End-of-Life in Italy: Critical and Bioethical Aspects of the Bill on Physician-Assisted Suicide

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Abstract. In Italy, on 10 March 2022, the Chamber of Deputies approved the bill "Dispositions in the matter of medical assisted voluntary death", formulated on the base of the recent sentence of the Constitutional Court n. 242/2019. Our study aims to analyze the bill, to evaluate its concrete applicability and highlight bioethical aspects and medico-legal criticalities.

Keywords: Physician-Assisted Suicide, sentence of the Constitutional Court n. 242/2019, medical assisted voluntary death

Introduction

Medically assisted suicide is the conscious act of ending one's existence by the self-administering of lethal doses of drugs by a subject who is "assisted" by a doctor who makes the necessary substances available.

On 14 February 2018 in Italy, the Court of Assizes of Milan suspended the trial against Marco Cappato, accused of having reinforced the suicidal intention of Fabiano Antoniani (known as DjFabo), suffering from tetraplegia and blindness following a serious car accident, helping him to perform medically assisted suicide in a Swiss clinic (1). In particular, the Court of Assizes of Milan, examining the innovations introduced by Law n. 219/2017 (Norms in the matter of informed consent and anticipated dispositions of treatment) (2), issued an order raising the question of the constitutional legitimacy of Article 580 of the Penal Code, which punishes imprisonment from 5 to 12 years "*anyone who determines others to suicide or strengthens the intention of suicide, or facilitates in any way the execution*".

On 25 September 2019, the Constitutional Court in its judgment n. 242 declared "*the constitutional illegitimacy of art. 580 of the Penal Code, in so far as it does not exclude the punishability of those who* [...] *facilitate the execution of the suicide intent, independently and freely formed, of a person kept alive by life support treatments and suffering from an irreversible pathology, a source of physical or psychological suffering which she considers to be intolerable but fully capable of taking free and conscious decisions, provided that those conditions and the manner in which they are carried out have been verified by a public structure of the national health service, after consulting the Ethics Committee responsible*" (3,4).

Based on the above judgment, on 10 March 2022, the Chamber approved the bill "*Dispositions in the matter of medical assisted voluntary death*", currently (on May 17) awaiting approval by the Senate of the Italian Republic (5).

In our study we propose to analyze the bill, to highlight bioethical aspects and application criticalities.

Subjects and Methods

Italian legal and jurisprudential sources on assisted suicide have been consulted. Moreover, the specific contents of the draft law "*Provisions on voluntary medically assisted death*", approved by the Chamber of Deputies on 10 March 2022, were analyzed (5).

Results

The analysis of the bill has allowed us to note critical and interesting bioethical issues inherent in the ambiguity of the definitions used (especially about the causal contribution of third parties in participating in the act of suicide), the preconditions and subjective requirements necessary to require medically assisted suicide and the conscientious objection of health professionals. We also highlighted the absence in the bill of references to conditions of vulnerability and fragility of the patient applicant.

Ambiguity of expressions used in the bill and of the concept of causal contribution of third parties

It should first be pointed out that the term "suicide" is used only once (Art. 6, c. 3) for the entire text of the legislation, and it is never sufficiently clear whether it refers to a case of medically assisted suicide or active euthanasia. This difference is not negligible either from a medico-legal point of view nor from a bioethical point of view because it implies the different causal interventions of third parties in the execution of the decision of others to end their lives. Active euthanasia is defined as the killing of a consenting subject by "active" administration by the health care provider of a lethal dose of a drug. On the other hand, medically assisted suicide involves the patient's self-administration of the lethal drug: the doctor prescribes and prepares the drug, but the last gesture must be carried out independently. In other words, in assisted suicide, the health care provider intervenes in the preparation of suicide, but not in the administration of the lethal substance which must in any case be autonomous. The draft law often refers to the requirement of "autonomy" of suicide, but does not specify with sufficient clarity the role of health workers in the enforcement procedure of "voluntary death". In the text, there are often too generic and misleading expressions that risk creating application confusion and requiring regulatory additions. Moreover, in art. 8 c. 1 and 2 (*Exclusion of punishability*), it states that "[…] *the provisions of Articles 580 and 593 of the Penal Code do not apply to doctors and medical and administrative staff who have carried out the procedure of voluntary medically assisted death and to all those who have in any way facilitated the sick person to activate, to investigate and complete the aforementioned procedure if it is carried out in compliance with the provisions of this Act* […]". We believe the bill does not clarify sufficiently which are the "third parties" that can legitimately assist in the execution of voluntary death (health care personnel, administrative personnel and "*all those*"?) and what is the specific and practical role of each figure in the enforceability of the lethal act ("[...] *all those who have facilitated in any way* [...]). This opens the way to unacceptable uncertainties relating to the causal contribution of third parties in participating in the irreversible act of participating in the realization of the suicidal will of a human being. Failing to remedy these structural defects would mean accepting a priori foreseeable claims in terms of liability by the family members of the patient. These claims would find ample room because they are supported by the serious lack of legislation that does not suit the particular complexity and burdensome nature of the issue.

The ambiguity of the expressions and the problem of the causal contribution of third parties traceable in the bill are however in contradiction with the recent explicit"no" of the Constitutional Court to the referendum aimed at the legalization of euthanasia by the partial repeal of Article 579 of the Criminal Code (murder of the consenting). Indeed, on 15 February 2022, the Constitutional Court called the referendum "inadmissible" because "*following the repeal, albeit partial, of the rule on the murder of the consenting* [...], *would not be preserved the constitutionally necessary minimum protection of human life in general and with particular reference to the weak and vulnerable persons*"(6). We believe that the guarantee of the protection of human life is also achieved through clear laws that leave no room for questionable interpretations.

Prerequisites, conditions, and requirements towards

Based on what is stated in art. 3 c. 1 of the draft law, can request "*voluntary death medically assisted*": an adult capable of understanding and will, able to make free decisions, current and aware, and is adequately informed.

Moreover, among the prerequisites of the request, there is also the previous involvement of the subject "*in a path of palliative care*" aimed at alleviating his state of suffering. From the text, it is clear that, for a subject to be able to submit the request for voluntary assisted death, he must have explicitly refused or voluntarily stopped the palliative care in which, however, he must be "*previously involved*". We consider it highly questionable that the conditions include the necessary refusal by the subject of palliative treatment. It is not acceptable to oblige the subject to add to the inevitable psychological suffering linked to the choice of deliberately and consciously interrupting one's life the psychophysical suffering linked to the symptoms of the disease, avoidable thanks to palliative treatments. These do not have a therapeutic and healing goal but are treatments aimed at improving the patient's quality of life as much as possible, reducing the level of suffering and pain. We, therefore, believe that access to palliative care should be guaranteed to the patient until the time of the voluntary act of dying while respecting the constitutional rights to health and self-determination.

Moreover, in art. 3 c. 2, the draft law specifies that the person who applies for a medically assisted voluntary death must be in two concomitant conditions. First of all, the person must be kept alive by medical treatment, the interruption of which would cause his death. In addition, it is necessary that the applicant is suffering from "*a pathology attested by the attending physician or specialist doctor* [...] *as irreversible and with poor prognosis, or be the bearer of an irreversible clinical condition*"; these pathological conditions must also cause "*physical and psychological suffering that the person himself finds absolutely intolerable*".

Also in this case we consider the contradictory legislation because it introduces an ambiguous alternative wording: 1- "*pathology certified* [...] *as irreversible and with poor prognosis*" and 2- "*irreversible clinical condition*". The text, in other words, equates two conditions that are not comparable in terms of specificity. If the first definition is complete (including the medical attestation of the pathology, its irreversibility and its prognostic judgment) the second is too generic. It is known that there are irreversible clinical conditions compatible with long life and not harbingers of poor prognosis such as legitimizing the request for assisted suicide. Therefore, we consider such definition not only pleonastic but also potentially to risk to create serious interpretative difficulties. This risk is even more concrete in the light of the marked subjective interpretation on which the legislation is based in the assessment of the physical and psychological suffering of the applicant that must "simply" be considered "*absolutely intolerable*" by the subject, without requiring a specialist examination. In addition, we also consider that the condition that the applicant should be kept alive by medical treatment of vital support and the interruption of which would cause his death is too general and hasty. What treatments are involved? Furthermore, what is the time lag between the interruption of treatment and the patient's death? Provocatively it could be argued that a patient suffering from insulin-dependent diabetes mellitus (clinically irreversible pathology) can legitimately request medically assisted suicide if the pathology causes subjectively intolerable suffering for the subject. The same person would also be entitled to make a request for a medically assisted death because kept alive by a life-saving medical treatment (insulin injections) without which he would face death.

Failure to provide guarantees for vulnerable persons

As already mentioned, the Constitutional Court last February declared "*inadmissible*" the referendum on euthanasia and the even partial repeal of art. 579 of the Penal Code for the protection of human life, with particular reference to "*weak and vulnerable persons*". Moreover, the Constitutional Court itself in its judgment No. 50/2022 (7) states that situations of vulnerability and weakness do not refer only to minors, infirmity of mind and mental deficiency. In fact, these situations can be linked to factors of various nature (affective, family, economic, social). Yet, the bill nowhere takes into account the question left open by the Constitutional Court, neglecting the special vulnerability of those who apply for assisted suicide. In fact, the text limits the possibility

of assisted suicide to subjects fully autonomous, emotionally balanced, fully willing and ready to know and understand information on their state of health and not conditioned by contingent situations (family, economic, etc.). This situation is the ideal one which makes the indications of the document impeccable. However, one cannot but consider that it is a major hypothesis: more frequently patients suffering from serious diseases that deserve life-saving treatments are often afraid, fragile, often elderly, in a state of mental confusion and particularly prone to the tendency to undergo external conditioning. Such situations - numerically prevalent to the previous ones - must be adequately considered to avoid the medical abandonment of vulnerable patients and to guarantee the protection of their right to life and of their full and conscious right to self-determination (8-10).

Conscientious objection

Conscientious objection is introduced in the legislative sphere when a rule provided for by the legal system is associated with a socially significant split in the health sector. Actually, as in the case of voluntary termination of pregnancy, even in the case of assisted suicide, provision must necessarily be made for the possibility of refusal by the health care professional to act if the act is contrary to his ideological convictions (social, moral or religious) (10). In this regard, the bill appears sufficiently comprehensive, taking up in fact in art. 6 what was already expressed in art. 9 of Law 194/1978 on Voluntary Termination of Pregnancy (11). Moreover, the article dedicated to conscientious objection is the only one of the entire legislation in which it explicitly speaks of "suicide" (art. 6, c. 3), precisely about the specific purpose of the procedures and activities carried out by the consenting doctor. Moreover, it will be necessary that the physicians involved in the assisted suicide will be adequately formed and experienced to avoid misinformation and confusion (12-18).

Conclusions

Based on our analysis, we believe that the final legislation will have to be the result of a formal revision of the current draft law. The changes will be essential first of all to definitively and formally resolve the confusion between the concept of "medically assisted suicide" and "active euthanasia". Moreover, removing ambiguous expressions from the text will avoid opening the way to interpretative - and therefore applicative - opinions on the legislation. In addition, we also believe that a structural revision is necessary to better qualify the "identity" of the "third parties" legitimately involved in assisting suicide and the type of contribution that each figure will be entitled to offer. The structural review will also be essential to clarify the subjective assumptions and conditions that make the request for assisted suicide legitimate. Finally, it will be essential to include in the legislation specific indications that are the prerogative of fragile and vulnerable subjects (a not inconsiderable issue recently raised by the Constitutional Court).

When we have to navigate the field of the rights to life and self-determination, a rigorous examination of the potentially arising bioethical, medico-legal and legal issues is essential, in order not to incur errors, superficiality and/or inaccuracies that could be reflected on the fundamental rights of suffering people.

Declaration of conflicting interests: The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding: The authors received no financial support for the research, authorship, and/or publication of this article.

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