

NOTES

HAS ITALY DISCOVERED VIRGIL? UTILIZING THE BRITISH ARCHETYPE TO CREATE END-OF-LIFE LEGISLATION IN ITALY

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I. INTRODUCTION

The right to life and conversely the right to death have long been debated politically, ethically, and legally.¹ A deep chasm divides individuals primarily into two camps: (1) those that

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¹ See generally NEIL M. GORSUCH, *THE FUTURE OF ASSISTED SUICIDE AND EUTHANASIA* 1-7 (Robert P. George ed., Princeton Univ. Press 2006); JOHN KEOWN, *EUTHANASIA, ETHICS AND PUBLIC POLICY: AN ARGUMENT AGAINST LEGALISATION* 1-5 (Cambridge Univ. Press 2002).

recognize an inherent right to premature self-determination; and (2) those that believe the act of unnaturally ending life is immoral and should be proscribed by law.² Recognizing the extreme sensitivity this issue demands, supranational governing bodies have repeatedly refused to embroil themselves in the battle, instead deeming end-of-life legislation the sole province of the individual European Union (EU) Member States.³

Standing at opposite ends of the spectrum of the euthanasia debate are Switzerland and the United Kingdom (UK). For nearly a century, Swiss law has explicitly permitted its citizens to assist another in ending his or her life.⁴ Switzerland finds ethical footing in altruistic reasoning and liberal philosophy.⁵ In contrast, British law is relatively conservative, expressly criminalizing any act that aids another in ending his or her life.⁶ While recent developments in September 2009 may lead to a gradual liberalization of UK legislation,⁷ such enactments have yet to materialize.

In this polarized environment, Italy is unique because it has no explicit end-of-life legislation.⁸ Italian courts have applied the Penal Code on an ad hoc basis, stretching the law in an attempt to

² The right to life and, conversely, the right to death have long been debated politically, ethically, and legally. See GORSUCH, *supra* note 1, at 4. Neil Gorsuch has summarized the incongruity:

[V]arious contemporary moral and legal writers have given conflicting views. Some have suggested that history is moving inexorably toward legalisation [of assisted suicide and euthanasia]; others contend that there is no meaningful way to distinguish between the right of a patient to refuse care and the right of a patient to seek out euthanasia; a virtual chorus has argued that proper respect of a patient for personal autonomy and self-determination demands that we respect the right of individuals to take their lives with willing assistants; and others still submit that legalization would carry with it more benefits than costs and would thus maximize social happiness on a utilitarian scale.

Id.

³ PENNEY LEWIS, *ASSISTED DYING AND LEGAL CHANGE 1* (Oxford Univ. Press 2007). “The question whether assisted dying should be legalized is often treated, by judges and commentators alike, as a question which transcends national boundaries and diverse legal systems.” *Id.*

⁴ See *infra* Part IV.

⁵ Samia A. Hurst & Alex Mauron, *Assisted Suicide and Euthanasia in Switzerland: Allowing a Role for Non-physicians*, 326 *BMJ* 271, 271 (2003), available at <http://www.bmj.com/cgi/reprint/326/7383/271>.

⁶ See *infra* Part V.

⁷ Sarah Lyall, *Guidelines in England for Assisted Suicide*, *N.Y. TIMES*, Sept. 24, 2009, available at http://www.nytimes.com/2009/09/24/world/europe/24britain.html?_r=2&th=&emc=th&pagewanted=print.

⁸ See *infra* Part VI.

encompass this exceptionally delicate issue. This has resulted in a significant amount of litigation that lacks both consistency and clarity.⁹ In 2009, the Italian Senate passed a bill seeking to establish conservative end-of-life policies in tune with the Roman Catholic Church.¹⁰ However, the bill received heavy criticism as it asserts principles that contradict the majority view of European medical professionals.¹¹ Various international organizations, as well as domestic institutions, have implored the Italian legislature to give the controversial act more time for debate.¹² Currently, the bill awaits review by the lower house of Parliament, the Chamber of Deputies.¹³

This Note argues that the contemporary British legislative model provides a practical framework upon which Italy can draft effective end-of-life policies (ELPs). In many regards, UK legislation conforms to conservative Italian orthodoxy, yet it also is able to account for progressive liberal idiosyncrasies in the Italian system. This Note provides a context for the discussion by surveying the legal and historical development of divergent end-of-life legislation in Switzerland and the UK. The Note considers several legal, political, and cultural factors inherent to Italy before advocating for the implementation of the British archetype.

Part II introduces terminology necessary for understanding end-of-life legislation. Part III discusses the general *laissez-faire* attitude of international supervisory European entities, such as the European Court of Human Rights. Part IV summarizes the liberal model implemented in Switzerland. Part V surveys the conservative approach of the UK and addresses recent legal developments that may gradually liberalize British law. Part VI provides an overview of the historical and legal landscape of Italy. Part VII analyzes the proposed bill that awaits review by the Chamber of Deputies. Finally, Part VIII argues that several factors, germane to Italy's particular dilemma, should foster the development of more liberal ELPs and that the British model can serve as a functional framework for future Italian end-of-life

⁹ *Id.*

¹⁰ Disposizioni in Materia di Alleanza Terapeutica, di Consenso Informato e di Dichiarazioni Anticipate di Trattamento, Senato, n. 10 (2009), <http://www.senato.it/service/PDF/PDFServer/BGT/00409737.pdf>.

¹¹ *See infra* Part VII.

¹² *Id.*

¹³ Allegato A, Seduta n. 158, Apr. 2, 2009, *available at* http://documenti.camera.it/leg16/resoconti/assemblea/html/sed0158/allegato_a.comunicazioni.01.htm.

legislation.

II. DEFINING END-OF-LIFE PROCEDURES

Euthanasia is an overly broad term often used to characterize a multitude of life-ending procedures.¹⁴ Its definition varies across jurisdictions, professions, and national borders.¹⁵ In some countries, such as Italy, the legislature has yet to construct a precise legal definition of euthanasia.¹⁶

For the purposes of this examination, there are several distinct terms that require explanation before analyzing ELPs.

A. *Euthanasia v. (Physician) Assisted Suicide*

The principal factor that distinguishes euthanasia from assisted suicide is the individual who executes the action that results in death.¹⁷ Euthanasia can be defined as “the intentional causation of the death of a [person] suffering from a severe and incurable disease, in order to put an end to his/her pain and distress.”¹⁸ There are generally three essential elements: (1) the conduct causing another’s death;¹⁹ (2) the nature of the disease;²⁰ and (3) the motive of the actor.²¹ Physician assisted suicide can be defined as “the ending of one’s life through the voluntary self-administration of lethal medications prescribed by a physician for that purpose.”²² The broader definition of assisted suicide is “any act which intentionally helps another to commit suicide . . . by ‘providing him with the means to do so.’”²³

¹⁴ LEWIS, *supra* note 3, at 4-5.

¹⁵ Rohith Srinivas, *Exploring the Potential for American Death Tourism*, 13 MICH. ST. U. J. MED. & L. 91, 94 (2009).

¹⁶ Francesco Viganò, *Euthanasia in Italy*, in EUTHANASIA IN INTERNATIONAL AND COMPARATIVE PERSPECTIVE 167, 167 (Marc Groenhuijsen & Floris van Laanen eds., Wolf Legal Publishers 2006).

¹⁷ Srinivas, *supra* note 15, at 94.

¹⁸ Viganò, *supra* note 16, at 168.

¹⁹ *Id.* When analyzing conduct, it is important to distinguish between an act and an omission. *Id.*

²⁰ *Id.* The affliction must involve great pain and distress that cannot be substantially assuaged by palliative care, from which there is no hope of recovery. *Id.*

²¹ *Id.* In some countries, such as Switzerland, the principal must take action “out of compassion towards the [individual], so that his/her act could be regarded as a ‘mercy killing,’ [sic] rather than as a common homicide.” *Id.*

²² Katrina George, *A Woman’s Choice? The Gendered Risks of Voluntary Euthanasia and Physician-Assisted Suicide*, 15 MED. L. REV. 1, 1 n.1 (2007).

²³ LEWIS, *supra* note 3, at 5.

B. Voluntary v. Non-voluntary Euthanasia

Voluntary euthanasia is when an individual “helps another in putting an end to his/her life, in response to a repeated and informed consent, under certain pre-established conditions, according to his/her request and/or will”²⁴ Non-voluntary euthanasia constitutes “all situations where the patient is *unable to express any wish* about his/her death, being unconscious or mentally confused.”²⁵ It is important to note that non-voluntary euthanasia is distinct from involuntary euthanasia, which is the killing of a person who does not desire to be euthanized.²⁶

C. Active v. Passive Euthanasia

Active euthanasia is “positive conduct”²⁷ by a third party with the “aim of ending someone’s life.”²⁸ Passive euthanasia refers to “letting die”—“*inaction* by a person (usually a doctor) who has a *duty* to give a treatment to a patient in order to prevent his/her death.”²⁹ In practice, this situation typically arises when there is a request for the withdrawal of life-sustaining treatment, such as artificial ventilation or nasogastric feeding and hydration tubes.³⁰ Recently, a significant portion of the debate on euthanasia in both Italy and the United States has focused on passive euthanasia and the withdrawal of life-sustaining treatment.³¹

D. Indirect Euthanasia

Indirect euthanasia refers to medical treatment, which is “directly aimed at alleviating the suffering of the patient in terms of palliative care,” but has the foreseeable side effect of shortening the patient’s life.³² The acceleration of death is usually induced through prescription medication.³³

²⁴ Nuno Ferreira, *Latest Legal and Social Developments in the Euthanasia Debate: Bad Moral Consciences and Political Unrest*, 26 MED. & L. 387, 390 (2007).

²⁵ Viganò, *supra* note 16, at 169.

²⁶ *Id.*

²⁷ *Id.*

²⁸ Ferreira, *supra* note 24, at 389.

²⁹ Viganò, *supra* note 16, at 170.

³⁰ *Id.*

³¹ See Jeff Israely, *A Controversial End to Italy’s Own Terri Schiavo Case*, TIME, Feb. 9, 2009, available at <http://www.time.com/time/world/article/0,8599,1878184,00.html>.

³² Viganò, *supra* note 16, at 171.

³³ Ferreira, *supra* note 24, at 390.

E. Advance Treatment Directive

An advance treatment directive is a document in which the author specifies the medical treatment he or she desires under particular conditions.³⁴ A directive can address a treating physician directly or indirectly through an appointed medical proxy.³⁵ As of late, the subject of considerable debate in both the medical and legal arena has been the enforceability of a negative directive—the prior documented will of a patient rejecting mechanical breathing support or artificial hydration and feeding apparatuses when the individual is in a vegetative state.³⁶

III. SUPRANATIONAL EUROPEAN ENTITIES

Europe is torn over how it should treat its terminally ill and comatose citizens.³⁷ On one side are EU Member States, such as Belgium,³⁸ the Netherlands³⁹ and Luxembourg,⁴⁰ that have legalized certain life-ending procedures. Juxtaposed to those countries are Spain⁴¹ and Poland,⁴² which expressly prohibit any form of euthanasia or assisted suicide. The division is not surprising as ELPs require legislators, judiciaries, law enforcement officials, and medical professionals to engage in a delicate balancing act that involves sensitive legal, political, ethical, cultural, and religious factors.⁴³ Considering the intrinsic

³⁴ CRISTIANO VEZZONI, *ADVANCE TREATMENT DIRECTIVES AND AUTONOMY FOR INCOMPETENT PATIENTS: AN INTERNATIONAL COMPARATIVE SURVEY OF LAW AND PRACTICE, WITH SPECIAL ATTENTION TO THE NETHERLANDS* 5 (Edwin Mellen Press 2008).

³⁵ *Id.* An advanced directive is equivalent to a living will, which is frequently used in the United States. *Id.*

³⁶ *Id.*

³⁷ *Euthanasia: A Continent Divided*, BBC NEWS, Feb. 11, 2009, <http://news.bbc.co.uk/2/hi/europe/7322520.stm>. In 2006, the International Academy of Comparative Law at its XVIIth Congress in Utrecht, Netherlands, dedicated one session solely to the “heated doctrinal debate on the admissibility of certain kinds and types of euthanasia.” EUTHANASIA IN INTERNATIONAL AND COMPARATIVE PERSPECTIVE, *supra* note 16, at 1.

³⁸ JOHN GRIFFITHS, HELEEN WEYERS & MAURICE ADAMS, *EUTHANASIA AND LAW IN EUROPE* 295 (Hart Publishing 2008).

³⁹ *Id.* at 51.

⁴⁰ Jeff Israely, *Luxembourg’s Monarch Steps Back on Euthanasia Bill*, TIME, Dec. 12, 2008, available at <http://www.time.com/time/world/article/0,8599,1865825,00.html>.

⁴¹ Graciela Nowenstein, *Spain*, in *EUTHANASIA AND LAW IN EUROPE*, *supra* note 38, at 443, 443.

⁴² Witold Kulesza, *Euthanasia in Poland*, in *EUTHANASIA IN INTERNATIONAL AND COMPARATIVE PERSPECTIVE*, *supra* note 16, at 227, 229.

⁴³ See *EUTHANASIA IN INTERNATIONAL AND COMPARATIVE PERSPECTIVE*, *supra*

complexities of each individual EU Member State, it would be impractical for an international governing body to attempt to draft strict end-of-life legislation.

A. The European Court of Human Rights

The European Court of Human Rights (ECHR) interprets the Convention for the Protection of Human Rights and Fundamental Freedoms (Convention) “in the most ‘intimate aspects of the relations between the citizen and the State.’”⁴⁴ Although the ECHR adjudicates many disputes that are “not traditionally handled in an international forum[,]” the court walks a fine line in order to avoid trampling the rights of the individual EU Member States.⁴⁵

Article 2 of the Convention states: “Everyone’s *right to life* shall be protected by law.”⁴⁶ In 2002, a British citizen petitioned the ECHR to broadly interpret the phrase “right to life” to include the right to death.⁴⁷ The ECHR declined to construe Article 2 as protecting the right to self-determination in relation to issues of life and death.⁴⁸ The complexity of the issue, coupled with the inability of the court to identify a homogeneous European position, forced the ECHR to leave the determination of ELPs to the individual European Union Member States.

The decision of the ECHR did not settle the dispute and in late 2005, the European Commission asked the European Union Network of Independent Experts on Fundamental Rights (EUNIEFR) to issue an opinion on the matter.⁴⁹ As part of a

note 16, at 1.

⁴⁴ Emily Wada, *A Pretty Picture: The Margin of Appreciation and the Right to Assisted Suicide*, 27 *LOY. L.A. INT'L & COMP. L. REV.* 275, 287 (2005) (quoting J.G. MERRILLS, *THE DEVELOPMENT OF INTERNATIONAL LAW BY THE EUROPEAN COURT OF HUMAN RIGHTS* 9 (Manchester Univ. Press 1993) (1988)).

⁴⁵ *Id.*

⁴⁶ Convention for the Protection of Human Rights and Fundamental Freedoms art. 2, Nov. 4, 1950, 213 U.N.T.S. 221 (emphasis added), available at http://www.hrcr.org/docs/Eur_Convention/euroconv.html. Article 2 of the Convention asserts: “Everyone’s right to life shall be protected by law. No one shall be deprived of his life intentionally save in the exception of a sentence of a court following his conviction of a crime for which this penalty is provided by law.” *Id.*

⁴⁷ Wada, *supra* note 44, at 277.

⁴⁸ *See id.*

⁴⁹ E.U. Network of Independent Experts on Fundamental Rights, Opinion N° 4-2005: The Right to Conscientious Objection and the Conclusion by EU Member States of Concordats with the Holy See, Dec. 14, 2005, http://ec.europa.eu/justice_home/cfr_cdf/doc/avis/2005_4_en.pdf. EUNIEFR “monitors the situation of fundamental rights in the

forty-page opinion, EUNIEFR issued the following statement:

[A]lthough neither euthanasia nor assisted suicide are protected as such under the European Convention on Human Rights or any other international human rights instrument, in a State where euthanasia or assisted suicide are partially decriminalized, the right to religious conscientious objection . . . should not be exercised in a way which leads to depriving any person from the possibility of exercising effectively his or her rights as guaranteed under the applicable legislation.⁵⁰

Conservatives argued that the opinion was an attempt to make “assisted suicide, same-sex marriage and access to contraception to be among the ‘human rights’ guaranteed to citizens of the EU.”⁵¹ However, contrary to this assertion, the opinion merely emphasized the ECHR’s prior ruling that ELPs were the sole province of the sovereign EU Member States.⁵² The statement reiterated that no international human rights law protected either euthanasia or assisted suicide.⁵³ EUNIEFR asserted that only in countries that have partially decriminalized either practice, should citizens not be precluded from availing themselves of their legal rights.⁵⁴

IV. SWITZERLAND

In regards to ELPs, Switzerland illustrates a unique approach distinct from all other European countries. Although all forms of active euthanasia are criminalized,⁵⁵ Switzerland has legalized passive euthanasia, *Sterbehilfe*,⁵⁶ and assisted suicide. First, under Swiss law, “[d]eaths due to withholding or withdrawing of life-

Member States and in the Union as well as opinions on specific issues related to the protection of fundamental rights in the Union.” *Id.* at 1.

⁵⁰ *Id.* at 22.

⁵¹ *EU Panel Calls for Protection of Assisted Suicide, ‘Gay’ Marriage*, 9 CATH. FAM. & HUM. RTS. INST. No. 3 (2006), http://www.c-fam.org/publications/id.442/pub_detail.asp.

⁵² See Opinion N° 4-2005, *supra* note 49.

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ Swiss law does not expressly recognize euthanasia; nevertheless, “murder upon request by the victim” (omicidio su richiesta della vittima) is illegal under Article 114 of the Swiss Penal Code. Codice Penale Svizzero [CP] [Swiss Penal Code] Jan. 1, 1990, RS 311.0, art. 11 (Switz.), available at http://www.admin.ch/ch/i/rs/311_0/a114.html. See Hurst & Mauron, *supra* note 5, at 272.

⁵⁶ Georg Bosshard, *Switzerland*, in EUTHANASIA AND LAW IN EUROPE, *supra* note 38, at 463, 464-65.

prolonging treatment are considered ‘natural’ deaths,” and need not be reported to criminal authorities.⁵⁷ Second, in nations that allow assisted suicide, legislation generally requires the involvement of physicians as a necessary safeguard because they “know how to ensure a painless death, and are in a position to offer palliative care knowledgeably.”⁵⁸ Switzerland, surprisingly, does not require that an individual aiding suicide be a certified physician or have any prior medical training.⁵⁹

A. *Passive Euthanasia*

The withholding or withdrawing of life-sustaining medical care is legal according to Swiss common law and permitted under the ethical guidelines produced by the Swiss Academy of Medical Sciences (SAMS).⁶⁰ One commentator argues, “This reflects the deeply rooted sentiment . . . that in . . . case[s] of passive [euthanasia] it is the disease rather than the physician’s decision or action that is responsible for the patient’s death.”⁶¹ Over the last thirty-five years, the European definition of passive euthanasia has expanded to include the withholding of artificial nutrition and hydration, as well as the discontinuance of life-prolonging devices such as respirators.⁶²

Passive euthanasia is not limited to situations where death is imminent; as such, competent patients have the legal right to refuse treatment at any time during their affliction.⁶³ Likewise, incompetent patients may have life support discontinued based upon their prior written will.⁶⁴ Under these circumstances, a patient’s immediate family becomes a vital source of information, although the final decision is left to the treating physician.⁶⁵ However, if a patient, prior to incapacitation, had appointed a health care proxy, he or she is entitled to provide or refuse consent to treatment on behalf of the patient.⁶⁶ SAMS currently holds

⁵⁷ *Id.* at 465-66.

⁵⁸ Hurst & Mauron, *supra* note 5, at 271.

⁵⁹ *Id.*

⁶⁰ Bosshard, *supra* note 56, at 465.

⁶¹ *Id.*

⁶² *Id.* at 466.

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ Bosshard, *supra* note 56, at 465.

⁶⁶ *Id.* In contemporary medical practice, such an explicit unequivocal health care proxy is rare. *Id.*

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advance treatment directives as binding “as long as they apply to the actual situation and there is no indication that they no longer reflect the patient’s current wish.”⁶⁷

B. Assisted Suicide and Voluntary Euthanasia

The determinative element in Swiss euthanasia law is the subjective intent of the individual assisting in the suicide.⁶⁸ A comment by the federal government during the drafting of the first penal code in 1918 colorfully illustrates Switzerland’s position. In the statement, the government declared that suicide is not a crime, and that altruistic intentions may inspire an individual to assist another in ending one’s life.⁶⁹ Article 115 of the modern penal code states: “[S]omeone who for *selfish motives* aids or abets another person in suicide will be punished, whether the suicide was completed or attempted, by imprisonment of up to five years or a fine.”⁷⁰ Article 115 requires neither the complicity of a physician nor even that the patient be terminally ill. Prosecution is extremely rare and usually ensues only if there are doubts as to the patient’s competency to have made an informed decision.⁷¹ As a result, investigations into instances of assisted suicide are typically “open and shut cases.”⁷²

C. Physicians’ Responsibility

In Switzerland, the legal and ethical responsibilities of physicians are not entirely clear, as the penal code arguably conflicts with Article 11 of the narcotics law.⁷³ The narcotics law requires that “drug[s] be used, dispensed and prescribed according to the established rules of medical practice”⁷⁴ In an attempt

⁶⁷ *Id.* at 467 (quoting Schweizerische Akademie der Medizinischen Wissenschaften, Reglement für das Nationale MD-PhD Programm des Schweizerischen Stiftungsverbundes (2005)). This contrasts the initial position of SAMS, which held that “refusal of life-preserving treatment in a written directive ‘should not be heeded if the patient’s condition would, according to general experience, permit a return to interpersonal communication and a reinforcement of the will to live.’” *Id.* at 467-68.

⁶⁸ See Hurst & Mauron, *supra* note 5, at 271.

⁶⁹ *Id.*

⁷⁰ Codice Penale Svizzero [CP] Jan. 1, 2007, RS 311.0, art. 115 (Switz.) (emphasis added), available at http://www.admin.ch/ch/i/rs/311_0/a115.html.

⁷¹ Hurst & Mauron, *supra* note 5, at 271.

⁷² *Id.*

⁷³ See Bosshard, *supra* note 56, at 473.

⁷⁴ *Id.*

to clarify the ambiguity, SAMS further muddled the discussion by stating that assisted suicide is “not a part of a physician’s activity.”⁷⁵ This resulted in two divergent interpretations: (1) physicians should not assist suicide; and (2) assisted suicide is outside the purview of professional oversight, and therefore physicians have the freedom of choice as whether to assist, like any citizen under the penal law.⁷⁶

Courts have provided some clarification, holding that “assisting suicide is not in principle incompatible with the rules of medical practice, but that an obligation to ascertain the patient’s competence . . . is a prerequisite to the prescription of a lethal drug for the purposes of assistance in suicide.”⁷⁷ In 2004, SAMS released new guidelines, which were more restrictive than the penal code, further limiting the type of patient that a physician may assist.⁷⁸

D. Right-to-Die Organizations

Another distinguishing characteristic of Swiss ELPs is that the legislature has not issued a single statutory provision or administrative statement prohibiting its citizens from assisting in the suicides of non-Swiss residents.⁷⁹ Switzerland’s liberal model, which focuses on the subjective intent of individuals, coupled with the absence of any legislation prohibiting those who seek to utilize Swiss ELPs from entering the country, provided a fertile environment for the development of several right-to-die organizations in the 1980s.⁸⁰ The Swiss government has left regulation entirely up to the individual right-to-die organizations, as they are entitled under the law to establish their own internal policies and controls.⁸¹

1. EXIT

In 1982, Exit Deutsche Schweiz and Exit ADMD, ‘*Association pour le Droit de Mourir dans la Dignité*,’ (EXIT)

⁷⁵ Hurst & Mauron, *supra* note 5, at 272.

⁷⁶ *Id.*

⁷⁷ Bosshard, *supra* note 56, at 473.

⁷⁸ *Id.* at 474.

⁷⁹ Srinivas, *supra* note 15, at 106.

⁸⁰ *See* Bosshard, *supra* note 56, at 463. *See also* Srinivas, *supra* note 15, at 106.

⁸¹ Srinivas, *supra* note 15, at 106.

began to market assisted suicide services to severely ill patients.⁸² EXIT required that a person seeking assistance have an affliction with “poor prognosis, unbearable suffering or unreasonable disability.”⁸³ Until the early 1990s, the organization distributed booklets that instructed members on how to commit suicide by either self-asphyxiation using a plastic bag or by ingesting a combination of drugs.⁸⁴ The narcotics included hypnotics, which the manual instructed could be acquired by approaching several physicians and falsely informing them that one suffers from insomnia.⁸⁵

Many members of EXIT did not agree with its initial practices and after a decade, the organization began to offer personal guidance to individuals seeking assistance.⁸⁶ EXIT’s current method of ending life requires a person to ingest a lethal dose of prescription barbiturates.⁸⁷ EXIT emphasizes the presence of a volunteer at the time of ingestion because experience has demonstrated that patients without assistance often have difficulties imbibing the lethal dose “in such a way as to achieve their objective with certainty.”⁸⁸

2. *Dignitas*

Although EXIT has established self-imposed restrictions offering services only to Swiss citizens, another end-of-life organization—Dignitas—markets itself internationally.⁸⁹ In 1998, Ludwig Minelli, a lawyer, founded Dignitas in order to assist patients in drafting living wills and in painlessly ending their lives.⁹⁰ Dignitas requires that participants have at least two consultations with an organization representative, accompanied by a break in between sessions,⁹¹ before, typically,⁹² administering a

⁸² Bosshard, *supra* note 56, at 472. Hereinafter, Exit Deutsche Schweiz and Exit ADMD will be referred to in the aggregate as EXIT.

⁸³ *Id.* at 474-75.

⁸⁴ *Id.* at 472.

⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ Bosshard, *supra* note 56, at 472.

⁸⁸ *Id.* at 475.

⁸⁹ Srinivas, *supra* note 15, at 106.

⁹⁰ Roger Boyes, *Murky Truth Behind Swiss Suicide ‘Clinic’ Dignitas*, TIMES ONLINE, Oct. 25, 2008, http://www.timesonline.co.uk/tol/life_and_style/health/article5006805.ece.

⁹¹ *Id.* In cases involving non-terminally ill patients, a longer waiting period of eight weeks is usually required. *Id.*

⁹² In 2008, Swiss medical supervisory boards cracked down on physicians who had the

drink containing a deadly dose of sodium pentobarbital.⁹³ Dignitas demands that its patients have the capacity to understand and participate in the procedure.⁹⁴

Throughout the 1990s, the number of assisted suicides of Swiss citizens completed at EXIT tripled to roughly 100 per annum, and by 2004 it had further increased to around 200.⁹⁵ Dignitas also saw its numbers increase dramatically in the last several years. From October 10, 2002, until April 2, 2004, twenty-two people committed suicide with the assistance of Dignitas representatives, but by 2008, the organization averaged more than 100 deaths per year.⁹⁶ Over fifty percent of Dignitas patients are German, with the remainder primarily coming from the UK, France, and Austria.⁹⁷ In 2008, Switzerland had a total population of approximately seven million and roughly 62,000 deaths.⁹⁸ EXIT and Dignitas combined accounted for only 0.483% of total deaths in Switzerland in 2008.

V. THE UNITED KINGDOM

In contrast to the liberal Swiss model, Britain ostensibly appears to be firmly grounded in conservative traditionalist principles. For example, both active euthanasia and assisted suicide are criminalized under British law.⁹⁹ The former constitutes murder and is automatically punishable by a mandatory life sentence, while the latter subjects an individual to fourteen years imprisonment.¹⁰⁰ Moreover, unlike Switzerland, neither the patient's consent nor the offender's subjective intent

authority to prescribe sodium pentobarbital. Due to the limited availability of the narcotic, Dignitas resorted to using helium gas as a means of ending the life of its members—a practice it has since terminated.*Id.*

⁹³ See *id.* See also *Paralyzed Player Killed Himself*, BBC NEWS, Dec. 10, 2008, http://news.bbc.co.uk/2/hi/uk_news/england/hereford/worcs/7774802.stm; 'If You Drink This, You Will Die:' Father Reveals What Paralysed Rugby Son Was Told Before He Took Poison in Swiss Suicide, DAILY MAIL ONLINE, Dec. 11, 2008, <http://www.dailymail.co.uk/news/article-1093139/If-drink-die-What-paralysed-rugby-boy-told-took-poison-Swiss-suicide.html>.

⁹⁴ Srinivas, *supra* note 15, at 106-07.

⁹⁵ Bosshard, *supra* note 56, at 477.

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ See Penney Lewis, *England and Wales*, in EUTHANASIA AND LAW IN EUROPE, *supra* note 38, at 349, 359-60.

¹⁰⁰ *Id.* at 359, 364. However, a trial judge has the discretionary power to decide if or when a convicted criminal may be eligible for parole. *Id.* at 364.

are relevant in determining criminal liability.¹⁰¹

Notwithstanding the aforementioned summary of UK law, contemporary legislation paints an overly simplified picture of the British ELP debate. Since the establishment of Swiss end-of-life organizations, an increasing number of British citizens have traveled to Switzerland in order to utilize its suicide clinics.¹⁰² Although legislation has been slow to account for this “death tourism,” the euthanasia debate has been fervently argued in the political, legal, and social theater since the Renaissance.¹⁰³

A. *Early British Conceptions of Euthanasia*

Discussions concerning euthanasia and assisted suicide in the UK date back to the early modern English intellectuals of the 1500s.¹⁰⁴ In 1516, Thomas More wrote of the practice of euthanasia in *Utopia*: “Should life become unbearable for these incurables the magistrates and priests do not hesitate to prescribe euthanasia [The sick] end their lives willingly either by starvation or drugs Still the Utopians do not do away with anyone without his permission”¹⁰⁵ In the seventeenth century, Francis Bacon, an advocate for euthanasia and physician assisted suicide, wrote in his book *Advancement of Learning*: “I esteem it the office of a physician not only to restore the health, but to mitigate pains and dolors; and not only when such mitigation may conduce to recovery, but when it may serve to make a fair and easy passage.”¹⁰⁶

For more than two centuries, opponents stood steadfast on their respective sides of the issue, but, by 1906, British interest began to dwindle as the argument became increasingly viewed as static.¹⁰⁷ It was not until 1931, when Dr. C. Killick Millard became president of the Society of Medical Officers of Health, that the modern legal debate arose.¹⁰⁸ In his first address as president, Millard forcefully argued that the British government legalize both

¹⁰¹ *Id.* at 359.

¹⁰² Srinivas, *supra* note 15, at 107-08.

¹⁰³ See Ezekiel J. Emanuel, *Why Now?*, in *REGULATING HOW WE DIE* 175, 178 (Linda L. Emanuel ed., Harvard Univ. Press 1998). See also Srinivas, *supra* note 15, at 92.

¹⁰⁴ Emanuel, *supra* note 103, at 178.

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ See *id.* at 186.

¹⁰⁸ *Id.* at 188.

euthanasia and assisted suicide, and even offered a model bill.¹⁰⁹ Millard's speech galvanized a movement that culminated in the foundation of the Voluntary Euthanasia Legislation Society.¹¹⁰ This organization, which included prominent members of both the Royal College of Surgeons and the Royal College of Physicians, attempted to pass a bill legalizing euthanasia, but the House of Lords rejected the proposed legislation in 1936.¹¹¹

B. Suicide Act of 1961

In the early 1960s, the British Parliament passed the Suicide Act of 1961, which expressly prohibits one from aiding another in his or her efforts to commit suicide.¹¹² Although Section 1 states that suicide is legal, Section 2(1) criminalizes assisting the act: "A person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be liable on conviction on indictment to imprisonment for a term not exceeding fourteen years."¹¹³ Section 2(4) further asserts: "[N]o proceedings shall be instituted for an offense under this section except by or with the consent of the Director of Public Prosecutions."¹¹⁴

C. Assisted Suicide and Voluntary Euthanasia

1. Diane Pretty

Over the past eight years, sections 2(1) and 2(4) of the Suicide Act of 1961 have led to a great deal of litigation. In 2002, Diane Pretty, a forty-three year old English citizen, was suffering from the advanced stages of motor neuron disease,¹¹⁵ which resulted in

¹⁰⁹ Emanuel, *supra* note 103, at 188.

¹¹⁰ *Id.*

¹¹¹ *Id.* at 188-89. The House of Lords denied the bill by a vote of 35 to 14. *Id.*

¹¹² Suicide Act, 1961, c. 60 (Eng.), available at <http://www.statutelaw.gov.uk/content.aspx?activeTextDocId=1132509>.

¹¹³ *Id.*

¹¹⁴ *Id.*

¹¹⁵ Motor neuron disease is a progressive neurological disorder, which destroys the cells that control essential voluntary muscle activity, such as speaking, walking, breathing, and swallowing. Amyotrophic lateral sclerosis, also known as Lou Gehrig's disease, is ultimately fatal as all signals to voluntary muscles are eventually disrupted. This disorder typically results in respiratory failure. *Motor Neuron Disease Fact Sheet*, NAT'L INST. OF NEUROLOGICAL DISORDERS & STROKE, http://www.ninds.nih.gov/disorders/motor_neuron_diseases/detail_motor_neuron_diseases.htm.

the complete loss of use of her limbs.¹¹⁶ Due to the affliction, it was impossible for Pretty to end her life—legal under Section 1—without the help of her husband—illegal under Section 2(1). Pretty sought advanced immunity for her husband from the Director of Public Prosecutions (DPP) in order to avoid criminal prosecution under Section 2(4), but her request was denied.¹¹⁷ On appeal, the British judiciary upheld the DPP’s discretionary right to bring an action against her husband should he assist Pretty’s suicide in any manner.¹¹⁸

Subsequently, Pretty filed a suit against the UK with the ECHR.¹¹⁹ Pretty argued that the Suicide Act of 1961 violated the Human Rights Act of 1988, as ratified by the Convention.¹²⁰ Specifically, she asserted that “the right to die flows directly from the right to life guaranteed in Article 2 [of the Convention]; therefore, the state had an affirmative duty to protect the right to self-determination with respect to life and death.”¹²¹ The ECHR ultimately ruled in favor of the UK, holding, “[B]ecause Article 2 proscribes the intentional taking of life except in limited circumstances, it would be inconsistent to accept that it also ensures the right to procure another’s help in committing suicide.”¹²² The court further held:

[T]he fact that the UK’s Suicide Act does not distinguish between those physically capable, and those not, of committing suicide [cannot] be seen as breaching European rules on discrimination. Cogent reasons exist for not seeking to distinguish between those able and unable to commit suicide unaided. The borderline between the two categories would often be a very fine one, and to seek to build into the law an exemption for those judged to be incapable of committing suicide would seriously undermine the protection of life which the 1961 Act was intended to safeguard, and greatly increase the risk of abuse.¹²³

¹¹⁶ Wada, *supra* note 44, at 277. See Robert Verkaik, *Diane Pretty Loses Case, While Miss B ‘Dies with Dignity,’* THE INDEPENDENT, Apr. 30, 2002, <http://www.independent.co.uk/news/uk/crime/diane-pretty-loses-case-while-miss-b-dies-with-dignity-658602.html>.

¹¹⁷ R. (on the application of Pretty) v. DPP, [2001] UKHL 61, [2002] 1 A.C. 800, 803.

¹¹⁸ *Id.*

¹¹⁹ Verkaik, *supra* note 116.

¹²⁰ Srinivas, *supra* note 15, at 109.

¹²¹ Wada, *supra* note 44, at 277.

¹²² *Id.* at 277-78.

¹²³ Verkaik, *supra* note 116.

2. *Reginald Crew*

The following year, a case similar to that of Diane Pretty gained international attention.¹²⁴ Reginald Crew, a seventy-four year old citizen of Great Britain, who also suffered from a fatal form of motor neuron disease, sought to travel to the Swiss suicide clinic Dignitas with his wife and daughter in order to end his life.¹²⁵ In an effort to increase public awareness on the issue of assisted suicide, Crew permitted the British television show *Today* to document his story.¹²⁶ In an interview, Crew said, “Even getting up in the morning is like running a four-minute mile and I am sick of it. It is killing my family to look after me and it is killing me to have to live like this. I just want to be taken from this earth.”¹²⁷

On January 20, 2003, Crew ingested a fatal dose of barbiturates and died at the Dignitas clinic in Zurich.¹²⁸ The next day, Merseyside police began an investigation into Crew’s death, but subsequently stated that they could not determine whether criminal charges would be filed against Crew’s wife because the decision was the sole province of the Director of the Crown Prosecution Services.¹²⁹ In the end, the Director did not press any charges.¹³⁰

People on both sides of the debate were outraged with the outcome. In one corner, supporters of assisted suicide characterized the UK as the “backward cousin of Europe.”¹³¹ A reporter for the Kirkby Times wrote, “Once again England stands out for its inhumane almost medieval practice of insisting patients die in pain.”¹³² Opponents of assisted suicide were infuriated because authorities failed to charge Mrs. Crew. Dominica Roberts

¹²⁴ See Desmond Avery, *Assisted Suicide Seekers Turn to Switzerland*, 81 BULLETIN OF THE WORLD HEALTH ORGANIZATION No. 4 (2003), available at http://www.scielosp.org/scielo.php?pid=S0042-96862003000400019&script=sci_arttext.

¹²⁵ *Q&A: Assisted Suicide*, BBC NEWS, <http://news.bbc.co.uk/2/hi/health/1958414.stm> (last updated Jan. 20, 2003).

¹²⁶ Srinivas, *supra* note 15, at 110.

¹²⁷ *Terminally-ill Briton Dies at ‘Assisted Suicide’ Swiss Clinic*, DAILY MAIL ONLINE, Jan. 20, 2003, <http://www.dailymail.co.uk/news/article-155658/Terminally-ill-Briton-dies-assisted-suicide-Swiss-clinic.html>.

¹²⁸ *Death Tourism*, THE WORLD FEDERATION OF RIGHT TO DIE SOCIETIES, <http://www.worldrtd.net/node/560> (last visited Sept. 19, 2010).

¹²⁹ *Id.*

¹³⁰ *Id.*

¹³¹ *Merseyside Mans Fight for a Dignified Death*, KIRKBY TIMES NEWS, http://www.kirkbytimes.co.uk/news_items/reginald_crew_euthenasia.html (last visited Sept. 19, 2010).

¹³² *Id.*

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of the ProLife Alliance stated, “This is a sad day because it sends out an entirely false message that ill people are not worth keeping alive. Voluntary euthanasia inevitably leads to involuntary euthanasia so this is bad news for . . . [the] frail and vulnerable.”¹³³

In response to a request by the Voluntary Euthanasia Society to clarify the Crown Prosecution Service’s policy on Section 2(4) of the Suicide Act of 1961, Lord Charles Falconer, Minister of the State for the Home Office, issued the following reply:

As you know, Section 2(1) of the Suicide Act 1961 makes it an offence in this country to aid, abet, counsel or procure somebody to commit suicide. Provided that the aiding, abetting [sic] etc takes place in this country, we believe (though the point is untested by the courts) that the offence under Section 2(1) is committed even where the suicide occurs abroad. However, aiding, abetting, etc, of suicide abroad is a matter for the authorities in whose jurisdiction the suicide occurs. It is therefore for the Swiss authorities to determine whether any offence has been committed under Swiss law. . . . [T]his is a matter of law in the country concerned and not one in which the [British] Government should intervene.¹³⁴

Lord Falconer’s statement did not sufficiently clarify the ambiguity concerning either Section 2(1) or 2(4). It remained equivocal as to when individuals—particularly family members—will be criminally prosecuted for assisting a suicide.

3. *Diane Purdy*

In 2008, Diane Purdy, a forty-six year old citizen of the UK suffering from multiple sclerosis, requested a written confirmation from the DPP that her husband would not be charged if he helped her travel to Dignitas in Switzerland.¹³⁵ The DPP refused to meet her request and declined to offer further guidance.¹³⁶ Consequently, Purdy filed a civil suit in the High Court in London.¹³⁷ Purdy argued that the DPP acted illegally by not providing guidance on how prosecutorial determinations were reached and, moreover, that under Article 8 of the Convention,

¹³³ *Id.*

¹³⁴ *Death Tourism*, *supra* note 128.

¹³⁵ *Q&A: Assisted Suicide Ruling*, BBC NEWS, <http://news.bbc.co.uk/2/hi/health/8177246.stm> (last updated July 30, 2009).

¹³⁶ Srinivas, *supra* note 15, at 111.

¹³⁷ *R. (on the application of Purdy) v. DPP*, [2008] EWHC 2565 (Admin), [2009] H.R.L.R. 7.

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her “right to respect for private and family life” was being breached by the ambiguity in the law.¹³⁸ The High Court ruled in favor of the government.¹³⁹ The court held that the guidelines did not require clarification and that her Article 8 right had not been violated.¹⁴⁰

On appeal, the House of Lords reversed the lower court’s decision.¹⁴¹ The Law Lords held that the Suicide Act of 1961 was unclear and ordered the DPP to draft an “offence-specific policy” enumerating elements that the DPP should consider when determining whether to prosecute under Section 2(1).¹⁴² On September 23, 2009, the DPP released an interim policy, which lists thirteen factors that may discourage authorities from prosecuting and sixteen factors that may support prosecution.¹⁴³ In an official statement, Kier Starmer, the new Director of Public Prosecutions, said that the law has not changed and that there are “no guarantees against prosecution.”¹⁴⁴ He emphasized that the new guidelines do not in any way legalize euthanasia, and they apply to citizens who travel abroad to commit suicide as well as those who end their lives domestically within England and Wales.¹⁴⁵

The preliminary measures have garnered both support and criticism. Sarah Lyall, a reporter for the New York Times wrote that the DPP, in its efforts to codify its decision-making process, has raised new issues regarding the role of physicians in assisted suicide and “the new guidelines are likely to make it easier for the terminally ill and those with degenerative diseases to receive help in committing suicide.”¹⁴⁶ According to Simon Gillespie, the chief executive of the Multiple Sclerosis Association of Great Britain and Northern Ireland, “[The new guidelines] explore assisted suicide without the support of medical professionals . . . their only

¹³⁸ *Id.*

¹³⁹ *Id.*

¹⁴⁰ *Id.*; *Q&A: Assisted Suicide Ruling*, *supra* note 135.

¹⁴¹ *R. (on the application of Purdy) v. DPP*, [2009] UKHL 45, [2009] 3 W.L.R. 403, 404.

¹⁴² *Id.* at 423; *Q&A: Assisted Suicide Ruling*, *supra* note 135.

¹⁴³ *DPP Publishes Interim Policy on Prosecuting Assisted Suicide*, THE CROWN PROSECUTION SERVICE (Sept. 23, 2009), http://www.cps.gov.uk/news/press_releases/144_09/ [hereinafter *DPP Publishes Interim Policy*]. See INTERIM POLICY FOR PROSECUTORS IN RESPECT OF CASES OF ASSISTED SUICIDE, DIRECTOR OF PUBLIC PROSECUTIONS (2009), http://www.cps.gov.uk/consultations/as_consultation.pdf.

¹⁴⁴ Sarah Lyall, *supra* note 7.

¹⁴⁵ *Id.*

¹⁴⁶ *Id.*

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likely resource is Google.”¹⁴⁷ Penny Lewis, a law professor at the Center of Medical Law and Ethics at King’s College London, stated that “[The guidelines] close down any kind of movement toward physician-assisted suicide,” thereby preventing the possibility that it will become a “professional activity conducted by doctors or would-be suicide supervisors” as in Switzerland.¹⁴⁸

D. Advance Treatment Directives

1. Competent Patients

The Mental Capacity Act of 2005 (MCA) codified British common law, which previously legalized anticipatory refusals of medical treatment, including life-sustaining care.¹⁴⁹ Under the MCA, “[a] mentally competent adult patient has an absolute right to refuse to consent to medical treatment, even where that refusal may lead to death.”¹⁵⁰ The statute states that a competent person may decide that if:

- a. at a later time and in such circumstances as he may specify, a specified treatment is proposed to be carried out or continued by a person providing health care for him, and
- b. at that time he lacks capacity to consent to the carrying out or continuation of the treatment,

the specified treatment is not to be carried out or continued.¹⁵¹

The author of the advanced treatment directive may withdraw or alter the order at any time while competent, but the decision will cease to be effective if “there are reasonable grounds for believing that circumstances exist which [the author] did not anticipate . . . which would have affected his decision had he anticipated them.”¹⁵² Medical care “will not be proposed or continued if it is not in the patient’s best interests.”¹⁵³

¹⁴⁷ *Id.*

¹⁴⁸ *Id.*

¹⁴⁹ Lewis, *supra* note 99, at 358. See Mental Capacity Act, 2005, c. 9, §§ 24-26, http://www.opsi.gov.uk/Acts/acts2005/pdf/ukpga_20050009_en.pdf.

¹⁵⁰ Lewis, *supra* note 99, at 357.

¹⁵¹ Mental Capacity Act, 2005, c. 9, § 24(1)(a)-(b).

¹⁵² *Id.* at § 25(4)(c).

¹⁵³ Lewis, *supra* note 99, at 356.

2. *Incompetent Patients*

Since 2007, a proxy may make medical care decisions for an incompetent patient, “whether the proxy was appointed by the individual when still competent or judicially appointed.”¹⁵⁴ If a proxy has not been appointed, the patient’s doctor will serve as such unless the jurisdiction of the Court of Protection is invoked.¹⁵⁵ Regardless of who chooses the medical treatment, all care will be determined according to the “best interest test,” which balances the potential benefit against the possible harm that may follow the proposed procedure.¹⁵⁶ The MCA states that the individual determining the patient’s best interest:

Must consider, so far as is reasonably ascertainable—

- a. the person’s past and present wishes and feelings,
- b. the beliefs and values that would be likely to influence his decision if he had capacity, and
- c. the other factors that he would be likely to consider if he were able to do so.¹⁵⁷

E. Passive Euthanasia

In 2001, the General Medical Council published guidelines in an attempt to reconcile advanced treatment directives with the Suicide Act of 1961.¹⁵⁸ The document stated:

Prolonging life will usually be in the best interests of a patient, provided that the treatment is not considered to be excessively burdensome or disproportionate in relation to the expected benefits. Not continuing or not starting a potentially life-prolonging treatment is in the best interests of a patient when it would provide no net benefit to the patient.¹⁵⁹

Airedale NHS Trust v. Bland is the principal authority on passive euthanasia as effectuated by the withdrawal of life-sustaining medical care pursuant to an advanced treatment

¹⁵⁴ *Id.* at 351.

¹⁵⁵ *Id.*

¹⁵⁶ *Id.* at 352.

¹⁵⁷ Mental Capacity Act, 2005, c. 9, § 4(6).

¹⁵⁸ WITHHOLDING AND WITHDRAWING LIFE-PROLONGING TREATMENT: GOOD PRACTICE IN DECISION-MAKING, GENERAL MEDICAL COUNCIL (2009) [hereinafter WITHHOLDING AND WITHDRAWING], available at http://www.gmc-uk.org/guidance/ethical_guidance/withholding_lifeprolonging_guidance.asp.

¹⁵⁹ *Id.* at § 11.

directive.¹⁶⁰ Family members of Anthony Bland—a patient who was in a persistent vegetative state—petitioned the House of Lords for permission to allow Bland’s doctors to remove his artificial nutrition and hydration tubes as they believed removal was in Bland’s best interest.¹⁶¹ The Law Lords held, “[A]lthough the intention of the doctor would be to bring about Bland’s death, the proposed withdrawal would be lawful as it constituted an omission rather than an act.”¹⁶² Lord Goff added that as a matter of law, “[A]pplications should be made to the court for a declaration in every case where doctors proposed to discontinue treatment of [persistent vegetative state] patients.”¹⁶³ Consequently, proxies must seek approval by the Court of Protection in cases involving the withdrawal of artificial nutrition and hydration from patients in a persistent vegetative state.¹⁶⁴

VI. ITALY

In the midst of the ideological debate over ELPs, Italy is indecisive and hesitant to draft explicit statutory provisions. The nation is acutely in need of comprehensive end-of-life legislation, yet unsure of which direction to pursue.¹⁶⁵ Italy does not have an official definition of euthanasia,¹⁶⁶ nor any formal edict concerning the general subject-matter.¹⁶⁷ Nonetheless, due to several highly publicized cases in which severely incapacitated patients and/or their caretakers sought to terminate life-sustaining treatment, a discussion has arisen concerning the entire range of ELPs.¹⁶⁸

¹⁶⁰ Airedale NHS Trust v. Bland, [1992] UKHL 5, [1993] A.C. 789, 789. See Lewis, *supra* note 99, at 353.

¹⁶¹ Bland, A.C. 789 at 789. See Lewis, *supra* note 99, at 353.

¹⁶² Lewis, *supra* note 99, at 353.

¹⁶³ *Id.* This practice was included in the Code of Practice issued under the Mental Capacity Act of 2005. *Id.* at 353-54.

¹⁶⁴ *Id.* at 354. “This practice of seeking approval judicial approval [by the Court of Protection] in [persistent vegetative state] [] cases has not as of yet been extended to other instances cases where a decision is made to withdraw life-sustaining treatment, including [artificial nutrition and hydration] [] and ventilation.” *Id.*

¹⁶⁵ See generally Viganò, *supra* note 16, at 167-86.

¹⁶⁶ The term euthanasia is not included in any existing Italian legislation, but “the term is commonly referred to in doctrinal debate as well as in public discussion, although its precise meaning remains mostly undefined.” *Id.* at 167. “The core of the term seems to be the intentional causation of the death of a patient from a severe and incurable disease, in order to put an end to his/her pain and distress.” *Id.* at 168.

¹⁶⁷ *Id.*

¹⁶⁸ See Sofia Moratti, *Italy, in EUTHANASIA AND LAW IN EUROPE*, *supra* note 38, at 395, 408-09.

On March 26, 2009, the Italian Senate approved a bill¹⁶⁹ that aimed to establish basic statutory guidelines for life-ending care.¹⁷⁰ However, the existing version, which currently awaits approval by the Chamber of Deputies, has fallen under heavy criticism.¹⁷¹ Opposition Senator Umberto Veronesi, an oncologist, vociferously declared that he would campaign for a referendum to abolish the statute, should it become law.¹⁷² Despite disagreement on the bill itself, legislators seem to concur that “a just law is necessary for the good of our society and our civilisation.”¹⁷³

A. *Legislative History*

1. *Constitution of the Italian Republic*

In 1948, the Constitution of the Italian Republic (Constitution) “radically changed the structure of the relationship between the individual and the state, placing the person at the centre”¹⁷⁴ In Article 2¹⁷⁵ and Article 3,¹⁷⁶ the Constitution identifies “the inviolable rights of man as the priority values” on

¹⁶⁹ See *infra* Part VII.

¹⁷⁰ *Italian Senate Approves Right-to-die Restrictions*, ZIMBIO (Mar. 26, 2009, 2:56 PM), <http://www.zimbio.com/Eluana+Englaro/articles/14/Italian+Senate+approves+right+die+restrictions>.

¹⁷¹ *Id.*

¹⁷² *Id.*

¹⁷³ *Italy Seeks Clarity on Euthanasia*, BBC NEWS, Feb. 10, 2009, <http://news.bbc.co.uk/2/hi/7881441.stm>.

¹⁷⁴ E.P. Fabris & M. Piccinni, *Legal Aspects of the End-of-life Decisions in Italy: The Penal Relevance of the Limitation of the Treatment in the Terminally Ill and the Problem of Causality by Omission*, 25 EUR. J. OF ANESTHESIOLOGY 58, 5119 (2008), available at http://journals.lww.com/ejanaesthesiology/Fulltext/2008/02001/Legal_aspects_of_end_of_life_decisions_in_Italy_.10.aspx.

¹⁷⁵ Article 2 reads: “The Republic recognises and guarantees the inviolable rights of the person, both as an individual and in the social groups where human personality is expressed. The Republic expects that the fundamental duties of political, economic and social solidarity be fulfilled.” Art. 2 Costituzione [COST.] (It.), http://www.senato.it/documenti/repository/istituzione/costituzione_inglese.pdf.

¹⁷⁶ Article 3 reads:

All citizens have equal social dignity and are equal before the law, without distinction of sex, race, language, religion, political opinion, personal and social conditions. It is the duty of the Republic to remove those obstacles of an economic or social nature which constrain the freedom and equality of citizens, thereby impeding the full development of the human person and the effective participation of all workers in the political, economic and social organisation of the country.

Id. art. 3.

which the Italian legal system is founded.¹⁷⁷ Among these inviolable rights are the right to life, the right to health, and the right to moral and personal freedom.¹⁷⁸

Article 32 expressly acknowledges the right to health and contributes to defining the limitations within which physicians assume the role of guardian of a patient's "goods, health, and life."¹⁷⁹ Article 32 states:

The Republic safeguards health as a fundamental right of the individual and as a collective interest, and guarantees free medical care to the indigent.

No one may be obliged to undergo any health treatment except under the provisions of the law. The law may not under any circumstances violate the limits imposed by respect for the human person.¹⁸⁰

Article 2, Paragraph 2, alludes to the notion that "health treatment may only be imposed in exceptional cases, reserving the legislature's exclusive power to define new crimes and with the absolute limit of respect for the human person."¹⁸¹

2. *Penal Code*

a. Active Voluntary Euthanasia

The Italian Penal Code (IPC) does not explicitly define euthanasia or assisted suicide, but both are considered unlawful through interpretation of existing statutes. If a patient carries out the final act that brings about death, any contribution to the patient's action by another person constitutes the crime of aiding and abetting suicide and is punishable by imprisonment of five to twelve years under Article 580, *Istigazione o aiuto al suicidio*.¹⁸² Considering the mitigating circumstances under Article 62, *Circostanze attenuanti comuni*, typically seen in cases of euthanasia, the sentence may be reduced to a minimum of two years and three months incarceration.¹⁸³ There may be a further

¹⁷⁷ Fabris & Piccinni, *supra* note 174, at 59.

¹⁷⁸ *Id.*

¹⁷⁹ *Id.*

¹⁸⁰ Art. 32 COST. (It.).

¹⁸¹ Fabris & Piccinni, *supra* note 174, at 59.

¹⁸² Viganò, *supra* note 16, at 171-72; Codice Penale Italiano [C.P.] [Italian Penal Code] art. 580 (It.), available at <http://www.altalex.com/index.php?idnot=36653>.

¹⁸³ Viganò, *supra* note 16, at 172; Codice Penale Italiano [C.P.] art. 62 (It.).

reduction of three months if the defendant accepts a plea bargain without going to trial.¹⁸⁴ As a result, a person accused of aiding and abetting suicide has a significant chance of avoiding prison entirely, as imprisonment not in excess of two years is typically suspended on parole in the Italian legal system.¹⁸⁵

In a situation where the patient agrees or requests that another person conduct the action causing his or her death, the latter is guilty of homicide of a consenting person.¹⁸⁶ This crime is punishable by imprisonment of six to fifteen years under Article 579, *Omicidio del consenziente*.¹⁸⁷ Punishment for this crime is subject to the same reductions as previously stated and, thus, incarceration may also result in parole.¹⁸⁸ However, under Article 579, there are strict requirements for consent: “victim shall not be younger than 18, nor insane, nor otherwise mentally disturbed, nor shall his/her consent be obtained by force, menace or fraud.”¹⁸⁹ If the requirements are not fulfilled, the defendant is subject to Article 575, *Omicidio*, and punishable by imprisonment of twenty-one to twenty-four years.¹⁹⁰ This provision frequently proves troublesome for defendants because patients, who request a mercy killing, often suffer from crippling pathological illnesses that affect their mental condition, thereby, diminishing the validity of consent.¹⁹¹

b. Active Non-voluntary Euthanasia

Active non-voluntary euthanasia is punishable as voluntary homicide under Article 575.¹⁹² Sentencing can be mitigated depending on the circumstances under Article 62 and if the defendant accepts a *giudizio abbreviato*—a simplified trial based only on the evidence proffered by the prosecution during pre-trial investigation.¹⁹³ The trial judge, however, is unable to suspend the sentence on parole if the term of imprisonment exceeds two

¹⁸⁴ Viganò, *supra* note 16, at 172.

¹⁸⁵ *Id.*

¹⁸⁶ *Id.*; Codice Penale Italiano [C.P.] art. 579 (It.).

¹⁸⁷ Viganò, *supra* note 16, at 172; Codice Penale Italiano [C.P.] art 579 (It.).

¹⁸⁸ Viganò, *supra* note 16, at 172.

¹⁸⁹ *Id.*

¹⁹⁰ *Id.*; Codice Penale Italiano [C.P.] art. 575 (It.).

¹⁹¹ Viganò, *supra* note 16, at 172.

¹⁹² *Id.*

¹⁹³ *Id.*

years.¹⁹⁴ In cases of mercy killings, judges often express that the inflexible legal framework is unjust.¹⁹⁵ As a result, some judges may, at times, “force the law and the consolidated interpretations of some elements of the crime . . . in order to ensure a more lenient penalty for the accused”¹⁹⁶

c. Passive Voluntary Euthanasia

The treatment of passive voluntary euthanasia is more controversial than the judicial application of the ICP to active voluntary euthanasia and active non-voluntary euthanasia.¹⁹⁷ There is a general consensus amongst international medical and legal scholars that “treatment may, *in principle*, be performed only on the basis of a patient’s informed consent.”¹⁹⁸ Conversely, it follows that such care may not be undertaken, *in principle*, if a competent patient objects to it.¹⁹⁹ No law unequivocally states this, but it is explicitly purported in Article 5²⁰⁰ of the Oviedo Convention on Human Rights and Biomedicine (Oviedo Convention), which Italy signed in 1997.²⁰¹

Although these principles appear evident, they do not have full legal force because Italy has yet to ratify the Oviedo Convention, despite Parliament having passed a law authorizing the government to deposit the instrument of ratification in 2001.²⁰² Moreover, there is a great deal of uncertainty as to the Oviedo Convention’s exceptions, principally, when treatment is essential

¹⁹⁴ *Id.*

¹⁹⁵ *Id.* at 173.

¹⁹⁶ Viganò, *supra* note 16, at 173. This tendency is prevalent when the trial occurs before a Corte d’Assise—a mixed court of two professional judges and seven laypersons, which has jurisdiction over various types of homicides. *Id.*

¹⁹⁷ *See Id.*

¹⁹⁸ *Id.*

¹⁹⁹ *Id.*

²⁰⁰ Article 5 reads:

An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it. This person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks. The person concerned may freely withdraw consent at any time.

Oviedo—Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine art. 5, Apr. 4, 1997 [hereinafter Oviedo Convention], available at <http://www.portaledibioetica.it/documenti/001316/001316.htm>.

²⁰¹ Viganò, *supra* note 16, at 173.

²⁰² *Id.*

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to keeping an individual alive.²⁰³ While it is clear that medical doctors must provide life-sustaining treatment in emergency situations, it is unclear whether an exception applies when a competent patient rejects the care—such as blood transfusions, artificial hydration or feeding, or limb amputation—with full knowledge that his rejection may result in death.²⁰⁴

d. Passive Non-voluntary Euthanasia

Italian law, as it pertains to passive non-voluntary euthanasia, is even more convoluted than passive voluntary euthanasia.²⁰⁵ Although the majority of legal and medical professionals interpret Article 6 of the Oviedo Convention as granting the proxy of an incompetent patient the power to make decisions pertaining to the patient's medical treatment, Italian law does not currently recognize such a broad legal right.²⁰⁶ The international consensus argues that an appointed proxy, *administratore di sostegno*, must decide medical treatment in accordance with the incompetent patient's best interests.²⁰⁷ The best interest standard, which incorporates both subjective and objective criteria, is arguably inferred from Article 6, which states in Paragraph 2, "[T]he opinion of a minor shall be taken into consideration as an increasingly determining factor in proportion to his or her age and degree of maturity," and in Paragraph 3, "[T]he [incompetent adult] shall as far as possible take part in the authorization procedure."²⁰⁸

Despite this seemingly lucid interpretation of the Oviedo Convention, it is not clear how these principles extend to cases of passive non-voluntary euthanasia in Italy.²⁰⁹ For example, although a proxy may consent to a medical treatment to be performed on an incompetent patient, it does not logically follow

²⁰³ *Id.* at 173-74.

²⁰⁴ *Id.* at 174.

²⁰⁵ *Id.* at 176.

²⁰⁶ Viganò, *supra* note 16, at 176; Giuseppe Servillo & Pasquale Striano, *End-of-life: Still an Italian Dilemma*, 34 *INTENSIVE CARE MED.* 1333, 1333 (2007), available at <http://0-proquest.umi.com.ben.bc.yu.edu/pqdweb?index=9&did=1504099661&SrchMode=1&sid=1&Fmt=6&VInst=PROD&VType=PQD&RQT=309&VName=PQD&TS=1253813474&clientId=68805>. Legal proxies usually are parents when the incompetent patient is a child and a judicially appointed proxy in cases involving incompetent adults. Viganò, *supra* note 16, at 176.

²⁰⁷ Viganò, *supra* note 16, at 176.

²⁰⁸ *Id.*; Oviedo Convention, *supra* note 200, art. 6.

²⁰⁹ Viganò, *supra* note 16, at 176.

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that the proxy may also consent to a particular life-sustaining treatment being withheld or withdrawn.²¹⁰ This issue has garnered a significant amount of international attention both in Italy and the United States over the last decade, as exemplified by the cases of Piergiorgio Welby, Eluana Englaro and Terry Schiavo.

e. Indirect Euthanasia

In Italy, palliative treatments offered by a medical doctor to a terminally ill patient in order to reduce pain and suffering, whose side effects can shorten the patient's life expectancy, are lawful, despite potentially conflicting with the IPC.²¹¹ Under Article 575, a physician who administers a pain-killing treatment, knowing that it may accelerate the patient's death, would be guilty of voluntary homicide if the treatment does result in expedited death.²¹²

Scholars who have dealt with this question often conclude that justification lies in the practitioner's "*duty* to alleviate the patient's suffering and to provide palliative care."²¹³ This explanation likely entails a balancing between the two fundamental values inherent in the conflict: (1) the quality of life of a particular human being and (2) human life as an abstract value.²¹⁴ Regardless of its legal reasoning, it is noteworthy that no prosecution has ever been commenced against a medical physician for indirect euthanasia in Italy.²¹⁵

B. An Empirical Study: The Application of Existing Italian Legislation

1. Piergiorgio Welby

In 2006, the condition of Piergiorgio Welby, a terminally ill man suffering from muscular dystrophy, had deteriorated to the extent that he became paralyzed and entirely dependent on both a

²¹⁰ *Id.* at 176-77.

²¹¹ *Id.* at 180. The European End-of-life Project study demonstrated that "continuous deep sedation until death" takes place more often in Italy than in all other countries involved in the study, although this is least often accompanied by withholding artificial nutrition and hydration." Moratti, *supra* note 168, at 413.

²¹² Viganò, *supra* note 16, at 180.

²¹³ *Id.*

²¹⁴ *Id.*

²¹⁵ *Id.*

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ventilator and nasogastric feeding tubes.²¹⁶ In September of that year, Welby sent a letter to the Italian Head of State demanding the right to die and asked to be removed from artificial life support.²¹⁷ In Italy, the Head of State has no direct legislative power; therefore, the official could not grant Welby's request, but he was able to encourage parliamentary debate.²¹⁸ The majority denounced euthanasia, but favored advance directives, while the left-wing supported both, and the right-wing Christian party opposed both.²¹⁹

Thereafter, Welby's attorneys brought a case before the Civil Tribunal of Rome, seeking to enjoin Welby's doctors from continuing medical treatment.²²⁰ Consequently, the Minister of Health requested that the Council of Health, *Consiglio Superiore di Sanità*, issue an advisory statement addressing whether or not artificial ventilation was futile.²²¹ The Council of Health responded in the negative, concluding that treatment was not ineffective and that artificial ventilation in the case of Welby was not medical treatment, but rather normal care, which could not be withdrawn under Italian law.²²² As a result, the Tribunal rejected Welby's claim, holding that "the regulative gap surrounding refusal of treatment by a competent patient had to be filled by the legislator."²²³ Judge Antonio Salvio ruled, "Welby's right to have his respirator removed was not 'concretely safeguarded' by Italian law."²²⁴

²¹⁶ Moratti, *supra* note 168, at 401.

²¹⁷ *Id.* Welby wrote in his journal, "Up until a few years ago, muscular dystrophy patients died of severe respiratory insufficiency . . . [but] [t]hen, portable ventilators, tracheotomy, nasogastric feeding and last generation antibiotics came. Now, most dystrophy patients die of bedsores. Is this . . . progress?" *Id.*

²¹⁸ *Id.*

²¹⁹ *Id.* Welby's treating physician stated in an open letter, "[T]he law permits withdrawal of life-prolonging treatment if refused by a competent patient[,] but the law also requires intervention if an incompetent patient's life is in danger . . . I am apparently expected to withdraw the breathing tube now, but to re-insert it [when] the patient becomes incompetent." *Id.* at 402.

²²⁰ *Id.* at 402.

²²¹ Moratti, *supra* note 168, at 402.

²²² *Id.* The Council of Health based its decision on three factors: (1) artificial ventilation did serve to improve Welby's quality of life, because it supported cardiovascular, renal and cognitive functions; (2) artificial ventilation constituted normal care, not medical treatment, and therefore could not be withdrawn; and (3) although Welby's condition was severe, death was not imminent. *Id.*

²²³ *Id.* at 403.

²²⁴ *Italy Court Snubs Euthanasia Plea: An Italian Judge has Rejected a Request by a Terminally Ill Man to Have Doctors Switch Off His Life Support Machine*, BBC NEWS,

Rather than file an appeal, Welby decided to take the matter into his own hands. On December 23, 2006, an anesthetist at the Hospital of Cremona intravenously administered sedatives and disconnected the respirator.²²⁵ The anesthetist justified his actions under Article 32 of the Constitution, claiming he did not commit euthanasia because he had not injected a lethal narcotic.²²⁶ As a result of his actions, the anesthetist had to appear before the Council of the College of Physicians of Cremona (CCPC).²²⁷ On February 1, 2007, the CCPC quashed the matter, concluding that the sedatives and painkillers administered were in accordance with professional protocols and, therefore, could not constitute euthanasia.²²⁸

Notwithstanding the ethical approval of the CCPC, the investigating magistrate decided to charge the anesthetist with *Omicidio del consenziente*.²²⁹ However, on July 23, 2007, the magistrate dropped the charges purporting, “Welby had the *right* to refuse life-sustaining treatment[,]” and the doctor had a “correspondent *duty* to comply with Welby’s request to cease all vital support.”²³⁰ The center-left welcomed the magistrate’s decision as “a source of legal certainty for the medical profession.”²³¹ The reaction of the Catholic Church was reticent.²³² The Vatican’s position was characterized in a statement given by the former president of the National Bioethics Committee: “[The decision was] legally appropriate [but] ethically a doctor’s duty is to preserve life.”²³³ Following Welby’s death, the Catholic Church denied him a religious funeral.²³⁴

2. *Eluana Englaro*

Despite the Welby decision topically appearing to settle the issue of informed consent as it applies to life sustaining treatment,

Dec. 16, 2006, <http://news.bbc.co.uk/2/hi/europe/6186347.stm>.

²²⁵ Matthias Bock, Valter Ciarocchi & Christian J. Wiedermann, *Case Involving End-of-life Decision Issues in Italy*, 33 INTENSIVE CARE MED. 1041, 1041 (2007).

²²⁶ Moratti, *supra* note 168 at 403.

²²⁷ *Id.* at 404.

²²⁸ *Id.*

²²⁹ *Id.* at 405.

²³⁰ *Id.*

²³¹ Moratti, *supra* note 168, at 405.

²³² *Id.*

²³³ *Id.* at 405-06. The Centre for Bioethics of the Catholic University in Rome issued a similar statement. *Id.* at 406.

²³⁴ *Id.* at 404.

the debate over euthanasia and assisted suicide is far from settled.²³⁵ This disconnect is unequivocally illustrated by the case of Eluana Englaro.²³⁶ On January 18, 1992, twenty-one year old Eluana Englaro was involved in a devastating car accident that placed her in a coma—where she remained for seventeen years.²³⁷ In 1997, Eluana's father, Beppi Englaro, was appointed as Eluana's guardian and in 1999 he began petitioning for the removal of his daughter's artificial nutrition and hydration tubes.²³⁸

Mr. Englaro formally requested that the Court of Lecco authorize him, as a guardian, to order Eluana's treating physicians to withdraw medical treatment.²³⁹ The court denied his request, holding that the Italian legal system "grants unconditional protection to human life."²⁴⁰ Mr. Englaro appealed, but the Court of Appeals of Milan affirmed, ruling that "artificial nutrition must be regarded as 'basic care' and as such cannot be withdrawn."²⁴¹ Consequently, the Italian Minister of Health established the Oleari Commission, which was instructed to draft a report on nutrition and hydration for permanently comatose patients.²⁴² The Commission concluded that such care constituted medical treatment, the withdrawal of which is legitimate if based on the express will of the patient prior to incapacitation.²⁴³ If the patient becomes incapacitated before expressing his or her wishes, the

²³⁵ While the Court of Cremona deliberated Welby's case, Giovanni Nuvoli, a fifty-six year old former soccer player, who was suffering from amyotrophic lateral sclerosis (Lou Gehrig's Disease), also petitioned the Head of State for removal of his ventilator. The Court of Sassari refused removal pending the decision in the Welby case and ordered that police patrol Nuvoli's home to ensure that no one removed removed his ventilator. Nuvoli, like Welby, took action and circumvented the court's decision by removing his artificial feeding and hydration tubes. Following Nuvoli's death, investigators examined his home and, upon finding that the ventilator had not been removed, refused to file charges. Unlike Welby, the Catholic Church did not object to a religious funeral. *Id.* at 402, 406-07.

²³⁶ See Denis Cummings, *Eluana Englaro Case Divides Italian Government*, FINDING DULCINEA, Feb. 9, 2009, <http://www.findingdulcinea.com/news/Europe/2009/feb/Eluana-Englaro-Case-Divides-Italian-Government.html>. According to Agence France-Presse, who conducted a survey in 2009, 47 percent of Italians believed that Englaro should live and 47 percent believed that she should be allowed to die. *Id.*

²³⁷ *Id.*

²³⁸ Moratti, *supra* note 168, at 410-11.

²³⁹ *Id.* at 411.

²⁴⁰ *Id.*

²⁴¹ *Id.*

²⁴² *Id.*

²⁴³ Moratti, *supra* note 168, at 411.

Commission further concluded that the patient's guardian should determine care, but the magistrate must authorize his or her decision.²⁴⁴

In 2002, Mr. Englaro again petitioned the Court of Lecco based on the findings of the Oleari Commission.²⁴⁵ The court rejected his claim a second time, citing the lack of “official statements of the College of Physicians’ . . . on the issue and referred to the ‘full protection of life’ granted by the Italian legal system.”²⁴⁶ In his appeal, Mr. Englaro presented new evidence in an attempt to establish Eluana's express will prior to her incapacitation, but in October of 2003, the Court of Appeals of Milan affirmed, holding that “advanced directives have no legal status in Italy and provide no legal ground for decisions to withdraw treatment.”²⁴⁷ The court added that the report of the Oleari Commission was not binding on the judiciary.²⁴⁸

Mr. Englaro appealed and on April 20, 2005, the Court of Cassation—the Supreme Court of Italy—declined to review his petition.²⁴⁹ The court ruled that there was a conflict of interest between that of Beppi Englaro and his daughter, which could not be settled because it was impossible to determine the will of Eluana prior to incapacitation.²⁵⁰ In such a case, the Civil Code requires a “special curator, *curatore speciale*, who shares decision-making power with the guardian.”²⁵¹ Since a *curatore speciale* had not been appointed at that time, the Court of Cassation rejected the appeal without further consideration.”²⁵²

Consequently, Mr. Englaro appointed a *curatore speciale* and

²⁴⁴ *Id.*

²⁴⁵ *Id.*

²⁴⁶ *Id.* at 411-12.

²⁴⁷ *Id.* at 412.

²⁴⁸ See Moratti, *supra* note 168, at 412. On March 20, 2004, Pope John Paul II addressed the International Congress on “Life-sustaining Treatments and Vegetative State.” In his speech, the Pope confirmed the Catholic Church's position denouncing the withdrawal of life-sustaining treatment, including the proposed removal of artificial hydration and feeding apparatuses. Pope John Paul II, Address of John Paul II to the Participants in the International Congress on “Life-sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas” (Mar. 20, 2004), available at http://www.vatican.va/holy_father/john_paul_ii/speeches/2004/march/documents/hf_jp-ii_spe_20040320_congress-fiamc_en.html.

²⁴⁹ Moratti, *supra* note 168, at 412.

²⁵⁰ *Id.*

²⁵¹ *Id.*

²⁵² *Id.*

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filed a new petition with the Court of Lecco.²⁵³ In December 2005, the court rejected his claim for a third time maintaining that “it [is] not within the power of a guardian or a curator to request withdrawal of artificial nutrition and hydration.”²⁵⁴ Mr. Englaro once again appealed to the Court of Appeals of Milan, who heard testimony concerning Eluana’s will prior to incapacitation. In December 2006, the court affirmed, holding that since Eluana’s treatment was not medically futile, it could not be withdrawn.²⁵⁵ However, on appeal to the Court of Cassation, the decision of the appellate court was reversed.²⁵⁶ On October 16, 2007, the Court of Cassation ruled that “artificial nutrition and hydration is medical treatment that in principle can be withdrawn from an incompetent patient.”²⁵⁷

The decision was a veritable powder keg that exploded, dividing the nation from Trento in the north, straight through Rome, and down into Sicily in the south. One Italian newspaper, *La Repubblica*, reported, “With the instrumentalisation of a national and family tragedy, with the dark echo of those who would turn death into politics, the most dangerous phase for the fate of the republic in Italy’s recent history [has begun].”²⁵⁸ The financial newspaper, *Il Sole 24 Ore*, wrote, “[T]he time is ripe for an institutional crisis.”²⁵⁹ Cardinal Camillo Ruini declared, “Letting Eluana die, or to put it bluntly letting her starve and die of thirst, means . . . objectively killing a human being.”²⁶⁰

Despite the ruling, Mr. Englaro was unable to locate a hospice clinic in Italy willing to accept Eluana.²⁶¹ The health authority of Lombardy, the region of Italy where Eluana was receiving treatment, stated, “[D]octors would breach ‘professional duties and obligations’ if they allowed Eluana to die . . .”²⁶² The

²⁵³ *Id.*

²⁵⁴ Moratti, *supra* note 168, at 412. The Court of Lecco cited the majority position of the National Bioethics Committee, which in September of 2005 published an advisory document concluding that artificial nutrition and hydration constitute basic care. Accordingly, should they be discontinued, their removal is equivalent to euthanasia. *Id.*

²⁵⁵ *Id.* at 413.

²⁵⁶ *Id.*

²⁵⁷ *Id.*

²⁵⁸ Eva Clausen, *The Politics of Death*, EURO|TOPICS, Feb. 18, 2009, http://www.eurotopics.net/en/archiv/magazin/magazin_aktuell/debatte-englaro-2009-02.

²⁵⁹ *Id.*

²⁶⁰ *Id.*

²⁶¹ Cummings, *supra* note 236.

²⁶² *Id.*

Minister of Health warned that allowing Eluana to die would be illegal.²⁶³ It was not until a Lombardy court ruled that the local government must designate a facility for Eluana's death that Mr. Englaro was able to find a location where Eluana's life-sustaining treatment could be removed.²⁶⁴ Eluana was subsequently transferred to the La Quiete clinic in Udine, where she died on February 9, 2009, four days after the removal of her feeding tubes.²⁶⁵

VII. ATTO SENATO N. 10

DISPOSIZIONI IN MATERIA DI ALLEANZA TERAPEUTICA DI CONSENSO INFORMATO E DI DICHIARAZIONI ANTICIPATE DI TRATTAMENTO

Prior to the death of Eluana Englaro, Prime Minister Silvio Berlusconi's conservative cabinet introduced an emergency directive, forbidding the removal of her life-support.²⁶⁶ The decree was an attempt to circumnavigate the ruling of the Court of Cassation. President Giorgio Napolitano refused to sign the directive, declaring it: "[U]nconstitutional and damaging to the balance of powers"²⁶⁷ The measure was drafted into a four-line bill that simply stated: "[P]ending more comprehensive legislation' on such matters, 'in no case' can feeding tubes be removed from patients unable to make the decision for themselves."²⁶⁸ Before the Senate could fully review the proposal, Eluana Englaro died.²⁶⁹

In the weeks that followed, Berlusconi's cabinet drafted a more comprehensive bill strictly limiting what measures may be taken for incompetent end-of-life patients.²⁷⁰ On March 26, 2009, the Senate passed the bill 150-123.²⁷¹ If approved by the Chamber of Deputies, the act will grant a limited right to declare in a living

²⁶³ *Id.*

²⁶⁴ *Id.*

²⁶⁵ *Eluana Moved to Hospital to Die*, CATHNEWS, Feb. 5, 2009, <http://www.cathnews.com/article.aspx?acid=11534>; Israely, *supra* note 31.

²⁶⁶ Rachel Donadio, *Death Ends Coma Case that Set Off Furor in Italy*, N.Y. TIMES, Feb. 9, 2009, <http://www.nytimes.com/2009/02/10/world/europe/10italy.html>.

²⁶⁷ *Id.*

²⁶⁸ *Id.*

²⁶⁹ Gina Doggett, *'No Respect' in Italy Right-to-die Drama*, THE SYDNEY MORNING HERALD, Feb. 11, 2009, <http://news.smh.com.au/breaking-news-world/no-respect-in-italy-righttodie-drama-20090211-83ql.html>.

²⁷⁰ See *Italian Senate Approves Right-to-die Restrictions*, *supra* note 170.

²⁷¹ *Id.*

will what medical treatment is acceptable should one enter into a vegetative state.²⁷² The proposed legislation has received a great deal of criticism given that it: (1) explicates that patients cannot refuse artificial nutrition and hydration because they are vital for life support; (2) states that artificial nutrition and hydration might help in the relief of pain; (3) limits the validity of living wills to five years; and (4) gives physicians the right to disregard the express wishes of the patient.²⁷³

People on both sides of the ELP debate have implored the Italian government to reconsider the controversial bill.²⁷⁴ According to Lorenzo d'Avack, vice-president of the Committee of National Bioethics, "The bill is badly written and confusing."²⁷⁵ Umberto Veronesi, oncologist and opposition senator, has said, "The affair highlight[s] a characteristic of today's Italy, the enduring influence of the Catholic Church, and represents a negative countertrend to the current legislation of other European countries."²⁷⁶ Amedeo Bianco, president of the National Federation of Surgeons and Dentists, *Federazione Nazionale degli Ordini dei Medici Chirurghi e degli Odontoiarti* (FNOMCeO), believes that more time is necessary for debate: "We are convinced that a bill such as this needs a calmer environment, more geared towards dialogue, in order to reach balanced and widely shared solutions."²⁷⁷

VIII. ADOPTING A FUNCTIONAL LEGISLATIVE ARCHETYPE IN ACCORDANCE WITH ITALIAN IDEALS

A. Italian Attributes that Favor a Temperate Model

1. The Consensus Among Western Medical Professionals and Domestic Institutions

The advent of the European Union has created a

²⁷² Marta Paterlini, *Italy Urged to Give End-of-life Bill More Time for Debate*, 373 THE LANCET ISS. 9673, 1413, 1413 (2009), available at [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(09\)60803-5/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)60803-5/fulltext).

²⁷³ See *id.*

²⁷⁴ *Id.*

²⁷⁵ *Id.*

²⁷⁶ *Id.*

²⁷⁷ Paterlini, *supra* note 272, at 1413.

demonstrable intellectual thoroughfare throughout Western Europe, the likes of which the continent has never before seen. Characteristic of this modern environment is the free-flow of political philosophy, legal principles, religious creeds and, above all else, citizenry. Italian legislators cannot ignore the unified position of the majority of European medical organizations that recognizes artificial nutrition and hydration apparatuses as constituting medical treatment, which may be removed at the will of the patient either expressly or symbiotically via a proxy. Giuseppe Palumbo, Committee Chair for the House's Social Affairs Committee in Italy, stated as much in September 2009: "[T]he committee plans to take into consideration a recent statement by the National Guild of Doctors . . . which expresses the guild's official position, describ[ing] artificial feeding as a 'treatment'" ²⁷⁸

In Italy, several domestic institutions that officially consult the Upper and Lower House have expressly aligned themselves with the Western European consensus. The FNOMCeO, which formally advises the Italian Senate, maintains that artificial nutrition and hydration is a medical treatment. ²⁷⁹ The Oleari Commission, responding to an inquiry from the Italian Minister of Health, concluded that the discontinuance of such care is legitimate if based on the will of the patient or the patient's guardian. ²⁸⁰ Moreover, Italy ratified the Oviedo Convention in 2001. One can infer from this document that in instances of both passive voluntary and passive non-voluntary euthanasia, the best interest of the patient must be considered, which may not always include the continuance of life-prolonging treatment. ²⁸¹

2. *The Inherent Latitude in Italian Law*

The Constitution of the Italian Republic and the Italian Penal Code do not definitively proscribe less conservative ELPs. Even under contemporary Italian law, there is sufficient inherent flexibility for an incorporation of the Western European majority. First, Article 32 of the Constitution avers that one cannot be

²⁷⁸ *House Committee Set to Resume Work on Living Wills Bill*, LIFE IN ITALY, Sept. 10, 2009, <http://www.lifeinitaly.com/node/7634> (last visited Feb. 2, 2010) [hereinafter *House Committee*].

²⁷⁹ Paterlini, *supra* note 272.

²⁸⁰ Moratti, *supra* note 168, at 411.

²⁸¹ See Viganò, *supra* note 16, at 176.

forced to submit to medical treatment except as regulated by law, which may not “violate the limits imposed by respect for the human being.”²⁸² The language incontrovertibly asserts that an individual cannot be forced to accept medical care that disrespects the patient. The drafters of the Constitution sought to preserve the sovereignty of the human being as opposed to the idiosyncratic opinions of treating physicians or the state.

Second, the IPC is devoid of explicit references to either euthanasia or assisted suicide and has intrinsic measures for the reduction of punishment.²⁸³ When faced with divisive ELP cases, Italian courts have utilized these mechanisms in order to grant leniency.²⁸⁴ The judiciary is neither isolated from international influence nor devoid of compassion when confronting a defendant who has ended the incessant pain and suffering of a loved one. Furthermore, indirect euthanasia, which incontrovertibly expedites death, is legal under the IPC.²⁸⁵ In the absence of explicit legislation to the contrary, it is possible that the Italian judiciary will increasingly align itself with the international consensus and more strongly emphasize the special circumstances surrounding the removal of life-sustaining treatment.

3. *The Close Geographical Proximity of Switzerland to Italy*

The close proximity of Italy to Switzerland is the most palpable and perhaps the strongest argument for the establishment of more liberal Italian ELPs. Roughly one-third of Italy's northern border lies adjacent to Switzerland, a nation that has unabashedly opened its doors to foreigners seeking to obtain peaceful closure to their lives.²⁸⁶ Considering the ease of travel between the two countries and the interrelatedness of its citizens, it is impractical to create zealous extraterritorial legislation or levy international travel restrictions. It is also unrealistic for the Italian legislature to ignore the imposing Swiss presence and restrict the ELP debate to Italy's national borders. The EU has repeatedly recognized “death tourism”—the journey of non-Swiss residents to Switzerland in order to utilize Swiss end-of-life clinics—as a significant issue in Member States such as Germany, Austria and

²⁸² Art. 3 COST. (It.).

²⁸³ See Viganò, *supra* note 16, at 167-86.

²⁸⁴ *Id.*

²⁸⁵ *Id.* at 180.

²⁸⁶ Srinivas, *supra* note 15, at 92.

the United Kingdom.²⁸⁷

Given the emotional and moral underpinnings of the end-of-life debate, it is evident that virtually no degree of restrictive legislation will absolutely deter all individuals from taking a brief trip to Switzerland for the purpose of ending what they perceive as the unnecessary pain and suffering of a loved one—whether that be in the form of assisted suicide or the removal of life-sustaining treatment. As the Chamber of Deputies reviews the bill recently passed by the Senate, it must not fail to consider how it intends for the Executive branch to effectuate the proposed act. If Italian citizens are willing to spend a few hours traveling to Switzerland in order to utilize Swiss end-of-life clinics, then it is unlikely that law enforcement will be able to successfully implement *Atto Senato n. 10*.

4. *The Roman Catholic Church*

The position of the Roman Catholic Church starkly contrasts the three prior arguments, which support the drafting of legislation categorizing artificial feeding and hydration as medical treatment that may be discontinued at the will of the patient. The Church believes that “each human life is a manifestation of God” and, therefore, “does not accept that human beings have a right to die.”²⁸⁸ While the Vatican accepts in certain situations that Catholic doctrine may not call for the continuance of aggressive life-prolonging treatment, it does not view life-support as treatment and deems its removal murder under the Fifth Commandment.²⁸⁹

In Italy, the Roman Catholic Church continues to maintain a “high moral authority” and holds an influential position in the debate over ELPs.²⁹⁰ The bill recently passed by the Senate closely reflects the position of the Vatican as Prime Minister Berlusconi declared, “The deference my government has mounted in favour of several cornerstones of civilized society that also form the basis of Catholic doctrine . . . demonstrate the excellent state

²⁸⁷ See *id.* at 102-07. See also Bosshard, *supra* note 56, at 477.

²⁸⁸ *Euthanasia – General Christian View*, BBC NEWS, http://www.bbc.co.uk/religion/religions/christianity/christianethics/euthanasia_1.shtml (last updated Mar. 8, 2009). See generally RICHARD MCCORMICK, *HEALTH AND MEDICINE IN THE CATHOLIC TRADITION 1-7* (Martin Marty & Kenneth Vaux eds., The Crossroad Pub. Co. 1984).

²⁸⁹ See Moratti, *supra* note 168, at 397.

²⁹⁰ *Id.*

of relations we have with the Church.”²⁹¹ Given the nexus between the State and the Vatican, it is clear that the development of ELPs will likely be neither a genial nor expeditious process.

Nevertheless, the Vatican has lost a cognizable degree of influence over Italian society and politics in the last fifty years.²⁹² Moreover, the Catholic Church recognizes a few limited quasi-liberal medical practices, such as the doctrine of double effect²⁹³—defined herein as indirect euthanasia—and the abstention of disproportionate life-prolonging treatment.²⁹⁴ Taking into account the leading view of Western medical professionals, the inherent latitude in Italian law and the close proximity of Italy to Switzerland, it is not clear that the Vatican will be able to dissuade leftward leaning ELPs. Countervailing influences may be strong enough to compel the Italian legislature to recognize passive euthanasia as it pertains to the removal of life sustaining treatment and alternative directives.

B. Application of the British Model to the Italian End-of-Life Dilemma

The statutory mode implemented in Britain can serve as a functional model for future Italian legislation. British law accounts for the international trend towards a more liberal statutory construct, yet strictly prohibits overt acts of active euthanasia and limits the applicability of living wills.²⁹⁵ The UK recognizes the right of patients to pre-determine medical care in specific situations, but it creates a regulatory power in the treating physician and the judiciary, so as to safeguard the best interest of patients.²⁹⁶

First, the primary fear of both the Italian government and the Roman Catholic Church is the decriminalization of active euthanasia. Neither wants to open the door to the active killing of

²⁹¹ *House Committee*, *supra* note 278.

²⁹² *See Moratti*, *supra* note 168, at 397.

²⁹³ *Id.*

²⁹⁴ *Id.* at 398. The Catholic Church permits abstention only in narrowly defined circumstances: “A very short life expectancy is the key factor. Death must be ‘imminent’ and ‘inevitable,’ so that the interference of human intervention with the plans of God for the individual’s life is minimal. ‘Normal care’ cannot be withheld, and artificial nutrition and hydration falls within this category.” *Id.*

²⁹⁵ *See* Suicide Act, 1961, c. 60 (Eng.); Mental Capacity Act, 2005, c. 9 (Eng.).

²⁹⁶ *See* Mental Capacity Act, 2005, c. 9 (Eng.). *See also* Passive Euthanasia, *supra* Part V.E.

Italian citizens. It is necessary that Italy first pass legislation explicitly defining active euthanasia. Once a precise definition is developed, Italy can adopt prosecutorial policies similar to the interim procedures established by the DPP. The British guidelines, which enumerate twenty-nine explicit factors relevant to determining whether or not to prosecute, should appease both the right and the left.²⁹⁷ On one hand, the measures permit law enforcement room to breathe as it decides if criminal charges should be levied, and gives the judiciary a greater deal of discretion in ruling whether indictments are appropriate.²⁹⁸ On the other hand, the guidelines have a deterrent effect because they apply to all Italian citizens, regardless of the site of euthanasiation, and do not definitively state when authorities will refrain from prosecution.²⁹⁹ One can envisage that such a system would dissuade individuals from traveling north to Switzerland for the purpose of utilizing Swiss right-to-die organizations.

Second, according to the MCA, the UK honors the right of competent patients to choose medical care prior to any form of incapacitation—not only a vegetative state as proffered in *Atto Senato n. 10*—but the act ~~do~~ not view living wills as irrefutable.³⁰⁰ Should Italy adopt a statute similar to the MCA, living wills cease to be effective if there is a reasonable basis for finding that exigent circumstances exist, which a patient did not initially anticipate, that would have affected his or her decision.³⁰¹ If this situation occurs, a court of jurisdiction must determine the best interest of the patient via prior attestations of the patient's will, the prerogative of the patient's medical proxy, and the professional opinion of treating physicians.³⁰²

This statutory design accounts for the position of the Vatican in two significant ways: (1) it limits the validity of living wills; and (2) it creates a decisive role for physicians in the final determination of treatment. The Roman Catholic Church supports the current version of the bill, which restricts the enforceability of living wills to five-years, thereby enabling the treating physician to deviate from the recorded will of the

²⁹⁷ DPP Publishes Interim Policy, *supra* note 143.

²⁹⁸ *Id.*

²⁹⁹ *Id.*

³⁰⁰ Mental Capacity Act, 2005, c. 9 (Eng.).

³⁰¹ *Id.*

³⁰² *Id.*

patient.³⁰³ The British model should appease critics of the bill as it honors the competent patient's orders prior to incapacitation, but should pacify supporters by respecting the notion that under certain circumstances the now incompetent patient may no longer desire to have those wishes enforced.³⁰⁴ Such a statute would reach a middle ground that appears to mollify both the left and the right.

Third, in cases involving incompetent patients, who have not formed advance treatment directives prior to incapacitation, British law turns to their medical proxy for ascertaining care that is in the best interest of the patient.³⁰⁵ The initial reference to a medical proxy is in accordance with opponents of the bill, but subsequent considerations align themselves with its proponents. The MCA states that in order to identify the best interest of the patient, a court must consider, in addition to the patient's wishes, his or her "beliefs and values" and "other factors."³⁰⁶ The language clearly allows for the faith of a patient to substantially influence what constitute his or her best interest without forcing that idiosyncratic belief on all other citizens.

Furthermore, under the MCA, if a medical proxy has not been appointed, the doctor functions as the default proxy, who again must determine the best interest of a patient with reference to his or her religious beliefs, and seek final approval by the appropriate court of jurisdiction.³⁰⁷ In reaching a professional opinion, the treating physician must balance the potential harm against the potential benefit of continuing medical treatment.³⁰⁸ The MCA implicitly holds that, provided treatment is "not excessively burdensome or disproportionate in relation to expected benefits," extending life is usually in the best interest of the patient, but when there is no net benefit to the patient, such care may violate this interest.³⁰⁹ The Sacred Congregation for the Doctrine of the Faith issued a similar statement in the Declaration on Euthanasia: "[I]t is morally acceptable to abstain from 'disproportionate' life-prolonging treatments."³¹⁰

³⁰³ Paterlini, *supra* note 272.

³⁰⁴ Mental Capacity Act, 2005, c. 9 (Eng.).

³⁰⁵ *Id.*

³⁰⁶ *Id.*

³⁰⁷ *Id.*

³⁰⁸ Lewis, *supra* note 99, at 352.

³⁰⁹ WITHHOLDING AND WITHDRAWING, *supra* note 158.

³¹⁰ See Moratti, *supra* note 168, at 398.

Finally, although British legislation provides a practical structure upon which Italy can base future ELPs, there remains at least one outstanding issue unaccounted for: “Does artificial feeding and nutrition constitute medical treatment?” The majority of European medical professionals and UK law both deem such care, as well as artificial ventilation and blood transfusion, as comprising treatment that may be discontinued at either the behest of the patient or in accordance with his or her best interest.³¹¹ Conversely, the Vatican considers this form of care as vital for life support, the removal of which amounts to murder.³¹² A compromise on this issue is key to achieving any potential legislation. It will undoubtedly require a significant amount of debate and concession, given the influential role of the Roman Catholic Church in the Italian political system. Regardless, pressure mounting from international consensus and the foreboding presence of Switzerland should serve to facilitate open dialogue and compromise.

IX. CONCLUSION

The long-standing debate over end-of-life policy is a decisive topic that extends beyond the public arena of law and politics, intruding into the private realm of religion and philosophy. Consistently, Europe has proven itself to be a continent divided, incapable of reaching a homogenous European perspective.³¹³ Although this fracture has split the region predominantly into two camps, Italy exists for the moment without explicit legislation covering euthanasia, assisted suicide, or advance treatment directives.³¹⁴ Recent disputes, however, have galvanized a political movement that seeks to soon establish precise statutory guidelines in Italy.

The United Kingdom exemplifies a traditionally conservative model of end-of-life legislation that as of late has begun to incorporate modern concepts.³¹⁵ Imperfect as it is, the British archetype serves as a functional framework that Italy should utilize in its efforts to formulate legislation. Modern British law incorporates several distinct approaches that would account for

³¹¹ See *supra* Part VIII.A.1.

³¹² Paterlini, *supra* note 272.

³¹³ See *Euthanasia: A Continent Divided*, *supra* note 37.

³¹⁴ See Viganò, *supra* note 16, at 167.

³¹⁵ See Lewis, *supra* note 99.

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the varied concerns of parties along both the Italian left and right. The mere transplant of British policy onto the Italian legal system will not solve the country's unique dilemma, but, nonetheless, it should move the discussion towards a compromise. In the ensuing months, Italy stands to take unprecedented steps in the formulation of domestic end-of-life policy, which would be well served by reference to contemporary British legislation.