



*Presidency of the Council of Ministers*  
NATIONAL BIOETHICS COMMITTEE

**NOURISHMENT AND HYDRATION OF PATIENTS IN  
PERSISTENT VEGETATIVE STATE**

30<sup>th</sup> September 2005

1. Recently, public opinion around the world has been profoundly shaken by the story of a woman who lived for fifteen years in a vegetative state and was left to die following the decision of a judge who authorised the husband's request (against her patents' wishes) to remove the nourishment tube from which the woman's life depended. Considering the considerable number of people who, also in Italy, are in a persistent vegetative state (PVS); also taking into account the controversy about considering or not the nourishment and hydration by nasogastric tube or percutaneous endoscopic gastronomy (PEG) as medical treatment and/or therapeutic obstinacy, the NBC believes that it is necessary to stress in this respect some fundamental principles of bioethics.

2. With the expression *persistent vegetative state* (once called *wakeful coma*) we indicate a clinical condition (deriving from a serious neurological impairment) characterised by an apparent state of wakefulness without consciousness, with eyes open, frequent aimless mastication movements, motor reflexes of the limbs limited to reflexes of retraction to nociceptive stimuli without purposeful movements. The patients in PVS sometimes smile for no apparent reason; the eyes and the head can rotate towards sounds and moving objects, without fixing the gaze. Vocalisation, if present, consists of incomprehensible sounds; there is spasticity, contractions, urinary and faecal incontinence. Cardiocirculatory and respiratory functions are preserved and the patient does not need the support of equipment. The gastrointestinal function is preserved, even though the patient is unable to take nourishment by mouth due to serious dysfunctions of the mastication and swallowing. If it is true that some terminally ill patients can become PVS patients, it is also true that people in a PVS are not always terminally ill patients (as they can survive for years if properly assisted). It is also wrong to associate the PVS condition to coma: the comatose state is in fact devoid of wakefulness, whilst people in a PVS, although they do not offer clear exterior signs of consciousness, alternate phases of sleep and wakefulness. The main bioethical problem is the *state of dependence from others*: these are people who, to survive, need the same things as any other human being (water, food, heating, cleanliness and movement), but who are not able to provide for them independently, needing to be helped, supported and looked after in all their functions, even the simplest ones. What must be strongly stressed is that people in a PVS do not generally need sophisticated, expensive and difficult to access technologies; what they need to live is care, intended not only in the sense of *therapy*, but also and mostly of *care*: they have the right to *be looked after*. In this sense we can say that people in a PVS require *assistance with a high and at times very high human content*, but a *low technological content*.

3. There is no doubt that the onset of PVS is a tragic event and even more tragic is the permanence (for a length of time that is difficult to predict) in such a state. But there is also no doubt that although PVS is definitely an extremely tragic pathological state, it does not in the least impair the dignity of the people affected and their full rights: it is therefore not possible to justify in any way not only the negation, but not even a weakening of their right to care, who they enjoy like any other human being. In fact we must not forget that it is

not the quality of the pathology or the probability of recovery to justify the care: this finds its sufficient and exclusive reason in the need that the patient, as *weak subject*, has to be looked after and eventually undergo medical therapy. It is also common intuition, easy to argue bioethically, that the weaker the patient, the more is the ethical and legal duty to look after him/her, which weighs on the healthcare system, on his/her family and on each single individual, who has the ability and opportunity. It is the opinion of the NBC that when the family is available to assist the patient in PVS at home, it is the duty of the institutions to support as much as possible the financial and care burdens.

4. To bioethically justify the basis and limitations of the right to care and the care towards people in PVS, we must therefore remember that *what must be guaranteed is basic sustenance*: nourishment and hydration, whether they are administered naturally or artificially. *Nourishment and hydration* must be considered *ethically due acts* (as well as deontologically and legally) as they are *indispensable to guarantee the basic physiological conditions for life* (guaranteeing survival, removing the symptoms of hunger and thirst, reducing the risks of infections due to nutritional deficiencies and immobility). Even when nourishment and hydration must be given by other people to PVS patients artificially, there are reasonable doubts whether such acts can be considered “medical procedures” or “medical treatments” as such, similarly to other vital support therapies, like, for example, mechanical ventilation. Water and food do not become, in fact, medical therapy only because they are administered artificially; this is a procedure that (although it undoubtedly requires a careful choice and preliminary evaluation by the doctor), apart from the small initial intervention, can be managed and controlled also by the patient’s family (as hospitalisation is not necessary). It is a procedure that, respecting minimal conditions (bathing, controlling posture), can be tolerated, managed at home by non-expert personnel appropriately trained (as demonstrated by the fact that *patients who are not in PVS* can be nourished in this way without it impeding a life of daily relationships). Care procedures do not become medical procedures only because they are carried out initially and periodically monitored by healthcare workers. The methods in which the elements necessary to sustain life (fluids, nutrients) are taken or administered is irrelevant from a bioethical point of view: naturally or artificially supplying (with the help of techniques that substitute natural ways) nourishment and hydration, eat or drink independently or thanks to others (in a surrogate manner, outside of the active participation of the individual) are not differentiating elements in the bioethical evaluation. The fact that nourishment is given through a tube or stoma, does not make water or food an artificial preparation (similarly to walking, which does not become artificial when the patient needs a prosthesis). Nor can we believe that water and food become medical or healthcare therapy only because another person supplies them. The problem is not the method of the act towards the patient, it is not how he/she is nourished or hydrated: nourishment and hydration are due acts because they are basic life supports, as they allow the individual to stay alive. Even though it was a medical treatment, the judgement on the appropriateness and suitability of such a treatment should depend only on the objective condition of the patient (namely, his/her effective clinical needs

measured in risks and benefits) and not on the judgement of others about the quality of life, current and/or future.

5. If it is not very convincing to define the PEG a “medical procedure”, we should exclude even more the possibility that it will be generally considered as “therapeutic obstinacy”. The decision to not undertake or discontinue artificial nourishment and hydration is not governed by the principles regulating medical procedures (with reference to other life support systems): it is generally thought right to discontinue a medical procedure when it becomes persistence, namely, an insistence to obstinately postpone death at any cost through technology, prolonging life beyond the limits of the possible (when the illness is serious and incurable, excluding with certainty that it could be reversed, when death is imminent and the prognosis terminal, therapies are disproportionate, onerous, expensive, ineffective and useless to improve the condition of the patient from a clinical point of view). As long as the organism is genuinely benefiting from artificial nourishment and hydration, they are forms of *primary and proportionate routine care* (effective, inexpensive financially, easy to access and practical, not requiring sophisticated equipment and being, in general, well tolerated). The discontinuation of such practices must be evaluated not like the rightful interruption of therapeutic obstinacy, but rather as a form, from a particularly cruel human and symbolic point of view, of “*abandonment*” of the *patient*: in fact it is not a coincidence that, as an act of coherence, the immediate euthanasia of the patient in PVS for whom the discontinuation of nourishment and hydration has been decided is required by many, in order to avoid that after a process that can last up to two weeks they end up “dying of hunger and thirst”.

6. There are instead no doubts on the ethical obligation to discontinue nourishment in the hypothesis that in the imminence of death the organism is no longer able to assimilate the substances provided: the only limit objectively recognisable to the ethical obligation to nourish the person in PVS is the organism’s ability to assimilate (therefore the possibility that the procedure achieves its aim because there is no positive reaction to the treatment) or a state of intolerance linked to food that is clinically verifiable.

7. We must therefore talk about the *human value* of the *care* of patients in PVS. If we generally feel that it is our duty to provide water and food to people who are not able to get it independently (children, the sick and the elderly), as a sign of a civilisation characterised by humanity and solidarity in recognising the duty to look after the weakest, in the same way we should believe that it is our duty to give food and fluids to patients in PVS, taking care of their physical needs and accompanying them emotively and psychologically, in their peculiar condition of vulnerability and fragility. This is an attitude that has a strong human, symbolic and social significance of care for others. We cannot reduce the decision to care/not care for, assist/not assist a patient in PVS to the cold utilitarian logic of balancing costs and benefits (considering the benefits to be limited in terms of recovery and the high costs of care), calculating the quality of life of others (and ours, seeing the sick as a “burden” for the family and society), limiting the considerations to convenience and opportunity and not also to the duty and responsibility of solidarity towards others.

8. In the context of this document it is appropriate to elaborate some considerations regarding the possibility that an individual, in drawing up *Advance Care Statements*, includes the request to discontinue nourishment and hydration, in anticipation of finding his/herself in a possible situation of PVS in his/her future. There is no doubt that formulating this request is absolutely legitimate, just as there is no doubt that a similar request cannot be completely generic, being very difficult to predict the specific way in which such particular events could come true in the future. The fundamental ethical criterion to assess the legitimacy of the content of *Advanced statements* identified by the NBC in a document formally dedicated to the *Advanced treatment statements* and approved on the 18<sup>th</sup> of December 2003. In it, at paragraph 6, the NBC has unanimously affirmed that in the *Statements* “each individual has the right to express his or her wishes, including in advance, with respect to any therapeutic treatment or medical procedure about which they can legitimately express their current wishes”. It is therefore not to be doubted that when nourishment and hydration have an *extraordinary* character and their discontinuation has been legitimately requested by the patient in his/her *advanced statements*, the doctor could access this request (in the ways indicated by the NBC in the abovementioned document), even though this solution seems to preclude the great difficulty (psychological and human) mentioned above, of letting the patient die of starvation. The hypothesis – which in these pages is considered typical – in which nourishment and hydration are routine primary care rather than a medical procedure, is however different. According to NBC members subscribing to this document, the request in *advanced care statements* to discontinue this treatment, appears in fact like the request of *euthanasia by omission*, similar both ethically and legally to an intervention of *active euthanasia*, illegal in all respects.

9. In light of the previous considerations, the NBC conclusively confirms that:

- a) Human life must be considered a value that cannot be disposed of, regardless of the level of health, the perception of the quality of life, autonomy or ability to discern;
- b) Any distinction between lives worthy and unworthy to be lived is to be considered arbitrary, as dignity cannot be attributed, variably, on the basis of the conditions of existence;
- c) The hydration and nourishment of the patients in PVS must be ordinarily regarded as primary life support;
- d) Discontinuing the hydration and nourishment of patients in PVS is to be considered ethically and legally legitimate on the basis of objective parameters and when the hypothesis of a genuine therapeutic obstinacy is realised;
- e) The abovementioned discontinuation is to be considered ethically and legally unlawful every time it is carried out not on the basis of the real needs of the person concerned, but on the basis of the perception that others have of the patient’s quality of life.

*In the plenary meeting of the 30<sup>th</sup> of September 2005 this document was agreed upon by the following NBC members:*

Prof. Salvatore Amato, Prof. Sergio Belardinelli, Prof. Paola Binetti, Prof. Adriano Bompiani, Prof. Luisa Borgia, Dr. Carlo Casini, Prof. Francesco

D'Agostino, Prof. Luigi De Carli, Prof. Luciano Eusebi, Prof. Giovanni Federspil, Prof. Angelo Fiori, Prof. Aldo Isidori, Prof. Corrado Manni, Prof. Luca Marini, Prof. Vittorio Mathieu, Prof. Laura Palazzani, Prof. Paola Ricci Sindoni, Prof. Giancarlo Umani Ronchi.

*The following NBC members voted against this document:*

Prof. Mauro Barni, Prof. Luisella Battaglia, Prof. Cinzia Caporale, Prof. Isabella Coghi, Prof. Lorenzo d'Avack, Prof. Carlo Flamigni, Dr. Laura Guidoni, Prof. Demetrio Neri.

*Abstained from voting:* Prof. Silvio Ferrari.

## **PERSONAL REMARK**

The undersigned, absent from the plenary meeting of the National Bioethics Committee on the 30<sup>th</sup> of September 2005, communicate their agreement with the document *Nourishment and Hydration of Patients in Persistent Vegetative State*.

Prof. Maria Luisa Di Pietro  
Dr. Gianfranco Iadecola  
Prof. Elio Sgreccia

## PERSONAL REMARK

The statement that characterises the NBC document , according to which the hydration and nourishment of patients in PVS should be regarded as a rightful primary “support” for the patient and not strictly as a medical treatment, expresses an ideological framework for the issue, respectable but completely unrelated to the clinical reality and the autonomy both of the patient (whose advance statement is ignored) and of the doctor, who is in this way deprived of his fundamental professional authority, which is to establish in science and conscience the moment when a therapy of even mere life support becomes futile and cruel persistence (condemned by ethical, deontological and scientific instance). On the other hand, the treatment in question is continuously characterised by medical assessments and choices based time after time on the specific condition of each patient and it develops through checks and prescription of specific and specialist medical expertise: which is reflected in every guideline, every clinical-scientific framework of PVS, to the point that repeating it is superfluous.

The document approved by the majority of the NBC is instead based on premises that are scientifically wrong and it is therefore incompatible with medical practice that is not dominated by ideology.

This does not mean that the diagnosis of PVS authorises in itself the abandonment of the patient and of every curative measure; but given the absolute “certainty” of no-recovery after no longer than a year (to be considered in any case with extreme prognostic care), it is the exclusive matter of a clinical-scientific evaluation supported, as it must be in the majority of developed countries, by guarantees and technical and temporal evidence, maybe to be indicatively established, the way it has already happened (peacefully) for the condition of the irreversible cessation of all encephalic functions, certifiable only in the convergence of the parameters and signs, based on science and endorsed by the law, so that they *allow* the discontinuation of every life support treatment.

Moreover, the same position of clarity can be found in the opinion expressed by a scientific commission purposefully created (1999) by the Ministry of Health, Prof. Veronesi.

Prof. Mario Barni

## NOTES

Regretting the fact that it has not been possible to pursue to the end the drafting of a single although not unified document, Prof. Mauro Barni, Prof. Luisella Battaglia, Prof. Cinzia Caporale, Prof. Isabella Maria Coghi, Prof. Lorenzo d'Avack, Prof. Renata De Benedetti Gaddini, Prof. Carlo Flamigni, Prof. Silvio Garattini, Prof. Laura Guidoni, Prof. Demetrio Neri, Prof. Alberto Piazza, Prof. Marco Lorenzo Scarpelli, Prof. Michele Schiavone, are in favour of discontinuing the hydration and nourishment of patients in PVS in some circumstances and with appropriate safeguards. The same Professors therefore declare their vote against the *Document*<sup>1</sup> approved by the majority of NBC members, explaining this choice in the following considerations.

1. Leaving aside the first three paragraphs of the *Document* which, appropriately modified during the discussion that took place in the plenary meeting of the 16<sup>th</sup> of September, can be endorsed as a description of the clinical framework called "vegetative state" (paragraph 2) and as introduction to the type of problems to tackle (paragraph 3), a first point of disagreement is the content of paragraphs 4-5-6 and 7, in particular with regards to the thesis according to which artificial nourishment and hydration cannot be considered medical treatments as such.

In this regard, it is necessary to stress that there is a tendency, constant and increasingly widespread in the national and international scientific community, in favour of the opposite thesis, that is, that artificial nourishment and hydration are in every way a medical treatment<sup>2</sup>, like other life support treatments, such as, for example, mechanical ventilation. Mechanical ventilation which, on the contrary, the *Document* believes inappropriate to mention as an element of comparison: almost as if mechanically supplying air to a patient who cannot breathe it in him/herself, is not just as "essential to ensure the basic physiological conditions for life", as much as, according to the *Document*, supplying artificial nourishment and hydration.

These last ones are treatments that presume scientific knowledge and that only doctors can prescribe, only doctors can carry out by introducing a nasogastric tube or other even more complex methods, and only doctors can assess and eventually reorganise; this even if the mere execution can be carried out – as it happens for many other medical treatments – by nursing staff or in general those who assist the patient. In fact it is not "food and water" – as stated in the *Document* – that are supplied, but chemical components, solutions and preparations that imply technological procedures and scientific knowledge; and the methods to administer them are certainly not comparable to "providing water and food to people who are not able to get it independently (children, the sick and the elderly)" (paragraph 7). This highly evocative and emotionally engaging language, which the paragraphs in question are full of, is aimed at supporting the thesis of a "strong human, symbolic and social significance of care for others" (paragraph 7) demonstrated by the administration, even artificially, of "food and water". However, again, it is incomprehensible – in the sense that the *Document* does not provide any reasons for this – why in the same context it is claimed that "this value does not regard, for example, artificial respiration or dialysis". In an ethics of taking care, the more or less

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<sup>1</sup> Following, in the note titled: *Document*.

<sup>2</sup> See, finally, the Guidelines of the Italian Society for Parenteral and Enteral Nutrition (2002), with relative bibliography.

technological nature of the treatments cannot be discriminatory: any medical or non-medical treatment, even the simplest one, can and should have the value of care for others.

2. In any case, although we maintain that if we consider the nature of this or that treatment we cannot ignore the opinion of the scientific community, I stress that the judgement on the bioethical appropriateness of these treatments depends only partially – or even not at all, as claimed by some of the writers – by considering them medical treatments, as to a certain extent the *Document* admits in the sentence that closes paragraph 4.

The solution of medical-legal problems could maybe depend on considering them as such, but the judgement of bioethical appropriateness certainly does not depend on it, and in any case not automatically, which – just like in any other treatment – must take into account other factors. Amongst these: the patient's condition and the perception of his/her own life that the patient can manifest, in various forms, before entering PVS.

It is not about formulating judgements or agreeing with “the judgement of others” – as presented in the *Document* – on these patients' “current and/or future quality of life”, but, on the contrary, it is about exploring the possibility of recreating the judgement that the patient would have formulated about his/her condition, or of verifying what preferences the patient has explicitly and clearly expressed in the form of advanced statements. The two different paths open, according to the bioethical principle we refer to: in Great Britain, for example, the aim is generally to establish if the permanence in that condition is in the patient's “best interest”; whilst in the USA the respect of the patient's autonomy is seen as the prevailing interest, even when he/she can no longer exercise it. These and other possible paths can be followed to find humanly acceptable solutions to these dramatic situations. The signatories of this note are hoping that the NBC reconsiders the issue, the analysis of which was already started in the previous mandate, as they are issues requiring much more in depth study.

3. We must also observe – with particular reference to paragraphs 5 and 6 – that artificial hydration and nourishment can almost never become a form of therapeutic obstinacy (although they can become simple persistence), not even in the cases, rare but conceivable, listed in paragraph 6.

With regards to this paragraph, we must however highlight that it is not realistic, or scientifically appropriate, to talk about an organism that “is no longer” able to assimilate the substances supplied (in this case the treatment, amongst other things, would be completely futile). It is on the other hand realistic to talk about an organism that has an increasingly reduced capacity to assimilate without it being possible in abstract to identify the threshold below which the ability to assimilate becomes insufficient and, therefore, the nutrients administered artificially do not achieve their biological goal to change, albeit in a more limited manner, the biohumoral parameters.

We therefore do not understand for which reason the discontinuation of these treatments in the case of patients in PVS<sup>3</sup> - which in any case have no awareness of being fed and hydrated – would be “a form, particularly cruel from a human and symbolic point of view, of “abandonment” of the patient” (which,

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<sup>3</sup> Which, for some of the signatories, can in any case happen only on the basis of an explicit expression of will by the patient through advanced statements.

according to the same approved *Document*, would need, from those suggesting it, the coherence of asking also these patients' euthanasia), whilst this "abandonment" according to the same *Document*, would not happen in the case of patients with a reduced or very reduced (but presumably never inexistent, at least as long as the patients are alive) capacity to assimilate, for whom the *Document* envisages the "dutifulness" of the discontinuation. And we also do not understand why the psychological and human difficulty of leaving a patient "to die of hunger and thirst", is considered important in the case of patients in PVS and not also in the case of other type of serious patients with the same reduced capacity to assimilate: does it perhaps matter that in the first case the dying process may last for two weeks, whilst in the second case it may last "only" for a few days or a few hours?

Leaving aside the fact that what happens in reality is certainly not due to the harrowing images that the language used in the *Document* would lead us to think, if the problem is the psychological and human distress of those who treat the patients (if this is a valid reason), then – once the discontinuation of those treatments has been decided – in the terminal stage we could proceed, in one as in the other case, to sedation; in the second case obviously with the patient's consent, if conscious.

There is therefore no need to call into question the issue of active euthanasia: in the framework of the ethical debate on the matter it is possible to argue in favour of the interruption of life support treatments (including artificial hydration and nourishment) without thereby accepting the hypothesis of a direct euthanasia<sup>4</sup>.

4. A further point of disagreement is the content of paragraph 8, relatively to the possibility of incorporating a request of not starting or discontinuing artificial hydration and nourishment in the Advanced care statements.

The Document *Advanced Care Statement*, approved unanimously by the NBC the 18<sup>th</sup> of December 2003, reads: "each individual has the right to express his or her wishes, including in advance, with respect to any therapeutic treatment or medical procedure about which they can legitimately express their current wishes". In the opinion of the writers, from this follows the logic consequence that any treatment or intervention needs the person's availability, regardless of whether ordinary or extraordinary, or whether it can be seen as therapeutic obstinacy or not, or – even more so, as artificial nourishment, is an intervention the termination of which causes effects that can be easily understood by the patient without any need for particular information or knowledge – whether it is "routine primary care". We don't see, in fact, how it is possible to argue that a conscious person refusing any of these interventions can be forced to suffer their administration. And with regards to the issue under discussion, it is important to recall that art. 51 of the Italian Code of Medical Deontology says: "When a person of sound mind voluntarily and consciously refuses to take nourishment, the doctor has the right to inform him/her of the consequences that this decision can have on his/her health conditions. If the

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<sup>4</sup> About this, see also paragraph 120 of the Charter for Health Care Workers of the Pontifical Council for Pastoral Assistance to Health Care Workers: "The administration of food and liquids, even artificially, is part of the normal treatment always due to the patient when this is not burdensome for him: their undue suspension could be real and properly so-called euthanasia".

person is aware of the possible consequences of his/her decision, the doctor *must not force him/her or take part in behaviours to compel him/her to take artificial nourishment, but he/she must continue to assist him/her*" (italics by the writers).

If therefore a person, in the full consciousness of his/her condition and of the consequences of his/her eventual refusal, is free to decide on any intervention offered, including artificial nourishment, then, under the principle mentioned above, it is not possible to take away from the same person the freedom of giving advanced statements to a similar end, and therefore also with regards to starting or not artificial hydration and nourishment, in case he/she should find him/herself in the condition, on the basis of medical knowledge and available protocols, of being diagnosed as being in a vegetative state.

5. With regards to the concluding considerations presented in paragraph 9, they obviously come from the content of the previous paragraphs and therefore they are not acceptable to the signatories of this note to the *Document*.

In conclusion, it seems however dutiful to observe that to reason bioethically about PVS, it is not strictly necessary to call into question the controversy on the value of human life, also because in this way the discussion moves to the level of the more complex and, often, abstract notions of the world and man, on which it is not the NBC's task to take position. We should, if anything, try to reason about the object of the controversy, asking, for example, if, with regards to whether it is disposable or non-disposable, life can be considered as simple biological existence or as biography, as being alive or having a life, an existence.

Finally, the writers don't believe that it is appropriate to recall the distinction between lives worthy or unworthy to be lived, because it is always true that people's dignity does not depend on the conditions in which they find themselves: instead, it might be the conditions people find themselves in that are more or less worthy of the people. And, in this case, it is the writers' belief – for some, always subordinating this decision to the consent explicitly expressed by the patient previously -, that discontinuing treatments that maintain undignified conditions is maybe to be seen as an extreme tribute to the dignity of the person.

Prof. Mauro Barni  
Prof. Luisella Battaglia  
Prof. Cinzia Caporale  
Prof. Isabella Maria Coghi  
Prof. Lorenzo d'Avack  
Prof. Renata De Benedetti Gaddini  
Prof. Carlo Flamigni  
Prof. Silvio Garattini  
Dr. Laura Guidoni  
Prof. Demetrio Neri  
Prof. Alberto Piazza  
Dr. Marco Lorenzo Scarpelli  
Prof. Michele Schiavone

## PERSONAL REMARK

In full agreement with the principles and content of the document *Nourishment and Hydration of Patients in Persistent Vegetative State*, approved by the National Bioethical Committee in the Plenary meeting of the 30<sup>th</sup> of September 2005, we believe that it is appropriate to stress – in our capacity of doctors – that what was stated with regards to persistent vegetative state is also true for “permanent vegetative state”, about which the judgement of irreversibility has a character of probable prognosis and not absolute certainty, as occurrences of reversibility are known also after a considerable amount of time from the event that damaged the brain. Anyway, even in cases of “permanent vegetative state” it is still a human life that must be respected and protected, even more so because in conditions of extreme weakness.

Prof.ssa Paola Binetti  
Prof. Adriano Bompiani  
Prof. Bruno Dallapiccola  
Prof.ssa Maria Luisa Di Pietro  
Prof. Giovanni Federspil  
Prof. Angelo Fiori  
Prof. Aldo Isidori  
Prof. Corrado Manni

## PERSONAL REMARK

After having read the document “Nourishment and Hydration of Patients in Persistent Vegetative State” in the text approved in the plenary meeting of the 30<sup>th</sup> of September 2005 (which I could not attend), I want to make known my full agreement with the conclusions formulated in paragraph 9, precisely as follows, as a personal reason:

a) From a bioethical point of view, in Europe the person in PVS is not a former person (according to the principles formulated on the super-principle of autonomy), but is a person in the full sense, whose dignity must be protected guaranteeing, in line with the “Convention on Human Rights and Biomedicine” (art. 1) “without discrimination, respect for their integrity”;

b) From a constitutional point of view, in Europe the person in PVS, as any other person, “has the right to life”, and consequently “to his physical and mental integrity” (European Union Charter of fundamental rights, articles II-62 and II-63);

c) From a deontological point of view, in Italy “the doctor cannot abandon the incurable patient, but must continue to assist him/her even just to lessen the physical and psychological pain” (Code of medical deontology, art. 20), in view of “a medicine that takes care” (Ventafridda – De Conno, 1990), keeping in mind that if this is “the philosophy of palliative care” (*ibid.*), it must be even more so for the care of patients in PVS, who certainly cannot be considered incurable;

d) From the point of view of terminology, there is no need to use a fashionable term (care) to highlight that the alternative between “medical procedure” and “assistance” here is a false problem: we can simply refer to Zingarelli to discover (or rediscover) that “care” means both “all medicines and remedies to treat an illness” as well as “the constant and solicitous interest in something or someone”.

Prof. Francesco Donato Busnelli