Original article: bioethics

The Italian legislator's silence on physician-assisted suicide: legal and bioethical implications

Rosagemma Ciliberti[1], *Nicola Bragazzi*[2], *Anna Siri*[3], *Paolo Petralia*[4], *Alessandro Bonsignore*[5,6]

[1]Section of History of Medicine and Bioethics, Department of Health Science (DISSAL), University of Genoa, Genoa, Italy; [2]Laboratory for Industrial and Applied Mathematics (LIAM), Department of Mathematics and Statistics, York University, Toronto, ON M3J 1P3, Canada; [3]UNESCO Chair in Anthropology of Health. Biosphere and healing systems, University of Genoa, Genoa, Italy;[4]General Direction of the Local Health Authority ASL4, Liguria, Italy; [5]Department of Health Science (DISSAL); [6]IRCCS – Policlinico San Martino Ist, Genoa, Italy

Abstract. The issue of the end of life and, in particular, those of euthanasia and physician-assisted suicide are certainly the most controversial ethical, medical and law issues with well-known news judicial cases. Within the international context, the authors analyze the ethical and legal debate in the Italian system in light of the recent ruling of the Italian Constitutional Court amending article 580 of the Criminal Code, allowing the physician-assisted suicide under certain conditions. Legal background information on the right to die is described and discussed. The rapid succession of judicial cases on the end of life underlines the urgency of a discipline capable of providing adequate references to social issues and duly considering possible interference or abuse. Further legislative efforts are needed by the Italian Parliament and the Professional College of Physicians for the concrete activation and effective functioning of the Italian Council's decision.

Key words: bioethics, end of life, Italian Legislation, physician-assisted suicide, assisted dying, palliative care, euthanasia, self-determination, anthropological perspectives

Introduction

Recently in Italy, the Court of Assizes of Massa (MS), Tuscany, has pronounced on the complex topic of the end of life, ruling on the story of Davide Trentini, aged 53 years old, who has been suffering from chronic progressive multiple sclerosis since 1993. Trentini, totally invalid, with the need for continuous assistance and complaining from severe and intolerable pain, asked for and obtained assistance to access voluntary death in Switzerland. The Court acquitted the defendants Schett Wilhelmine (also known as Mina Welby) and Marco Cappato from the crime of physician-assisted suicide.

This story has followed other similar painful cases, all with important bioethical and juridical implications, including the story of Fabiano Antoniani (also known as DJ Fabo), who was accompanied to Switzerland to access physician-assisted dying.

The rapid succession of judicial cases on the end of life underlines the urgency of a discipline capable of providing adequate normative references and meeting contemporary societal needs.

On the subject of self-determination and the end of life, the Italian legislator had intervened with the Law 219/2017 (Rules on informed consent and advance healthcare directives) to affirm, in full harmony with a personalistic ethical approach, the freedom to refuse treatments and to determine the choices concerning the end of life using advance treatment provisions (1). Furthermore, the legislation explicitly establishes that "the doctor who respects the will of

the assisted person is exempt from civil and criminal liability".

The Italian legislator's choice was made after years of discussions regarding the issue of the free choice of predetermining treatments for a moment in which the fragility of human existence could no longer allow the person to express his/her will. This debate was intertwisted with that concerning an entirely different topic, the access to physician-assisted dying.

The possibility of refusing and/or interrupting treatments, even the life-saving ones, along with the recognition of the exemption of liability for the doctor who stopped the therapy at the request of the patient, has fueled a hot debate on euthanasia, configuring the right to die with dignity. This recognition has, in fact, undermined the principle of the absoluteness of life disposal even though the same legislation has expressly stated that "The patient cannot require medical treatments contrary to the law, professional ethics or good clinical care practices; in the face of such requests, the doctor has no professional obligations or duties".

Moreover, the debate is complicated by the absence of a clear ethical and normative definition of the concept of "euthanasia", even at the international level. For instance, the Belgian Advisory Committee on Bioethics Committee has defined euthanasia as an "act performed by a third party who intentionally puts an end to a person's life at the request of the said person" (2, 3). In Canada, euthanasia has been defined as "a deliberate act undertaken by one person with the intention of ending the life of another person to relieve that person's suffering where the act is the cause of death" (4). The Danish law does not define active or passive euthanasia and these terms, which are not explicitly regulated, are mostly utilized to describe what is legal or illegal under the law [5]. In Denmark, "euthanasia consists of a doctor taking the life of a severely suffering and possibly even dying patient who requests the doctor to do so" (6).

The normative references

Based on the rules governing the exercise of self-determination regarding the end of life, the doctrine has made a distinction between "open" and "closed" model systems (7).

The former ones admit under strict conditions he physician-assisted suicide and even the consensual homicide. These conditions are: the will expressed by the assisted person to put an early end to his/her life; the existence of terminal illnesses; and, compliance with certain procedures.

Only a few countries have chosen to legislate directly on euthanasia and physician-assisted suicide such as the American state of Oregon, Canada and European countries like Belgium, Switzerland and the Netherlands (8). In addition to physician-assisted suicide, the latter countries admit consensual homicide, which is the killing of a consenting person, provided it is carried out by a physician. They also allow the possibility of resorting to the "termination of life on request" against minors aged more than 16 years, provided that the parents "were involved in the decision' (Article 2.3), opening also at young people between 12 and 16 years, provided that they are deemed "capable of reasonable assessment of their interests" and provided that their parents agree (Article 2.4).

In Australia, the Autonomous Region of the Northern Territory was the first to introduce a law on euthanasia but was later forced to repeal law it. The Swiss laws provide a very limited discipline on the subject of the end of life. The penal code, in force since 1937, limits itself to providing two provisions: namely, the Article 114, which establishes relatively light penalties for those who kill a person at his/her explicit and repeated request and for reasons of compassion, and the Article 115, which provides minor criminal sanctions against those that help a person to commit suicide, for "selfish motivations", such as pecuniary profit. If these "selfish motivations" do not exist, physician-assisted suicide is considered a lawful conduct. These two provisions are the result of a long harmonization effort between 26 different cantonal criminal codes.

The "closed" model systems admit only the right to refuse treatment, even when life-saving. Many European countries belong to this model, such as the United Kingdom, which in 2005 approved a law (the so-called Mental Capacity Act) which recognized the validity of advance directives, making doctors who did not respect them punishable (article 5). Similarly, Spain in 2002 recognized the cogency/binding of advance directives (article 1), provided that they are not in conflict with the legal system or with the rules of

medical practice (article 3). France is another country, which in 2005 approved a law on the "rights of patients and the end of life", which essentially regulates passive euthanasia and advance directives. Germany punishes medical assistance to suicide as "failure to help" (article 323c of the penal code).

Concerning the possibility to set not only a "right to let die", but the "right to die", the European Court of Human Rights (ECHR, sentence 29.04.2002, Pretty versus The United Kingdom, 2346/02) stated that given the juridical existence of the right to life (a right not in contrast to the right to die) as defined in the article 2 of the Convention, a right to death to be exercised against third parties and state authorities cannot be inferred. The ECHR has also confirmed the legitimacy of the discretion of the legal systems of the individual States in prohibiting assistance to suicide to protect the right to life even in judgments that have in any case recognized the possibility of death for the claimant (see Haas v. Switzerland, Lambert and others v. France) (9, 10).

Italy_belongs to the so-called "closed" model systems. The expressly unlawful criminal murder of the consenting and of the aid (article 579 of the penal code) or incitement to suicide (article 580 of the penal code) excludes the admissibility of euthanasia. The Italian legal system does not even contemplate "euthanasia" as a specific case that is based on the possibility of determining in advance the end of the life of a person who, being in a situation of unfortunate illness as a source of great suffering, expressly manifests the will to terminate his/her own life.

Even the Italian Court of Cassation recently confirmed (judgment 15 February 2018, n. 7390) the setting that excludes the application to this crime of extenuating circumstances of particular moral and social value (provided in the Article 62 of the criminal code). In the absence of a collective consensus of euthanasia as a practice, *pietatis cause* cannot, in fact, justify the application of mitigation circumstances. Furthermore, already in 2008, the Italian Court of Cassation, with sentence no. 13410, had underlined that the existence of a mental illness that that affects the validity of the consent of the person requesting euthanasia, must constitute the more severe crime of willful murder rather than that of the consensual homicide.

On the distinction between the crime of murder of the consenting party and that of instigation or aid in suicide, the Court of Cassation, with sentence no. 3147 of 1998 (11), affirmed that one could speak of "murder of the consenting person in the case that the one who causes death in practice replaces the would-be suicide, albeit with the consent of the latter, taking the initiative on his/her own, as well as in terms of the of material causation, even in the scenario of generic volitional determination, while there will be instigation or facilitation of suicide every time the victim has retained the dominion of his/her action, despite the presence of a conduct extraneous to the determination or help in the realization of his/her purpose, and has carried it out, even materially, by his/her own hand".

An important turning point in the Italian legal debate on the existence of a "right to die" is represented by the intervention of the Constitutional Court (ordinance no. 207 of 2018) on the case mentioned above of Dj Fabo, which has been new with useful, unprecedented implications potentially incisive both theoretically and practically. The issue at stake was the assessment of the legitimacy of Article 580 of the Italian penal code which punishes physician-assisted suicide in front of the Constitutional Court pronouncement related to people with medical conditions which are considered irreversible (end-stage) or entailing unbearable suffering (12).

Still under investigation, it was the equation of the sanction envisaged for the conduct of "suicide facilitation" to that of moral incitement in terms of the re-educational purpose of the penalty and in terms of reasonableness. In fact, it was noted that only the latter is more invasive and incisive in the deliberative path of the suicidal aspirant from a causal point of view compared to the conduct of those who limit themselves to autonomously facilitating a deliberate suicide choice.

The decision of the Court is an undeniable openness to the physician-assisted suicide in breach of the classic ethical and legal approach traditionally adopted in Italy, according to which the doctor's job is to defend life and cure disease; possibly also to accompany the patient with dignity to inevitable death, but not to cooperate in such a way that death process occurs more quickly. In fact, with this ruling the Italian judge definitively repudiates the classical orientation that has framed the solidarity-oriented intervention only in

function of life conceived as an absolute and unavailable asset. According to the Court, the great scientific advancements should be taken into account, implying a new scenario, different from that at the time in which the criminal code was initially enforced. Within this scenario, in the case of conditions of intolerable physical or psychological suffering from irreversible pathologies, self-determination related wills can be conjugated with the right to health and to the protection of the dignity of a human, to ensure the best quality of life possible.

Rejecting an approach based on a merely abstract dialectic where the principles of protection of life and self-determination are placed in a priori terms and conceived as being antagonistic to each other, the Constitutional Court tends to privilege the concrete human and existential dimension of the person to seek the balance between these principles in the function of the real and specific context in which the person finds himself/herself acting. The reality experienced by the subject prevents abstract and absolute answers anchored in theoretical principles to impose decisions that touch the personal sphere, being the individual an inviolable person.

The person as a real individual should be considered as a whole, in its flesh and blood, in his/her fragility, in his/her intimate weakness, and above all in terms of the subjective and very personal perceptions that the patient has of his/her conditions.

According to the Court, in some cases, the help of a third party is the only way "to avoid, in respect of one's own concept of personal dignity, artificial maintenance in life no longer wanted/desired that an individual has the right to refuse based on art. 32, second paragraph, of the Constitution". Otherwise, as observed, the unconditional absolutization of the right to live would tragically risk transforming itself into a duty to live at any cost of suffering. This principle had also already been expressed in the Eluana Englaro case, in which the Court of Cassation stated: "The principle inspired by ethical personalism that animates our Constitution, which sees in the human person an ethical value per se (i.e., in itself), prohibits any exploitation of the same for any heteronomous end, conceives solidarity and social interventions in a person-oriented way to target his/her development purposes and not vice versa, and looks to the limit of "respect for the human person" in reference to the single individual, at any moment of his/her life and at his/her persona as a whole, in view of the bundle of ethical, religious, cultural and philosophical values and principles underlying his/her volitional determinations".

Recalling the European jurisprudence, the Italian Court explicitly excludes the existence of a right to die, emphasizing that "given the right to life, guaranteed by the Article 2 of the ECHR, the right to renounce living cannot be inferred, and therefore a real right – the right to die – has been affirmed for some time by the ECHR, precisely in relation to the issue of aid for suicide". The Court reiterates therefore the legitimacy of the indictment for incitement to and of aid in planned dying.

In particular, recalling the recent law no. 219 of 2017, the Italian Judge in fact underlines the rule according to which life is an asset to be protected against any possible exploitation, recognizing that this incrimination " is [...] functional to the protection of the right to life, especially of the weakest and most vulnerable subjects … which could be happily induced to leave life prematurely, if the legal system allowed anyone to cooperate even only in the execution of their suicidal choice, perhaps for reasons of personal gain".

However, the Italian Constitutional Court held that the absolute prohibition of assisting suicide is in contrast with the patient's freedom of self-determination "with consequent infringement of the principle of human dignity, as well as of the principles of reasonableness and equality in relation to the different subjective conditions".

The Court in the context of the murder of consenting, stated that the law 219/2017 identified the hypothesis of non-punishment of the doctor who respects the will of a given patient to refuse medical treatment, in the case this determines his/her death. For this reason, according to analogical reasoning, the same treatment should be recognized as part of the aided suicide where help is wanted and demanded from a person suffering from an irreversible disease. In particular, according to the Court, "if, in fact, the cardinal importance of the value of life does not exclude the obligation to respect the decision of the patient to put an end to his/her existence by interrupting health

treatments - even when active conduct is required, at least on a naturalistic level, by third parties (such as the detachment/unplugging 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 be translated into an absolute obstacle, criminally graded, to the acceptance of the patient's request for help that will save him/her from the slower course - appreciated as contrary to his/her own idea of a dignified death - consequent to the aforementioned interruption of the life-support measures".

This assimilation made by the Italian judge between the respect of interruption of treatment and the murder of the consenting person also raises perplexity. In the hypothesis of the interruption of treatment, the behavior required consists in the interruption of a medical treatment that is no longer "supported" by the person's consent (not necessarily consisting of active conduct) and, as such, arbitrary. Therefore, the death event occurs as a result of the disease without any acceleration imposed by the conduct/event (13). In the hypothesis of physician-assisted suicide, on the contrary, it is necessary to utilize tools that allow the person to cause his/her death with a completely different and autonomous causal course compared to that deriving from the course of the pathology.

The Court has also postponed the discussion of the issues of constitutionality raised in the article 580 of the criminal code, hoping that, in the meantime, the Parliament would be able to legislate on that point based on the criteria indicated by the same Court. Almost a year after the issuance of this ordinance, given the inaction of the Parliament, on 25 September 2019, the Constitutional Court (14) deemed "not punishable under the article 580 of the criminal code, under certain conditions, whoever facilitates the execution of the intention to commit suicide, autonomously and freely formed, of a patient kept alive by life-sustaining treatments and suffering from an irreversible pathology, a source of physical or psychological suffering which he/she considers intolerable but fully capable of making free and conscious decisions, provided that such conditions and details concerning the execution of such decisions have been thoroughly verified by a public national health service, after consulting the territorially competent ethics committee". This decision of the Court is innovative as it removes the prohibition of the doctor's active cooperation in procuring death, at least concerning patients who are in the conditions described by the Italian judge.

The ruling of the Constitutional Court certainly does not say the last word on the question, in relation to which neither an abstentionist attitude of the legislator nor an extremely interventionist attitude that restricts the possibilities of choice of individuals can be accepted today.

Finally, the Italian Judge's clarification deserves particular attention, when clarifying that "dependence on life support measures and treatments" does not necessarily and exclusively mean "dependence on a machine". The category of health treatments beyond artificial nutrition and hydration includes any health treatment, whether carried out using pharmaceutical therapies or with medical or other healthcare personnel or with the aid of medical machinery. In other words, according to the Italian Judge, life-sustaining treatment must be understood as "any health treatment, the interruption of which would result in the death of the patient even in a non-rapid manner".

Ethical profiles

The theme of the end of life and, in particular, those of euthanasia and physician-assisted suicide are certainly the most controversial ones within the Italian arena of the contemporary bioethical debate.

The progress achieved in improving human survival, even in extremely precarious conditions, has given rise to challenging moral questions about situations with unprecedented and controversial implications for the health workers themselves.

In particular, the public debate on physician-assisted suicide testifies to the great difficulty of reconciling two fundamental principles of bioethics: the preservation of life and the determination of the human will.

The strictly private and intimate dimensions that revolve around these principles solicit, moreover, a reflection on the level of intensity, or invasiveness, of the legislator's intervention aimed at protecting those rights.

Identifying and understanding the complicated relationship between reasoning-based bioethics and the regulatory bodies means to analyze how the increasing demands for freedom of choice and disposing of our own body and the existence of body constraints can or, possibly, "should" be recognized as new individual rights are being claimed.

Is it morally permissible claiming the right to intervene on a sphere so intimate such as that which concerns the will to continue to live or choose to die?

Quoting the French philosopher Michel Foucault, "the old right to *let* die or *let* live has been replaced by the new power to *make* life or to *reject* death" (15).

As already pointed out, biomedical advances have also changed the traditional vision of life, of death profoundly, and also of the rights, dramatically changing the scenarios where the juridical system has historically operated in the last centuries. Moreover, the question has an ethical and juridical dimension, and has much more general existential, psychological, philosophical and anthropological implications.

It is not without coincidence that the French philosopher and writer Albert Camus underlined that "to judge whether life is worth living or not worth living is to answer the fundamental question of philosophy" (16).

A physical or mental infirmity inherited, or accidentally acquired, does not affect the person's dignity. The dignity is a value and, together, a property inherent to the person and not adversely affected by illness, disability or states of deprivation and physical/mental suffering. This means that the person is not involved in his/her physical and biological components, nor in his/her ability to perform actions or not his/her functions.

In the Catholic conception, but also the Kantian secular one, dignity is the intrinsic value of every rational, unconditional and inalienable being, which means that every man must be treated as an end and not as a means. The value of human dignity, recognized by different philosophical and/or religious traditions, finds protection in national and international legal systems and in the activity of the judicial bodies that have increasingly expanded the category of inviolable rights. However, an individual and "subjective" dimension of dignity cannot be neglected, which necessarily includes the inalienable right of the "competent" person to decide independently whether to continue living in a situation of suffering or to terminate his/her human existence in advance. The right to live with dignity is inexorably intertwined with the right to die with dignity or, perhaps, better with the right to continue to live with dignity in all phases of existence according to the personal conception of a "good life". Such a concept highlighting the close relationship between the personal mode of understanding of life and death is well expressed in the Georg Simmel's words "As we understand life and how we conceive death are only two aspects of a unified attitude of thinking of the end" (17).

The subjective dimension of dignity does not imply any moral relativism, rather the moral claim of being respected in practice and making responsible choices that autonomy confers on each one of us to according to the values that it shares (18).

Helga Kuhse pointed out that "the notion of human dignity plays a very dubious role in contemporary bioethical discourse … [It] has a tendency to stifle arguments and debates and encourages the drawing of moral boundaries in the wrong places" (19). Consequently, many authors (including Macklin, Wetz, and Kuhse) suggest expunging the concept of dignity from the ethical debate (20).

The recognition of the value of the good of life must support and make the most of the individual and collective responsibility of taking care of the other, particularly in serious suffering situations. This responsibility entails respect and closeness to those who, in harmony with their dimension of dignity, choose to continue to live even in situations of great physical and mental difficulty, identifying the meaning of their existence in unquestionable spiritual reasons (religious or otherwise). But the responsibility of taking care of the other also involves respecting different conceptions that can identify suffering and disability situations as damaging to one's own dignity. In both cases, continuing to live or not may or may not be respectful of the person's dignity. The distinction is not the quantity of life granted, nor its quality but its conformity with the person's will and his/her conceptions of existence.

In this conception, the respect for the dignity of the person is the foundational dimension not only of the recognition of freedom of the person to accept,

refuse or discontinue treatment, but also and especially conceived as a help for a person who is experiencing severe and unbearable suffering and that it is not in the possibility of being able to put an end to one's own existence independently.

The pluralism of values and the recognition of a democratic state's secularity exclude imposing an authoritarian worldview, especially if ideological and preconceived. The protection of the respect for scientific/medical principles must therefore be in harmony with the equally indispensable protection of the assisted person's freedom, except obviously in cases of pathological conditions that compromise decision-making freedom.

Excluding a reductionism of the person's life to biology alone, the conception of those who believe that not only biological life but also the "biographical" one, that is to say, the "lived" one, falls within the concept of dignity cannot be accused of being wrong. Is it respectful of the person's dignity to ignore the request for help that comes from a person who can no longer tolerate living? Is it respectful of the dignity to force a person to describe in detail his/her suffering, his/her intimate precariousness to claim a request that belongs only to his/her existence? Is it respectful of the dignity to ignore his/her conception of the good life and his/her will?

Appropriately, the Italian National Committee for Bioethics in 1995 highlighted the need to avoid "interposing between us and those who 'live to die' the screen of our beliefs, no matter how right you may believe they are, to meet up the beliefs, the religion and even the lack of a religious reference, or any other type of position that the person facing death presents" (21).

This warning was not considered even concerning the theme of the beginning of life. After years of debate and opposition, the Italian legislator has, in fact, approved a highly restrictive law on assisted fertilization (the Italian law n.40 of 2004) emblematic of a state unable to take into account the various moral options.

Of course, linking disease, disability, suffering or the very limitations of medicine with a death offer is morally unacceptable. The severity of the disease, the precariousness of existence and the frailties increase the responsibility of taking care and must not constitute an abandonment of the treatment or, even worse, rejection of existence. In his speech, Pope Francis recalled "the anguish of the condition that brings us to the threshold of the supreme human limit, and the difficult choices that must be taken, expose us to the temptation to escape from the relationship" (22).

However, one cannot ignore the reality of the various situations utilizing general and abstract categorizations and especially preconceived ideological theories.

The Italian legislator's silence may then represent an inability, or worse, an unacceptable refusal to cope with the various dramatic aspects of the human existence, with the physician-assisted suicide being a tragic and extreme choice of *piety*. This would burden doctors of the intolerable responsibility for addressing judicial paths with uncertain and variable outcomes without clear and explicit regulations. These already exist in other countries, such as the United Kingdom, in which the ECHR found the Suicide Act to be compliant with the Convention, protecting the right to life in general and, in particular, that of the weakest and most vulnerable subject, such as the chronically or terminally ill individual. In Italy, the need of opinion of the local ethics committee, requested by the Italian Court for in all cases involving a request for physician-assisted suicide, can help provide public assurance of human rights protection. However, there are many open questions regarding the organization of existing ethics committees predominantly oriented evaluating studies on clinical trials of medicinal products (23).

In the ethical debate on this issue, an essential aspect is represented by the call to palliative care accompanying the dying as a response to requests for help in suicide. In reality, these acts of care must not constitute an alternative, but always present dimensions that are also compatible with choices for requesting help for suicide which require regulations and normative references that also allow the doctor to express his or her conscientious objection as well as for other health professionals possibly involved in the process.

The Italian code of medical ethics, as in other countries, expressly prohibits physicians from performing targeted acts cause the patient's death. In the absence of a change in the code of ethics, a patient

will have the right to be witnessed a suicide, but no doctor will help him, due to the deontological prohibition (24). However, the concrete activation and effective functioning of the Italian Council's decision need for the support of medical societies to develop training, support, and implementation standards to aid physicians in this process.

Another open ethical issue is the management of conscientious objection to protect the rights of health operators who object against participating in physician-assisted suicide, similarly to what is established in other areas of Italian law (25).

Conclusions

The implications of the various ethical and legal issues concerning the end of life are certainly very complex. This complexity does not exempt from the responsibility of identifying normative solutions, reasonably convincing and acceptable, which allow adequate management of the "dying" individual, fully respectful of the dignity of the suffering person, of his/her existential and cultural conceptions as well as of the pluralism of the community. The direction to follow is to believe that freedom of choice is an inalienable right together with the concept of dignity.

Legitimate but personal moral positions should therefore not be placed at the foundation of a plural state legal order, in which various ethnic groups, cultures and religious confessions with often divergent values coexist. On the contrary, legal norms must be configured in such a way as to allow decisions that comply with the different ethical convictions of the society within which they are issued.

The debate requires the inclusion of reflections on how assisted suicide policy can introduce long-term changes in our society's social relations.

There is a lack of discussion about the social consequences of hidden expectations and obligations regarding to access to health care resources, terminal and chronic illness, disability, and suffering.

This is even more true in our culture, where independence and self-sufficiency are valued while dependency is stigmatized as inappropriate and shameful. Old age, disability, dependency, and deprivation pose severe challenges to social policy development.

Legalizing physician-assisted suicide is brought up in the name of autonomy. It brings up the importance of debating the fears and constraints disabled people face in the context of widely held public values that define "social value". Is there only the illusion of freedom of choice when discussing the right to discontinue medical treatment? The ethical debate must adequately address the extent to which such choices are constrained when there are the resources necessary to ensure an independent quality of life.

References

1. Ciliberti R, Gorini I, Gazzaniga V, De Stefano F, Gulino M. The Italian law on informed consent and advance directives: New rules of conduct for the autonomy of doctors and patients in end-of-life care. J Critical Care 2018; 48:178-82.
2. Belgian Advisory Committee on Bioethics. Opinion n. 1 of 12 May 1997 concerning the advisability of a legal regulation on euthanasia. Available from: https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/opinion_1_web.pdf
3. Belgian Advisory Committee on Bioethics. Opinion n. 73 of 11 September 2017 on euthanasia in case of non-terminally ill patients, psychological suffering and psychiatric disorders. Available from: https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/opinion_73_web.pdf
4. The Special Senate Committee on Euthanasia and Assisted Suicide. Of Life and Death. Final Report of. Ottawa: Supply and Services Canada; 1995. Available from. https://sencanada.ca/content/sen/committee/351/euth/rep/lad-e.htm
5. Council of Europe. Steering Committee On Bioethics (Cdbi). Replies to the questionnaire for member states relating to euthanasia. Strasbourg, 20 January 2003 CDBI / INF (2003) Available on: https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016803a72c2
6. The Danish Council of Ethics End of life. Ethical Challenges and Problems. 2006. Available from: https://www.etiskraad.dk/~/media/Etisk-Raad/en/Publications/End-of-Life-2006.pdf?la=da
7. Casonato C. Fine vita: il diritto all'autodeterminazione. Il Mulino 2017; 4(17):597-604

8. Banović B, Turanjanin V. Euthanasia: Murder or Not: A Comparative Approach. Iran J Public Health 2014; 43(10):1316-23.
9. European Court of Human Rights. Affaire Haas c. Suisse. 20 Janvier 2011. Available from: http://hudoc.echr.coe.int/eng?i=001-102939
10. European Court of Human Rights. Case of lambert and Other v. France. 5 June 2015. Available from: http://hudoc.echr.coe.int/eng?i=001-155352
11. Italian Court of Cassation, 02/06/1998, n. 3147.
12. Casonato C. Assisted suicide in Italy: constitutional right or wishful thinking? BioLaw Journal 2019; 2:147-9.
13. Molinelli A, Bonsignore A, Rocca G,Ciliberti R. Medical treatment and patient decisional power: The Italian state of the art. Minerva Med 2009; 100 (5):429 - 434".
14. Press release dated 25.09.2019 issued by the Press Office by the Constitutional Court.
15. Foucault M. La volontà di sapere. Milano: Feltrinelli; 2009.
16. Camus A. Il mito di Sisifo. Bompiani: Milano; 2009: 7.
17. Simmel G. Metafisica della morte e altri scritti. Milano: Se; 2012: 9.
18. Neri D. Autonomy and dignity at the end of life. Politeia 2017; 33:117-25.
19. Kuhse H. Is there a tension between autonomy and dignity? In: Kemp P, Rendtorff JD, Mattson Johansen N (Eds) Bioethics and Biolaw, Vol. II: Four Ethical Principles. Copenhagen: Rhodos International Science and Art Publishers and Center for Ethics and Law; 2000: 61-73.
20. Schroeder D. Dignity: Two Riddles and Four Concepts. Camb Q Healthc Ethics 2008; 17:230-8.
21. NBC Bioethics issues related to the end of human life. Rome: 1995.
22. Message of the Holy Father Francis to the Participants in the European Regional Meeting of the "World Medical Association " on "End-of-Life" Issues. Available from: http://www.vatican.va/content/francesco/it/messages/pont-messages/2017/documents/papa-francesco_20171107_messaggio-monspaglia.html
23. Petrini C. After the Italian Constitutional Court's ruling on the absence of criminal liability for assisted suicide: the role of ethics committees and clinical ethics. Ann Ist Super Sanità 2019; 55(4):311-3.
24. Patuzzo S, De Stefano F, Ciliberti R. The Italian code of medical deontology. Historical, ethical and legal issues. Acta Biomed 2018; 89(2):157-64.
25. Baldelli I, Massaro A, Penco S, Bassi AM Patuzzo S, Ciliberti R. Conscientious objection to animal experimentation in Italian universities. Animals 2017; 7(3).24

Correspondence:
Alessandro Bonsignore
Section of Legal and Forensic Medicine, Department of Health Science (DISSAL), University of Genoa, Genoa, Italy.
University of Genoa, Genoa, Italy
E-mail: alessandro.bonsignore@unige.it,