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ORIGINAL RESEARCH

Physician–Patient Relationship, Assisted Suicide and the Italian Constitutional Court

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Abstract In 2017, Italy passed a law that provides for a systematic discipline on informed consent, advance directives, and advance care planning. It ranges from decisions contextual to clinical necessity through the tool of consent/refusal to decisions anticipating future events through the tools of shared care planning and advance directives. Nothing is said in the law regarding the issue of physician assisted suicide. Following the DJ Fabo case, the Italian Constitutional Court declared the constitutional illegitimacy of article 580 of the criminal code in the part in which it does not exclude the punishment of those who facilitate the suicide when the decision has been freely and autonomously made by a person kept alive by life-support treatments and suffering from an irreversible pathology, the source of physical or psychological suffering that he/she considers intolerable, but fully capable of making free and conscious decisions. Such conditions and methods of execution must be verified by a public structure of the national health service, after consulting the territorially competent ethics committee. This statement admits, within strict and regulated bounds, physician assisted suicide, so widening the range of end-of-life decisions for Italian patients. Future application and critical topics will be called into question by the Italian legislator.

Keywords Physician assisted suicide · Italian law · End-of-life decision · Autonomy

Introduction

Dramatic advances in medicine and technology have given modern physicians powerful tools for intervention. In the past, medicine was largely inefficacious when measured by life extension: most major medical breakthroughs contributing to the prolongation of life have evolved in recent years (Singer 2000).

Social and cultural developments have progressively modified the doctor–patient relationship with a growing sense of the importance of self-determinism on the part of individuals and growing concern for individual rights (Lindberg, Johansson, and Broström 2019).

As patients claim an increasingly participatory role with their physicians in making decisions, these changing practices have created new benefits and burdens in the doctor–patient relationship and a sharper focus on it. Physicians have felt the need to think beyond the perceived "medical benefits" that a proposed treatment might offer and are challenged

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to learn more about the patient's values, goals, and hopes for outcomes. People placing a high value on personal autonomy are more likely to choose medical treatments consistent with their goals and to refuse treatments and therapies providing outcomes incongruent with their life plan. A more active, autonomous role for patients who advocate greater control, reduced physician dominance, and more mutual participation has progressively taken place (Wheeler 2017).

With this growing emphasis on patient autonomy and centrality in the decision-making process, the concept of "informed consent" has become a very articulated one in which gradual but clear developments have occurred, helping patients to become more and more aware of their rights to participate in end-of-life decision making (Romo et al. 2017).

The End-of-Life Debate

A number of ethical and legal issues cluster around decisions regarding the end of life (Shreves and Marcolini 2014). Bioethical discussion over the past years has led to considerable agreement on many points, while some issues remain controversial, even in this age of autonomy, such as those concerning the person's right to intentional and direct assistance from their physicians in dying (Macleod, Wilson, and Malpas 2012; Fontalis, Prousali, and Kulkarni, 2018; Colburn 2019).

This still remains a contentious issue, even in the terminology itself (Friesen 2020). Terms such as "medically assisted dying," "medical aid in dying," "physician aid in dying," "physician-assisted suicide," and "death with dignity" are often used interchangeably. Ethically, however, they are not indistinguishable, and each are defined by different values (Friesen 2020). The European Association for Palliative Care (EAPC) defines physician-assisted suicide (PAS) as "a physician intentionally helping a person to terminate his or her life by providing drugs for self-administration, at that person's voluntary and competent request" (Radbruch et al. 2016).

The central knot of the debate remains whether patients can lawfully receive medically administered or self-administered medication from a health provider to end life at their own competent and voluntary request. In specific circumstances, could a patient unable to take any action alone, request another person (mostly the physician) to take an action designed to immediately and painlessly end the patient's life?

Questions are still problematic, and there have been years of discussion across this troubled terrain, mostly depending on background beliefs linked to bioethical reflection about the meaning of human life and dignity, the significance of suffering and dying, and the commitment to autonomy or self-determination (Fontalis, Prousali, and Kulkarni, 2018; Sulmasy et al. 2018; Dugdale, Lerner, and Callahan 2019).

The two most common arguments in favour of PAS are respect for patients' values and relief from suffering, based on appeals to the principle of beneficence/non-maleficence and respect for patient autonomy (Beauchamp and Childress 2004).

Advocates for physician-assisted death argue that this is a natural extension of individual liberty, allowing death by choice, the final autonomous act of a rational person. They claim that this practice must necessarily be regulated because medicine has the power to prolong life so that people who survive may be left to suffer a devastated existence with no means of escape except through death by their own hand or by the hand of the physician or another person. Prohibiting physician-assisted death would be in conflict with the right of individuals to choose to die when quality of life has deteriorated to a point that its continuation is unacceptable for the patient (Dugdale, Lerner, and Callahan 2019). On the opposite side, some argue that autonomy has a relational nature and that limits to self-determination exist (Synder Sulmasy and Mueller 2017).

A further argument in favour of aid in dying is that it may represent the only chance to bring relief to those who suffer greatly. In this view, assisting someone to put an end to his/her life, if this appears to be the only way to avoid unbearable suffering, may be considered ethically acceptable as an act of compassion that respects patient choice and fulfills an obligation of non-abandonment (Quill 2016). It has been also argued that the distinction between forgoing life-sustaining treatment and suicide is arbitrary, denying equally suffering patients an equal opportunity to end their lives (Miller, Truog, and Brock, 2010).

Supporters of PAS argue that when the patient is suffering intolerably, wants to meet death, and is able to give consent, it is beneficent to assist the patient in ending his/her life. Not to do so would be to act maleficently as it violates the dignity and autonomy of the suffering patient. From this view, the patient's request for PAS is likely to be negotiated in the patient–physician relationship. Advocates of PAS (and even euthanasia) are also prone to justify these practices by affirming that, from an ethical point of view, they are equivalent to the withdrawal or withholding of life-support treatments (WWLST) (Goligher et al. 2017), which is generally held to be morally acceptable. They insist that in both these practices, the physician take an action usually leading to the immediate or proximate death of the patient. If withdrawal or withholding of treatments (even if life-sustaining) are accepted when further clinical benefits are not foreseeable, consistent with the patient's values, then a physician should be allowed both to provide a medication which the patient could take to bring a painless end to his life and to take an action designed to immediately and painlessly end the life of the patient.

This controversial issue is likely to be resolved by appealing to the principle of the double effect (PDE), which recognizes that a single action may have two effects, one of which is intended and the other is inevitable but unintended (McIntyre 2004). In this case, the intention is the comfort of the patient, and the attempt to alleviate suffering through medication could be considered morally good. The intent is not to shorten the patient's life, even though it is foreseen that the medical action may lead to a somewhat earlier death. The key consideration in the still very heated debate is the intent of the physician: allowing the patient to die in WWLST as opposed to deliberately ending life in PAS (Ely, Azoulay, and Sprung 2019). In this view, the distinction between "intention" and "foresight" is focused (McClelland and Goligher 2019). Others claim that this argument puts too much emphasis on intention and not enough on outcome, arguing that WWLST is categorically different from PAS as the latter necessarily requires intent to cause death whereas in WWLST the intention of hastening death is neither necessary nor intrinsic to the practice. The issue is even more complicated, as establishing the real intention behind the physician's act may be troubled and fraught with difficulties and the physician's intentions may be multiple and ambiguous (Douglas, Kerridge, and Ankey 2008).

In the ongoing debate regarding end-of-life care and decisions many other important factors are at play.

Supporters of PAS identify respect of the value of patients' "well-being" (Barutta and Vollmann 2015) as pivotal in justifying PAS. Some opponents of PAS argue that it might not represent an informed meaningful decision (Shariff 2011) if valid alternatives are lacking (i.e., good palliative care (PC) services). In 2003, the EAPC task force stated that "the provision of euthanasia and physician-assisted suicide should not be part of the responsibility of palliative care" (Materstvedt et al. 2003); however, a "a synergistic relationship" between PC and PAS (and euthanasia) is conceivable, as both of these practices could represent possible therapeutic options in the palliative care context (Van den Block et al. 2009; Bernheim et al. 2014). The debate on the issue is still ongoing (Zenz, Tryba and Zenz 2015), and opposing opinions are confronting each other. In PAS opponents' view, PAS should be an extreme measure to turn to only when all therapeutic alternatives have been exhausted. If good quality PC is available, requests for PAS would be unlike to occur or they could be fewer (McCormak, Clifford, and Conroy 2012). On the other hand, it could be noteworthy that relief from excruciating and intractable pain is not the only reason for requesting PAS, loss of dignity and/or autonomy, very resistant even to good quality PC, being other sustainable reasons (Rietjens et al. 2009). Humiliation over needing care and anger over threatened loss of independence may represent powerful emotions leading to PAS choice. Such a position recognizes that even in the full availability of good PC, it is likely that PAS (and euthanasia) will continue to be sought by some patients (Hudson et al. 2015), since PC cannot fully relieve all people's suffering. Some have claimed that prohibiting PAS while the goal of optimizing PC is not fully achieved will remove the only option for many patients to avoid further suffering in the meantime (van Delden and Battin 2009). An opposite view is that, given the small number of PAS requests, investment in PC worldwide could have a much greater impact in the general population than investment in facilitating and legalizing PAS (Hudson et al. 2015). Allocating resources into legalizing PAS in response to the request of few would steal resources for PC, and policymakers might be tempted to save on scarce resources for PC (Hudson et al. 2015).

Finally, concerns about implications of PAS for people with disability have been expressed (Krahn 2010; Frost, Sinha, and Gilbert, 2014; Tuffrey-Wijne et al. 2018).

The original focus of the debate on the legalization of PAS was centred on terminally ill, hopeless patients; however, this concept has been challenged and some authors argue that assisted death could be an option also for patients suffering from psychiatric disorders *(*Kim, De Vries, and Peteet 2016). The eventual widening of PAS legalization also to individuals with disabilities and psychiatric disorders has been on the ethical agenda for a long time (Gill 2004), showing a multitude of academic perspectives on the issue (Frati et al. 2014) and a starkly opposite position on the part of mainstream disability right scholars, activists, and, more generally, people with disabilities (Riddle 2017). The position of one of the most influential disability rights international groups (Not Dead Yet) can brilliantly summarize most of the criticisms and perplexities surrounding PAS legalization for disabled people: "assisted dying is the ultimate expression of society's fear and revulsion regarding disability" (Bickenbach 1998); furthermore, those who oppose PAS legalization for disability were concerned that people with disabilities might hasten the death experience because of social, emotional, or financial strains placed on family and/or friends. It has been suggested that permitting PAS devalues the lives of people with disabilities. It could even be speculated that assisted dying could be viewed as an expected choice rather than a free one (Frost, Sinha, and Gilbert 2014).

Advocates of PAS legalization for disabled people have argued that these concerns are perhaps overstated, stating that allowing them to live and die as they wish guarantees their autonomy (Riddle 2017). Every person, including people with disabilities, have the right to act autonomously and to freely and voluntarily make choices. Consequently, people with disabilities also have the right to maintain control at the end of their lives if capable of expressing a reasoned and conscious choice (Riddle 2017). Thus, as for PAS in psychiatric patients, the issue of decisional capacity has figured prominently in the debate (Nicolini et al. 2020), since the stringency of decision-making capacity requirements should increase in proportion to the potential risk to the patient (Parker 2004).

The Italian Landscape

As a consequence of some previous end-of-life cases that had a deep impact in the Italian debate (Botti and Vaccari 2019), a great deal of attention has been given to the need for competent adults to record their wishes about their healthcare in some formal way, and end-of-life issues are germinating in a vastly more congenial bioethical and legal soil. In 2017 Italy passed a law (law 219/2017) that provides for a systematic discipline on informed consent, advance directives, and advance care planning (Ciliberti et al. 2018; Di Paolo et al. 2019; Gristina, Busatta, and Piccinni 2019; Veshi, Koka, and Venditti 2019).

The law firmly recognizes full patient autonomy in the healthcare decision-making process. This right ranges from decisions contextual to clinical necessity through the tool of consent/refusal to decisions anticipating future events through the tools of shared care planning and advance directives (Di Paolo et al. 2019). However, it is clear from the law that patients' autonomy is not absolute and that limits to it exist, represented by both the principles of physicians' medical code and the good clinical practices. Also regarding the advance directives (ADs) (article 4), the law clearly stated that physicians have the duty to respect patients' wishes except when these are incongruous with respect to the patient's current clinical condition or in the event of therapies becoming available that could not have been foreseen when ADs were formulated (Botti and Vaccari 2019; Di Paolo et al. 2019). Conclusively, as mentioned above, the Italian law evoked the general principle that patients cannot demand health treatment contrary to the law, professional ethics, or good clinical practices; with regard to these requests, the doctor have no professional obligations. A further limit to patients' autonomy relies on compliance with the principle of beneficence of any treatment. Physicians have the duty to refrain from non-beneficial treatments, as both the code of medical ethics and the law (article 2) reject therapeutic obstinacy, supporting pain management therapy and pain relief, while opposing ineffective and disproportionate clinical treatments. In the light of this law, the paradigm of relationship-based care becomes critical for improving patients' health, based on respect for patient autonomy and self-determination even in the event of incapacity; the law explicitly affirms the patient's right to refuse or ask for the suspension of life-prolonging treatments. The law explicitly allows patients, in such clinical conditions as when the burden of symptoms and/or pain is no longer acceptable, to decide to let themselves die by requesting WWLST. Furthermore, the law established palliative measures, stating that relief from pain should be ensured even when a patient refuses other life-prolonging treatments. The dispositions set out in the new law recognize the patient's own right to balance the possibilities of prolonging life by continuing or starting treatment against comfort, quality of life, and personal wishes and beliefs (Ciliberti et al. 2018; Botti and Vaccari 2019; Di Paolo et al. 2019; Veshi et al. 2019; Viola et al. 2020).

It can realistically happen that decisions made by the patient hasten death. Under particular clinical conditions, non-treatment decisions (WWLST), and terminal sedation to relieve intolerable pain or symptoms through the administration of high-dose drugs are inevitably burdened by the consequence of anticipating the death of the patient. Under the law provisions such decisions must be respected by the physician.

The law does not allow physicians to intentionally help a person to die by providing drugs for self-administration at that person's voluntary and competent request.

In this way, an unreasonable limitation of the patient's freedom of self-determination in the choice of treatment (including those aimed at freeing the patient from suffering) could arise. The central question is: if those who are kept alive by life support treatments can, under certain conditions, make the decision to end their existence by interrupting such treatment, why can the same person, under certain conditions, not decide to choose the administration of a lethal drug and the successful outcome of an immediate death, thus avoiding the slower, burdensome clinical course due to the interruption of the life support treatments?

Nothing is said in the law regarding the issue of "physician assisted suicide"; in particular, the law specifically states that patients cannot require medical acts that are illegal or contrary to the physician's code of medical ethics or good clinical practices (article 1) (Botti and Vaccari 2019). This article of the law must be interpreted in the light of provisions made by the Italian Criminal Code, which bans any form of incitement and aid to suicide (article 580) (Botti and Vaccari 2019). Article 580 of the Italian Criminal Code is likely to determine an unconstitutional discrimination between those subjects who are able to end their lives by themselves, without the need for external help, and those who are physically unable to do so due to the seriousness of their pathological conditions, with consequent discrimination against the cases most worthy of consideration for their physical and psychological suffering. An unreasonable discrimination would also result in a law that recognizes the legitimacy of WWLSTs burdened by a lethal outcome, while punishing instead the active conduct of facilitation of the immediate cause of death in similar conditions.

In this context, the Italian Constitutional Court recently made a pronouncement regarding the case of Fabiano Antoniani, known as DJ Fabo.

The DJ Fabo Case

DJ Fabo was a young man who, following a serious car crash, was left blind and tetraplegic in 2014. He required assistance to breathe and eat. DJ Fabo maintained intact his mental faculties and was thus aware of his irreversible condition; he firmly expressed his willingness to end his life and fought for his right to die. However, he was unable to gain that right in Italy and chose to end his life at a euthanasia clinic in Switzerland. Marco Cappato, a member of the "Luca Coscioni Association," a society that supports PAS, made the arrangements and accompanied him to a Dignitas facility in Switzerland where DJ Fabo took his own life by self-administration of lethal pentobarbital sodium on February 27, 2017, at the age of forty. Marco Cappato was sued for incitement to and aiding in suicide by the public prosecutor at the Court of Milan. On 14 February 2018, the Court of Assizes of Milan raised the question of constitutional legitimacy of article 580 of the criminal code before the Constitutional Court that, in the Italian legal system, is charged with the task of passing judgement in cases relating to the constitutional legitimacy of laws and acts having the force of laws.

The Constitutional Court Ruling

In October 2018, the Constitutional Court (judgement no. 207/2018) explained that a tightly argued and coherent response to the thorny question raised by the Court of Milan would require not a mere modification of the article of the penal code but a comprehensive review, eventually in the context of the "relationship of care and trust between patient and doctor," appropriately enhanced by article 1 of law 219/2017. The court postponed the discussion of the question of constitutional legitimacy of article 580 of the penal code until September 24, 2019, thus offering a clear indication to the Italian Parliament to legislate on the issue of medically assisted suicide. After the deadline provided to parliament, and in the continuing silence of the Italian legislator, on November 22, 2019, the Italian Constitutional Court (judgement no. 242/2019) declared the constitutional illegitimacy of article 580 of the criminal code

> … in the part in which it does not exclude the punishment of those who facilitate suicide when the decision has been freely and autonomously made by a person kept alive by life-support treatments and suffering from an irreversible pathology, source of physical or psychological suffering that he/ she considers intolerable, but fully capable of making free and conscious decisions, provided that such conditions and methods of execution have been verified by a public structure of the national health service, after consulting the territorially competent ethics committee.

The Constitutional Court took the following position.

The provision referred to in article 580 of the Criminal Code is not, in itself, in conflict with constitutional principles, since it is strongly justified by the need to protect life, especially in the case of the weakest and most vulnerable people, by avoiding external interference in an extreme and irreparable choice like that of suicide.

A limited conceptual area exists in which the provision of article 580 does not comply with the Constitutional Charter: that is, cases involving severely ill people, affected by an irreversible disease, burdened by intolerable physical and/or psychological suffering, who are kept alive by life-support treatments and who are fully competent.

Within this area, the court identified some essential prerequisites for aid to suicide to be judged not punishable.

One prerequisite is the capacity and full decisional autonomy of the patient. This excludes the possibility that the request for assisted suicide may come from a minor (under eighteen) or from an incompetent patient through a surrogate or a trustee. A further point is that patients are presumed to be competent in the healthcare setting. However, the very nature or the severity and the duration of the disease may render the patient incapacitated as regards decision-making. Severe disease can undermine the ability of patients to deliberate and make decisions for themselves. To ensure that individuals retain as much autonomy or self-determination as is legally requested, the court determines competence in a very specific manner, clearly stating that the patient requesting the aid to suicide must have "effective" decision-making autonomy, despite the very serious conditions of personal suffering. Decision-making capacity remains a critical concern; medical professionals are called upon to offer professional judgements as to its presence or absence. The patient's self-determination and the free and informed nature of the choice must be ascertained. The concept of awareness concerns the capacity to understand the clinical situation, including any alternatives to the suicidal decision, that is, those regarding deep palliative sedation and WWLSTs. Awareness concerns the capacity to evaluate the different options and make a choice between different alternatives.

A further prerequisite is actuality and revocability of the choice. It has to be stressed that the decision must come from a constantly aware patient through the whole decision-making process until the moment of the execution of the assisted suicide. Regarding PAS, decision-making capacity must exist along a continuum, referring to the ability of the patient to make the specific decision to end his/her life, time to fully understand the nature of his/her medical condition, to discern between the different alternatives (deep sedation, withholding of life-support treatments), and finally to maintain this choice consistently over time.

As a consequence, the request for PAS cannot be included in advance directives (ADs). According to law 219/2017, the aim of ADs is the patient's deliberation regarding treatments that may become necessary in a future time if the patient should become incompetent; thus ADs cannot concern the request for an exit plan that requires the full awareness of patients.

To be eligible for PAS, a patient must be at least eighteen years of age and capable of making decisions regarding his/her health, be affected by a grievous and irremediable pathological condition, and have made a free, voluntary request for PAS without any external pressure or interference, grounded on full information regarding the means available to relieve suffering, including palliative care. The constitutional judges underline that involvement in a palliative care path must be "a prerequisite of the later choice of any alternative path by the patient."

Finally, the verification of the conditions that make the aid to suicide legitimate must also be entrusted to public structures of the national health service. The latter will also be responsible for verifying the relative operating procedures, which evidently must be such as to avoid abuse to the detriment of vulnerable people, to guarantee the patient's dignity and avoid suffering to the patients themselves. The delicacy of the value at stake also requires the intervention of an adequately skilled committee, which could guarantee the protection of these particularly vulnerable situations. Pending the intervention of the Italian legislator, this task is entrusted to the territorially competent ethics committees. These committees, as consultation and reference bodies for ethical problems that may arise in the health practice, are, in fact, invested with consultative functions intended to guarantee the protection of a person's rights and values concerning any clinical trials involving humans.

It is worth noting that the declaration of constitutional illegitimacy limits itself to excluding punishment for aiding suicide in the cases considered, without creating any obligation for physicians. It remains, therefore, up to the conscience of the single doctor, to choose whether or not to fulfill the patient's request.

Following this ruling, on February 6, 2020, article 17 of the Italian Code of Medical Ethics was coherently modified. The original draft of this article ("Acts aimed at causing death") provided that "The doctor, even at the request of the patient, must not perform or favour acts aiming to cause his death." The current wording of article 17 is therefore the following:

> The doctor, even at the request of the patient, must not carry out or favour acts aimed at causing his/her death. The free choice of the doctor to facilitate, on the basis of the principle of self-determination of the individual, the intention of suicide autonomously and freely formed by a person kept alive by life-support treatments, suffering from an irreversible pathology, which is a source of physical suffering or psychological intolerable, but yet who is fully capable of making free and conscious decisions (Constitutional Court ruling 242/19 and related procedures), must always be assessed case by case. This implies, if all the above elements exist, the non-punishment of the doctor from a disciplinary point of view.

Future Issues

In the light of the sentence, looming on the horizon are a number of complexities which need to be analysed.

First of all, a central question remains open: would helping the patient to end his/her life be an obligation of the medical profession resulting from its possession of knowledge that the patient both needs and is entitled to? Or should a weaker view not impose such an obligation on the physician?

The court provides a warrant for legalization of assisted suicide which would empower physicians who wish to participate. As with many other ethically sensitive medical topics (abortion, ADs), the challenge is how to balance two potentially conflicting values: the physician's right to freedom and the patient's choices. Conscientious objection (CO) to PAS becomes a part of the existing, thorny international debate on the theme (Rhodes 2019; Ben-Moshe 2019; Wilkinson 2017; Salloch 2016; Ely, Sprung, and Somerville 2017; Stayl and Emanuel 2017).

On the one hand, it could be said that physicians have the right to refuse acts and treatments which go against their conscience. On the other hand, one can speculate that this right is not absolute if it contrasts and limits patients' rights, values, needs, and priorities, thus resulting in the further harassment of patients themselves. According to this view, nothing could be more restrictive of a patient's rights than to refuse their request for "assistance in dying."

Also in Italy, the debate regarding CO is deeply rooted (Meaney, Casini, and Spagnolo 2012; Minerva 2015; Bo, Zotti, and Charrier 2017). The Italian Constitution recognizes a sort of "freedom of conscience" as a pivotal right, protecting freedom of religion, expression, and thought. The various deontological codes for healthcare professionals recognize the right to CO, and professional associations of healthcare professionals have reiterated the right of their members not to be forced to carry out interventions that are contrary to their moral beliefs (Meaney, Casini, and Spagnolo 2012). Previous studies have demonstrated that highly religious physicians are more likely to oppose PAS than those with low religiosity (Curlin et al. 2008; Cavalieri et al. 2002; Meier et al. 1998). Unexpectedly, more recent surveys report a significant positive correlation between higher religiosity and positive attitudes toward euthanasia (Hains and Hulbert-Williams 2013), suggesting the prevalent importance of individual differences in determining these attitudes and perhaps reflecting a broader cultural shift in attitudes since earlier research in this area.

Closely linked to CO issue, a further critical conceptual knot will remain that of the accommodation of all the parties involved in PAS: patients, healthcare professionals, the healthcare system (Wicclair 2019).

Undoubtedly, PAS is a contentious healthcare policy issue, destined to have significant impact on the Italian public health system, where responsibility for healthcare is shared between the central and regional governments that in turn delegate this responsibility to local health authorities. Large differences in regional health service organization and provision exist in Italy (France, Taroni, and Donatini 2005). There being multiple health authorities across the country, the risk of different operative policies regarding PAS is high, also considering that a recent study by D'Angelo et al. demonstrated the presence of inequity in access to palliative care among advanced cancer patients (D'Angelo et al. 2020). Other studies reported that the extension of palliative care services provided to frail non-cancer and paediatric patients is still inadequate in Italy (Scaccabarozzi et al. 2017, 2019).

In this complex contest, the strict definition of procedures and plans and nursing and physician protocols in a national legislated context will be necessary to guide PAS practices and to avoid PAS being used inappropriately (Petrini 2019). Specific reporting and audit systems are desirable to further develop national policies and best practices on such an impactful event as PAS and to scrutinize the quality of the whole process of PAS, mostly regarding assessment procedures (Pesut et al. 2020).

Conclusions

Whatever personal positions there may be on the fundamental questions and moral presuppositions, the ruling of the Constitutional Court will impact on the ethical-juridical debate and on the physician–patient relationship and its fundamental purposes. Undoubtedly, the Constitutional Court has inaugurated a new and courageous path, continuing that already taken by Law 219/2017 and has enlarged the margins of patient self-determination.

Under the conceptual framework delineated by the constitutional judges and bylaw 219/2017, patients and physicians may share the intention to hasten death by PAS and this intention is negotiable between them but is of no concern to third parties, since patient and physician are always free to contract each other as they choose. Patients and physicians are autonomous in that they agree to pursue a course towards death together and freely enter into a strict care relationship with each other.

The statement of the Constitutional Court seems to admit, within strict and regulated bounds, the principle of PAS, so widening the range of end-of-life decisions and acts for Italian patients. Now the challenge will be the balancing of the legal plan with that of the professional codes of ethics and finding the right balance that from the principles passes to the practical application. It could be critical for medical and healthcare personnel to follow their organization's defined code of ethics and conduct despite their personal convictions (Atkinson Smith, Torres, and Burton 2020). Future application and critical topics such as conscientious objection will be called into question by the Italian legislator.

Authors' contributions ET and PF designed the study. MDP carried out the main work at each step. AM and MS supported the bibliographic research and contributed to the plan of the paper. ET drafted the manuscript and made major revisions.

All authors have discussed and revised the manuscript and have read and approved the final version.

Declaration

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