Conscientious objection in Italian law n. 219/2017: a space for reflection still to be traced

Pamela Tozzo, Matteo Sanavio, Carola Salasnich, Luciana Caenazzo*

CONSCIENTIOUS OBJECTION IN ITALIAN LAW N. 219/2017: A SPACE FOR REFLECTION STILL TO BE TRACED

ABSTRACT: Italian Law no. 219/2017, containing provisions on informed consent and advanced directives, represents the landing place that the Italian legislature has reached following a long debate in relation to the issues of end of life and living wills. Although many authors have given the law a positive reception, some critical aspects have arisen, such as the issue of conscientious objection for healthcare professionals. Recognizing that the debate is far from being resolved, this article highlights the controversial aspects of conscientious objection as covered by Law no. 219/2017, but also the more general regulatory assumptions regarding this issue.

KEYWORDS: Conscientious objection; Italian Law 219/2017; informed consent; advanced directives; healthcare professional

1. Law n. 219/2017: a summary of the regulatory framework

Italian Law no. 219/2017 entitled *Provisions for informed consent and advance treatment directives*, assumed the force of law on January 31st, 2018 and represents the result reached by the Italian legislature after a long debate on end-of-life issues and living wills[1].

This discussion originated and was especially fostered by a series of cases of public interest and to which, substantially, the solution had been provided by jurisprudence.

In general, Law no. 219/2017 is not simply a set of rules of conduct concerning end-of-life scenarios and advanced directives (ADs) but it is a comprehensive piece of legislation that regards informed

* *Pamela Tozzo: Department of Molecular Medicine, University of Padova, Via Falloppio 50, 35121 Padova (Italy). Mail: pamela.tozzo@unipd.it; Matteo Sanavio: Department of Cardiac, Thoracic, Vascular Sciences and Public Health, University of Padova, Via Falloppio 50, 35121 Padova (Italy). Mail: matteo.sanavio@studenti.unipd.it; Carola Salasnich: School of Law, University of Padova, Padova (Italy). Mail: carola.salasnich@studenti.unipd.it; Luciana Caenazzo: Department of Molecular Medicine, University of Padova, Via Falloppio 50, 35121 Padova (Italy). Mail: luciana.caenazzo@unipd.it.*

[1] Italian Law n. 219/2017, *Norme in materia di consenso informato e di disposizioni anticipate di trattamento*, Gazzetta Ufficiale Serie Generale n. 12, 16-01-2018.

consent (IC) and the related legal and ethical issues. Substantially, the law reproduces the practices that had already been consolidated in health facilities and the principles already affirmed in jurisprudence, in accordance with the Italian constitution[2] and European principles[3].

Law no. 219 is made up of eight articles[4] which govern, in particular, the IC of the patient (art. 1)[5], the use of palliative care (art. 2)[6], the IC in case of minor patients and mentally incapable patients (art. 3)[7], ADs (art. 4)[8] and advance care planning (ACP) (art. 5)[9].

The legislature establishes, in art. 1, that no medical treatment can be started or continued without the free and informed consent of the patient, except in the cases expressly provided for by the law; these provisions are in accordance with the national and European principles that protect the right to life, health, dignity and self-determination of the person. In the same article it is stated that there must be «promoted and enhanced the relationship of care and trust between the patient and the physician, which is based on informed consent, in which the patient's decision-making autonomy and the doctor's competence, professional autonomy and responsibility meet». All the other members of the healthcare team contribute to this relationship too and, if the patient authorizes it, even his/her relatives or trusted ones can participate.

This law seems to recall, in this way, a classic contractual relationship between the parties, where patient and physician are on an equal footing, in contrast to the previous paternalistic conception where physicians autonomously took all the clinical decisions as based on their superior knowledge[10]. In fact, there cannot be any patient's consent without information about their health condition, all the possible risks and consequences of the medical treatments, possible alternatives and related consequences. This informative process is made up of a continuous dialogue between physician and patient,

[2] Constitution of the Italian Republic – English version, https://www.senato.it/documenti/repository/istituzione/costituzione_inglese.pdf (last visited 24/04/2020).

[3] Council of Europe, European Court of Human Rights, *European Convention on Human Right*, 1950, https://www.echr.coe.int/Documents/Convention_ENG.pdf (last visited 24/4/2020). Council of Europe, *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,* 1997, https://rm.coe.int/168007cf98 (last visited 24/4/2020).

[4] C. Casonato, *Forum: La legge n. 219 del 2017, Norme in materia di consenso informato e di disposizioni anticipate di trattamento Introduzione: la legge 219 fra conferme e novità*, in *BioLaw Journal – Rivista di BioDiritto*, 1, 2018, 11-12.

[5] S. Canestrari, *Forum: La relazione medico-paziente nel contesto della nuova legge in materia di consenso informato e di disposizioni anticipate di trattamento (commento all'art. 1)*, in *BioLaw Journal – Rivista di BioDiritto*, 1, 2018, 20-24.

[6] P. Morino. *Forum: L'articolo 2 nella prospettiva della medicina palliativa*. in *BioLaw Journal – Rivista di BioDiritto*, 1, 2018, 43-45.

[7] G. Ferrando, *Forum: Minori e incapaci*, in *BioLaw Journal – Rivista di BioDiritto*, 1, 2018, 46-52.

[8] F.G. Pizzetti, *Forum: Prime osservazioni sull'istituto delle disposizioni anticipate di trattamento (dat) previsto dall'articolo 4 della legge 22 dicembre 2017, n. 219*, in *BioLaw Journal – Rivista di BioDiritto,* 1, 2018, 54-60.

[9] M. Di Paolo, F. Gori, L. Papi, E. Turillazzi, *A review and analysis of new Italian law 219/2017: "provisions for informed consent and advance directives treatment"*, in *BMC Medical Ethics*, 20, 17, 2019, 1-7; P. Veronesi, *Forum: La pianificazione condivisa delle cure*, in *BioLaw Journal – Rivista di BioDiritto,* 1, 2018, 66-69.

[10] R. Ciliberti, I. Gorini, V. Gazzaniga, F. De Stefano, M. Gulino, *The Italian law on informed consent and advance directives: New rules of conduct for the autonomy of doctors and patients in end-of-life care*, in *Journal of Critical Care,* 48, 2018, 178-182.

where the information should be appropriate to the patient's educational level and comprehension ability[11] and where consent should be documented in a written form and included in the medical record. Nevertheless, the patient is not obliged to receive information: in fact, he/she can renounce it and, if he/she wants to, nominate a trustee who can receive information and give consent on his/her behalf.

Although consent is essential and legitimizes the physician's treatment of the patient, the law provides that in emergency or urgent situations, the physician's intervention, in order to have a chance of success, can be carried out even without the patient's consent.

With Article 2, the law deals with palliative care and provides that, even after a refusal or a withdrawal of consent to health treatments, the physician should alleviate the patient's suffering through an adequate pain therapy and palliative care; the purpose of this provision is to prevent the patient's decision from possibly causing a therapeutic abandonment by the physician. At the same time, it is provided that, in cases of patients with a poor short-term prognosis or who are about to perish, the doctor should refrain from any unreasonable obstinacy in the administration of care and from using unnecessary or disproportionate treatment, and should apply, if necessary and with the patient's consent, continuous palliative sedation.

Art. 3 deals with informed consent in the case of minors or mentally incapable patients. In this case, informed consent is expressed by their legal guardian, taking into account their will as much as possible; therefore, even these individuals should be put in a position to express their will and, for this reason, it is provided that, in cases of conflict, when the legal guardian refuses the proposed treatment and the physician considers it necessary, the decision should be taken by the judge.

One of the major innovations of Law no. 219/2017 is the introduction, for the first time in legislative terms, of ADs in our legal system, which are regulated by Article 4. ADs regard every competent and adult person that, in preparation for any possible loss of the capacity for self-determination and after having acquired adequate medical information, can establish in advance his/her own will regarding the healthcare treatments he/she wants to be subjected to, as well as about the consent or refusal of them[12]. Reiterating what had been established in Law 219/2017 about artificial nutrition and hydration, that are considered as health treatments, the consequence is that, even in the context of the ADs, it is possible to refuse artificial nutrition and hydration. The law establishes some specific formal requirements to draft the ADs: they must be written in the form of an official document, authenticated private writing or private writing personally delivered to the civil registry office of the municipality of residence or to the healthcare facilities, where legally permitted; those who are not able to use these means due to a physical impairment can use a video recording or other devices that allow them to communicate.

ADs are binding for the physician, but Law 219/2017 provides that they can be disregarded in specific and limited cases, such as those reported in paragraph 5: «the doctor must take into account the ADs, which may be disregarded, in whole or in part, by the same doctor, in agreement with the trustee, if they clearly appear incongruous or do not correspond to the patient's current clinical condition, or if

[11] Italian Court of Cassation, judgement n. 2177/2016. Italian Court of Cassation, judgement n. 20984/2012.

[12] P. DELBON, S. CACACE, A. CONTI, *Advance care directives: Citizens, patients, doctors, institutions*, in *Journal of Public Health Reserch,* 8, 3, 2019, 1675.

there are therapies which were unforeseen at the time of writing and which can offer concrete possibilities for improving the quality of life». These provisions do not affect the possibility of the doctor disregarding the ADs even when they contain indications that are contrary to the law, medical ethics or good clinical-care practices (art. 1, par. 6). It is also provided that the patient may, at any time, renew, modify or revoke his/her previous ADs, with the same forms provided by the law and in specific emergency or urgency situations, this can also be done verbally and in the presence of two witnesses. The person who draws up ADs can nominate a trustee who represents him/her in the relationship with the doctor and the healthcare team when he/she loses the legally defined ability to understand and to exercise volition. The trustee will receive all the information about the disease and the possible treatments to be administered to the patient when he/she become incapacitated, contributing to respecting the patient's will. In addition, in this case it is provided that, in the event of a conflict between the doctor and the trustee, when the latter refuses the treatments that are considered appropriate and necessary by the doctor, the decision will be taken by the judge.

Article 5 regulates ACP[13], which, in contrast to ADs, concerns a patient affected by a disease that is under unrestrainable evolution and represents an agreement between the patient and the physician about a future treatment plan. All the healthcare professionals involved should respect this plan when the patient is in such a condition where he/she will not be able to express his consent and, even in this case, it will be possible for him/her to nominate a trustee. Since a disease is, in this case, already present, the information to the patient will be much more complete and up to date than in the case of ADs and, consequently, it will be more difficult for the physician to disregard the patient's will.

Although most doctors have welcomed Law no. 219/2017, some critical aspects have arisen and among them is the issue of conscientious objection (CO), which is still debated since the law does not mention CO for healthcare professionals in contrast to other Italian laws that deal with bioethical issues.

In particular, the main critique is that the law does not provide for the conscientious objection of the physician in the event that the patient decides not to start or to interrupt a lifesaving treatment and so to be allowed to die. It was found that, unlike other Italian laws that deal with bioethical issues, in Law no. 219/2017 there is no express reference to a conscientious objection and this has provoked the protest of some doctors and health facilities, especially those with Catholic roots.

The debate on the appropriateness of conscientious objection by healthcare professionals continues to be intense and often polarizing in Italy in light of the new provisions of Law no. 219/2017.

While a sort of compromise vision may be the way to go, the parameters of this compromise should still be discussed and articulated with particular reference, for example, to the protection of patients from unjust discrimination, guaranteeing access to health services and determining standards to regulate the request and authorization for conscientious objection. Recognizing that the debate is far from being resolved, in this contribution, the authors outline the admissibility of conscientious objection in the areas regulated by Law no. 219/2017.

[13] G.R. Gristina, L. Busatta, M. Piccinni, *The Italian law on informed consent and advance directives: its impact on intensive care units and the European legal framework*, in *Minerva Anestesiologica,* 85, 2019, 401-11.

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2. The balance between patient self-determination and doctor autonomy

Article 1 of Law no. 219/2017 has become very important because it confirms the difference between the right to self-determination and the right to health, as previously described by the jurisprudence: «the informative relationship between doctor and patient is an integral part of the health care contract between patients and healthcare facilities and, therefore, it is not possible to refer it to as a pre-contractual obligation or to an accessory instrument of health practice».

The provisions of art. 1 paragraph 5 explain the right of the patient to refuse any diagnostic assessment or healthcare treatment, as well as to withdraw personal consent at any time, even when this decision may result in the treatment's withdrawal. The right to self-determination is seen as being of paramount importance and it does not encounter any limit, not even when abiding by it causes a loss of life. In this regard, in the same paragraph, it is explained that artificial nutrition and hydration are medical treatments and, so, they can be refused[14].

Similarly, the provision of paragraph 6 states that: «the doctor must respect the patient's will to refuse or renounce treatments and, as a consequence, is exempt from civil or criminal liability». Therefore, if respecting the patient's will could lead to consequences concerning his/her health, including lethal events, the doctor is not liable, under civil or criminal law, also when the withdrawal or non-initiation of therapeutic treatments can lead to the patient's death, in particular as regards life-sustaining treatments (e.g. cardiocirculatory support drugs or mechanical ventilation)[15].

Law no. 219/2017 does not provide anything about the consequences of compensation for violation of the information obligation, therefore the provisions of the jurisprudence are still valid and the obligation to prove the correctness and completeness of the information provided to the patient lies with the healthcare professional.

However, it should be noted that the appropriateness of medical treatment is independent from the violation of informed consent, since this constitutes an autonomous source of responsibility, which exists when the patient, due to inadequate or absent health information, is unable to make an conscious decision[16]. In fact, the Italian Supreme Court stressed that: «the right to self-determination is different from the right to health, because the former represents a form of respect for individual freedom and a means for the pursuit of one's interests, and it manifests itself not only in the faculty to choose between the various possibilities of medical treatment, but also in the possibility of refusing or withdrawing any medical treatment».

Therefore, just as there may be medical liability for personal damage in the presence of the breach of a patient's right to self-determination, it is possible to recognize a prejudice to the same right even in the absence of physical or psychological damage and this can be independently compensated[17]. Indeed, the violation of the right to self-determination can find compensatory space even without an

[14] It should be noted that this solution was already appreciated in 2007 by the Court of Cassation decision 04.10.2007 n. 21748, which, ruling on the Englaro case, had qualified these practices as healthcare treatments.

[15] G. R. GRISTINA, *Forum: La legge n. 219 del 2017 - Considerazioni in merito ai commi 5, 6 e 7 dell'articolo 1 della legge sul consenso informato e sulle disposizioni anticipate di trattamento*, in *BioLaw Journal – Rivista di BioDiritto,* 1, 2018, 28-30.

[16] Italian Court of Cassation, judgement n. 9374/1997, n. 5444/2006 and n. 9085/2006.

[17] Italian Court of Cassation, judgement n. 2847/2010.

injury related to the right to health. The necessary condition is that this type of damage «borders on serious prejudice», as established by Court od Cassation decisions no. 26972 and no. 26974/2008. A further innovative element is the reversal of the burden of proof that the Court of Cassation had described[18] in the case of invalid consent even in the absence of harm to the patient's health: the violation of the right to self-determination must be demonstrated by the patient.

The principle of self-determination of the patient finds some limits in the second part of paragraph 6, which states: «the patient cannot request medical treatments that are contrary to the law, to the professional code of conduct or to good clinical practices; with regard to these requests, the physician has no professional obligations». This provision refers to the request for disproportionate or unscientific treatments and solves a problem that is highly significant concerning legal certainty and, to some extent, for medical ethics: that of the request for "obstinacy" in treatments that have become useless, or that are scientifically untrusted. However, the law does not describe those cases in which a doctor refuses to carry out the treatments requested by the patient, which are not contrary to the law, ethics and good practices[19]. It is admitted that the patient may ask for treatments that differ from those indicated by the doctor, but the roles of the doctor-patient relationship should not be reversed and, if these treatments are included in the cases indicated in paragraph 6, the doctor can refuse to carrythem out without incurring professional liability. The medical liability exception does not apply in the cases where the refusal of treatment is justified by an incorrect diagnosis or therapy or when the doctor does not respect the patient's will to refuse or withdraw treatments for which initially he/she gave valid consent.

Furthermore, the law specifies that the patient cannot ask for «contrary to the law» treatments, including euthanasia or assisted suicide, which are prohibited in Italy.

This provision confirms that Law no. 219/2017 did not introduce "active" euthanasia into our legal system, as well as assisted suicide, which, however, still became part of it about two years ago, following the Constitutional Court's decision no. 242/2019.

Furthermore, paragraph 9 of art. 1 attributes to each health facility the obligation to comply with the law, ensuring the necessary management and organization of the flow of information between healthcare professionals and patients[20]. In fact, the information cannot be entrusted exclusively to the individual doctor, but should be managed in a more complex and structured organizational context. In this sense, the Court of Milan considered a healthcare facility directly responsible for an infringement

[18] «[i]n the presence of harm to health due to the unpredictable consequences of a necessary and correctly performed therapeutic act (*secundum legem artis)*, but in the absence of the patient's preliminary information and the related valid consent, it is necessary to believe that the patient would have refused treatment if he had been adequately informed of possible complications». In this situation, «the burden of proof must be demonstrated by the patient because: a) the causal connection between a medical error and an injury to health must always be described by those who request compensation; b) the patient must demonstrate the reasons why he would have refused treatment if he/she had been adequately informed; c) it is necessary to establish the patient's subjective choice: therefore, the burden of proof must be in close proximity to the patient; d) the deviation of the patient's choice from the doctor's opportunity does not correspond to the "*id quod plerumque accidit*"».

[19] B. De Filippis, *Biotestamento e fine vita. Nuove regole nel rapporto medico-paziente: informazione, diritti, autodeterminazione*, Cedam, 2018.

[20] M. Di Masi, *Effetti redistributivi della Legge n. 219/2017 nel rapporto fra medico e paziente*, in *Giurisprudenza Penale*, 2019. https://bit.ly/3e8CADw (last visited 08/6/2020).

upon informed consent because «the need to guarantee full information for patients and the consequent obligation to verify that patients do not enter the operating room without a full awareness of their choice, is up to each member of the health team»[21].

3. The legal significance of conscientious objection in healthcare provisions in Italy

CO remains a hotly debated topic with strong arguments for and against its use in contemporary healthcare[22]. It could be defined as the refusal to obey a legal precept, the observance of which is required by the rules established in a precise ordering, by a subject in the name of his religious, moral, philosophical or ethical beliefs[23].

In this sense, CO represents an individual choice, intimately connected to the values of each subject. It is determined by the relationship between the subject's values and the duties to which he/she is called to respond following the law's provisions. The origin of the expression "conscientious objection" lies in the military field, in which the refusal to participate in military service is motivated by the refusal to potentially kill another person. More recently, this concept has been extended to other areas, in particular to the provision of healthcare services[24]. CO has, in the Italian legal system, an exceptional character as provided in few regulatory references, in which the sacrifice of some patients' rights is deemed to justify conscientious objection. Examples in this regard are CO to compulsory military service (Law No. 772 of 15 December 1972), CO to voluntary termination of pregnancy (Law No. 194 of 22 May 1978)[25], objection of conscience in the application of medically-assisted procreation techniques (Law 19 February 2004, no. 40)[26] and CO in animal experimentation (Law 12 October 1993, no. 413)[27].

Today, the two Italian laws that allow CO in the medical field are on the voluntary termination of pregnancy (no. 194/1978) and on medically-assisted reproduction (no. 40/2004).

With regard to Law 194/1978, the point is regulated by art. 9, first paragraph, which allows doctors not to take part «in the procedures and interventions for the termination of pregnancy», while the third paragraph limits the objection to the «completion of the procedures and activities specifically and necessarily aimed at determining the termination of pregnancy», excluding «antecedent and

[21] COURT OF MILAN, judgement n. 2423/2009.

[22] V. TURCHI, *Nuove forme di obiezione di coscienza,* in *Stato, Chiese e pluralismo confessionale*, 2010; A. PUGIOTTO, *Obiezione di coscienza nel diritto costituzionale*, in *Digesto delle discipline pubblicistiche*, X, Torino 1995.

[23] J. ARTHUR, C. FIALA, K. GEMZELL DANIELSSON, O. HEIKINHEIMO, J.A. GUÐMUNDSSON, *The dishonourable disobedience of not providing abortion*, in *The European Journal of Contraception & Reproductive Health Care,* 22, 1, 2017, 81.

[24] H. SHANAWANI, *The Challenges of Conscientious Objection in Health care*, in *Journal of Religion & Health,* 55, 2, 2016, 384-93.

[25] V.S. PESCE, *Law number 194 of 22 May 1978. Regulations for social protection of maternity and on voluntary interruption of pregnancy. Practical observations for complying with the law*, in *Minerva Ginecologica,* 31, 1-2, 1979, 1-7; M. PIRAS, P. DELBON, P. BIN, C. CASELLA, E. CAPASSO, M. NIOLA, A. CONTI, *Voluntary termination of pregnancy (medical or surgical abortion): forensic medicine issues*, in *Open Medicine (Warsaw),* 11, 1, 2016, 321-326.

[26] I. RIEZZO, M. NERI, S. BELLO, C. POMARA, E. TURILLAZZI, *Italian law on medically assisted reproduction: do women's autonomy and health matter?*, in *BMC Womens Health,* 16, 2016, 44.

[27] I. BALDELLI, B. BIOLATTI, P. SANTI, G. MURIALDO, A.M. BASSI, G. SANTORI, R. CILIBERTI, *Conscientious Objection to Animal Testing: A Preliminary Survey Among Italian Medical and Veterinary Students*, in *Alternatives to Laboratory Animals,* 47, 1, 2019, 30-38.

consequent assistance». In other words, the conscientious objection for healthcare professionals is limited to «the activity of the operators engaged exclusively in the treatment of the voluntary termination of pregnancy», and underlines that «the staff working in the family counselling centre is not directly involved in carrying out this practice, but only in activities of medical diagnosis of pregnancy and certification attesting the woman's request for voluntary termination of pregnancy». However, art. 9 of Law 194/1978 also requires conscientious-objector personnel to intervene when the woman's life is in danger[28].

Law no. 40/2004 recognizes the right to conscientious objections for healthcare personnel providing a formulation which is, in many respects, completely identical to that used for Law no. 194/1978: that is, it is possible to refuse the requested service where this consists of «carrying out the procedures and activities specifically and necessarily aimed at determining the medically-assisted procreation intervention». On the other hand, assistance activities preceding and following the intervention remain excluded from the scope of the provision and, therefore, from the possibility of being refused through conscientious objection[29].

From a jurisprudential point of view, professional autonomy has been explicitly recognized by the Constitutional Court starting from decision no. 282/2002, which states that «the basic rule [of the practice of medical art] is the autonomy and responsibility of the doctor who, always with the patient's consent, makes professional choices based on the state of knowledge available».

Nowadays, CO in healthcare is regulated to a greater or lesser extent, in many western liberal democracies. However, the development of the use of CO among healthcare professionals is a complex issue and not without thorny issues[30].

Although several theories have been proposed to support the justification of conscientious objection, the rights and beliefs of healthcare professionals, if exercised, necessarily have a potential impact on patients' health and their access to care[31].

In this way, various legislators have tried to minimize the possible impact of the objection to the provision of care to patients. If freedom of conscience can be defined as the individual right to behave in accordance with one's own convictions of conscience, then CO can constitute an expression of this freedom when individual convictions dictated by ethical, moral or religious principles conflict with regulatory obligations.

CO should be understood according to a more specific meaning compared to a generic attitude of intentional dissent towards the command of authority, which is expressed in the refusal to obey a precept of the legal system deemed contrary to obligations deriving from one's moral convictions. Moreover, the distinction of CO from the option – or clause – of conscience, which intends to preserve

[28] I. Pellizzone, *Forum: Obiezione di coscienza nella legge 194 del 1978: considerazioni di diritto costituzionale a quarant'anni dall'approvazione della legge n. 194 del 1978*, in *BioLaw Journal – Rivista di BioDiritto*, 3, 2018, 111-122.

[29] V. Fineschi, M. Neri, E. Turillazzi, *The new Italian law on assisted reproduction technology (Law 40/2004)*, in *Journal of Medical Ethics*, 31, 9, 2005, 536-539.

[30] R.J. Weiner, *Conscientious Objection: A Talmudic Paradigm Shift*, in *Journal of Religion & Health*, 2020; J. Savulescu, U. Schuklenk, *Doctors Have no Right to Refuse Medical Assistance in Dying, Abortion or Contraception*, in *Bioethics,* 31, 3, 2017, 162-170.

[31] F. Minerva, *Conscientious objection in Italy*, in *Journal of Medical Ethics,* 41, 2015, 170–173.

the principles of "science and conscience" of the individual professional in specific and particular situations, is less clear-cut, as, for example, in Article 22 of the current Italian Code of Medical Deontology. Compared to the latter, the CO recognized by the law has a more general character, as it follows a declaration by the subject to abstain, for the future, from certain services[32].

The issue of CO raises the question of what is the best strategy for balancing the rights of the healthcare professional compared to those of the patient who should receive benefits from that healthcare professional[33].

This question leads to a more general question on how to better reconcile the conflicting rights of two individuals who do not share the same ethical sensitivity on a topic, such as abortion, assisted reproductive technologies or end-of-life assistance[34].

The possibility for healthcare professionals to raise CO finds its presupposition in the fact that law and morality do not always coincide and the legislature can sometimes impose what individual morality forbids because of the possibility that instances of conscience can be in opposition to compliance with the regulatory precept. The objector does not question the validity of the law as such or of the legal system as a whole or even the legitimacy of the state authority, but asks to be allowed not to obey the law in order to be able to act consistently with respect to its moral values.

The CO does not constitute refusing to carry out a treatment by the healthcare professional because it is considered scientifically inappropriate in relation to the specific case, since in this case it would be a legitimate exercise of the professional autonomy of the healthcare professional. In conscientious objection, instead, the healthcare professional refuses to provide a service because it pursues a purpose, or involves the occurrence of a result, which the doctor considers unacceptable according to his/her moral beliefs, although this service perfectly responds to the *leges artis* and is suitable to produce a benefit according to the patient's perception of his/her best interest.

"Positive" CO indicates that the CO is substantiated in an action, rather than in an omission, thus leading to the violation of a legal obligation not to do, rather than to do. Positive CO arises, therefore, as opposed to the negative one, in which, however, in the face of a positive legal duty, there lies the will of the objector to omit the prescribed conduct. In fact, the conscientious objection relating to the obligations not to do must be excluded because non-compliance with the obligation would coincide with the complete violation of the principle of the law. In this sense, some authors[35] speculated that CO is not applicable, for example, when a patient expresses his/her will not to start a treatment, but only in cases where it is a matter of continuing or withdrawing the treatment.

CO arises from the perception of being subjected to a conflict between different duties: in other words, the objector warns that he cannot adapt to one of the duties to which he is called without at the same time avoiding the other duty. In some cases, the law contemplates the possibility of objecting, and in

[32] T.M. POPE, *Legal briefing: conscience clauses and conscientious refusal*, in *Journal of Clinical Ethics,* 21(2), 2010, 163-76.

[33] B. DICKENS, *Legal Protection and Limits of Conscientious Objection: When Conscientious Objection is Unethical*, in *Medicine and Law,* 28, 2009, 337–47.

[34] C. LAMB, M. EVANS, Y. BABENKO-MOULD, C.A. WONG, K.W. KIRKWOOD, *Conscience, conscientious objection, and nursing: A concept analysis*, in *Nursing Ethics,* 26, 1, 2019, 37-49.

[35] M. SCHIAVI, *Disposizioni anticipate di trattamento e obiezione di coscienza per medici e notai. profili interpretativi della legge 22 dicembre 2017 n. 219*, in *L-Jus – Rivista Semestrale Del Centro Studi Rosario Livatino*, 1, 2018.

these situations, the legislature has given legal relevance to the possibility that a moral instance may justify the choice not to respond to a legal obligation. In other cases, since the legislature has not foreseen this possibility, there is an uncertainty of interpretation on the admissibility of the conscientious objection, both from a legal and ethical point of view[36].

In conscientious objection, the conflicting duties would pertain to different levels, one juridical and the other moral, while, in order to have an authentic antinomy, the conflicting norms should both have a legal nature and belong to the same system. The aforementioned opinion has been subjected to close criticism by the most recent doctrine, which has not failed to observe how in a pluralistic democracy like ours we cannot totally disregard the juridical relevance of the moral duties imposed by individual conscience.

This conflict can meet with three logically acceptable solutions: a) the total denial of the relevance of any individual moral imperative that it is contrary to objective law (prevalence of law over conscience); b) the full and unconditional recognition of freedom of conscience, which would allow personal exemption from any regulatory imposition (prevalence of conscience over the legal rule) and c), as an intermediate solution, where it is necessary to find the specific cases in which the individual may disregard regulatory obligations, even if in contrast with his/her conscience (balance between law and conscience). This conflict cannot obviously be resolved by the simple imposition of law, without any juridical relevance of the personal reasons of conscience, which seems to be an intrinsic assumption in the pluralistic nature of the ordering of a democratic state such as ours, as permeated by the value of the dignity and freedom of the person. Nowadays, it is therefore necessary to find a legal basis that gives juridical relevance to a duty that, otherwise, in the absence of an express legislative interposition, would seem to rest exclusively on a moral level[37].

This regulatory basis should be sought in the constitutional rules that implicitly protect the freedom of conscience of every citizen. If there is a convergence of opinions on the assumption that freedom of conscience is founded in our Constitution, even in an implicit form, differences remain, however, regarding the identification of the constitutional rule from which this freedom is allowed to descend. In general, it can be said that the constitutional basis for freedom of conscience would lie in Articles 2, 3, 19 and 21 of the Italian Constitutional Charter. The corollary of such an approach is that the «drama of the choice between two duties» afflicting the objector would become a real juridical antinomy between different rules of conduct, one of which is derived from an ordinary law, while the other has its roots in the ethical and ideal convictions of the individual that are protected by the Constitution.

In this case, and it is usually the case of conscientious objection, we will not witness the automatic prevalence of the constitutional norm over the ordinary one, but we will have to deal with a conflict between rights. On the one hand, the right of the objector to freedom of conscience, which is a constitutionally protected right, and the rights of patients, whose respect is imposed by legal obligation (e.g. the right to self-determination of the woman in the case of voluntary termination of pregnancy),

[36] C. ZAMPAS, *Legal and ethical standards for protecting women's human rights and the practice of conscientious objection in reproductive healthcare settings*, in *International Journal of Gynecology and Obstetrics*, 123, 2013, 563-5.

[37] J.A. HUGHES, *Conscientious objection, professional duty and compromise: A response to Savulescu and Schuklenk*, in *Bioethics,* 32, 2, 2018, 126-131.

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also normally guaranteed by the Constitutional Charter. This conflict may only be resolved by balancing the conflicting interests.
Even where we admit that in CO (whether or not it is foreseen by an ordinary law) the antimonial relationship is established between two duties with legal relevance, it remains in fact to be determined who is responsible for balancing interests which underlie the reconstruction of CO as a manifestation of a constitutionally guaranteed freedom.

4. The position of the Catholic Church regarding CO in Law no. 219/2017

During the debate that led to the approval of Law no. 219/2017 there were various interventions by representatives of the Catholic Church.
One of them is the message during the World Medical Association European Region Meeting on End-of-Life Questions from Pope Francis who offered a deep reflection on the frailty of life and the need to support it with good practices, whose interesting parts for our discussion are reported as follows.
Interventions on the human body are becoming more and more effective, but they are not always decisive: they can support biological functions that have become insufficient, or even replace them, but this is not the same as promoting health. Therefore, a supplement of wisdom is needed, because today the temptation to insist on treatments that produce powerful effects on the body is more insidious, but sometimes they do not benefit the integral good of the person. In particular, regarding therapeutic obstinacy, the Pope affirmed that there is no obligation to always use all the potentially available therapeutic means and that, in specific cases, it is legitimate to abstain[38]. It is therefore morally lawful to reject the application of therapeutic treatments, or to suspend them, when their use does not correspond to the ethical and humanistic criterion that can be defined as «treatment proportionality»[39]. The peculiar aspect of this criterion is that it takes into consideration the result that can be expected, considering the patient's condition and his physical and moral strength. It allows to reach a decision that can morally qualifies as a renunciation of therapeutic obstinacy.
Relative to the importance of the physician-patient relationship in terms of the autonomy and freedom of the involved parties, the Pope highlights that illness play the main role: decisions must be made by the patient, if he/she has the competence and capacity. The patient, in dialogue with the doctors, has the right of self-determination based on the evaluation of the treatments that are proposed to him/her, to judge their effective proportionality in the concrete situation, to reject treatments if they are not considered to be proportional. This is not an easy assessment in today's medical activity, in which the therapeutic relationship becomes increasingly fragmented by the technological and organizational context.
Law no. 219/2017 has been judged by the various exponents of the Church to be positive in some aspects, including the importance of informed consent and palliative care, but has also raised criticism and observations.

[38] Pii PP. XII, *Acta Apostolicae Sedis XLIX*, 1957, 1027-1033.
[39] Congregazione per la Dottrina della Fede, *Dichiarazione sull'eutanasia*, in *Acta Apostolicae Sedis* LXXII, 1980, 542-552.

A partially favorable reaction arises from the New Charter of Healthcare Workers stating that, excluding any euthanasic act, the patient can express his/her will in advance regarding the treatments to which he/she would like to be subjected in the event that he/she is no longer able to express his/her consent or dissent[40].

Furthermore, it reported that even artificial nutrition and hydration, when they are not too burdensome or of any benefit, are among the basic treatments due to the dying person. The latter point has also been shared by the Italian Episcopal Conference (CEI) which in its document reaffirms that providing food and drink are essential acts and not medical treatments[41].

The Permanent Council of the Italian Episcopal Conference judged Law no. 219/2017 to be ideological and controversial, especially in defining hydration and artificial nutrition as medical treatments or in not providing for the possibility of conscientious objection by the doctor[42]. The euthanasia procedure is still unlawful because it proposes the interruption of life, causing death[43].

It is thus clear that the point that gives rise to the most discussion is the fifth paragraph of the first article because it gives the impression that the patient can also refuse this type of treatment, which is intended to keep him alive. If this was the case, there would be a case of "passive euthanasia", which is fiercely opposed by the Catholic Church.

Since the withdrawal of artificial hydration or nutrition (therefore, the so-called passive euthanasia) is also possible, and given the duty of healthcare facilities to guarantee «the full and correct implementation of the principles» referred to in Law no. 219/2017, the question of the possible conscientious objection of the doctor within Catholic healthcare structures has already been raised by the association of religious structures (Aris).

The answer should be negative because the law clearly specifies that all healthcare structures, «public or private», have a duty to «guarantee with their own organizational methods the full and correct implementation of the principles referred to in this law, ensuring the information necessary for patients and adequate training of staff»[44] , thus not contemplating the possibility that the person loses his/her rights only because he/she is hospitalized in a place of a religious stamp[45].

Critical issues were also highlighted by Catholic exponents in paragraph 6 of art. 1, which, stating that the doctor is obliged to respect the patient's willingness to refuse or withdraw medical treatment, seems to remove any possibility of objection for the doctor. It was thus proposed to emphasize the fact that the same paragraph specifies that the patient cannot demand health treatments contrary to

[40] Pontificio consiglio per la pastorale della salute, *Nuova carta degli operatori sanitari*, Libreria Editrice Vaticana, 2017.

[41] A. TORNIELLI, *Biotestamento, la CEI pronta alla battaglia. "Non applicheremo una legge così". Il cardinale Bassetti: «Si garantisca libertà ai nostri reparti»*, in *La Stampa*, 18 Dicembre 2017, https://www.lastampa.it/vatican-insider/it/2017/12/18/news/biotestamento-la-cei-pronta-alla-battaglia-non-applicheremo-una-legge-cosi-1.34084674 (last visited 08/06/2020).

[42] https://www.chiesacattolica.it/wp-content/uploads/sites/31/2018/04/18/Comunicato-finale-25-gennaio-2018.pdf.

[43] *Messaggio del Santo Padre Francesco ai partecipanti del meeting regionale europeo della World Medical Association sulle questioni del "fine vita"*. Vaticano, aula vecchia del sinodo, 16-17 novembre 2017.

[44] M. RODOLFI, S. PENASA, C. CASONATO, *Consenso informato e DAT,* in *Speciali - Il Civilista*, 2018.

[45] L. BENCI, *Consenso informato e testamento biologico (dat): cosa cambia con la nuova legge,* www.lucabenci.it (last visited 08.06.2020).

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the law, professional code of conduct or good clinical-care practices; in the face of these requests, the doctor has no professional obligations. Moreover, in this sense, it is also a modification of Art. 17 of the Code of Medical Deontology in the sense that the doctor, even at the request of the patient, should not carry out or aid in acts aimed at causing the patient's death. In light of this provision, the withdrawal of treatment or its suspension should never be carried out if motivated by the arbitrary will to kill, but if perceived only as a disproportionate treatment in reference to the patient's clinical condition[46].

It can be said that Law no. 219/2017 was not welcomed by the Church: it was defined as «censurable»; «unacceptable»; however, although not satisfied, some Catholic leaders recognized the law as not a sign of civilization[47].

Furthermore, in line with the concerns expressed by the CEI, the aspects that leave room for ambiguous interpretations need to be specified and deepened with the subsequent application regulations for the law's application[48].

5. Conscientious objection and Italian Law no. 219/2017

The possibility for healthcare professionals to raise CO in situations regulated by the Law 219/2017 is debated.

Since the law equates the right to refuse a treatment with the right to renounce it, (i.e. to revoke consent to ongoing treatments), it is feared that the physician's role may be reduced to that of a mere executor of patient requests. If the physician loses the right to object, he or she may be obligated to act in a way inconsistent with specific ethical principles, i.e. when the patient asks to discontinue ongoing proportionate therapies[49].

On the other hand, it has been pointed out that if the law recognizes a legal right to conscientious objection, this is an implicit admission of permissible acts of euthanasia, but the Italian legal system still prohibits euthanasia, as this law also does[50].

Moreover, according to this view, a place for CO would have transformed each act of withdrawing into an act of euthanasia. However, such a conclusion would be inconsistent with most of the literature on such matters[51].

[46] MONSIGNOR C. NOSIGLIA, *Dat e obiezione di coscienza*, in *Bioetica News Torino*, 2018.

[47] A. TORNIELLI, *Biotestamento, la CEI pronta alla battaglia*, 13, 42.

[48] L. BUSATTA, *Forum: La relazione al Parlamento sull'applicazione della legge*, in *BioLaw Journal – Rivista di BioDiritto*, 1, 2018, 81-84.

[49] D.W. BROCK, S.A. WARTMAN, *When competent patients make irrational choices*, in *The New England Journal of Medicine,* 322, 22, 1990, 1595-9; J. KUŘE, *Conscientious objection in health care*, in *Ethics & Bioethics* (in Central Europe), 6, 3-4, 2016, 173–180; D.W. BROCK, *Conscientious refusal by physicians and pharmacists: who is obligated to do what, and why?*, in *Theoretical Medicine and Bioethics,* 29, 2008, 187–200.

[50] D.P. SULMASY, *Italy's New Advance Directive Law: When in Rome….,* in *JAMA Intern Med,* 178, 5, 2018, 607-608.

[51] Italian Committee for Bioethics, *Bioethical reflections on medically assisted suicide*, 18 July 2019, http://bioetica.governo.it/en/opinions/opinions-responses/bioethical-reflections-on-medically-assisted-suicide/ (last visited 24/04/2020); Italian Committee for Bioethics, *Deep and continuous palliative sedation in the imminence of death*, 29 January 2016, http://bioetica.governo.it/en/opinions/opinions-responses/deep-and-continuous-palliative-sedation-in-the-imminence-of-death/ (last visited 24/04/2020).

A possible analysis of the problem can be structured, in our opinion, on two areas of reflection:
1) the presence in the text of the law of a hidden reference to a "conscience clause";
2) the admissibility of a form of CO, in relation to the aim of the law itself.
As regards the first point, Italian law no. 219/2017 does not describe any form of CO for healthcare professionals and, in particular, Art. 4 par. 5, states that: «physicians are required to respect advanced directives», and thus seems to exclude it. However, Di Paolo et al.[52] have identified in Art. 1 par. 6 an indirect reference to a «deontological conscience clause» when it describes that: «patients cannot request treatment contrary to law, professional ethics or clinical-care practices; in these situations, a physician has no professional obligations». Indeed, this sentence could be related to the aforementioned Art. 22 of the Italian Code of Medical Deontology: «[t]he doctor, who is requested to perform services that clash with his/her conscience or with his/her clinical conviction, can refuse this work, unless his/her behaviour causes immediate harm to the patient […]». Interpreting in a uniform way Art. 1 par. 6 with Art. 22 of the Italian Code of Medical Deontology, it could be thought that the doctor could refuse any intervention requested by the patient that conflicts with his/her conscience. According to this approach, CO would be configured, due to its constitutional value, as a perfect subjective right, which cannot be criticized in the motivations that govern it and it is able to exempt from any liability or sanctioning (civil or criminal), because, as expressed in paragraph 6 of article 1, any «professional obligation» for the doctor would no longer be valid.
However, this interpretation is not acceptable. In fact, as we have seen, the law concerns professional autonomy of the doctor and not conscientious objection, so believing that this form of objection has been introduced without a specific legal framework seems to be very unlikely[53].
Furthermore, it would not be reasonable for the legislature to consent for doctors to choose whether and to what extent to implement a law, allowing them not to respect the law in the situations established by themselves and to arbitrarily refuse the patient's requests or directives whenever they perceive some form of moral conflict, showing a contrast between the value of life for the healthcare professional and the patient's self-determination.
This would lead to a distortion of the hierarchy of legal sources, according to which the law must define the scope of validity and effectiveness of the ethical rules, and not *vice versa*[54].
The absence of a specific conscientious objection should lead to considering that the law could be held unconstitutional for violation of freedom of conscience and a form of violence against the doctors[55].
It is possible that a judge will decide, before a doctor who, for reasons of conscience, acts contrary to Law no. 219/2017 and refuses to practice or to withdraw a medical treatment, to raise a question of

A. KNOETZE, F. DE FREITAS, *The Protection of Conscientious Objection against Euthanasia in Health Care*, in *Potchefstroom Electronic Law Journal,* 22, 2019; J. SHAND, *A Reply to Some Standard Objections to Euthanasia*, in *Journal of Applied Philosophy,* 14, 1, 1997, 43–47.

[52] M. DI PAOLO, F. GORI, L. PAPI, E. TURILLAZZI, *A review and analysis of new Italian law 219/2017: "provisions for informed consent and advance directives treatment"*, 9, 2.

[53] S. CACACE, *La nuova legge in materia di consenso informato e DAT: a proposito di volontà e di cura, di fiducia e di comunicazione*, in *Rivista Italiana di Medicina Legale e del Diritto in campo sanitario*, 3, 2018, 935-946.

[54] D. PARIS, *Forum: Legge sul consenso informato e le DAT: è consentita l'obiezione di coscienza del medico?*, in *BioLaw Journal – Rivista di BioDiritto*, 1, 2018, 31-35.bus

[55] L. PALAZZINI, *Le DAT e la legge 219/2017: considerazioni bioetiche e biogiuridiche,* in *Rivista Italiana di Medicina Legale e del Diritto in campo sanitario, 3, 2018, 965-978.*

the legitimacy of the law to the Constitutional Court, regarding the absence of a specific conscientious objection. It would then be for the Court to balance the constitutional values involved, in the light of the specific case, and provide an answer.

In fact, the law in effect will tell us if and how many cases of conscientious objection will emerge and in relation to what benefits. Only if these issues cannot be reasonably resolved through an adequate internal legal organization, will the Supreme Court or the legislature have to intervene to clarify the issue.

As regards the second point, the law focuses on the good "relationship" between healthcare team and patient, seen from various perspectives and in different situations, which arises from the respect of mutual duties and rights. In particular, in order to establish an authentic therapeutic alliance between healthcare professionals and patients, informed consent becomes the key element of this relationship as stated in art. 1 – par. 2[56]. This relationship is supported by the patient's freedom to decide on their own health, accepting or refusing any treatments, and the healthcare professional's autonomy, which consists of the duty and the right to exercise their practice responsibly in light of the scientific knowledge. These counterbalanced autonomies are defined in the law by Art. 1 – par. 1, 3, 4, 5 and 6[57].

All of these provisions highlight that one party should not be overwhelmed by the counterparty. No abandonment is contemplated within the legislative text, nor a passive acceptance of the patient's will.

However, this ideal balance begins to falter in cases described in art. 3, 4 and 5, namely where there is no possibility of communicating directly with the patient, due to the patient's loss of capacity. In fact, in situations where it is impossible to obtain fully-informed consent, the law establishes useful alternatives aimed at extending the patient's wishes over time: ADs, ACP and the nominee of a "trustee" by the patient. In cases where the doctor is obliged to no longer treat a capable patient, but with what has been indicated in previously drawn up ADs or ACP, or with a trustee appointed beforehand, there is the concrete risk that there will be interpretative doubts about the patient's real will. In fact, in these situations, there might be conditions in which the doctor may suffer an internal conflict between their personal beliefs and the instructions given by the patient at an earlier time. In these cases, healthcare professionals may choose to raise CO, based on an internal conflict between their personal beliefs and the wishes previously expressed by the patient. However, the automatic admissibility of CO in every situation may cause an imbalance in the healthcare relationship in favour of healthcare professionals,

[56] The relationship of healthcare and trust between patient and doctor is based on informed consent where the patient's decision-making autonomy meets the doctor's competence, professional autonomy and responsibility.

[57] «1. This law [...] establishes that no health treatment can be started or continued without the free and informed consent of the person [...] 3. Everyone has the right to know his/her own health conditions and to be fully informed about it [...]; everyone can refuse, in whole or in part, to receive health information ... 4. Informed consent, acquired in the ways and with the most appropriate tools for the patient's condition, is documented in writing or through video recordings and [...] it is included in medical record and in the electronic health record. 5. Every person capable of acting, has the right to refuse, in whole or in part, with the same forms of the subsection 4, any diagnostic evaluation or health treatment proposed by the doctor for his/her pathology […]. The patient may change his/her mind and his/her will must be noted in the medical record and in the electronic health record. 6. Doctors are obliged to respect their patients' refusal or rejection of medical treatment and, in these situations, they are not civilly or criminally liable».

who can freely, even if improperly, promote their right to CO, subjugating the patient's wishes to their moral and ethical beliefs.

According to some authors[58], the reasons for the absence of conscientious objection would be the impossibility of reconciling the objection with the higher interests involved, such as the right to health and self-determination. This interpretation is inspired by the decision of the Constitutional Court no. 43/1997, which established that the protection of «rights of conscience» should not be unlimited and unconditional, but should be subordinated to the evaluation of the legislature in individual cases. In other words, in situations where the healthcare professional's actions are closely related to the patient's death event, such as those governed by Law no. 219, CO is not admissible.

A different point of view is related to the opportunity for the professional to disregard, in whole or in part, the patient's dispositions when they appear clearly incongruous or do not correspond to the patient's current clinical condition or there are new therapies that could not be foreseen at the time of subscription, in order to offer concrete opportunities to improve living conditions (art. 4 – par. 5). So, in these cases the rejection of the patient's disposition should be based on scientific principles that must be explained in relation to the specific clinical case in order to demonstrate the technical incongruity between ADs and the current clinical situation. One might think that, in a similar situation, if the law allowed CO, the doctor could easily reject the patient's AD without any technical justification.

In this regard, it is possible that the exercise of professional medical autonomy could lead two different doctors, in dealing with the same case, to act in different ways. In fact, the concept of autonomy may imply the possibility of making different choices. A possible way out of the impasse consists of retrieving the sense of proportionality as a balance between medical evidence and the patient's personal perspective on his/her condition since neither one of those aspects may stand alone in absolute terms. Therefore, a judgement of proportionality strives to hold both sides together and this may be possible only considering the background of a relationship between the physician and the patient. We hold that the law in question goes that way by offering a good balance between the patient's right to self-determination and the professional autonomy of the physician.

It is clear that, if the legislature did not foresee a possibility of conscientious objection, then the intent was probably to exclude it and, by reason of our considerations, we think that CO is not admissible and called for in Law 219/2017[59]. In fact, at present, the literal evaluation of the law would seem to establish that a doctor cannot disregard a patient's ADs if they conflict with their ethical-moral convictions, since there is no mention of CO in the law[60].

However, as healthcare professionals, we feel the need to accept the individual's freedom of conscience, especially for the healthcare professionals who must respect the rights of others by law. Therefore, they must always maintain a balance between the protection of others' freedoms and personal freedom. We believe that, in some specific and particular cases, the professional must have the

[58] C. LUZZI, *La questione dell'obiezione di coscienza alla luce della legge 219/2017 tra fisiologiche esigenze di effettività e nuove prospettive di tutela*, in *Dirittifondamentali.it*, 1,2019.

[59] B. LIBERALI, *Prime osservazioni sulla legge sul consenso informato e sulle DAT: quali rischi derivanti dalla concreta prassi applicativa?*, in *Rivista di Diritti Comparati*, 3, 2017, 267-280; F. GALLO, *Questioni di fine vita e obiezione di coscienza*, in *Diritto e Salute*, 4, 2018.

[60] E. CANALE, I. DEL VECCHIO, *La (mancanza di una) clausola di coscienza nella legge italiana sul fine vita,* in *Giurisprudenza Penale Web*, 1-bis - "Questioni Di Fine Vita", 2019.

opportunity to invoke a personal clause of conscience that goes beyond the legislative dictates without, however, treading upon them.

In this regard, it is possible to summarize some practical consequences as follows:

- the invocation of a conscientious-objector clause would be admissible even in cases where there is no precise regulatory provision governing its exercise, but in these cases, it becomes an essential condition for the exercise of the right to abstain, that the conditions exist not to prejudice the rights of others;
- the doctor who, on the basis of his/her own convictions, believes that he/she cannot execute a request for interruption of treatment, expresses to the patient or whoever represents him/her and to the head of the health service a motivated decision to evade what is required;
- the healthcare professionals who work in critical situations cannot know *a priori* if and in which cases a patient's request may be contrary to the dictates of his/her conscience.

6. Conclusion

Italian Law no. 219/2017 represents the culmination of a long Italian legislative debate in relation to the issues of end of life and living wills. It has been a discussion that had originated and had been fed mainly by a series of important media events that had moved public opinion and to which, in fact, it was jurisprudence that had provided a solution. This article highlights one of the most important and controversial issues of Law no. 219/2017 – namely, the possibility for healthcare professionals to raise CO for topics regulated by the law itself. CO seems not to be neither admissible nor anticipated under the provisions of Law no. 219/2017. Nevertheless, the invocation of a conscience clause would be admissible even in cases where there is no precise regulatory provision governing the exercise of CO, but in these cases, it becomes an essential condition for the exercise of the right to abstain that the conditions exist not to prejudice the rights of others. In some specific and particular cases, the doctor should have the possibility to invoke a personal conscience clause that goes beyond legislative dictates, without stepping on them, while maintaining a balance between the protection of the patient's freedoms and personal freedom of conscience.