Stato, Chiese
e pluralismo confessionale

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"Se prestarsi, o no": Conscientious Objection and Regulatory Gaps in Medically Assisted Suicide

"Se prestarsi, o no": obiezione di coscienza e lacune normative nel suicidio medicalmente assistito

ABSTRACT: Judgment No. 242 of 2019 of the Italian Constitutional Court brought to constitutional visibility two structural lacunae of the normative framework governing medically assisted dying: the absence of any structured mechanism of conscientious objection - replaced by an absolute and unaccountable freedom of individual physician discretion - and the failure to construct a normative bridge to Law No. 219/2017 on informed consent and advance treatment directives. Five years of regional legislative fragmentation have confirmed empirically that neither administrative nor legislative activism at the sub-national level can remedy either lacuna: the first falls within exclusive state competence; the second, even where partially addressed, cannot generate the nationally uniform, foreseeable, and accessible framework that the ECHR's positive obligations doctrine demands. Read through the two-track jurisprudence of the ECtHR on Articles 8 and 9 ECHR - patient-side obligations running from *Pretty* through *Haas* and *Mortier*; physician-side obligations originating in Bayatyan - both lacunae generate distinct international duties that Italy has so far refused to discharge. The article's central theoretical contribution is the reconceptualisation of conscientious objection from a domain of absolute individual moral sovereignty - in which the physician's lex poli silently nullifies the patient's lex fori - to a chorological practice: an institutionally structured third space in which incommensurable value systems encounter each other without either colonising the other. Two complementary legislative instruments - a statute integrating Law No. 219/2017 with a structured conscientious objection mechanism, and a national procedural protocol

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supplemented by regional clinical ethics boards - are proposed as the minimum adequate response to Italy's constitutional and international obligations.

ABSTRACT: La sentenza n. 242 del 2019 della Corte costituzionale ha reso evidenti due lacune strutturali dell'attuale quadro normativo in materia di suicidio medicalmente assistito: l'assenza di qualsiasi meccanismo strutturato di obiezione di coscienza - sostituito da una libertà assoluta e non responsabilizzata della discrezionalità individuale del medico - e il mancato raccordo con la l. n. 219/2017 sul consenso informato e le disposizioni anticipate di trattamento. Cinque anni di frammentazione legislativa regionale hanno confermato empiricamente che né l'attivismo amministrativo né quello legislativo a livello sub-nazionale possono rimediare alle due lacune: la prima ricade nella competenza esclusiva statale; la seconda, anche laddove parzialmente affrontata, non può generare il quadro procedimentale nazionalmente uniforme, prevedibile e accessibile che la dottrina delle obbligazioni positive della CEDU richiede. Lette attraverso la giurisprudenza a doppio binario della Corte EDU sugli artt. 8 e 9 CEDU - obblighi lato paziente che corrono da *Pretty* attraverso *Haas* e *Mortier*; obblighi lato medico originati da Bayatyan - entrambe le lacune generano obblighi internazionali distinti che l'Italia ha finora rifiutato di adempiere. Il contributo teorico centrale dell'articolo è la riconcettualizzazione dell'obiezione di coscienza da dominio di sovranità morale individuale assoluta - in cui la lex poli del medico azzera silenziosamente la lex fori del paziente - a pratica corologica: uno spazio terzo strutturato istituzionalmente in cui sistemi di valori incommensurabili si incontrano senza che l'uno colonizzi l'altro. Due strumenti legislativi complementari - una legge che integri la l. n. 219 del 2017 con un meccanismo strutturato di obiezione di coscienza e un protocollo procedurale nazionale integrato da comitati etici regionali - sono proposti come risposta minima adeguata agli obblighi costituzionali e internazionali dell'Italia.

KEY-WORDS: Medically assisted dying - conscientious objection - freedom of conscience - positive obligations - indecisive delaying. Suicidio medicalmente assistito - obiezione di coscienza - libertà di coscienza - obblighi positivi - inerzia legislativa.

Objection as Spatial and Communicative Practice: The Theoretical Case for Institutional Design - 7. Chorologies of Conscience: Designing the Two Instruments - 8. Concluding Observations: From the Accabadora's Silence to a Statutory Framework for Conscientious Objection and Informed Dying.

1 - Introduction: two structural lacunae of the normative framework

In Michela Murgia's novel *Accabadora*[1], the figure of Bonaria Urrai - a Sardinian woman who secretly accompanies the dying to their death - embodies a moral world that precedes codification, where compassion enacted at the threshold of life and death resists the categories of written law. The accabadora operates in the suspended space between the withdrawal of medical care and the silence of legal prohibition: she inhabits the normative void that every legal order, however developed, continues to leave at its margins. The parallel with the Italian Constitutional Court's landmark Judgment No. 242/2019[2] in the Cappato-Antoniani case is not merely literary. The accabadora acts without institutional acknowledgment, without procedure, without accountability: the physician at the end of life, under the regime of unstructured discretion that *Considerato in diritto*, punto 6 of the same judgment establishes, occupies a structurally analogous position - present at a constitutionally significant threshold, yet institutionally invisible. What distinguishes the two figures is precisely what the law is called to provide: transparency, procedure, and public justifiability[3].

The Court's ruling sought to transform a field of normative silence into an articulated framework for discursive orientation. By recognising the non-punishability of medically assisted suicide under stringent constitutional conditions, it displaced the accabadora's gesture from the domain of the unspeakable toward the domain of the legally regulated - but only partially, and only in one dimension[4].

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[1] **M. MURGIA**, *Accabadora*, Quercus, London, 2012 (original Einaudi, Torino, 2009). On law-and-literature as hermeneutic lens see **R. COVER**, *Nomos and Narrative*, in *Harvard Law Review*, 97, 1983, pp. 4-68.

[2] **CORTE COSTITUZIONALE**, sentenza 22 novembre 2019, n. 242, in *Giurisprudenza costituzionale*, 2019, pp. 2882-2912.

[3] See **D. PULITANÒ**, *Il diritto penale di fronte al suicidio*, in *Diritto penale contemporaneo*, 2018, 7-8, pp. 57-76.

[4] See **S. CANESTRARI**, *Una sentenza "inevitabilmente infelice": la "riforma" dell'art. 580 cp da parte della Corte costituzionale*, in *Rivista italiana di diritto e procedura penale* 4.4, 2019,

The judgment brought to constitutional visibility two lacunae of the normative framework. A preliminary conceptual clarification is necessary: these are not lacunae *of* the judgment itself, which operated within the limits of the question *prospettata* and of its own constitutional competence, and which did so precisely as it was required to. The lacunae are not the Court's failure; they are the normative system's residue after the Court's necessary and limited intervention. They emerge from the space that only legislation can fill, and their persistence after 2019 is the product of parliamentary indecisive delaying, not of judicial inadequacy.

The first lacuna concerns the nature of the physician's moral freedom: The Court spoke not of a structured right of conscientious objection - such as that codified by Article 9 of Law No. 194/1978 in the field of abortion - but rather of an unstructured freedom of conscience: it left each physician to choose "se prestarsi, o no, a esaudire la richiesta del malato", without creating any positive obligation on the healthcare system to ensure effective service provision in the event of individual refusal.

A conceptual clarification is required at the outset, because the very notion of a lacuna "concerning conscientious objection" might appear ill-founded. Conscientious objection in its classical form presupposes a legal duty from which the objector seeks exemption; and Judgment No. 242/2019 creates no duty to perform - a point the Constitutional Court has since reaffirmed in Judgment No. 204/2025, which expressly excludes any individual obligation on the part of healthcare personnel to carry out the procedure. Were the analysis to stop there, the objection would be well taken: where there is no duty to perform, there is nothing to object to, and the language of conscientious objection would be misplaced. The lacuna this article identifies is of a different order. It does not concern an unmet duty of individual performance, but the absence of the institutional architecture through which individual refusal is rendered systemically manageable - registration, referral, and facility-level substitution - in the absence of which the aggregate exercise of refusal renders the patient's access factually unavailable. This is precisely the logic of Article 9 of Law No. 194/1978: no individual physician is compelled to perform, yet the facility bears an organisational duty to guarantee the service irrespective of the

pp. 2159-2179; **F. PALAZZO**, *La sentenza Cappato può dirsi "storica"*?, in *Politica del diritto*, 51(1), 2020, pp. 3-14.

objection rate among its staff. The lacuna, in other words, is located not at the level of the individual physician's duty, but at the level of the system's organised response to the aggregate of individual choices.

The salience of this lacuna increases, moreover, precisely along the trajectory of the Court's own case-law. In 2019 the National Health Service was assigned a verifying role - ascertaining the access conditions and monitoring the modalities of execution. With Judgment No. 135/2024 the Court recognised a "situazione soggettiva tutelata" encompassing the right to be accompanied by the National Health Service; and with Judgment No. 204/2025 it affirmed a correlative organisational duty on the azienda sanitaria locale to plan realistically for personnel substitution, so that the voluntary character of participation does not translate, in practice, into denial of access. As the role of the public healthcare system shifts from passive verification toward active provision and accompaniment, the question of how individual refusal is to be organised ceases to be hypothetical: the more the system is required to act, the more the absence of a structured mechanism for managing refusal hardens into a genuine - and increasingly consequential - normative gap.

This formulation acquires its fullest normative expression in *Considerato in diritto*, punto 6, a passage of deceptive brevity whose lexical choices construct, term by term, a specific legal architecture: one of pre-legal moral discretion rather than of structured institutional accommodation.

The Court announces that the ruling *"si limita a escludere la punibilità"* - foreclosing, through the technique of jurisdictional self-restraint embedded in that verb, any expansive reading of the operative paragraph as a source of positive entitlements or duties on either side of the therapeutic relationship[5]. It adds, with an emphatic absolute

[5] The verb *si limita* is a classic technique of jurisdictional self-restraint: it signals that the operative effect of the ruling is defined by subtraction rather than addition. It was the indecisive delaying of the Italian Parliament on this issue that led to Judgment no. 242/2019. This act of judicial innovatio constitutes a paradigmatic example of an "additive manipulative" decision: the Court did not simply strike down an unconstitutional provision but re-calibrated its application, introducing cumulative criteria - irreversible pathology, intolerable suffering (physical or psychological), dependence on life-sustaining treatments, and the patient's full capacity for self-determination - under which assisting suicide would no longer entail criminal liability. In doing so, the Court remained formally within the limits of its judicial. function while edging toward a quasi-legislative role, filling a normative vacuum that Parliament had

quantifier, that it acts *"senza creare alcun obbligo"* - categorically declining to activate the organisational mechanism that Article 9(4) of Law No. 194/1978 imposes on healthcare facilities[6]. The moral choice is then *"resta affidato"* - not granted by the ruling but left intact, held in escrow by the pre-existing moral order, a fiduciary remainder rather than a new juridical endowment[7]. The adjective *"singolo"* atomises responsibility at the level of the physician-as-person, foreclosing both collective professional and institutional accountability[8]. And the symmetrical formula *"se prestarsi, o no"* grants refusal and participation formally equal normative weight, encoding no hierarchy between default and exception of the kind that the abortion statute carefully constructs[9]. The cumulative effect of these five lexical choices is a coherent architecture of pre-legal moral discretion, in which the physician's conscience is left where the Court found it - undisturbed, unstructured, and institutionally unconstrained.

The practical consequence is that the ruling created a right of access for patients without creating the institutional infrastructure necessary for that right to be effectively realised - precisely the

failed to address. Rather than simply declaring unconstitutional the Article 580 of the Penal Code, which criminalizes assistance in suicide, the Court reshaped it. It set out new constitutional criteria that determine when liability applies, transforming a blanket prohibition into a rule modulated by dignity, autonomy, and health. In this way, the Court stayed within its judicial role, but also took on a quasi-legislative function, compelled to act where Parliament had failed to provide guidance.

[6] The absolute quantifier *alcun* renders the negation categorical. Compare art. 9 L. 194/1978, which does impose a duty of timely referral. See **R. GUASTINI**, *Le fonti del diritto. Fondamenti teorici*, Giuffrè, Milano, 2010, pp. 378-395.

[7] The passive voice construction *resta affidato* draws on a register of fiduciary rather than regulatory relations. On *foro interno* see **V. PACILLO**, *Coscienza e destrutturazione*, in *Il Diritto Ecclesiastico*, 1, 2025, p. 52; **A. PASSERIN D'ENTRÈVES**, *Obbligo politico e libertà di coscienza*, in *Rivista internazionale di filosofia del diritto*, 1973, p. 41 ss.

[8] The adjective *singolo* atomises moral responsibility at the level of the physician-as-person, foreclosing institutional accountability. This stands in direct contrast to art. 9(4) L. 194/1978, which imposes on the healthcare facility the duty to ensure effective service provision regardless of the objection rate among its staff.

[9] The grammatical symmetry of *se prestarsi, o no* gives refusal and participation equal normative standing, encoding no hierarchy between default and exception. See **M. D'AMICO**, *Il "fine vita" davanti alla Corte costituzionale fra profili processuali, principi penali e dilemmi etici (Considerazioni a margine della sent. n. 242 del 2019),* in O*sservatorio costituzionale* 2020, 1, pp. 1-17.

asymmetry that the Convention system identifies as a violation of positive obligations under Articles 8 and 9 ECHR[10].

The second lacuna lies not in any failure to reference Law No. 219/2017 - which the Court explicitly invoked in its operative paragraph as the procedural framework for verifying access conditions - but in the Court's failure to construct a complete normative bridge between its ruling and the full clinical architecture of that statute[11]. While Arts. 1 and 2 of the law were mobilised as a verification mechanism, the Court left unexplored the systematic integration of Art. 5's model of shared care planning - a model specifically designed for patients with irreversible pathologies of incessant evolution - as the relational and institutional structure within which medically assisted dying must necessarily be situated. The result is an engagement that is procedurally anchored but architecturally incomplete. Both lacunae - equal in constitutional significance - define the argumentative trajectory of this article.

The overarching thesis is that a constitutionally coherent and Convention-compliant response to the normative void requires two complementary legislative instruments: a statute on medically assisted dying structured around the informed-consent architecture of Law No. 219/2017, and a mechanism of conscientious objection modelled on Article 9 of Law No. 194/1978 - instruments that are not alternatives but mutually reinforcing components of the same normative project[12].

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[10] On the dual access-accommodation deficit as a violation of positive obligations under Arts. 8 and 9 ECHR, see ECtHR, *Haas v. Switzerland*, no. 31322/07, 20 January 2011; **A. MADERA**, *Assisted Suicide in Italy: Navigating the Frontiers of "Legitimate Medicine"*, in *Journal of Law, Religion and State*, 2022, 2-3, pp. 94-133, fn. 23, pp. 100-104.

[11] L. 22 dicembre 2017, n. 219, *Norme in materia di consenso informato e di disposizioni anticipate di trattamento*. See **P. TOZZO, M. SANAVIO, C. SALASNICH, L. CAENAZZO,** *Conscientious objection in Italian law n. 219/2017: a space for reflection still to be traced*, in *BioLaw,* 2020, 2, pp. 269-85.

[12] The theoretical framework underlying the communicative and deliberative dimension of the present proposal draws, in preference to Habermas's system-theoretic account of juridification, on the participatory conception of deliberative democracy developed by Cristina Lafont - a theoretical choice that requires brief justification. Habermas's account in **J. HABERMAS**, *Faktizität und Geltung*, Suhrkamp, Frankfurt am Main, 1992, conceives of law as a medium through which communicative rationality is translated into institutional steering: the normative legitimacy of legal norms derives from their procedural genesis in discursive processes, but once produced they operate as systemic imperatives that coordinate behaviour without requiring ongoing deliberative engagement. Applied to the present problem, this generates a persuasive account of why the Constitutional Court's formula "resta affidato alla coscienza del singolo medico" is communicatively inadequate - it bypasses the institutional channels

2 - The regional response to parliamentary indecisive delaying: a patchwork that confirms the diagnosis

The five years separating Judgment No. 242/2019 from the enactment of the first Italian regional law on medically assisted suicide constitute a narrative of constitutional failure whose documentary record confirms empirically both structural lacunae identified in § 1, and demonstrates that regional activism - however constitutionally legitimate and practically indispensable - cannot substitute for national legislation. The Constitutional Court intervened again with Judgment No. 135/2024, broadening the definition of dependence on life-sustaining treatment and confirming that a person meeting the access conditions has a *"situazione soggettiva tutelata"* including the right to be accompanied by the National Health Service[13]. Across the country, five individuals

through which conflicting moral claims must pass to acquire democratic legitimacy - but it does not tell us what deliberative architecture should replace it.

Lafont's participatory conception addresses precisely this lacuna: **C. LAFONT**, *Democracy Without Shortcuts: A Participatory Conception of Deliberative Democracy*, Oxford University Press, Oxford, 2020, pp. 1-45 and pp. 167-210. Against both epistocratic and lottocratic "shortcuts" - in which democratic legitimacy is produced by experts or randomly selected bodies without genuine citizen deliberation - Lafont insists that the affected parties must themselves participate in the elaboration of the norms that govern them, not merely accept outcomes produced by deliberative surrogates.

Applied to the end-of-life context, this principle generates a stronger and more precise argument for the two-instrument proposal than Habermas's more abstract discourse ethics: the patients and healthcare professionals whose fundamental interests are at stake in medically assisted dying cannot be adequately represented either by the Constitutional Court's ablative interventions or by the patchwork of regional administrative measures documented in § 2. They require a genuinely participatory legislative process - precisely the parliamentary deliberation whose repeated absence this article identifies as the constitutional pathology of the Italian framework. See further **C. LAFONT**, *Human Rights, Sovereignty, and the Responsibility to Protect*, in *Human Rights Quarterly*, 35, 2012, pp. 101-123; **C. LAFONT**, *Accountability and Global Governance*, in *Ethics & Global Politics*, 3, 2010, pp. 239-260.

[13] The five documented cases: (i) Federico Carboni ("Mario"), Marche, 16 June 2022; (ii) "Gloria", Veneto; (iii) "Anna", Friuli-Venezia Giulia; (iv) unnamed man, Emilia-Romagna; (v) "Vittoria", Veneto. Cases (ii)-(v) identified by pseudonym. See **J. CAMATTI et al.**, , *Updates on Medically Assisted Suicide in Italy: Approval of First Regional Law in February 2025*., in *Medicine, Science and the Law*, 66, no. 2 (2026), pp. 107-113 (*https://doi.org/10.1177/00258024251362541*); **R. CECCHI et** al., *Medically Assisted Suicide in Italy: Recent Legal Developments*, in *Medicine, Science and the Law*, 64, pp. 77-81 (2024).

exercised that right, each through a different regional health service, each after litigation that no law had made unnecessary[14].

Regional responses to this vacuum have taken two structurally distinct forms. The first is the administrative track: several regions - most notably Puglia and Emilia-Romagna - adopted executive measures that designated ethics committees, established verification procedures, and set internal timelines. The second is the legislative track: in Tuscany, the Regional Council approved the model proposal on 11 February 2025, producing the first regional law on medically assisted suicide in Italian legal history[15].

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[14] Two strands of Italian scholarship that the present analysis engages but does not develop at length deserve specific acknowledgment. The first is Roberto Pinardi's work on the Constitutional Court's decisional techniques, which includes three contributions directly concerned with the Cappato proceedings: **R. PINARDI**, *Il caso Cappato e la scommessa della Corte (riflessioni su un nuovo modello di pronuncia monitoria)*, in *Giurisprudenza costituzionale*, 2018, pp. 2459-2479 (comment on ord. n. 207 del 2018, which identified the ordinanza as a first example of a third species of "incostituzionalità accertata ma non dichiarata" and anticipated the structural difficulties that the subsequent sentenza n. 242 del 2019 would compound); **R. PINARDI**, *La Corte ricorre nuovamente alla discussa tecnica decisionale inaugurata con il caso Cappato*, in *Forum di Quaderni costituzionali*, n. 3 del 2020, p. 104 ss.; e **R. PINARDI**, *Le pronunce Cappato: analisi di una vicenda emblematica della fase attualmente attraversata dal giudizio sulle leggi*, in *Consulta online*, 2020, pp. 1-39, disponibile anche in **AA. VV.**, Liber Amicorum *per Pasquale Costanzo* (*https.giurcost.org/contents/ giurcost/ LIBERAMICORUM/pinardi_scrittiCostanzo.pdf*).

The last contribution provides the most comprehensive analysis of both pronouncements and identifies the "doppiamente additivo" character of the decision's dispositif - a device operating at the temporal as well as the substantive level - which converges with the present article's account of the ruling's ablative technique and its deliberate preservation of legislative space. Pinardi's taxonomy of the new decisional model - identifying it as an instance of "incostituzionalità accertata ma non dichiarata" distinct from both outright dismissals for legislative discretion and rejections with accertamento - is the indispensable domestic doctrinal framework for reading the structural lacunae that the double-ruling technique generated but could not fill.

The second strand is Massimo Donini's criminal law analysis of the Cappato proceedings: **M. DONINI**, Libera nos a malo. *I diritti di disporre della propria vita per la neutralizzazione del male*, in *Sistema Penale*, 2020, (*sistemapenale.it*). Donini's analysis of the *scriminante procedurale* as a justification cause grounded in subjective right rather than administrative authorisation converges with the present article's account of the *scriminante relazionale* element - identified by Colaianni - that the two-instrument proposal must preserve rather than displace.

[15] REGIONE TOSCANA, l.r. 14 marzo 2025, n. 16, *Modalità organizzative per l'attuazione delle sentenze della Corte costituzionale 242/2019 e 135/2024*, BUR Toscana n. 18 del 17

A third form must also be recorded and analysed, because it is the most probative for the two-lacuna thesis: the blocking track. In Lombardy, Piedmont, and Friuli-Venezia Giulia, regional councils adopted a preliminary constitutional-objection procedure that halted the Coscioni proposal at the legislative gate; in Veneto, the proposal stalled without formal rejection. The blocking track is the strongest empirical evidence for the article's central argument. A constitutional right whose practical accessibility depends on the political composition of the regional government in which the patient happens to reside is not a right in the Convention sense: it is a privilege of geography. This territorial fragmentation violates the constitutional principle of equality in access to essential health services - a principle that operates independently of, and prior to, the Convention obligations discussed in § 3[16].

Corte costituzionale Judgment No. 204 of 4 November 2025 substantially upheld the Tuscany law. The Court's central holding is that the regional law falls within the *tutela della salute* concurrent competence of Article 117(3) of the Constitution, because it regulates only the organisational and procedural profiles of the regional healthcare system without creating new rights or modifying the substantive access criteria[17]. The Court also noted, with barely concealed rebuke, that regional competence cannot be precluded by the fact that the State has not yet acted, despite the numerous invitations the Court itself has repeatedly addressed to Parliament.

This holding must be confronted with the most direct objection that the second lacuna faces. In Judgment No. 204/2025 the Court did not treat the regulatory framework as fragmentary; on the contrary, it reconstructed a body of "principi fondamentali" that it presented as already solid at the state level, deriving them from Articles 1 and 2 of Law No. 219/2017 on the refusal and interruption of life-sustaining treatment, from Law No. 38/2010 on palliative care and pain therapy,

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marzo 2025. Analysis in **G.L CONTI**, *Dare a Cesare quel che è di Cesare (E comunque meglio Kierkegaard di San Tommaso)*, in *Osservatorio sulle Fonti*, 1/2025, p. 38 ss.

[16] Corte Cost., sentenza 4 novembre 2025, n. 204 (*Government of Italy v. Tuscany Region*), published 29 December 2025. The Court held that the law falls within the regional concurrent competence in tutela della salute (Art. 117(3) Cost.) and regulates only organisational and procedural profiles. Specific provisions in arts. 3, 4, 5, 6, and 7(2) were declared unconstitutional.

[17] The competence ceiling on regional CO regulation derives from Art. 117(2)(l) Cost. (criminal law as exclusive state competence). No regional law has attempted to create a CO registry or referral duty analogous to Art. 9 of L. 194/1978.

from Law No. 833/1978 establishing the National Health Service, and from its own jurisprudence - an enumeration on which the Court rested the very allocation of competences that permitted the limited regional intervention. If the framework is solid enough to structure the State-Region divide, in what sense does a lacuna in the bridge to Law No. 219/2017 persist?

The answer is that the solidity the Court invokes operates at one level and not at another. The enumerated principles suffice to allocate organisational competence; they do not supply the relational and clinical architecture - the shared care-planning model of Article 5 of Law No. 219/2017 - within which medically assisted dying must be situated. The Court's reconstruction mobilises Law No. 219/2017 as a verification mechanism (Articles 1 and 2) while leaving its relational core unintegrated. The lacuna therefore survives the Court's own characterisation of the framework as solid: it is, indeed, a critique of that characterisation. The point is reinforced by the instability of the framework's contours - Judgment No. 135/2024 had already extended the notion of life-sustaining treatment - which shows that the "bridge" to Law No. 219/2017 is not a settled structure but one the Court has had to redraw at each successive intervention. A framework that requires continual judicial recalibration is not, in the relevant sense, the solid, foreseeable, and accessible one that the Convention's quality-of-law requirements demand.

The significance of this demarcation for the two-lacuna thesis is twofold. First, the structured CO mechanism that the thesis identifies as necessary - mandatory registration, referral duties, facility-level accommodation obligations - falls squarely within the exclusive state competence over criminal and civil law under Article 117(2)(l) of the Constitution[18]. Even the most comprehensive regional law - Tuscany's L.R. 16/2025 - makes no provision for a structured CO mechanism: the physician's freedom remains governed entirely by the *"si limita"* and *"resta affidato"* of punto 6, precisely as before the law was enacted. Second, regional laws can partially fill the second lacuna, but this partial filling is binding only within the enacting region's territory. It cannot produce the nationally uniform, accessible, and foreseeable procedural

[18] **G. SEVESO et al.**, *Medically Assisted Suicide in Italy After Regional Law No. 16/2025, Medicine,* in *Science and the Law* (2025), DOI: 10.1177/00258024251380962, note the absence of any provision for the accommodation of healthcare professionals who object.

framework that both the Constitutional Court's jurisprudence and the ECHR's positive-obligations doctrine require.

The aggregate result is a constitutionally perverse inversion. Italy has a landscape in which the practical accessibility of a constitutionally recognised right depends on the political composition of the regional government in which the patient resides - a constitutional pathology that admits of a precise legal characterisation: it violates the principle of formal equality before the law (Art. 3 Cost.) as applied to access to essential health services, and the *livelli essenziali di assistenza* guarantee under Art. 117(2)(m) Cost. Judgment No. 204/2025 confirms the constitutional legitimacy of the Tuscany model but cannot generate the national uniformity that only a parliamentary statute can provide. The regional experience confirms rather than contradicts the two-instrument proposal. The constitutional architecture confirmed by Judgment No. 204/2025 maps directly onto the two-lacuna framework and clarifies why legislative action at national level is not one option among several but the only structurally adequate response. The first lacuna - the absence of a structured conscientious objection mechanism - lies entirely within the exclusive state competence over criminal and civil law under Article 117(2)(l) of the Constitution. No regional legislature can create a CO registry, impose referral duties, or establish facility-level accommodation obligations analogous to Article 9 of Law No. 194/1978; any attempt to do so would, as the Court noted, invade the sphere of penal and civil law reserved to the State. Tuscany's law confirms this by design: it says nothing about CO, because it cannot.

The second lacuna - the absence of a systematic normative bridge to Law No. 219/2017 - occupies different constitutional terrain. Regional legislation can, within the concurrent competence in tutela della salute under Article 117(3), regulate the organisational and procedural profiles of the regional healthcare system's participation in the assisted dying procedure. This is precisely what the Tuscany model does, and what the Court has upheld. But two structural constraints prevent regional action from closing the second lacuna completely: it binds only the territory of the enacting region, and it cannot address the substantive access criteria, which are matters of constitutional law defined exclusively by this Court's jurisprudence and, ultimately, by parliamentary statute.

The aggregate consequence is that the two lacunae require, each, a different legislative remedy - and neither can be remedied by regional action alone. The first lacuna demands a national statute because only

national law can create binding CO obligations enforceable throughout the public healthcare system. The second lacuna demands a national statute because only national law can produce the uniform, foreseeable, and systematically integrated procedural framework that both the Court's constitutional jurisprudence and the Convention's positive-obligations doctrine require. Institutional loyalty in the form of leale collaborazione istituzionale is a necessary transitional virtue; it is not a substitute for the two instruments whose structural necessity this article seeks to demonstrate[19].

3 - The judgment in the European public law frame: two lacunae, two obligations

The two structural lacunae identified in the preceding section do not merely constitute domestic legislative gaps. Read within the European Public Law frame[20] constituted by the ECHR system, the Charter of

[19] Constitutional Court, Judgment no. 303 of 1 October 2003, Official Gazette of the Italian Republic, Special Series no. 39/2003. The Court, in redefining the relationship between State and regional competences following the reform of Title V of the Constitution, emphasizes the principle of loyal cooperation as a necessary criterion in cases of overlapping competences, requiring the use of cooperative procedural instruments (such as agreements and institutional coordination mechanisms), particularly in fields characterized by cross-cutting or intersecting powers.

[20] The concept of European Public Law as a coherent normative framework - distinct from both international law and comparative constitutional law - has been theorised primarily by **A. VON BOGDANDY**, *Founding Principles of EU Law: A Theoretical and Doctrinal Sketch*, in *European Law Journal*, 16, 2010, pp. 95-111; **M. KUMM**, *The Cosmopolitan Turn in Constitutionalism: On the Relationship between Constitutionalism in and beyond the State*, in **AA.VV.**, *Ruling the World? Constitutionalism, International Law and Global Governance*, a cura di J. DUNOFF, J. TRACHTMAN, Cambridge University Press, Cambridge, 2009, pp. 258-324; and, with specific reference to the Council of Europe system, **C. GRABENWARTER**, *The European Convention on Human Rights: Inherent Constitutional Tendencies and the Role of the European Court of Human Right*s, in *ELTE Law Journal*, 1, 2014, pp. 101-115. The concept designates the ensemble of legal norms, principles, and institutional relationships that emerge from the overlapping operation of national constitutional orders, EU law, and the ECHR system, generating a multi-level normative space in which each level conditions and is conditioned by the others.

Its impact on the Italian constitutional order has been decisively shaped by the *sentenze gemelle* of the Constitutional Court - Corte Cost., sentenza n. 348/2007 and sentenza n. 349/2007 - which established the ECHR as a *norma interposta* under Article 117(1) Cost., requiring Italian legislation to conform to Convention obligations as interpreted by the ECtHR. The practical consequence for the present article is that

Fundamental Rights of the European Union, and the comparative evidence of Member State regulatory models, they generate distinct but convergent international obligations that Italy has so far failed to discharge.

The first lacuna generates what may be described as a dual access-accommodation deficit. On the patient side, the absence of any institutional mechanism ensuring effective access to medically assisted suicide translates into a violation of the positive obligations arising under Article 8 ECHR.[21] The Convention requires that any permission be rendered practically effective through legal norms that are accessible, foreseeable, and uniformly applicable - requirements drawn from the Court's settled jurisprudence on the quality of law beginning with *Sunday Times v. United Kingdom*. On the physician side, the normative void of punto 6 produces a distinct Convention problem - but one that requires more precise articulation than an unmediated application of Article 9 ECHR. *Bayatyan v. Armenia* established that a sincere and insurmountable conflict of conscience can constitute a protected manifestation of belief under Article 9(1), subject to proportionality review under Article 9(2). The Court's subsequent inadmissibility decisions in *Grimmark v. Sweden* and *Steen v. Sweden*[22] make clear, however, that Article 9 does not guarantee public-sector physicians an unconditional right to refuse lawful procedures: where a healthcare professional has accepted contractual obligations inconsistent with their

domestic normative gaps in the regulation of medically assisted dying are not merely internal legislative deficiencies: they simultaneously constitute failures of compliance with a European Public Law framework whose obligations are directly enforceable before Italian courts. On the Italian dimension of this framework see further **B. RANDAZZO**, *Giustizia costituzionale sovranazionale. La Corte europea dei diritti dell'uomo*, Giuffrè, Milano, 2012; **R. CONTI**, *La Convenzione europea dei diritti dell'uomo. Il ruolo del giudice*, Aracne, Roma, 2011.

[21] **A. MADERA**, *Assisted Suicide*, cit., pp. 100-104; **G. RICCI**, **F. GIBELLI**, **A. SIRIGNANO**, *From Ruling No. 242/2019 to the Italian Law on Medically Assisted Death*, in *European Review for Medical and Pharmacological Sciences*, 26 (2022), pp. 4546-4549. On foreseeability see ECtHR, *Sunday Times v. United Kingdom*, no. 6538/74, 26 April 1979, § 49.

[22] The Grimmark and Steen cases were declared inadmissible by a three-judge committee of the Third Section through a decision lacking detailed reasoning (Article 28 ECHR). Therefore, this was not a judgment on the merits, but rather a finding that the applications were manifestly ill-founded. The Court's reasoning can only be inferred from its references to domestic law and to the applicants' employment contracts.

objection, the interference with their freedom of conscience may be proportionate. The Article 9 argument for structured CO must therefore be reformulated. It is not that every physician has a Convention right to object; it is that a State which has legalised a procedure but provided no mechanism for its ordered accommodation - leaving both the objecting physician and the requesting patient without institutional recourse - fails to discharge its positive obligations under Article 9 read in conjunction with Article 8. The violation lies not in the content of any individual physician's choice, but in the State's refusal to organise the resulting conflict of interests through law. An unstructured discretion of the kind that punto 6 establishes does not satisfy that organisational duty: it merely defers the conflict to the bedside, at the expense of both parties[23].

The second lacuna generates a separate but connected Article 8 obligation. The right to effective access to end-of-life care decisions demands a procedurally adequate framework of informed consent, independent verification, multidisciplinary assessment, and documented decision-making[24]. A legal framework is foreseeable in the Convention sense only when it is formulated with sufficient precision to enable the citizen to regulate his or her conduct; an implicit application of Law No. 219/2017 to medically assisted dying satisfies neither foreseeability nor accessibility.

A complementary layer of obligation derives from the Charter of Fundamental Rights of the European Union. The rights most directly engaged - human dignity (Art. 1 CFR), bodily integrity (Art. 3 CFR), and the right of access to preventive healthcare (Art. 35 CFR) - delineate the boundaries within which national legislative choices must operate, to the extent that those choices fall within the scope of Union law within the meaning of Art. 51(1) CFR[25]. The Charter framework excludes models in which the dignity of the patient is structurally subordinated to the convenience of institutional inaction.

Among the Member States that have legalised assisted dying, a convergent model of "structured accommodation" has emerged - combining robust patient access guarantees with organised

[23] **S. AHLIN DOLJAK,** *Voluntary Termination of Life and Conscientious Objection*, in *Bogoslovni vestnik*, 84(2), pp. 365-376 (2024).

[24] **C. GRABENWARTER**, *The European Convention*, cit., pp. 109-111; **D. SHELTON**, *Remedies in International Human Rights Law*, 3rd ed., Oxford University Press, Oxford, 2015, pp. 214-232.

[25] **C. GRABENWARTER**, *The European Convention*, cit., (fn 23), pp. 110-114; ECtHR (Grand Chamber), *Bayatyan v. Armenia*, no. 23459/03, 7 July 2011, §108.

conscientious objection mechanisms[26]. This convergence matters for the margin of appreciation doctrine, though it must be qualified: three or four Member States do not constitute a "European consensus" in the demanding sense deployed by the Court in Strasbourg. What the comparative evidence does establish is a convergence of regulatory models relevant as emerging evidence of a common European standard of structured accommodation. As this standard consolidates, the margin of appreciation available to Italy will continue to contract[27].

The Article 46 ECHR dimension reinforces the constitutional urgency of legislative action, though it must be framed with appropriate epistemic precision. No ECtHR judgment has yet found Italy in violation of Articles 8 or 9 in connection with medically assisted dying; and the Court has, from *Pretty* through *Haas*, consistently accorded Member States a significant margin of appreciation in this domain. The immediate argument from Article 46 is therefore not that Italy has already violated the Convention but that the trajectory of the Strasbourg jurisprudence - from conditional non-violation in *Pretty*, to positive obligation in *Haas*, to procedural violation in *Mortier* - makes legislative inaction progressively more difficult to justify[28]. As the comparative evidence of structured accommodation consolidates across Member States, the margin of appreciation available to Italy contracts. The five documented Italian cases between 2019 and 2025 - each resolved through individual civil litigation rather than institutional mechanism - exhibit precisely the structural characteristics that the Court has identified, in analogous contexts, as indicators of systemic legislative failure. They do not yet constitute an admissible application; they constitute the evidentiary record from which such an application could be constructed if

[26] **S. SMET**, *Conscientious Objection under the European Convention on Human Rights*, in J. TEMPERMAN, J. GUNN & M. EVANS (eds.), *The European Court of Human Rights and the Freedom of Religion or Belief*, Brill, Leiden, 2019, pp. 297-300; **S. AHLIN DOLJAK**, *Voluntary Termination,* cit., p. 376 (2024); **M.J. VALERO**, *Freedom of Conscience of Healthcare Professionals and Conscientious Objection in the European Court of Human Rights*, in 13, *Religions* 2022, 13(6), 558, pp. 1-21.

[27] ECtHR, *Pretty v. the United Kingdom*, no. 2346/02, 29 April 2002. The Court found no violation of Art. 8 in the UK's prohibition but held that such a prohibition *may* constitute an interference even where justified under Art. 8(2): the evolution from this conditional non-violation to the positive obligations doctrine of *Pretty* is the decisive doctrinal development for the Italian case.

[28] ECtHR, *Pretty v. the United Kingdom*, no. 2346/02, 29 April 2002, §67; ECtHR, *Haas v. Switzerland*, no. 31322/07, 20 January 2011; ECtHR, *Mortier v. Belgium*, no. 78017/17, 4 October 2022.

parliamentary indecisive delaying persists. Article 46 does not compel Italy to act now; it identifies the institutional trajectory that continued inaction will generate.

4 - The judgment in the perspective of ECtHR case-law on Articles 8 and 9 ECHR: a two-track analysis

The ECtHR's case-law on end-of-life decisions and conscientious objection can be read - with the two lacunae of the normative framework as the analytical lens - as generating a two-track set of positive obligations whose parallel neglect in Italian law reveals the full depth of the constitutional problem[29]. The Court has, on each track, developed a body of doctrine that points directly toward the two-instrument solution: but it has so far declined to integrate the two tracks into a coherent normative framework, leaving that integration to national legislatures. Italy's failure to undertake it is the precise constitutional gap this article addresses.

[29] ECtHR, *Haas v. Switzerland*, App no 31322/07, 20 January 2011: the State must structure domestic law so that the right to choose the timing and manner of death is not rendered illusory by the absence of a procedurally adequate framework. The scholarship of Javier Martínez-Torrón on the intersection of religious freedom, conscientious objection, and European human rights law provides an essential comparative and theoretical foundation for the two-track analysis developed in § 4. Beyond the contribution cited in the text - **J. MARTÍNEZ-TORRÓN**, *Freedom of Conscience and the Fundamental Right Not to Kill*, in **AA.VV.**, *Abortion: a comparative constitucional law perspective*, Reigada, a cura di A. TRONCOSO, 2024, pp. 493-515 - the following works are directly relevant to the present argument: **J. MARTÍNEZ-TORRÓN**, *The (Un)protection of Individual Religious Identity in the Strasbourg Case Law*, in *Oxford Journal of Law and Religion*, 1, 2012, pp. 363-398, which provides the most systematic analysis of the ECtHR's inconsistent treatment of individual religious claims and identifies the structural asymmetry between institutional and individual dimensions of religious freedom that the Court has yet to resolve; **J. MARTÍNEZ-TORRÓN**, *Limitations on Religious Freedom in the Case Law of the European Court of Human Rights*, in *Emory International Law Review*, 19, 2005, pp. 587-636, which anticipates the proportionality framework that *Bayatyan v. Armenia* would subsequently constitutionalise.

Taken together, these contributions establish that the failure of Judgment No. 242 del 2019 to activate a structured conscientious objection mechanism is not only a domestic legislative gap but a missed opportunity to position Italy at the leading edge of a European convergence that Martínez-Torrón's scholarship had already mapped.

The first track - patient-side obligations under Article 8 - runs from *Pretty v. United Kingdom* through *Haas v. Switzerland* and *Mortier v. Belgium*. In *Pretty*, the Court found no violation of Article 8 in the UK's blanket prohibition on assisted suicide, but crucially held that such a prohibition *may* constitute an interference even where it is justified under Article 8(2): the justification is conditional and depends on the proportionality of the measure and the existence of adequate procedural safeguards[30]. In *Haas*, the Court reinforced the positive obligation dimension: the State must structure domestic law in such a way that the right to choose the timing and manner of death is not rendered illusory by the absence of a procedurally adequate framework. *Mortier*[31] extended the positive obligation to oversight mechanisms and found a procedural violation of Article 2 ECHR - not only an Article 8 issue - in the inadequacy of Belgium's ex-post review mechanisms. The Article 2 dimension of *Mortier* is directly relevant to the Italian situation: the absence of a national oversight body represents a distinct Convention vulnerability beyond the Article 8 access deficit.

The second track - physician-side obligations under Article 9 - originates in *Bayatyan v. Armenia* and develops through *Grimmark v. Sweden* and *Steen v. Sweden*[32]. *Bayatyan* established, for the first time at Grand Chamber level, that an act motivated by genuine and sincere convictions can constitute a protected "manifestation" of belief under Article 9(1), subject to the proportionality review of Article 9(2). The distinction between *forum internum* - the inner space of belief, absolutely protected - and the external manifestation of belief in acts - conditionally protected - is fundamental here: conscientious objection is protected not as part of the inviolable inner forum but as a manifestation, which means it can be regulated proportionately by the State[33].

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[30] ECtHR, *Pretty v. the United Kingdom*, no. 2346/02, 29 April 2002, §67. The Court found no violation of Art. 8 but held that the prohibition may constitute an interference even where justified under Art. 8(2).

[31] ECtHR, *Mortier v. Belgium*, no. 78017/17, 4 October 2022. The Court found a procedural violation of Art. 2 ECHR - not only an Art. 8 issue - in the inadequacy of Belgium's ex-post review mechanisms.

[32] **M.J. VALERO**, *Freedom of Conscience*, cit. (fn 29), pp. 15-17; **A. MADERA**, *Assisted Suicide*, cit., fn 24, pp. 100-101.

[33] Extending the Bayatyan principle to conscientious objection in the healthcare sector is not a straightforward interpretative exercise. In Grimmark (2020), the Court declared inadmissible the claim of a right to conscientious objection for midwives within the Swedish public healthcare system, emphasizing their acceptance of contractual obligations that were incompatible with such a claim. The question of

The inadmissibility decisions in *Grimmark v. Sweden* and *Steen v. Sweden* should not be read as authoritative endorsements of the Italian status quo. The Court's reasoning rested on a specific feature of the Swedish employment context - the applicants had accepted contractual obligations that expressly encompassed the full range of midwifery duties - and declined to examine the merits of the underlying Article 9 claim. What the Court left unresolved is precisely the question that the Italian situation poses: whether a State may legalise a procedure and simultaneously decline to regulate the conditions under which healthcare professionals employed in the public system may or may not refuse to participate, leaving the allocation of that refusal entirely to individual discretion[34]. That question was not before the Court in *Grimmark* and *Steen*, because Swedish law had provided no CO regime to evaluate. It is precisely the question that punto 6 reproduces in Italy. The decisions therefore do not foreclose the Article 9 claim advanced in this article; they leave the issue to national legislatures and, implicitly, require them to address it through positive regulation rather than silence.

This employment-based distinction maps directly onto the Italian NHS physician context: it suggests that the protected scope of CO under Article 9 may be narrower for public-sector physicians than for independent practitioners, which reinforces the argument for a structured statutory mechanism - because without a formal statutory right of CO, the public-sector physician has no legal instrument beyond the unstructured discretion of punto 6, which may itself be legally fragile.

The critical point that emerges from reading the two tracks together is that both converge on the same structural deficiency: the absence of a legislative framework that mediates between them[35]. *Bayatyan* establishes that CO is a protected interest; *Pretty*, *Haas*, and

whether the Bayatyan analysis applies to physicians in the Italian National Health Service formally remains open—and, precisely for this reason, calls for legislative intervention to define the scope of conscientious objection in a manner that is foreseeable under Article 8 ECHR.

[34] **N. PAPADOPOULOU** & **L. WICKS**, *Taking "the Right to Life" Seriously*, in *Medical Law International*, 2025, 2, pp. 88-109.

[35] **F. FRENI**, *La protezione della vita umana "al tramonto", tra legge e libertà di coscienza*, in *Stato, Chiese e pluralismo confessionale*, Rivista telematica (*https://riviste.unimi.it/index.php/ statoechiese*), n. 6 del 2023, pp. 1-38; **A. RUGGERI**, *Rimosso senza indugio il limite della discrezionalità del legislatore*, in *Giustizia insieme*, 2019; **N. COLAIANNI**, *Incostituzionalità prospettata e causa di giustificazione dell'aiuto al suicidio*, in *Stato, Chiese e pluralismo confessionale*, cit., n. 2 del 2020, pp. 1-26 (identifying punto 6 as the "nervo scoperto" of the ruling).

Mortier establish that access must be effectively realised. Neither line of authority tells us how to reconcile the two in practice. That reconciliation is the work of the legislature; and it is precisely the work that the "freedom prior to duty" of punto 6 declines to undertake. The Court's jurisprudential deferral on the design question is a deferral to national legislative discretion. Italy has so far refused to exercise that discretion.

The symmetry between the two tracks that the analysis has traced - patient access under Article 8 and physician conscience under Article 9 - reflects a structural feature of proportionality doctrine that the ECtHR has not yet articulated but that national legislatures are implicitly required to address. Where a State legalises a procedure on grounds of individual autonomy, the same autonomy principle that justifies the permission generates a correlative claim: that those required to participate in the procedure must have their own autonomy - their capacity to act in accordance with sincere moral conviction - institutionally accommodated rather than simply overridden. Conversely, any accommodation of conscience that structurally impedes patient access fails the proportionality test that Article 8(2) imposes on interferences with the patient's right to self-determination. The two-instrument proposal is not merely a legislative convenience; it is the only regulatory design that satisfies the proportionality requirements of both Articles simultaneously[36]. A statute that protects access without accommodating conscience creates an unjustified burden on physician autonomy. A CO mechanism that operates without a guaranteed access pathway creates an unjustified burden on patient autonomy. Only the conjunction of both instruments, within a supervisory architecture that ensures accountability to both, produces a legal regime that is proportionate in the Convention sense - and therefore one that the Italian legislature is, under the positive obligations doctrine, constitutionally required to enact.

The convergence of the two ECtHR tracks - patient access under Article 8 and physician conscience under Article 9 - onto a single legislative lacuna does not exhaust the Convention's demands on Italy. *Mortier* adds a third dimension: the obligation to construct and maintain an oversight mechanism that is structurally independent of the assisted dying practitioners it supervises. The two instruments proposed in this

[36] **N. COLAIANNI**, *Incostituzionalità*, cit. (fn 38), pp. 2-8. For the contrary characterisation as *sentenza-legge* see **A. RUGGERI**, *La disciplina del suicidio assistito è "legge"*, in *Quad. dir. pol. eccl.*, 2019/3, p. 633 ss.; **F. FRENI**, *La protezione*, cit. (fn 38), § 3.

article must therefore be designed not merely to open access and accommodate conscience, but to embed both within a supervisory architecture that can render the procedure publicly accountable. A statute that creates access without oversight fails the *Mortier* standard. A CO mechanism that operates without a referral duty enforced by a visible institutional actor fails the access standard of *Haas* and *Pretty*. Only when both instruments are operative simultaneously - and only when both are anchored to a supervisory body with the independence that *Mortier* requires - does the Italian legal framework become structurally compatible with the positive obligations doctrine that Strasbourg has progressively elaborated from *Pretty* to *Mortier*. The constitutional urgency of parliamentary action derives precisely from this triangular structure: no single instrument, and no regional substitute, can produce the required combination of access, conscience, and accountability.

5 - Two lines of objection and their limits: judicial restraint, structural sufficiency, and the case for legislative architecture

The two-instrument proposal must confront two distinct lines of objection that, while apparently divergent in their premises, converge in their practical effect of resisting the legislative response this article identifies as constitutionally required[37]. The first contests the legitimacy of Judgment No. 242/2019 itself, characterising it as judicial legislation that exceeds the proper boundaries of constitutional adjudication in a civil law system. The second, advanced by scholars broadly sympathetic to the judgment's outcome, contests not the ruling's legitimacy but the characterisation of its treatment of conscientious objection as a structural lacuna: on this view, the ruling's three-line delegation of the CO question to individual physician discretion is "sufficient", because the Court was operating exclusively in the criminal law field[38].

[37] **N. COLAIANNI**, *Incostituzionalità*, cit. (fn 38), p. 19: "bisogna (tornare a) chiarire che la sentenza si muove nel campo penale e non in quello civile. Non essendovi una legge al riguardo, [...] la sentenza, perciò, non crea obblighi, ma solo liceità". A directly contrary position: **P. BILANCIA**, *Riflessioni sulle recenti questioni in tema di dignità umana e fine vita*, in *federalismi.it*, n. 5 del 2019.

[38] The five documented cases are catalogued in **J. CAMATTI et al.**, *Updates on Medically Assisted Suicide*, cit. (fn 13). In none of the five cases was the patient directed to a willing professional through an institutional mechanism - not the profile of a system managing CO through professional dialogue.

The first line of objection does not survive scrutiny. The characterisation of the ruling as "additive manipulative" - the Court re-calibrated the application of Article 580 of the Penal Code, introducing cumulative criteria under which assisting suicide would no longer entail criminal liability - is jurisprudentially accurate. In doing so, the Court remained formally within the limits of its judicial function while edging toward a quasi-legislative role. In a secular register, the Court played a role not unlike the accabadora: offering transitional guidance where law had fallen short.

The crucial internal inconsistency of the judicial overreach critique deserves to be foregrounded: one cannot simultaneously argue that the Court has already done the legislature's work and that the legislature is failing to do it. If the ruling is genuinely legislative in character, the legislature is superfluous; if the legislature is genuinely necessary, the ruling has not done its work. These two propositions are mutually exclusive. The two-instrument proposal rests firmly on the latter horn of this dilemma: the ruling is constitutionally proper and institutionally necessary, but constitutionally insufficient, precisely because a court cannot create the positive organisational infrastructure that effective rights require. The democratic legitimacy deficit generated by the ruling's quasi-legislative character is therefore not an argument against legislative supplementation - it is the strongest argument for it[39].

The double-ruling technique - *ordinanza-monito* followed by *declaratoria* - falls squarely within seventy years of constitutional jurisprudence on legislative omissions. The structural parallel with the 1975 abortion ruling is not a novelty but a recurrence of an established pattern. And the pattern carries a lesson that the first line of objection systematically evades: it was Parliament that refused the invitation in 1975, just as it refused it in 2018 and again in 2019. The juridical pathology documented in §2 is not judicial overreach; it is legislative indecisive delaying masquerading as the defence of democratic prerogative.

The second line of objection has three components: the Court was operating exclusively in the criminal law field; the practical management

[39] **N. COLAIANNI**, *Incostituzionalità*, cit. (fn 38), pp. 10-11, acknowledges the structural parallel between the two rulings at the level of the *scriminante procedurale*. The internal tension in his argument - accepting the parallel at the level of the *scriminante* while rejecting it at the level of the organisational infrastructure - is precisely the gap the two-instrument proposal fills.

of CO can be left to reasonable accommodations; and the analogy with Article 9 of Law No. 194/1978 is "more than forced, decidedly off-axis".

The first component is accurate as a description of the ruling's positive law effect and inadequate as a constitutional assessment of its consequences. It is precisely because the ruling creates *liceità* without *obblighi* that the structural lacuna arises. The Convention's positive obligations doctrine does not ask whether the Italian Constitutional Court was acting within the criminal law field - it asks whether the resulting normative framework, taken as a whole, ensures effective and foreseeable access to the non-punishable procedure.

The second component - that reasonable accommodations in practice will suffice - is empirically falsified by the five years of documented experience between 2019 and 2025[40]. Of the five individuals who accessed the non-punishable procedure between 2019 and 2025, two (Mario in Marche and Anna in Friuli-Venezia Giulia) did so only after civil litigation against the relevant ASL; in a fifth case (Vittoria in Veneto), judicial proceedings were initiated but resolved without a hearing when the ASL eventually complied - eight months after the original request. The remaining two cases (Gloria in Veneto and an unnamed patient in Emilia-Romagna) proceeded without recourse to litigation. This is not the profile of a system managing conscientious objection through structured institutional mechanisms: it is the profile of a system in which the pathway to access is geographically contingent, procedurally unpredictable, and in several documented cases dependent on the willingness of individual professionals whose distribution remains invisible to the patient.

The third component - the rejection of the Law No. 194/1978 analogy - is the most important to address because it touches the deepest structural question[41]. The argument is that the abortion statute required a dedicated organisational infrastructure because the procedure was clinically complex and concentrated in specialised units; assisted dying

[40] **MINISTERO DELLA SALUTE**, *Relazione al Parlamento sull'attuazione della L. 194/1978* (2021). The analogy from the abortion experience to the assisted dying context is structurally analogous, not identical; it is offered as a cautionary precedent demonstrating the general mechanism of CO aggregation, not as a deterministic prediction.

[41] **N. COLAIANNI**, *Incostituzionalità*, cit. (fn 38), p. 21: the analogy is "più che forzata, decisamente fuori asse" because "l'aiuto al suicidio può essere dato in qualsiasi reparto sia degente un malato". The present argument is that this claim is formally true when a willing professional is present and practically hollow when none is identifiable.

can be provided in any ward where the qualifying patient is already admitted. But this argument proves too much: the scholar who advances it himself acknowledges the structural parallel between the two rulings at the level of *procedurale*. To accept this parallel at the level of the *scriminante* while rejecting it at the level of the organisational infrastructure is internally inconsistent.

The deeper reason why the rejection of the analogy fails is structural, and is confirmed by the empirical record of Law No. 194/1978 itself. By 2020, 67% of public-sector gynaecologists were registered objectors, with rates exceeding 80% in several southern regions[42]. This inference from the abortion experience to the assisted dying context must be qualified: the analogy is offered as a cautionary precedent demonstrating the general mechanism - individual CO without a registry and facility-level obligations aggregates into territorial inaccessibility - rather than as a deterministic prediction[43]. A registry of conscientious objectors is not an organisational imposition on individual moral freedom; it is the institutional prerequisite for the claim that the procedure can be provided "in any ward" to have any practical meaning.

It should be noted that the sufficiency thesis contains an important correct element that the two-instrument proposal must incorporate. The thesis is right that the ruling creates a *scriminante relazionale* - a justification cause grounded in the therapeutic relationship rather than in a simple administrative authorisation. This means that the legislative architecture proposed in § 7 must be designed to operate through, not against, the therapeutic relationship: the structured CO mechanism must be built around the existing *alleanza terapeutica* model of Law No. 219/2017, not substituted for it[44].

Parliament has so far ignored four successive invitations from the Constitutional Court between 2018 and 2025. Three considerations suggest that this pattern may not be permanent. First, the intensification

[42] Colaianni's identification of the *scriminante relazionale* character of the ruling - that the justification cause is grounded in the therapeutic relationship - is an important correct element that the two-instrument proposal must incorporate: the structured CO mechanism is built around, not against, the *alleanza terapeutica* model of L. 219/2017.

[43] **N. COLAIANNI**, *Incostituzionalità*, cit. (fn 38), p. 2: "va così in tilt la fisiologia della produzione legislativa: il Parlamento omette di legiferare, lascia che i nodi vengano al pettine giudiziario e delega implicitamente ai giudici la soluzione".

[44] **F. FRENI**, *La protezione*, cit. (fn 38), §§ 6-7 (concertation model as "laicità procedurale"). The years 2019-2025 demonstrate that this model produces a territorial lottery, not a coherent procedural framework.

of Convention pressure following *Mortier* has substantially altered the risk calculus of continued inaction. Second, the political cost reduction achieved by the Tuscany model: Parliament no longer faces the task of legislating in a normative vacuum but the structurally easier task of nationalising a model that has been tested and constitutionally validated. Third, the concertation model proposed as an alternative by some scholars[45] has been empirically falsified by the very experience it was designed to prevent: the territorial lottery of 2019-2025 is precisely the outcome that soft-law pluralism was supposed to avoid.

The Italian constitutional system is, on the specific question of medically assisted dying, in a condition of equilibrium that is both stable and pathological: the Constitutional Court cannot go further without exceeding the boundaries of adjudication; Parliament will not go further without a political consensus that has so far eluded formation; and the cost of this equilibrium is borne by patients whose access to a constitutionally recognised non-punishable conduct depends on the political composition of their regional government and their willingness to engage in civil litigation. A legal order in which the practical enforceability of a fundamental right depends on geography and litigation is one in which the equal dignity of persons has been sacrificed to the convenience of legislative indecisive delaying.

6 - Conscientious objection as spatial and communicative practice: the theoretical case for institutional design

The European Public Law analysis of §§ 3-4 establishes what Italy is obliged to do; the spatial and communicative theory developed in this section explains why the specific institutional form of the two-instrument proposal is the appropriate response. Before turning to that theory, however, a preliminary philosophical diagnosis is necessary - one that illuminates not only the structure of the problem but the reason why it resists purely technical solutions.

Judgment No. 242/2019, read in the light of the Kantian philosophical tradition from which the constitutional protection of conscience draws its deepest roots, reveals a specific and consequential

[45] **K. KNOTT**, *Spatial Theory and Method for the Study of Religion*, in 41(2) *Temenos*, 2005, pp. 153-184; **R.H. MURRAY**, *The Embodiment of Conscience*, in *Journal of Religious Ethics*, 2015, 43, no. 1, pp. 45-67.

choice between two registers of Kantian thought that are not easily reconcilable[46]. The Kant of the *Groundwork of the Metaphysics of Morals* constructs the moral law as the absolute, unconditional foundation of all obligation[47] - the categorical imperative as the first criterion that precedes and conditions every juridical command. Autonomy, in this register, is self-legislation: the rational being gives itself the law, and it is from this self-giving that human dignity derives its inviolability. It is this Kant - the Kant of the primacy of moral conscience over any external authority - that appears to underlie the Court's formula *"resta affidato alla coscienza del singolo medico"*: conscience as a value that the law cannot touch because it precedes the law.

The Kant of the *Metaphysics of Morals* is, on this specific question, almost unrecognisable. The sovereign power is not limitable by individual conscience. The remedies available to the subject who faces an unjust law are exclusively juridical - petitions, public critique through legitimate channels, acceptance of legal consequences. Conscientious objection as an act of resistance to legal obligation does not exist in the mature Kant: conscience remains in the *foro interno*, and there it must remain. To resist the supreme legislative authority under any pretext whatsoever destroys the very foundation of the political community. What the Metaphysics of Morals offers is not the suppression of conscience but its juridical displacement: moral conviction remains in the forum internum, and it is precisely because it stays there that the external legal order can demand compliance and channel dissent through legitimate juridical channels. The conscience that cannot accept a law does not thereby acquire the right to refuse its external legal effects - it acquires the duty to contest through petition and public critique, within

[46] Opinion of AG **E. SHARPSTON**, Case C-238/19 EZ v. Bundesrepublik Deutschland, ECLI:EU:C:2020:404, § 69. This is an Advocate General's Opinion, not a binding CJEU judgment; its persuasive authority derives from its analysis of Arts. 9 ECHR and 10 CFR applied to sincere moral convictions. The case concerned CO to military service in asylum law; the transfer to the healthcare context is analogical.

[47] **I. KANT**, *Groundwork of the Metaphysics of Morals*, tr. M. GREGOR, Cambridge University Press, Cambridge, 1997, §§ I-III; **I. KANT**, *The Metaphysics of Morals*, tr. M. GREGOR, Cambridge University Press, Cambridge, 1996, Part I: Doctrine of Right, § 49. The tension between the two registers - the *Groundwork's* primacy of moral conscience as pre-legal absolute and the *Metaphysics'* insistence on juridical mediation - is examined by **C. BAGNOLI**, *Moral Autonomy as a Political Ideal*, in *Ethics*, 2010, 121(1), pp. 1-22. The specific application of this tension to Judgment No. 242/2019 is, to the Author's knowledge, an original contribution of this article.

the political community whose authority it implicitly affirms by remaining within it[48].

The paradox of Judgment No. 242/2019 is that it operates in the register of the *Groundwork* - conscience as pre-legal absolute - in a situation that requires the register of the *Metaphysics of Morals* - conscience mediated through institutional structure. By leaving the physician's moral freedom unstructured and unaccountable, the Court has given the *lex poli* of the individual physician the authority to override the *lex fori* of the patient's constitutional right, without the juridical mediation that the Kantian legal order itself demands. This is a constitutional inversion that even the Kant of the *Groundwork*, with his insistence on the universalisability of maxims, would not have sanctioned: a maxim of absolute conscientious refusal, if universalised, would render the constitutional right inattuable by definition.

This philosophical diagnosis does not resolve the problem; it clarifies its depth. The institutional architecture required to escape the paradox cannot be merely technical - because the paradox operates at the level of the conceptual foundations of the relationship between conscience and law. What is required is a framework that honours both registers of the Kantian tradition simultaneously: the *Groundwork's* insistence on the inviolability of the moral person, and the *Metaphysics of Morals'* insistence that moral conviction finds its legitimate institutional expression only through structured, legally mediated channels. This is precisely what the spatial and communicative theory of conscientious objection, to which this section now turns, is designed to provide.

The spatial approach to moral agency - the recognition that acts of conscience are never abstract but always situated in physical, social, and inner dimensions that give them their weight and consequence - offers more than a philosophical framework. Read in light of the two lacunae and the two-track Convention analysis, it provides the theoretical justification for the specific institutional design that the proposal requires.

[48] The application of this tension to constitutional adjudication on medically assisted dying has not, to the author's knowledge, been developed in the existing literature on Judgment No. 242/2019. The broader tension between the two Kantian registers in relation to legal obligation is examined by **A. RIPSTEIN**, *Force and Freedom: Kant's Legal and Political Philosophy*, Harvard University Press, Cambridge MA, 2009, pp. 9-46, and by **C. BAGNOLI**, *Moral Autonomy as a Political Ideal*, in *Ethics*, 2010, 121(1), pp. 1-22.

The physical dimension of conscientious objection reveals why the "freedom prior to duty" of punto 6 is institutionally inadequate. Individual physician refusal does not occur in a moral vacuum; it occurs in a healthcare system where the aggregate effect of individual refusals determines whether patients can in practice access constitutionally recognised rights. A registry of conscientious objectors is not an intrusion into the private space of moral conviction; it is the mechanism that renders individual moral freedom institutionally legible, allowing health systems to map the distribution of available personnel. The protection of CO under Articles 9 ECHR and 10(1) CFR is conditioned on the sincerity, consistency, and institutional manageability of the claim: precisely the conditions that a registration mechanism is designed to verify and sustain. The referral duty transforms the negative freedom of refusal into a positive contribution to the system's communicative capacity - ensuring that the physician's "no" does not become the patient's dead end.

The social dimension of conscience explains why the ethics boards proposed in § 7 are not peripheral to the legislative architecture but central to it[49]. Clinical ethics boards are communicative spaces in which the moral reasons of objectors, patients, colleagues, and institutions can be articulated, heard, and translated into shared procedural guidance. They operationalise what the theory of communicative action demands of a democratic legal order: not the suppression of moral disagreement but its institutional channelling into structured deliberation. The ethics board's mandate is threefold: deliberative (providing structured forums in which irreconcilable conflicts can be mediated); monitoring (tracking territorial disparities in access and objection rates); and normative (generating guidance documents translating statutory principles into practice-level standards).

The inner dimension of conscience[50] points directly toward the role of Law No. 219/2017 in the legislative architecture. The *alleanza terapeutica* model embedded in Articles 1(2) and 5 of that law operationalises the inner dimension of moral reasoning at the clinical level: it frames the physician-patient relationship not as a relation of

[49] L. 22 dicembre 2017, n. 219, art. 1(2) e art. 5. See **S. RODOTÀ**, *Il diritto di avere diritti*, Laterza, Bari, 2013, pp. 245-280.

[50] The chorological framework is used here as a secondary theoretical register, enriching but not replacing the primary participatory-deliberative framework drawn from Lafont (see fn. 12)

compliance but as one of shared deliberation oriented toward the patient's values and life-plan[51]. The failure of Judgment No. 242/2019 to engage with this model is not a deliberate refusal but a lacuna of the normative framework that the judgment brought to light without filling: the question of the procedural architecture of access was not *prospettata* before the Court and could not therefore be addressed by it. Bridging this lacuna requires explicit legislation.

Finally, the post-secular dimension of conscientious objection - the recognition that the vocabulary of CO carries moral genealogies that traverse religious, philosophical, and secular traditions - explains why the legislative architecture must be designed as a space of structured intercultural dialogue rather than as a set of fixed rules imposing a single normative grammar. The tension between the two lacunae is not a zero-sum conflict to be resolved through the victory of one value over another. It is a communicative problem amenable to institutional design - which is precisely what the two instruments proposed in § 7 provide: not a "tyranny of uniformity" but a "normative habitat" in which plural values coexist without structural subordination of one to another.

7 - Chorologies of conscience: designing the two instruments

The institutional theory of § 6 and the European Public Law analysis of §§ 3-4 converge on a legislative architecture that is not merely theoretically coherent but operationally specifiable. This section translates that architecture into a concrete *de lege ferenda* proposal, addressing in sequence the three structural nodes: the mechanics of the CO registry, the content and enforcement of the referral duty, and the facility-level obligation across different territorial scenarios.

The *lex ferenda* must perform two simultaneous operations. The first addresses the second lacuna: it must anchor the four criteria identified by the Constitutional Court - irreversible pathology, intolerable suffering, dependence on life-sustaining treatment, and full capacity for self-determination - to the procedural architecture of Law No. 219/2017. This means incorporating, as the procedural gateway through which all requests are evaluated and verified, the informed-

[51] **C. CASONATO**, I*l fine-vita nel diritto comparato, fra imposizioni, libertà e fuzzy sets*, in A. D'ALOIA (ed.), *Il diritto al fine vita*, Edizioni Scientifiche Italiane, Napoli, 2012, p. 523 ss.

consent requirements of Article 1, the advance directive mechanism of Article 4, and the shared care-planning model of Article 5. The second operation addresses the first lacuna: it must transform the "freedom prior to duty" of punto 6 into a structured right of conscientious objection, modelled on Article 9 of Law No. 194/1978[52].

(a) Registration mechanics. The law must establish mandatory registration of conscientious objectors in regional registries administered by the competent regional health authority. Four design questions require explicit legislative resolution.

First, the *temporal dimension*: objection should be declared at the point of hiring or, for professionals already in post at the time of entry into force, within ninety days of that date -inspired by the model set out in Article 9(2) of Law No. 194/1978, but with a broader time limit of ninety days instead of thirty[53]. Failure to declare within the prescribed period creates a rebuttable presumption of availability; the presumption can be displaced by a late declaration, which takes effect at the beginning of the following calendar year.

Second, the *modularity question*: unlike the binary structure of the abortion law, medically assisted dying raises the possibility of partial objection - a physician who is willing to conduct eligibility assessments and participate in the shared care-planning process but unwilling to administer the lethal substance. The law should explicitly permit partial objection, provided it is declared in full specificity at the time of registration[54].

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[52] Spain: Ley Orgánica 3/2021, arts. 15-16. The Spanish registry is maintained by regional health authorities and accessible to them for personnel planning but not to the general public - a model balancing objector privacy against systemic transparency.

[53] Art. 9(2) L. 194/1978 (timing of declaration). The ninety-day transitional period is not derived from Article 9, paragraph 2, of Law 194/1978 - which sets a one-month deadline for submitting an individual declaration of conscientious objection -: the choice of a longer period responds to the need to guarantee organizations an adequate period of organizational adaptation before the transparency regime proposed in Section 7 comes into force.

[54] Three operational implications of partial objection require legislative resolution. First, the referral chain: a partially objecting physician who has conducted eligibility assessments and participated in the shared care-planning process under Law No. 219/2017 bears a heightened referral duty with respect to the specific element of the procedure refused. The registry must record not merely the fact of partial objection but its precise scope, so that the treating team can identify, before the planning process begins, whether a non-objecting colleague is available for the final administration stage. Failure to specify the scope at registration should be treated as equivalent to total

Third, the *confidentiality framework*: the registry must be accessible to the competent regional health authority for personnel planning purposes, and to the treating physician for the purpose of identifying a non-objecting colleague for referral[55]. It must not be publicly accessible in a form that discloses the identity of individual objectors[56]. The patient's informational interest is protected differently: the patient has a right to be told by the competent health authority whether a non-objecting professional is available in the relevant facility[57].

Fourth, *revocability*: objection should be revocable during an annual declaration window, with revocation taking effect at the beginning of the following calendar year. An urgency clause must, however, operate alongside this general rule: where a patient in an urgent clinical situation has submitted a request, a professional who has declared objection must be able to identify and effect a transfer to a non-

objection for referral-chain purposes, thereby creating an incentive for precision. Second, the registry architecture must include a subcategory structure distinguishing at minimum: (i) total objection (all stages of the procedure); (ii) partial objection limited to administration of the lethal substance; (iii) partial objection limited to participation in the ethics committee verification stage. The Spanish model (Ley Orgánica 3/2021, art. 16) does not provide for partial objection and offers no comparative guidance on this point; the design must therefore be original. Third, the risk of strategic partial objection - declaring partial objection as a compromise position in order to remain nominally available while effectively withdrawing from the most demanding element of the procedure - must be addressed through the sincerity requirement applicable to conscientious objection generally: the declaration must be accompanied by a written statement of the moral or professional grounds on which the specific refusal rests, reviewable by the regional health authority and subject to revision by the Ordine dei Medici in cases of apparent inconsistency between the declared scope and the professional's prior conduct.

[55] The patient's right to information is not equivalent to a right of access to the registry itself. The proportionate solution is for the competent regional health authority to serve as information intermediary: the patient has a right to be told whether a non-objecting professional is available in the relevant facility.

[56] The referral duty must specify: (i) maximum period - fifteen working days from the patient's request, modelled on the Belgian standard; (ii) professional characteristics of the receiving practitioner; (iii) written documentation obligations; (iv) disciplinary sanctions before the ORDINE DEI MEDICI, without prejudice to the patient's civil law remedy.

[57] The hub model designates in each ASL at least one identified facility - or a contractually engaged external team - with the organisational capacity to provide medically assisted dying to patients referred from objecting facilities. Belgium's system of designated euthanasia practitioners and Spain's Guarantees and Evaluation Commission (arts. 17-21 Ley Orgánica 3/2021) provide the comparative models.

objecting professional within the urgency timeline established by the protocol[58].

(b) The referral duty and its enforcement. The referral duty must be operationally specified in four dimensions: (i) *timeline*: the referring professional must complete the referral within fifteen working days of the patient's initial request; (ii) *professional characteristics*: the receiving practitioner must be qualified in end-of-life care and must not be a registered objector in relation to the specific element of the procedure being referred; (iii) *documentation*: the referral must be confirmed in writing with date, identity of the receiving facility, and contact details; (iv) *sanctions*: non-compliance constitutes a disciplinary violation subject to the ORDINE DEI MEDICI, without prejudice to the patient's civil law remedy.

The hub model. The claim that assisted dying "can be provided in any ward" is formally true when a willing professional is present and practically hollow when none is identifiable. The hub model is the institutional solution to this hollowness[59].

[60]Each health district (ASL) must designate at least one *hub facility* with the organisational capacity and personnel commitment to provide

[58] On the urgency track see art. 4 L. 219/2017 (advance directives) as the relevant procedural gateway for situations in which clinical deterioration makes the standard timeline inapplicable.

[59] The composition of regional clinical ethics boards must include: at minimum one physician with end-of-life expertise, one legal scholar or bioethicist, one psychologist or psychiatrist, and one lay member representing patient associations. See **R. SIGNORELLA**, *Libertas in legis "non iam" consistit. L'evoluzione del principio di separazione dei poteri attraverso la lente del diritto ad una morte dignitosa*, in *www.giurcost.org, 3/2025*, especially p. 1565 ss.

[60] Corte cost. n. 204/2025 (4 novembre-29 dicembre 2025), in G.U. n. 53, 1ª serie speciale, 31 dicembre 2025 (rel. Viganò e Antonini), giudizio di legittimità costituzionale della l.r. Toscana 14 marzo 2025, n. 16. The Court partially upheld the Government's challenge, declaring unconstitutional those provisions that crystallised substantive requirements or invaded exclusive state competences in criminal and civil law, while confirming the constitutional legitimacy of the law's organisational and procedural framework as an exercise of concurrent regional competence in health protection (art. 117(3) Cost.). On the conscience of healthcare personnel, the Court confirmed that no individual obligation to perform the procedure exists, while noting, in obiter, that the freedom of conscience of individual professionals does not dissolve the facility's organisational responsibility to ensure that the procedure can be accessed. The precise contours of that organisational responsibility in the absence of a national statute remain contested. Corte cost. n. 467/1991; n. 43/1997; n. 334/1996 remain authoritative for the general distinction between the foro interno and the external manifestation of

medically assisted dying to patients referred from other facilities within the district. The hub is not a dedicated unit; it is an organisational role assigned to an existing facility, with identified personnel, appropriate training, and operative protocols. Where internal resources within the ASL are insufficient, the healthcare facility is under an organisational duty to engage, through contractual instruments, external non-objecting practitioners capable of providing the service within the district. The organisational duty imposed on the azienda sanitaria locale to engage, where internal resources are insufficient, external non-objecting practitioners through contractual instruments does not require ex novo legislative invention: it rests on an existing statutory foundation that the lex ferenda must activate and specify. Article 3(1) of Legislative Decree No. 502/1992 assigns to each ASL the responsibility for ensuring health protection within its territorial area - a responsibility that includes the provision of all services to which patients hold an enforceable right. Article 8-bis of the same decree authorises ASLs to conclude accreditation and contractual arrangements with public and private healthcare providers for the delivery of services that the ASL itself cannot supply directly. Read together, these provisions generate an organisational duty: where the aggregate exercise of conscientious objection within an ASL renders a constitutionally recognised procedure factually unavailable, the ASL is under a statutory obligation, derivable from Articles 3(1) and 8-bis of d.lgs. 502/1992, to remedy the deficit through contractual engagement of willing external practitioners.

The lex ferenda must make this duty explicit and enforceable by: (i) specifying the threshold at which the deficit triggers the contractual obligation - defined as the inability to identify, within the hub facility, at least one non-objecting professional capable of managing the complete procedure; (ii) establishing a maximum timeline - thirty calendar days from the identification of the deficit - within which the contractual arrangement must be operational; (iii) providing that failure to meet this obligation constitutes a reportable deficit in the ASL's annual performance assessment under the National Health Service monitoring framework. This approach avoids the constitutional difficulty of imposing a duty to perform on any individual professional while ensuring that the ASL's collective organisational responsibility does not dissolve into the aggregate of individual refusals.

conscience; n. 204/2025 applies that distinction to the specific organisational context of medically assisted dying for the first time.

Judgment No. 204/2025 of the Italian Constitutional Court - decided on 4 November 2025 and deposited on 29 December 2025, G.U. n. 53 del 31 December 2025 - provides direct constitutional grounding for the hub model's core logic. Ruling on the constitutionality of the Tuscany regional law (l.r. n. 16/2025), the Court confirmed that the freedom of conscience of healthcare personnel precludes any individual obligation to perform the procedure, while simultaneously holding that this freedom imposes on the azienda sanitaria locale a correlative organisational duty: to plan realistically for personnel substitution so that voluntary participation does not translate, in practice, into denial of access. The hub model proposed here operationalises precisely this duty at the district level, providing the institutional mechanism through which the Court's implicit demand for "percorsi di sostituzione organizzativa" acquires concrete legislative form[61].

(b-bis) The national procedural protocol. The protocol must be adopted by Decree of the President of the Council of Ministers following national consultation, in accordance with the framework regulation procedure applicable to healthcare under Article 117(3) of the Constitution[62]. It must specify at minimum five elements: (i) the stages of assessment - the sequence of clinical, psychological, and ethical evaluations from initial submission to final verification, with maximum timelines at each stage; (ii) the composition of multidisciplinary verification teams - at minimum a physician with end-of-life expertise, a psychiatrist or psychologist, and a bioethics consultant; (iii) documentation and reporting obligations; (iv) urgent-case procedures; (v) the waiting period - a mandatory minimum of thirty days between

[61] The hub model's operational feasibility within the Italian NHS framework is confirmed by the Tuscany regional law (l.r. n. 16/2025), which - as Bilancia observes - resolves the conscientious objection question by providing that assistance is rendered on a voluntary basis and classified as institutional activity to be performed in working hours (**P. BILANCIA**, *La vita come valore fondamentale e principio costituzionale*, in *Dirittifondamentali.it*, 2/2025, p. 89). The Tuscany model does not impose on any individual professional the duty to perform the procedure; it imposes on the organisational system the duty to ensure that at least one willing professional is identifiable and available within the district. This is precisely the logic of the hub model proposed here, now confirmed at the regional level.

[62] The CME requirement does not impose a duty to perform the procedure; it imposes a professional duty of competence in the legal and ethical framework surrounding it. Physicians who declare total objection remain subject to the CME requirement on the legal framework; they are not required to participate in simulation exercises involving lethal medication.

the submission of the written request and the administration of the procedure, during which the patient retains the right to revoke or modify, subject to urgent-case exceptions.

Regional clinical ethics boards. The mandate of regional clinical ethics boards comprises three dimensions[63]. *Deliberative*: structured forums in which irreconcilable conflicts between objecting physicians and patients can be mediated through facilitated dialogue rather than judicial compulsion. *Monitoring*: systematic tracking of territorial disparities in access and objection rates, with reporting to the national oversight body on a quarterly basis. *Normative*: production of guidance documents translating statutory principles into practice-level standards.

(c) Two structural safeguards. The first concerns the protection of genuinely autonomous decision-making: the statute must mandate independent psychological assessment as a condition of the validity of any request, conducted by a professional independent of the patient's treating team. The second concerns professional formation: the statute should mandate continuing medical education on the ethical, legal, and communicative dimensions of end-of-life care as a condition of professional registration in the field, following the model established by Law No. 38/2010 on palliative care[64]. This requirement does not impose on objecting physicians any duty to perform the procedure; it imposes on all physicians the duty to engage with the legal and ethical framework surrounding it.

Together, the two instruments - the *lex ferenda* integrating Law No. 219/2017 with a structured CO mechanism, and the procedural protocol supplemented by regional ethics boards[65] - constitute a legislative architecture that is operationally implementable within the existing Italian constitutional and NHS framework. Its constitutional grounding

[63] L. 22 maggio 1978, n. 194, art. 9, especially art. 9(4). See **T. PAGOTTO,** *L'obiezione di coscienza nell'ordinamento italiano tra difficoltà applicative e tentativi di risoluzione*, in *Stato, Chiese e pluralismo confessionale*, cit., n. 14 del 2024, p. 141 ss.

[64] Belgium: Wet betreffende de euthanasie, 28 May 2002, art. 14. Spain: Ley Orgánica 3/2021, arts. 15-16. Portugal: Lei n.º 22/2023, art. 14. See **S. AHLIN DOLJAK**, *Voluntary Termination,* cit., fn 22.

[65] Case C-414/16, *Egenberger*, ECLI:EU:C:2018:257, §§52-53, 69; Case C-68/17, *IR v. JQ*, ECLI:EU:C:2018:696, §61: conflicts between fundamental rights are resolved through proportionality, not fixed hierarchies.

- in the positive obligations doctrine of the ECHR[66], the EU law[67] and the jurisprudence of the Italian Constitutional Court from Judgment No. 242/2019 through Judgment No. 204/2025[68] - ensures that the proposal is the minimum legislative response that Italy's international and constitutional obligations jointly require.

8 - Concluding observations: from the accabadora's silence to a statutory framework for conscientious objection and informed dying

The analysis conducted in the preceding sections has established, with the precision that constitutional and comparative law afford, what Italy is obliged to do and why the two-instrument proposal is the minimum adequate legislative response. This concluding section undertakes a different and complementary task: to illuminate the deeper philosophical architecture of the problem - the reason why the normative gap left by Judgment No. 242/2019 is not merely a technical deficiency but a structural paradox at the heart of any legal order that takes both individual conscience and democratic legitimacy seriously.

Freedom of conscience occupies a position of extraordinary primacy in Italian constitutional jurisprudence. The Constitutional Court has consistently treated it as a value that conforms the entire system - a right that precedes and conditions the exercise of all others, grounded in Articles 2, 3, and 19 of the Constitution[69]. But constitutional doctrine, precisely because it takes this primacy seriously, has always drawn a fundamental distinction: between the freedom of the *foro interno* - the absolute inviolability of moral conviction as such, the *lex poli* in the

[66] ECtHR, *Pichon and Sajous v. France*, no. 49853/99, 2 October 2001; ECtHR, *Grimmark v. Sweden*, no. 43726/17, 11 February 2020: professional CO must operate within the limits set by the contractual and public responsibilities of the profession.

[67] Art. 168(7) TFEU (healthcare organisation remains primarily within Member State competence, within the broader Charter framework). Art. 17 TFEU cannot be interpreted as granting religious or philosophical organisations authority to stand between the individual and the exercise of constitutionally recognised rights.

[68] Corte cost. n. 467/1991; n. 43/1997; n. 334/1996. The common thread is the distinction between the *foro interno* - the space of moral conviction as such, absolutely protected - and the external manifestation of conscience in acts, which can be regulated proportionately. The formula of Judgment No. 242/2019 elides this distinction.

[69] **G. DI COSIMO**, *Coscienza e Costituzione. I limiti del diritto di fronte ai convincimenti interiori della persona*, Giuffrè, Milano, 2000, especially p. 91 ss.

classical sense - and the freedom to act always according to conscience in the external world. The former is absolutely protected; the latter is not. A legal order in which every person could at all times act fully according to the dictates of their individual conscience would not be a democratic state but its dissolution[70]. This is the permanent tension at the heart of constitutional democracy, and it is a tension that cannot be resolved but only institutionally managed.

Judgment No. 242/2019, read through the lens of this distinction, reveals a structural paradox. By leaving the physician's choice *"alla coscienza del singolo medico"* - in absolute, unstructured freedom - the Court did not protect the *foro interno* of the physician, which requires no legal protection because it is by definition inviolable. It protected the *lex poli* of the physician in its external dimension: the freedom to act, or not act, according to conscience in the clinical space. And in doing so, without any mechanism of institutional mediation, it produced a constitutionally anomalous result: the *lex poli* of the physician, acting in the external world, effectively nullifies the *lex fori* - the constitutional right of the patient. The mediating function that only a third party can perform - the legislator, with its capacity to construct the institutional space in which both claims find regulated expression - was absent. The Court, by declining to activate that function, delegated the mediation to one of the two parties in conflict. This is not a solution; it is an abdication.

The Court's choice to frame the physician's objection in terms of "propria etica professionale" - deliberately avoiding any reference to religious belief - has a precise, if paradoxical, consequence for the Convention framework. Article 9 ECHR does not protect religious conviction alone: it extends to any belief that attains a sufficient degree of cogency, seriousness, cohesion, and importance, including non-religious philosophical and professional convictions, provided they are genuinely held and not merely motivated by the individual's personal advantage (ECtHR, *Campbell and Cosans v. United Kingdom*, 25 February 1982, §§36-37; *Eweida and others v. United Kingdom*, nos. 48420/10 et al., 15 January 2013, §81). The formula "propria etica professionale" therefore does not remove the Article 9 ECHR proportionality review from the picture: it complicates its application in a structurally significant way.

[70] **G. CAPUTO**, *L'obiezione di coscienza: un'erma bifronte fra tolleranza e fondamentalismo*, in **AA. VV.**, *L'obiezione di coscienza tra tutela della libertà e disgregazione dello Stato democratico*, Atti del Convegno di Studi (Modena 30 novembre-1° dicembre 1990), a cura di R. BOTTA, Milano, Giuffrè, 1991, p. 12 ss.

When an objecting physician grounds the refusal in identifiable religious conviction, the Strasbourg court can assess the sincerity, consistency, and weight of the belief against the competing rights of the patient. The proportionality analysis has a determinate object. When the refusal is instead grounded in "propria etica professionale", the conviction becomes self-referential: the physician defines the ethical standard, applies it to the procedure, and claims exemption by reference to the standard so defined. The sincerity and coherence of the conviction - the first and most critical filters in the Article 9 analysis - become difficult to assess because the criterion of assessment is internal to the objecting professional's own self-understanding. The result is not the formal exclusion of proportionality review but its practical neutralisation: a regime in which the strength of the physician's legal position is, as a structural matter, inversely proportional to the transparency of the motivational roots from which the objection actually grows. This inversion is constitutionally anomalous. The clinical reality of Italian healthcare - in which the objecting physician's motivation is, in the great majority of cases, substantially indistinguishable from religious conviction - makes it also systematically deceptive. The appropriate legislative response is not to require physicians to disclose their religious beliefs, which would itself raise Article 9 concerns, but to reattach the right of conscientious objection to a structured declaration process - precisely what the registry mechanism of § 7 provides - in which the professional grounds for objection are specified in writing and subject to consistency review. Transparency of motivation is not a condition of the right; it is a condition of its proportionate regulation.

A further dimension of the problem emerges when one moves from the individual to the systemic level. The experience of Law No. 194/1978 should counsel caution. That law structured conscientious objection with considerable precision - mandatory declaration, residual referral duties, facility-level obligations. And yet by 2020, 67% of public-sector gynaecologists were registered objectors, with rates exceeding 80% in several southern regions. What this demonstrates is that structured objection without adequate system-level guarantees and without the cultural conditions for genuine dialogue between the two positions can itself become a form of collective absolute freedom: the individual physician conforms to the legal structure of objection, but the aggregate effect is the same as if no structure existed - the right is

impracticable in entire territories. The structuring of objection is necessary but not sufficient.

This is the point at which Mario Ricca's framework of legal chorology ceases to be a theoretical supplement and becomes a structural necessity[71]. Ricca's insight is that the encounter between incommensurable value systems requires not merely a norm but a space: a third space of mediation in which neither culture is required to abandon its own grammar in order to be heard. Applied to the problem of medically assisted dying, the encounter is between two cultures that are, in the deepest sense, mutually unintelligible: the culture of the patient who claims the right to choose the moment of death as the ultimate exercise of self-determination, and the culture of the physician for whom participation in that act constitutes a fundamental violation of identity - moral, religious, professional - that no external norm can override without doing violence to the person. A legal system that simply subordinates one culture to the other resolves the conflict only by suppressing one of its terms. The chorological space does not resolve the conflict; it creates the institutional conditions under which the conflict can be lived, navigated, and managed without either term being extinguished.

The exit from the structural paradox identified in this article is therefore neither the suppression of the physician's freedom of conscience nor its absolute protection in unstructured form. It is the institutionalisation of that freedom within a framework that simultaneously guarantees its authentic exercise and prevents its aggregate exercise from rendering the correlated right inattuable. This means three things. First, distinguishing clearly between the *foro interno* - which requires no legal protection because it is constitutionally inviolable - and the external exercise of conscientious conviction, which can and must be regulated proportionately. Second, naming honestly the religious and cultural roots of the typical objecting position, rather than disguising them as *"propria etica professionale"*, so that the proportionality review of Article 9 ECHR can operate as it is designed to. Third, creating the chorological space - through registries, referral duties, ethics boards, and systemic guarantees - in which the two cultures do not merely

[71] **C.M. KORSGAARD**, *Self-Constitution: Agency, Identity, and Integrity*, Oxford University Press, Oxford 2009; **J. RAWLS**, *Political Liberalism*, Columbia University Press, New York, 1993, pp. 32-33.

coexist in formal legal terms but encounter each other in the institutional reality of clinical practice.

From the standpoint of European Public Law, the two complementary legislative interventions specified in §7 - a statute on medically assisted dying integrating Law No. 219/2017 and structuring CO through mechanisms modelled on Article 9 of Law No. 194/1978, supplemented by a national procedural protocol and permanent regional clinical ethics boards - are the minimum legislative response that Italy's international and constitutional obligations jointly require. Their complementarity is equally necessary: a statute without the chorological space produces legal conformity without cultural encounter; the chorological space without a statute produces dialogue without institutional backbone. Neither, alone, escapes the structural paradox.

Several questions remain open. First, the relationship between the proposed Italian statute and the possibility of future Union-level harmonisation: the comparative convergence documented in § 3 raises the question of what form the Italian framework should take to remain compatible with eventual EU regulatory development. Second, the implications of the proposal for general practitioners as distinct from hospital specialists: the hub model is designed with the NHS hospital context in mind, and the primary care context raises additional questions about the scope of the CO right. Third, the position of the minor who has acquired capacity for self-determination in the sense of Law No. 219/2017: the conditions of Judgment No. 242/2019 do not explicitly address age, and the legislature must address this explicitly. Fourth, the jurisprudential framework remains in motion: a further public hearing on questions connected to medically assisted dying is, at the time of writing, scheduled before the Constitutional Court, and the resulting decision may again recalibrate what is required of the National Health Service. The analysis advanced here is designed to hold across that development: whatever the precise contours of the Court's next intervention, it can only sharpen - not dissolve - the structural need for the two legislative instruments, since no further judicial recalibration can supply the organisational infrastructure that, by the Court's own repeated admission, only Parliament can create.

The accabadora's gesture was clandestine not because it was wrong - the novel does not judge it - but because the society in which it occurred had no institutional space for the encounter between compassion and death. The law is called to create that space: not to make

the encounter less morally weighted, but to make it institutionally legible, procedurally governed, and publicly accountable. What distinguishes the accabadora's silence from the institutional practice that this article proposes is precisely the presence or absence of that space - the chorological space in which the *lex poli* of the physician and the *lex fori* of the patient meet, neither extinguishing the other, under the governance of shared procedural norms. Transforming the physician's unstructured, unaccountable *"se prestarsi, o no"* into a publicly justifiable institutional practice does not resolve the moral tension between conscience and self-determination; it creates the conditions under which that tension can be lived in the open, rather than in the silence of the accabadora's night[72]. Persons - patients and physicians alike - are self-authenticating sources of valid claims. The legal order is bound to protect both: not by pretending the tension between them can be dissolved, but by constructing, with the precision that legislation alone can achieve, the institutional space in which both can be genuinely, sustainably, and equally heard.

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[72] Conscientious objection does not dissolve the tension between moral duty and legal obligation: it holds that tension in its most institutionally mature form. As Bertolino showed, the institution "coherently composes" the conflict not by eliminating either of its terms, but because the objector - refusing a single norm while remaining loyal to the legal order as a whole - accepts the alternative performance the system offers as the very site of that loyalty. On this basis, Berlingò argues that the disobedience entailed by objection does not undermine but rather exalts the law's foundational values, pressing the principle of legality beyond its formal surface toward its substantive dimension of adequation to justice. The tension does not close: it opens. Objection acquires a forward-looking character - something closer to "projectuality and creativity," almost an anticipation, or prophecy, of the positive law still in the making. **R. BERTOLINO**, *L'obiezione di coscienza negli ordinamenti giuridici contemporanei*, Giappichelli, Torino, 1967, p. 14 ff.; **S. BERLINGÒ**, *Ordine etico e legge civile: complementarietà e distinzione*, in *Iustitia*, 49 (1996), pp. 226-227.