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Constitutional Court and "Administrative Solutions" for Physician-Assisted Suicide in Italy

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Medical Assistence in Dying (MAiD) is a regulated process where a physician or nurse practitioner helps a mentally competent patient intentionally end their life at their own request. This practice involves either the direct administration of a drug by the clinician (euthanasia) or the prescription of a medication for patient self-administration (physician-assisted suicide, PAS). The right to die is among the most ethically and legally complex issues in bioethical discourse since the discipline's origins.

Numerous ethical arguments supporting the right to die are grounded in the principles of dignity, bodily integrity (particularly in the context of suffering), and autonomy (freedom of choice). Together, these principles support a broader understanding of personal self-determination that includes the possibility of choosing to anticipate one's own death. In sharp contrast, arguments such as the slippery-slope objection, protection of vulnerable groups, dignity of life, and related concerns have been invoked to oppose the legal recognition of the right to die [1].

Despite ethical debates, MAiD remains a central to the social, clinical, and cultural landscape of many Western countries, where research consistently shows generally favorable stakeholder attitudes [2]. Over the past decade, MAiD legalization has expanded globally, with countries adopting different regulatory frameworks governing eligibility, assessments, and integration with health, social care, and end-of-life systems [1]. MAiD remains highly debated in several countries, with Italy representing one of the most controversial cases.

MAiD and Italy: A Complex Landscape

Under Italian law, PAS and euthanasia are prohibited by *Article 580* and *Article 579*, respectively, of the 1933 Penal Code. *Article 580* establishes criminal liability for anyone who "*instigates another to commit suicide, or reinforces another's intention to commit suicide, or facilitates its execution in any way,*" while *Article 579* criminalizes the act of directly causing a person's death, even with their consent (consensual homicide). Specifically, regarding "incitement or aiding suicide," *Article 580* states that "*Anyone who instigates another to commit suicide, or reinforces another's intention to commit suicide, or facilitates its execution in any way, shall be punished, if the suicide occurs, with imprisonment from five to twelve years. If the suicide does not occur, but an attempt is made, the penalty shall be imprisonment from one to five years, provided that the attempt results in serious or very serious bodily injury. No punishment shall be applied if the suicide attempt does not result in injury.*"

In parallel, the right to self-determination has gained an increasingly central role within Italian jurisprudence, particularly with the *Law 219/2017* ("Law on informed consent and advance healthcare directives"). It draws on *Article 32* of the Italian Constitution – which states that *"no one may be obliged to undergo any given medical treatment"* – and the principles of dignity, autonomy, relationship of care, and respect for bodily integrity. The law affirms the right to self-determination in healthcare decisions, including those made at the end-of-life, marking a significant milestone in the protection of patients' rights. It ensures access to comprehensive information, effective pain management, and palliative care, while promoting active participation in clinical decision-making.

The *Law 219/2017* provides a clear legal framework for expressing advance directives and advance care planning regarding life-sustaining treatment, including the possibility of refusing or discontinuing such treatment, such

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as artificial ventilation, artificial nutrition, and artificial hydration. The law incorporates four key ethical, clinical, and legal concepts as follows:

- *Appropriate care:* The obligation of healthcare professionals to provide treatment and interventions are clinically justified, proportionate, and aligned with patients' values and goals.
- *Prohibition of unreasonable treatments:* Patients cannot be subjected to treatments that are futile, disproportionate, or excessively burdensome relative to the expected benefits. It protects individuals from interventions that prolong suffering without offering meaningful improvement in their quality of life.
- *Withholding or withdrawing treatment:* Patients have the right to refuse or discontinue medical treatments, even when such treatments are necessary to sustain life. Withholding treatment (not initiating a treatment) and withdrawing treatment (stopping an ongoing intervention) are ethically and legally recognised as expressions of patient autonomy, rather than acts intended to cause death.
- *Palliative care (e.g., palliative deep and continuous sedation):* Patients' right to care are focused on relieving suffering and improving quality of life (e.g., symptom management, psychosocial support), especially for patients with serious and/or terminal illness. Deep and continuous palliative sedation may be used in cases of refractory symptoms, which consists of reducing consciousness to alleviate intolerable suffering while providing basic care.

Furthermore, four tools can help ensure personal autonomy across present and future contexts, including:

- *Informed consent:* A competent individual agrees to a medical intervention (treatment, procedure or trial) after receiving, understanding, and considering all relevant information. It requires disclosure of the diagnosis, nature of the intervention, risks, benefits, and alternatives.
- *Advance directives:* Legal documents (e.g., living wills, durable powers of attorney for healthcare) allow individuals to specify in advance their preferences for medical treatment, including life-sustaining care. They only take effect if a person becomes unable to communicate their own decisions.
- *Shared care planning:* This collaborative, patient-centred process involves patients and clinicians, together with families and other healthcare professionals, jointly planning future care pathway by defining treatment options and supportive measures.
- *Surrogate decision-maker:* A legally or informally appointed person who makes healthcare or financial decisions on behalf of an individual who lacks the capacity to make their own decisions. They act based on the patient's known wishes, values, and preferences (substituted judgment), or if unknown, in their best interest.

The Case of DJ Fabo

In 2019, the Italian Constitutional Court – Italy's highest authority after Parliament – ruled on the case of Fabiano Antoniani, a young man who was tetraplegic and who, under *Law 219/2017*, could have accessed the withdrawal of life-sustaining treatments and deep palliative sedation. Since he was not fully dependent on artificial ventilation, discontinuing treatment would have led to death within a few days. However, in Fabiano's view, this perspective did not represent a dignified way to end his life, and he requested "a different way of departing from life," one that would be faster and entail less suffering for himself and his family.

The Italian Constitutional Court recognised that, "*The absolute prohibition of assisted suicide ultimately limits the patient's freedom of self-determination in choosing therapies, including those aimed at relieving suffering (…) by imposing, in the final analysis, a single way to take leave of life (…) thereby violating the principle of human dignity as well as the principles of reasonableness and equality in relation to different subjective conditions*" [2] Then, it confirms that under certain circumstances, those who assist a person in pursuing their suicidal intent may not be punishable.

The Italian Constitutional Court's ruling explicitly refers to the ethical – not the normative framework established by *Law 219/2017* – highlighting several points of ethical convergence. Both the ruling and the law respond to the concern that the dignity of individuals at the end-of-life may be jeopardized by changing conditions of dying. They

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share a focus on the relationship between care and dignity, emphasising the need to safeguard both. Moreover, they are grounded in a patient-centred approach that prioritises respect for personal dignity through the protection of both self-determination and vulnerability, ensuring that individuals are never abandoned in moments of fragility [3].

New Insight from Italian Constitutional Court

The Italian Constitutional Court ruling highlights the need to understand specific issues related to access to PAS. First, PAS is initiated by patients' explicit request rather than serving as a proposed treatment by healthcare professionals. Second, the ruling establishes specific eligibility criteria that patients must meet in order to access the PAS. Finally, the lack of uniform and immediate implementation of PAS across all Italian regions resulted in significant variability in organizational responses [4]. The five criteria governing access to PAS include:

- *Irreversible pathology:* The patient must suffer from an irreversible medical condition that cannot be cured or significantly improved.
- *Intolerable suffering:* The condition must cause physical or psychological suffering that the patient personally considers intolerable.
- *Dependence on life-sustaining treatments:* The patient must be kept alive by life-sustaining treatments (e.g., mechanical ventilation, artificial nutrition/hydration, other vital support systems).
- *Full decision-making capacity:* The patient must be fully capable of making free and informed decisions.
- *Clinical and ethical assessment:* These conditions must be verified by the National Health Service following a formal procedure, including medical assessments and ethical committee review.

Since the enactment of the Italian Constitutional Court sentence, developments in Italy have proceeded at two markedly different speeds. First, the Italian Parliament has approved a national law regulating medically assisted suicide. Second, opened by constitutional jurisprudence, citizens have requested that healthcare institutions assess whether they meet the required criteria, highlighting the legal and ethical need to provide clear answers to patients. Consequently, some Italian regions have started adopting internal procedures that promote justice, respect for self-determination, and the protection of vulnerable individuals faced with deciding upon PAS.

The Emilia-Romagna Regional Experience: Policy Addressing PAS

Emilia-Romagna (ER) became the first Italian region to issue a regional deliberation in 2024, establishing a clearly defined and uniformly applied pathway across all its healthcare facilities. Subsequently, Tuscany and Sardinia regions adopted regional laws in 2025 [5]. The regional deliberation implies the creation of two dedicated bodies – the "Area Vasta" Evaluation Commission and the Regional Clinical Ethics Committee (Comitato Regionale per l'Etica nella clinica, COREC) – and delineates their respective role and responsibilities in PAS criteria assessment [6]. The "Area Vasta" Evaluation Commission, consisting of seven health experts in law, psychiatry, palliative care, and psychology, is responsible for assessing whether the PAS criteria are met and for providing a preliminary written response. The COREC, composed of 22 health experts in clinical practice, healthcare assistance, and bioethics, provides a second evaluation of the PAS criteria, highlighting the ethical issues and vulnerable situations.

In addition to "Area Vasta" Evaluation Commissions and the COREC, the ER regional deliberation was the first to establish a clear internal pathway with the procedural steps for assessing patient requests, which set a timeline that the Commissions, COREC, and healthcare organisations must follow. This framework offers a structured model for defining responsibilities and outlines the procedures for the request evaluations related to managing PAS assessment and implementation (Figure 1).

Focus on the COREC Activity

Between February 2024 and November 2025, a total of 11 PAS requests were submitted to the Healthcare Directorate of the ER region three in 2024 and eight in 2025 – related to neurological conditions, cancer, and psychiatric and other chronic illness. As these requests were assessed by the COREC, four of these cases met the PAS criteria and were subsequently completed. The ER regional pathway safeguards vulnerabilities in the context of PAS request, as it guarantees a

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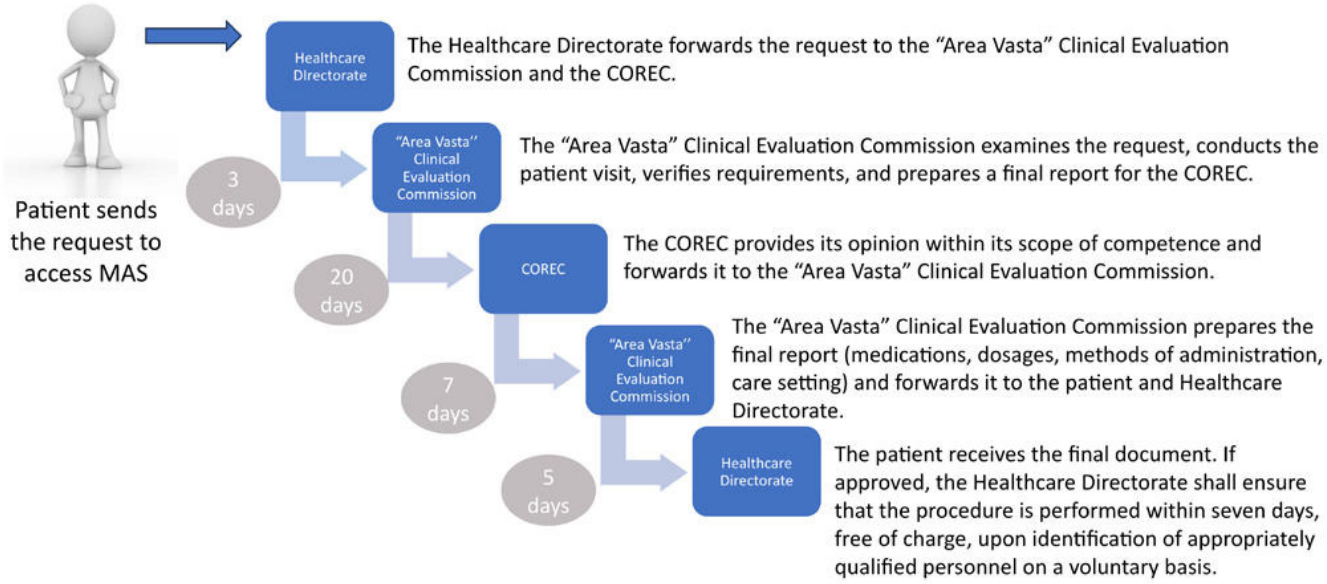

Figure 1. Procedural steps for managing patient requests for medically assisted suicide. Adapted by authors [7]. Abbreviations: Regional Clinical Ethics Committee, COREC; medically assisted suicide, MAS.

clear timeline to patients and families for multidisciplinary care management, as well as supports healthcare institutions in addressing this complex issue without national regulation.

The COREC evaluation addresses the vulnerability of patients and their family members, offering an ethical (rather than purely document-based) assessment, in close collaboration with the Evaluation Commission. Working together can expose challenges, particularly regarding complex definitions such as life-sustaining treatments and unbearable suffering, while raising broader ethical questions concerning the balance between self-determination and vulnerability in such contexts. Moreover, several practical challenges remain, including supporting patients who cannot self-administer medicine, the need for specialised staff and standardised protocols, concerns about territorial inequality, insufficient time to meet patients' needs, infrastructural limitations, and limited training to strengthen clinical competencies in palliative care.

Conclusion

The introduction of PAS requires the development of new ethical guidelines for healthcare professionals, clearly delineating the moral responsibilities and implications from clinical assessment to implementation. In Italy, the ER regional pathway represents a practical solution for providing healthcare professionals and citizens with a clear procedure for accessing PAS, in accordance with the principles of autonomy and equity. Furthermore, the pathway is particularly important given the absence of a national law regulating PAS.

Investing in evidence-based research on the practices and implementation processes can generate timely empirical evidence to assess the impact of the process and deepen understanding of the experiences of the actors involved. This information can help guide the development of high-quality recommendations to increase the acceptability of PAS within Italian society and the medical community. Since administrative solutions are alone insufficient, regulatory frameworks that ensure national uniformity and equitable access are needed to uphold the principles of justice and respect for self-determination.

Author Contribution Statement

MP, CB, and LDP conceptualised the study, MP prepared the original manuscript draft, and LDP critically reviewed the manuscript. All authors contributed to the manuscript revisions and approved the final version for publication.

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