of the ascertainable conditions indicated below. They believe that listening to and receiving the request for physician-assisted suicide, under the foreseen conditions, should be clearly distinguished from instigation to suicide, and should be accepted by virtue of the ethical principles of self-determination and the duty of beneficence of the doctor: ethical principles which are also in harmony with the personalistic principle and the principles of freedom, non-discrimination, free and conscious self-determination, typical of our legal system, and which, as also mentioned by the Constitutional Court in ordinance n. 207/2018, must be balanced against the protection of human life and other constitutionally relevant good.

It is believed that the balance of values conducive to aiding physician-assisted suicide is ethically and legally legitimate because the person has the right to preserve his dignity also and above all in the final stages of life. In certain circumstances, existence is impoverished to the point of not having anything to offer other than suffering or conditions in which the progressive loss of one's dignity is perceived. In these conditions a fully conscious request to be helped to die must be respected, without having to resort to continuous deep sedation and possibly face the withdrawal of life-sustaining treatments.

Such a balance of values and principles must take particular account of the fact that the following conditions must be present and simultaneously satisfied in order to legitimize the decision to provide physician-assisted suicide:

1. the presence of a serious and irreversible disease ascertained by at least two independent doctors (one of them from the NHS);
2. the presence of a prolonged state of physical or mental suffering of an intractable or unbearable nature for the patient;
3. the presence of an explicit request stated in a clear and repeated form, within a reasonable time frame.

It is the simultaneous satisfaction of these conditions that serve as a guarantee for the protection of the sick person and for the doctor willing to grant the request for assistance to die.

In this perspective, the presence of life-sustaining treatment is considered only a possible additional condition; to consider it a requisite would, in fact, create unreasonable and unconstitutional discrimination (pursuant to art. 3 of the Constitution) between those who are kept alive artificially and those who, although suffering from an extremely serious pathology and in great suffering, are not or as yet are not. Furthermore, it would compel the latter to accept a treatment that is also very invasive, such as artificial nutrition and hydration or mechanical ventilation, for the sole purpose of being able to request assisted suicide, thus envisaging a compulsory treatment without a satisfactory reason.

As in certain circumstances personal dignity can be guaranteed by the refusal of life-saving therapies and/or by the request to access continuous deep palliative sedation, so in other circumstances this dignity can instead be guaranteed by obtaining assisted suicide. Moreover, if it is possible to ascertain with certainty the will of the interested party requesting the suspension of life-saving therapies

allowing death to result, it is hard to see why it is not possible to do the same for the request of a person asking to be helped in another way to achieve the same result. This is all the more true if one considers that the request for assisted suicide comes at the end of a pathway of care and relationship with the doctor and with other figures of the health care team which enables knowledge of the patient and establishment of a relationship of trust, a therapeutic alliance in which the various alternatives are presented and which ensures that the will of the person concerned is authentic and not the result of external pressures playing on the state of vulnerability. Knowing that there is the possibility to preserve personal dignity until the end of one's life is a central aspect of one's overall well-being and provides that sense of security that can reassure our existence even if no assistance to die is actually requested.

Supporters of this position also advocate that palliative care should become effectively accessible to all those who request it within an integrated system of care. They underline that the deficiencies in palliative care are the sign of a serious and guilty inattention of our society towards those who are suffering and hope that we will proceed decisively in the spread of such care and in the training of adequate personnel. They believe, however, that the actual availability of palliative care does not exclude the possibility of the patient to still make a request for physician-assisted suicide. Such a request must be taken into consideration regardless because suffering must be alleviated anyway, and those who are already suffering cannot be penalized while waiting for greater social sensitivity towards this state.

In the hope that the legislator will legalize physician-assisted suicide, in certain particular cases, even though these Committee members, recommend that the person concerned should be sure of it being carried out within National Health Service facilities or in any case that its costs will be borne by the NHS, nevertheless it is believed that conscientious objection, with reference to the activities specifically and necessarily directed to assisting suicide, should be recognized by law to the doctor and other health care workers.

(Battaglia, Caltagirone, Caporale, Casonato, d'Avack, De Curtis, Donzelli, Garattini, Mori, Pitch, Savarino, Toraldo di Francia, Zuffa)

**C)** Other members believe that, on the bioethical and bio-juridical level, in the tragic situations taken into consideration in this document - patients suffering from an irreversible pathology, with physical and psychological suffering that are not treatable or considered absolutely intolerable, capable of making free and conscious decisions but not able to put an end to their own existence- the use of the term (physician-assisted) suicide is actually improper. Suicide is a lethal attack on one's own life and in these dramatic concrete events one does not really want to "kill oneself", but to free from a body that has become a prison.

Starting from the understanding of the drama of these extreme situations, this position distinguishes itself on the bio-juridical level, from those who still consider it advisable to always prohibit the conduct of the doctor that helps the patient to die (Da Re) and those who believe, instead, that it is possible to identify very limited areas in which to provide an exemption from liability for providing the patient with medical assistance in dying, in cases that are, in fact, exceptional and clearly defined (Canestrari).

This position, moreover, agrees on the importance of underlining the risks that would be involved in a decision, by our legislator, to decriminalize or legalize so-called physician-assisted suicide along the lines of those carried out by some

European countries (Switzerland, Holland, Belgium, Luxembourg). Proponents of this position in fact believe that the real dangers of a slippery slope would be significantly accentuated in the reality of the Italian health care system.

The freedom of self-determination, which must be the indispensable prerequisite in speaking of a conscious request for assistance in dying, is present only in a concrete context in which patients enjoy effective and adequate health care, where they can access all practicable palliative care treatments - including deep palliative sedation - and in which they are supported by appropriate medical, psychological and psychiatric therapy. Access to care, adequate facilities and appropriate resources must be guaranteed regardless of the legislative decision on the matter: the request for assistance in dying must never be an obligatory choice as would be the case if the state of suffering, objectively changeable and reducible, were to be rendered insuperable by a lack of adequate support and assistance.

In this regard, then, great concern is expressed, here in this particular place, regarding the contents of the "Report on the implementation of law No. 38 of March 15, 2010 *Provisions to guarantee access to palliative care and pain therapy*, which the Ministry of Health sent to Parliament in January 2019.<sup>10</sup> As is clearly stated in the document, the quality and provision of palliative care in residential and home care settings is highly inhomogeneous throughout the country, certainly not due to the inadequacy of health professionals but due to known serious structural deficiencies. This transmutes into the fact that in some Italian regions today a fundamental human right is not guaranteed: that of patients receiving in the final stage of life effective support aimed at controlling suffering in respect of their dignity.

In full awareness that the greater diffusion and strengthening of pain therapy and palliative care cannot completely eliminate requests for medical assistance in dying, but could significantly reduce them, excluding those dictated by causes related to alleviable suffering. As a priority, therefore, we intend to strongly reaffirm the need to homogenise access to palliative care throughout the country.

It is appropriate to conclude the exposition of this position with some reflections on the relationship between Law 219/2017 (Provisions for informed consent and advance treatment directives) and the issue of physician-assisted suicide.

With the entry into force of the aforementioned legislation, the legislation of our country aligns with the choices of the principal legal systems of the Constitutional States of liberal origin. Law 219/2017 clearly states the inviolable right to live all the phases of one's existence without undergoing medical treatment against one's will - a logical derivation of the right to the inviolability of the bodily sphere of every human being - and contains provisions that we believe to be of fundamental importance. For the purposes of the discourse developed within this position, it is sufficient to recall the regulation of advance treatment directives, shared care planning, (with respect to the evolution of the consequences of a chronic and debilitating disease or characterized by relentless progress with poor prognosis), the provision that provides for the medical treatment of continuous deep palliative sedation, which makes it possible to die without pain even after renouncing the continuation of life-sustaining treatments.

Unfortunately, Law 219/2017 has not yet been fully implemented and is not yet sufficiently known in the healthcare reality in our country. Now, it is a profound

---

<sup>10</sup> [http://www.salute.gov.it/portale/documentazione/p6\\_2\\_2\\_1.jsp?lingua=italiano&id=2814](http://www.salute.gov.it/portale/documentazione/p6_2_2_1.jsp?lingua=italiano&id=2814).



conviction of those who support this position that the indispensable application, enhancement and dissemination of the contents and institutions provided for by this legislation can have a powerful preventive and dissuasive effect in general on patients' suicidal behaviour and, in particular, of very many, even if not all the requests for physician-assisted suicide (medical assistance in dying).

(Canestrari, Da Re)

## **6. Recommendations**

Although there are these divergent positions, the Committee reached, after detailed discussion, the formulation of some shared recommendations, which are summarized as follows.

The ICB:

**1.** hopes that wherever discussion on this issue may take place – including Parliament - debate on physician-assisted suicide will develop with due attention to the moral, deontological and juridical-constitutional problems that it raises and with the due in-depth study required regarding such a delicate and deeply-felt issue for the human conscience;

**2.** recommends keeping in mind that issues relating to the end of life refer to far greater problems that society must consider and evaluate: the commitment to provide adequate care for incurable patients who are suffering; the professional and ethical values of doctors and other health care professionals; solidarity towards particularly vulnerable people in respect of human dignity,

**3.** calls for adequate information to be given, as verified and documented in the medical records, to incurable patients who are suffering regarding available access to a high standard of treatment and care, including experimental treatments, envisaging the alleviation of suffering realistically attainable;

**4.** considers it essential that every effort be made to implement information for citizens and update healthcare professionals of the regulatory provisions (Law 38/2010 and Law 219/2017) which currently guarantee the rights of persons to certified palliative care, and that these be effectively increased and accessible to all those requesting them in order to avoid requests for assisted suicide being motivated by suffering that could be treated, in an effective manner, with the consent of the sick person;

**5.** hopes for the promotion of greater participation by citizens in the ethical and legal discussion in order to develop and disseminate a culture of awareness and responsibility regarding the end-of-life (in this direction the ICB has long organized conferences for schools and meetings with citizens which should be further supported and implemented);

**6.** hopes for the promotion of biomedical and psychosocial scientific research and the bioethical training of health care professionals in this field (doctors, nurses, pharmacists, psychologists, etc.) as well as in the field of health care administration and organization.

## **PERSONAL REMARKS**

### **A personal remark by Prof. Francesco D'Agostino**

The Opinion on assisted suicide, approved by the ICB on 18 July 2019, is recommendable in several respects: for its clear language without any vagueness or ambiguity; extreme precision and considerable rigor in argumentation; absolute correctness in the exposition of the different and controversial theses on the subject, even when blatantly in irreducible contrast with each other. This writer is convinced that the reading of this Opinion can only be of great help to all those who want to deepen their knowledge of such a relevant and perturbing bioethical topic. Nevertheless, the undersigned has chosen to vote against, a decision which I intend to justify rapidly. The Opinion of the ICB, by explicit admission of those who drafted it and all those who collaborated in drawing up the final version, is essentially expository in nature, which in some parts of the text reaches its highest point as the best didactic exposition on this topic, that is, the best doxography; a balanced and intellectually honest doxography (and for this reason alone worthy of admiration), but it remains a doxography, and as such is inevitably cold. In doxographic investigations human cases, in their dramatic singularity, are not given prominence, prominence is given to the doctrines produced by conceptual considerations. The undersigned, on the other hand, is convinced that bioethics in general (and in particular bioethics entrusted to the reflections of a National Committee) must free itself from any doxographic temptation, especially when it is called upon to tackle lacerating topics, and it is fitting that they are perceived as such by all, in relation to which any attempt, albeit generous, at conceptual and/or ideological mediation can only lead to diminishing the anthropological and above all the ethical value. This is exactly the case of voluntary and conscious suicide (that is, not induced by psychopathological causes) and of the complex constellation of concepts that can be traced back to this form of suicide which has been examined in the Opinion by the ICB with such laudable and icy doctrinal attention. This is not the place to recall the well-known thesis of Camus, who believed that there was only one truly serious philosophical problem, that of suicide: one need only stress the fact that its legalization, which for years has found a place in the legal system of many countries historically and culturally close to ours, has produced a historically new and anthropologically tragic social effect, that of an undeniable bureaucratization of death, to which we are called on to take a position, before diving (however, only if we wish) into the complex questions of its case-law that this bureaucratization necessarily activates and which the Opinion by the ICB, in its very detailed analyzes, presents to the reader. An extreme example of this bureaucratization is the sad story of the Dutch adolescent Noa Pothoven, who, suffering from extremely intense psychological pain (however, no one denied its "treatability"), let herself die, without the intervention – which would have been dutiful bioethically - of adequate medical, emotional, family countermeasures. The undersigned considers that the question of suicide and all the various possible and imaginable forms of aid that it can legally obtain (in forms, however, very different from each other, as readily emerges from an analysis, albeit rapid, of comparative law), before being approached according to descriptive modalities, it must be addressed in a drastically prescriptive logic, accepting (or not accepting) a priori the possibility that suicide may have any possibility of being justified, legitimizing ethically and legally (accurately dictating the modalities)

practices aiding those who decide to take their own life. The no, expressed by the undersigned to the Opinion on assisted suicide by the ICB, wants therefore firstly to have the value of an existential affirmation, rather than a bioethical argumentation, an indispensable affirmation in a historical-cultural moment, like the current one, in which providing assistance and aiding suicide are presented by many as a perturbing, but not a scandalous option, a problematic option but one worthy of attention, a controvertible option, but one also perfectly attributable to today's dominant value system. Notwithstanding, of course, human and dialogical respect for those who accept this option, it is nevertheless essential that those who do not accept it strongly emphasize how it deconstructs (almost always in the serene unconsciousness of its advocates) the fundamental paradigm of bioethics, which as a critical paradigm demands not mere and serene presentation of opposing theses and least of all well-meaning attempts at mediation between them (as seen in the Opinion of the Committee), rather it demands firm decisions oriented to the lived experience of people in favour of one thesis or the other. Deciding, in any form, against legalization of assisted suicide does not mean lazily eluding a dialectical confrontation with those who are in favour of it: it simply means focusing on a fundamental option, which cannot be removed, or worse still hidden, but which must be proclaimed forcefully, because it is indispensable to an understanding not only of the practices of biological, biomedical and bioethical importance, but also and above all of the ideologies (and even the fantasies) activating and sustaining them, giving them psychological and social consistency and which have found and increasingly tend to find their place in regulatory legal systems. The undersigned hopes that his vote against the Opinion drawn up by the ICB may be perceived by readers of this Personal remark for what it is: the taking of an ethical stance, even prior to taking a doctrinal one, to which, the same paradigmatic salvation of bioethics can be entrusted, according to the writer, saving it from the fate of being reduced to biojuridics to which it now seems to be inexorably condemned and the document of the ICB, from which I distance myself, is an eloquent testimony of this.

Francesco D'Agostino  
Former President of the Italian  
Committee for Bioethics

## **A personal remark by Prof. Assunta Morresi**

A document drawn up by a pluralist committee like ours, which collects bioethical reflections on complex issues, can never be written as each member would do if he/she were the sole author, nor can it accurately describe the personal orientations and judgments held by each of us, and this opinion on physician-assisted suicide is emblematic of these inevitable limitations.

I therefore endorsed the final text because it clearly expresses my personal opposition to any form of assisted suicide, although I did not agree with certain passages in the course of the argumentation. In particular with this note I want to reiterate a conviction that has not found space in the document, but which I consider important for the current discussion. Let me start by stating that, by using the expression "euthanasia" or "euthanasic act" I also mean those procedures typical of "assisted suicide", as described in the opinion, both because I think there are no substantial differences from the moral point of view, and for the sake of simplifying reading.

I refer to the assessments regarding Law 219/2017, on *Informed consent and advance treatment directives*: a law that I believe goes beyond the legitimate possibility for a person to refuse or renounce medical treatment (a possibility that I agree with, as synthetically outlined by position a) in the opinion, which I identify with), and which opens to the legalization of some forms of death upon request, that is some of the procedures of euthanasia.

Without this regulation, in fact, one of the main arguments of ordinance n. 207/2018 of the Constitutional Court in favour of the partial decriminalization of assisted suicide, when it asks why it is always possible to die by interrupting life-sustaining intervention – that is, through the omissive behaviour of the doctor - and at the same time it is prohibited to do so in a faster way, in certain situations - through the active behaviour of the doctor, who gives the patient a lethal chemical product.

In my opinion, this reasoning by the Court is a logical argument, and is not contestable as instead it would seem from the opinion: Law 219/2017, entirely constructed around the concept of self-determination, allows to stop life-sustaining intervention such as feeding and artificial hydration, defining them as health treatments, that is, equating them with therapies, allowing them to be suspended regardless of any medical condition, based solely on the patient's wishes. In this way, without nourishment and water, one is always sure to die: regardless of whether or not he/she is a terminally ill patient and with the only clinically required condition of having to be fed by simple medical devices.

It is a law whose "spirit" - to use an expression of the Court – is well suited to open to more direct forms of euthanasia.

The ICB document rejects this logical connection also by choosing, consistently, a definition of euthanasia which is limited to the administration of lethal drugs only, excluding a priori any omissive behaviour.

In other words: if I circumscribe euthanasia to situations in which a doctor provides a lethal product to a patient, to cause his death, the suspension of mere life-sustaining intervention such as providing liquids and nutrients, by definition, will never be euthanasia, regardless of the intentions of whoever requests it and whoever performs it. And for this reason conscientious objection was not introduced in Law 219/2017: if the suspension of life-sustaining intervention by definition is never euthanasia, but always a normal medical act, conscientious objection cannot be brought into play.

The logical passage has instead been serenely recognized by the Consultative body, and also, previously, by the ordinance of the Court of Assizes of Milan, proving that the interpretation of some aspects of Law 219/2017 within the perspective of euthanasia is anything but imaginative.

For the Consultative body to see in Law 219/2017 an evident opening to euthanasia seems to me to prove the impossibility of eliminating ethical ambiguities by relying on simple definitions. The legislator has excluded all implications of euthanasia thanks to a rigid watershed, that is terminological more than conceptual: in order to make the renunciation of treatment never euthanasia one need only define nutrition and hydration therapies. The Court however has bypassed the impassable lexical wall with ease, making it clear by doing so that, faced with the extreme delicacy of the balance between the protection of freedom and human life, clinging to terminology is hopelessly insufficient.

However, I agree with the ICB when it rejects the idea of intervening on Law 219/2017, in order to change the regulations on assisted suicide, as suggested by the Consultative body: despite its coherency, it would however be another step, a substantial qualitative leap, an important and dangerous one towards recognition of the "right to die".

Assunta Morresi

## A personal remark by Prof. Maurizio Mori

Provision should be made for doctors opposed to physician-assisted suicide:

1. to have the possibility of resorting to conscientious objection which, however, is not a "constitutionally founded" practice,

2 to formally declare their unwillingness to provide the assistance which may be requested

In paragraph 4.2. dedicated to respect for the professional values of the doctor and health care workers, among other issues, the ICB has examined the problem that could arise "in the event of a law that legitimizes physician-assisted suicide" where this act is "profoundly contrary to the [...] profound convictions" of the same doctor. After reflection, it was concluded that, in this situation, "the possibility of conscientious objection for the doctor should be maintained" as well as for other health care workers involved in the practice.

I share the viewpoint of giving the doctor and other health care workers opposed to assisted suicide the possibility of recourse to conscientious objection, but I disagree with the additional claim that this possibility is justified by the idea that "conscientious objection in bioethics is constitutionally founded (with reference to inviolable human rights)", which would make the practice of objection a sort of "human right".

This idea goes back to a controversial Opinion of 2012, approved by the majority, which, in itself, does not bind the current composition of the Committee. Moreover, it goes beyond the specific competences of the ICB itself, which concern *ethics* and *bioethics*, and not juridical questions of constitutionality, which pertain to the Constitutional Court. The claim, then, is unfounded also for theoretical reasons, some of which have been set out by Prof. Carlo Flamigni in his Personal remark regarding the Opinion of 2012, to which I am referring.

I repeat: despite the fact that in bioethics the practice of conscientious objection is not "constitutionally founded" nor does it make "reference to inviolable human rights", if legislation favourable to physician-assisted suicide were to be approved - as I hope it will - it is appropriate to provide, together with the possibility of conscientious objection for health care workers, for objecting doctors to declare their choice, publicly communicating, that they are unwilling to provide the assistance which may be requested by the person concerned.

Maurizio Mori