Legalising euthanasia in Albania? To Act or Not To Act: That Is the Question

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Abstract

Legalising euthanasia and helping others who are suffering to die is debated throughout the world. Whether to permit assisted suicide and euthanasia today is among the most contentious legal and public policy questions. The right to life is a non -derogable right, Indivisible and inalienable. It is difficult to imagine a more fundamental human right than the Right to Life. But we have to recognize that life and death are two sides of the same coin. There can be no life without death and no death without life. The two are absolutely inseparable. If life is a fundamental human right then death is too?

This article presents a comparative analysis of euthanasia in several states. Few countries have changed their law's traditional prohibition on euthanasia. The best known public policy shift occurred, of course, in the Netherlands with the acceptance of the practice of euthanasia and this has led, most recently, to its formal decriminalisation by the Dutch Parliament. The only other changes have been the short-lived legalisation of euthanasia and assisted suicide in the Northen Territory of Australia and of the latter practice in the State of Oregon in America. Elsewhere in the world, the arguments in favor of, and pleas for,

legal change have fallen on deaf ears despite the knowledge that euthanasia does take place undetected.
We present in this article the debate on legalising euthanasia in Albania, which has been ongoing for a considerable length of time. Albanian law is clear on legal consequences of euthanasia. It is illegal, in the sense that it offends the criminal law. Deliberately taking another person's life amounts to the crime of murder and carries a mandatory life sentences. Perhaps the most important aspect of this debate concerns the meaning of words. It has not proved easy for citizens, jurists, theologians, health professionals and bioethicists to reach agreement in relation to the manner of designating the various possible actions that may take place at the end-of-life: patient refusal of treatment, with holding or withdrawal of futile therapies, palliative sedation, etc. The authors conclude that euthanasia violates the right to life and socio-economic aspects in Albania are obviously not suitable to legalise euthanasia and assisted suicide.

Key words: *euthanasia, right to life, legalization, dignity, Albania*

Introduction

Interest in euthanasia, also called ''dignified death" or ''death humanization" is relevant from the ethical and moral points of view, especially if it is oriented toward the detection of the motivations and conceptions of life subject to such practices. Originally one could describe euthanasia as a 'gentle and easy death', derived from the old Greek words 'eu' (good) and 'thanatos' (death). Nowadays a better description is ''the action of including a gentle and easy death".

The country that first legalized euthanasia, the Netherlands, defines euthanasia as the ''deliberate ending of life by taking action, usually by injection, to the veins of the patient, in order to kill him or her." Another definition states that euthanasia is ''the deliberate killing committed under the impulse of compassion in order to relieve the physical pains of a person suffering from an incurable disease and whose death is, therefore, inevitable"[1].

Euthanasia is one of many controversial themes all around the world nowadays. Along the years, decisions have been made, events have occurred, and minds have been transformed, in order to get this topic in the clouds of controversy. Ethics, dignity, and morality are three out of a plenty of reasons people peek towards its approval or disapproval[2]. The movement of opinion

[1] See Diaconescu, A.M., *Euthanasia*, Contemporary Readings in Law and Social Justice, 2012, 474.

[2] See Domínguez Grau P.,*Euthanasia Should Not Be Legal Because It Is an Act of Murder, Possible*

in favour of euthanasia, currently active, has characteristic connotations and motivations, aimed at demanding legalization. Whether to permit assisted suicide and euthanasia today is among the most contentious legal and public policy questions[3]. The right to life is a non-derogable right, indivisible and inalienable. It is difficult to imagine a more fundamental human right than the Right to Life. But we have to recognize that life and death are two sides of the same coin. The two are absolutely inseparable[4].

In many cases, medical end-of-life decisions precede dying. Such decisions, ranging from the alleviation of pain and symptoms and non-treatment decisions to the administration of drugs with the explicit intention of hastening death, seem to occur everywhere, although the frequency of the different types of decisions varies considerably between countries. These different types of decisions have been debated extensively in the international medical, legal and ethical literature. Usually, measures to alleviate pain are considered the least controversial[5].

Even if such a measure may have as a side effect that the patient dies sooner, this is generally considered an acceptable consequence, as long as the physician did not aim at hastening the patient's death, the side effect in not excessive and the measures taken are justified by the objective to reduce pain and suffering[6]. In the last five to ten years there has been increasing debate on a medical practice at the end-of-life that is difficult to place between the aforementioned end-of-life decisions. This practice is called terminal sedation, although other concepts are used as well (palliative sedation; deep sedation)[7].

There are several forms of assistance to end a person's life. When the patient is not able to kill himself because of a physical incapability, he will ask people around him (physician, family) for help; this is called ''assisted suicide". However, the most common form is ending of life by a third party with the ''use of processes that can accelerate or cause death to free an incurable patient from extreme suffering", this

Alternatives for Treatments Are Available, and Represents a Loss of Morals. Research Paper, Universidad del Turabo, available in www.academia.edu.

3 Erimia, C., *Ethical and Legislative Aspects on The Legalisation Of Euthanasia From The Patient Rights Perspective,* Journal of Law and Administrative Sciences, 5/2016, p. 49.

4 See Tepshi, A., *E drejta e jetës. Mbrojtja e kësaj të drejte referuar nenit 2 KEDNJ. Çështjet e fetusit, abortit dhe eutanazisë*. Doctoral Thesis, Tirane, 2016, p.16.

5 R.F. Esposito, *L'eutanasia nella stampa di massa italiana* . in Aa.Vv., *Morire sí, ma quando?,* p. 17.

6 Gevers S., *Terminal Sedation: A Legal Approach,* European Journal of Health Law 2003, 10, pp. 359-367.

7 Terminal sedation is the administration of sedative drugs with the aim to reduce the consciousness of a terminal patient in order to relieve distress; it is frequently accompanied by the withdrawal (or withholding) of life sustaining interventions, such as hydration and nutrition. It is typically a measure of the last resort to be considered in situations where all other measures to reduce pain and suffering have failed. See for more details Gevers S., *Terminal Sedation: A Legal Approach,* European Journal of Health Law 2003, 10: 360.

is called euthanasia”[8]. Some authors distinguish active euthanasia-which implies on active gesture or action from a third party, through the use of substances or the interruption of heavy treatments -from passive euthanasia-which occurs when the patient is not cured, or is not resuscitated. In both cases the will to cause death is the same, even if the means employed differ. This is either an active killing, or an omission causing death. According to criminal law the latter may also amount to murder and can therefore be prosecuted in criminal courts[9].

In fact, some people talk about *the right to die*, expression which does not denote man's right to cause its own death or to require death to be caused onto them as desired ,but the 'right to die with total serenity, with human and Christian dignity”[10].

The debate on legalising euthanasia in Albania has been ongoing for a considerable length of time. Albania law is clear on the legal consequences of euthanasia. It is illegal, in the sense that it offends the criminal law. Legalizing euthanasia in Albania will bring about profound changes in social attitudes toward illness, disability, death, old age and the role of the medical profession. Once euthanasia is legalized, it will increasingly become a 'treatment option', alongside regular medical or surgical treatments. If euthanasia become legal the decision to preserve or to shorten the patient's life or to assist the patient with PAS will be a characteristic of the medical profession. Legalizing euthanasia with increase the power doctors have over their patients and will considerably decrease patient autonomy.

A comparative analysis of euthanasia debate in several states.

Legalising euthanasia and helping others who are suffering to die is debated throughout the world. Few countries have changed their law's traditional prohibition on euthanasia. The best known public policy shift occurred, of course, in the Netherlands with the acceptance of the practice of euthanasia and this has led, most recently, to its formal decrimalisation by the Dutch Parliament. The only other changes have been the short-lived legalisation of euthanasia and assisted suicide in the Northern of Albania and of the latter practice in the State of Oregon in America. Elsewhere in the world, the arguments in favor of and pleas for legal change have fallen on 'deaf ears' despite the knowledge that euthanasia does take place undetected[11].

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[8] Duguet, A., *Euthanasia and Assistance to End of Life Legislation in France*, European Journal of Health Law 8: 109, 2001.

[9] Duguet, A., *Euthanasia and Assistance to End of Life Legislation in France*, European Journal of Health Law 8: 109-123, 2001.

[10] See L.R. Kass, *Is there a right to die?,* Hastings Center Report, 1993, 23, 1. pp. 34-43.

[11] Grubb A., *Euthanasia in England – A Law Lacking Compassion?* European Journal of Health Law 8: 89-93, 2001.

At the moment we have end of life legislation in US states of Oregon[12], Washington[13], Vermont[14] and California[15] the Netherlands[16], Belgium[17], Grand Duchy of Luxembourg,[18] Colombia[19], Canada[20] and Switzerland[21]. One can clearly see that end of life legislation is more the exception than the rule. The Netherlands become the first country in the world to give legal sanction to same forms of assisting suicide and euthanasia (1984).The Dutch supreme Court declared that although killing a patient remains a criminally punishable offense under the nation's Penal Code, physicians can claim an ''emergency defense" under certain circumstances. In the Netherlands, until 2002 euthanasia and physician assisting in suicide were only allowed on the basis of court decisions. The question whether the Criminal Code should be changed to bring existing legislation more in accordance with medical practice has been a matter of extensive debate from 1984 onwards (the year in which the Supreme Court acquitted a doctor who had performed euthanasia).After almost 20 years, the Termination of Life on Request and Assisted Suicide (Review Procedures) Act came into force on April 1, 2002[22].

Most health legislation in the Netherlands is subject to systematical, periodical evaluation studies. At the end of 2004, the Ministries of Health and of Justice ordered an assessment of the new law. This evaluation should not only concern its legal qualities (e.g. consistency with internationally law, relation to other national laws, legal clarity etc.) but also its functioning in practice (knowledge of and attitudes towards the Act; adherence of physicians to the due care requirements and to the duty to report euthanasia or assisted suicide to the municipal forensic pathologist; the performance of the review committees and the public prosecution in carrying out their tasks under the Act; efficacy and side effects of the Act etc.). In

[12] OREGON PUBLIC HEALTH DEVISION, Oregon death with dignity act: 2015 data summary, Oregon, Oregon Health Authority, 4 February 2016, 1.

[13] WASHINGTON STATE , The Washington Death with Dignity Act, Washington, Washington State Legislature, 4 November 2008, http://app.leg.wa.gov/rcw/default.aspx?cite=70.245 (consulted 20 April 2017)

[14] VERMONT GENERAL ASSEMBLY, Patient Choice at End Of Life, Vermont, Vermont Statutes Online, 4 March 2009, http://legislature.vermont.gov/statutes/chapter/18/113 (consulted 20 April 2017)

[15] CALIFORNIA, Bill AB-15 End Of Life, California, California Legislative Information, 9 June 2016, https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id= (consulted 20 April 2017)

[16] NETHERLANDS, Wet van 12 April 2001 houdende toetsing van levensbeëindiging op verzoek en hulp bij zelfdoding, http://wetten.overheid.nl/BWBR0012410/2014-02-15 (consulted 20 April 2017)

[17] BELGIUM, Wet van 28 May 2002 betreffende de euthanasia, Belgisch Staatsblad, 22 juni 2002.

[18] LUXEMBOURG, Loi de 16 March 2009 sur l'euthanasie et l'assistance au suicide, Mémorial A n° 46, 16 March 2009.

[19] REDACCION SALUD, "EPS deben garantizar el derecho a la muerte digna", El Tiempo, 17 April 2015, http://www.eltiempo.com/estilo-de-vida/salud/eutanasia-ministerio-de-salud-expide-protocolo-para-atendercasos-de-muerte-digna-en-colombia/15587816

[20] CANADA, "Bill C-14 to Amend the Criminal Code", Statutes of Canada 2016, 17 June 2016.

[21] Article 115 of the Schweizerischen Strafgesetzbuches.

[22] Gevers S., *Selected Legislation and Jurisprudence Evaluation of the Dutch Legislation on Euthanasia and Assisted Suicide*, European Journal of Health Law 14 *(2007) 369-379.*

connection with this evaluation of the Act, extensive research has been carried out so as to provide insight into practical developments in medicinal decision making at the end of life. Large nation-wide studies of this kind had already provided data on the frequency and characteristics of euthanasia, physician suicide and other medical acts that may hasten death in the past.

These large scale studies of medical practices at the end of life were conducted in 1990,1995 and 2001.The evaluation of the 2002 Dutch law offered a good opportunity for a follow-up on these previous studies, also to assess the effects of the law on end-of-life care. The evaluation report was published in May 2007. On the whole, the report gives a positive picture both of the law and of medicinal practice as it has evolved over the years. In general, the law has achieved its objectives well. The frequency of euthanasia and assistance in suicide has decreased and the percentage of cases reported has increased. There does not seem to be any question of a slippery slope with regard to life termination, either with or without the request of the patient. Although these is, therefore, little incentive for substantial changes to the present arrangements, the evaluation study has demonstrated that there are specific points on which both the law and existing practice may be improved. It ends therefor with a number of recommendations pertaining to the law, recommendations to improve law-related procedures, recommendations concerning training and provision of information, recommendations with regard to guidelines and institutional policies, and other recommendations. When a law has been evaluated, the government is expected to give its opinion on the results and to inform parliament to what extent it will implement the recommendations. For the present Dutch government, euthanasia is more than ever a sensitive issue since it rests on a coalition of Christian parties and the Social – Democratic Party. There is little or no room to alter the delicate balance that has been achieved between 'pro life' and 'pro choice' approaches. Until now, the government has not yet responded to the evaluation study in detail, but it has already announced that it will not make any proposals to change the law; no more will any other liberalization be allowed. Let's see at this moment other situations of the end of life in several countries who did not accept euthanasia.

England: English law is clear on the legal consequences of euthanasia. It is illegal, in the sense that it offends the criminal law. Deliberately taking another person's life amounts to the crime of murder and carries a mandatory life sentence. Likewise, helping another to commit suicide is a crime punishable with a maximum term of imprisonment of 14 years. That either of these is done with the consent of the individual is irrelevant, as are the "good motives" of the killer, that the individual is terminally ill and close to death anyway or that they are a doctor because there is no special exemption from the law. In short, English law has always, and continues to see no difference in principle between euthanasia and any other deliberate killing.

In the UK, the euthanasia debate has focused largely on voluntary active euthanasia (VAE) and patient-assisted suicide (PAS) which from the tip of an iceberg of euthanasia instances[23]. There are, however, two circumstances where the law does allow a different, less harsh response to compassionate killing. First, in circumstances where a person kills a suffering, it is often possible for the court to lower the criminal charge from murder to manslaughter on the grounds of diminished responsibility[24]. The defence arises where it can be shown that ''an abnormality of mind" has ''substantiality impaired his mental responsibility". Where a relative is driven to kill a suffering relative, this partial statutory defence to murder many be satisfied or, at least, be taken to be satisfied by a benevolent prosecutor and court. As the punishment for manslaughter is a matter for the judge, it is likely that a much more lenient punishment will be imposed, depending, of course, on the circumstances, and this may even result in a non-custodial sentence begin imposed by the court. Because of the nature of the defence, however, it is not in practical terms available to a doctor who 'eases the passing' of his or her suffering patient. A doctor is extremely unlikely to be able to show that the situation has produced the necessary psychiatric effect upon him.

Secondly, the courts have recognised that a doctor may prescribe and administer necessary pain relief to a patient even if this shortens the life of the patient. Sometimes it is said that is an application of the 'principle of double effect' in English law. Providing the doctor's primary motive is to relieve suffering and not to kill the patient, he will not act illegally if he acts in the patient's ''best interests" when managing their pain. It is also reflected in American and Canadian jurisprudence and in legislation in Australia. The precise legal basis for this in uncertain and it is not unproblematic. Nevertheless, it is clearly accepted by the courts and o doctor need not fear the law if he acts reasonably in administering pain relief whether that is to avoid 'physical' pain or extreme mental or psychological suffering.

Judges are reluctant to be drawn into resolving the policy arguments for and against allowing euthanasia and assisted suicide[25]. The balancing of these arguments

[23] M. Sayers *Non-Voluntary Passive Euthanasia: The Social Consequences of Euphemisms* European Journal of Health Law 14 (2007) 221-222.

[24] See Tepshi, A., *E drejta e jetës. Mbrojtja e kësaj të drejte referuar nenit 2 KEDNJ.* **Çështjet** *e fetusit, abortit dhe eutanazisë*. Doctoral Thesis, Tirane, 2016, p.17.

[25] Non-voluntary passive euthanasia, the commonest form of euthanasia, is seldom mentioned in the UK. The legal reasoning in *Airedale NHS Trust v Bland* contributed towards this conceptual deletion. By upholding the impermissibility of euthanasia, whilst at the same time permitting 'euthanasia' under the guise of 'withdrawing futile treatment', it is argued that the court (logically) allowed (withdrawing futile treatment and euthanasia). The *Bland* reasoning was incorporated into professional guidance, which extended the court's ruling to encompass patients who, unlike Anthony Bland, were sentient. But since the lawfulness of (withdrawing futile treatment and euthanasia) hinges on the futility of treatment, and since the guidance provides advice about withdrawing treatment from patients who differ from those considered in court, the lawfulness of such 'treatment decisions' is unclear. Legislation is proposed in order to redress the ambiguity that arose when moral decisions about 'euthanasia' were translated into medical decisions about 'treatment'. See M. Sayers *Non-Voluntary Passive Euthanasia: The Social Consequences of Euphemisms* European Journal of Health Law 14 (2007) 221-240.

is seen as being within the competence of the democratically elected legislature. English law may have entered a ' rights based' era but this will not affect the law as it pertains to euthanasia. The absolute prohibition seems destined to remain for the foreseeable future[26].

France. In France, euthanasia is discussed more from a philosophical than a legal point of view. While abundant materials on the sociological or ethical approach of death have been published, the legal aspect has been neglected, and deals primarily with comparative law[27]. In France, two opposing factions of opinion exist: (1) those people that condemn euthanasia as a breach to the respect of human life; and (2) those that defend it as a right to die in dignity. Medical professionals dealing with this issue act according to their conscience, gathering with their team to make an appropriate decision, in the respect of deontology. Through the years, various projects of propositions for laws have been prepared. But, no one has passed yet. Accepting euthanasia in exceptional circumstances carries also risks. For instance, the exception of euthanasia might create a duty of ending life, and put a social pressure on elderly or sever handicapped people[28].

Nowadays, 70% of people die in hospitals so, supporting end of life and death, needs the active cooperation of health professionals. All of them are very respectful of their duties. In the proposals for new legislation, physician are involved in the help of ending live. Among the defenders of death with dignity, some physicians would not agree with legislation allowing for active euthanasia, rather, they would prefer a law on the living will with anticipated medical recommendations. However, in their decision to support life until death, other physicians want to develop palliative cares and reconcile the patient's family with death, and society with the terminally ill patients and their families[29].

Spain. The debate on euthanasia in Spain has been ongoing from the beginning of the 20th century and remains extant. Perhaps the most aspect of this debate concerns the meaning of words. It has not proved easy for citizens, jurists, theologians, health professionals and bioethicists to reach agreement in relation to the manner of designating the various possible actions that may take place at the end-of-life: patient refusal of treatment, withholding or withdrawal of futile therapies, palliative sedation, and etc.[30]. Three periods can be identified: prior to

[26] Grubb A., *Euthanasia in England – A Law Lacking Compassion?* European Journal of Health Law 8: p.91, 2001.

[27] Duguet, A., *Euthanasia and Assistance to End of Life Legislation in France*, European Journal of Health Law 8: 109-123, 2001.

[28] See Tepshi, A., *E drejta e jetës. Mbrojtja e këtaj të drejte referuar nenit 2 KEDNJ.* **Çështjet** *e fetusit, abortit dhe eutanazisë*. Doctoral Thesis, Tirane, 2016, p.150.

[29] See Duguet, A., *Euthanasia and Assistance to End of Life Legislation in France*, European Journal of Health Law 8: p. 120.

[30] Simón-Lorda P., Barrio-Cantalejo, *End-of-Life Healthcare Decisions, Ethics and Law: The Debate in Spain,* European Journal of Health Law 19 (2012) 355-365; See Tepshi, A., *E drejta e jetës. Mbrojtja e*

1978, 1978-2002, and after 2002. The debate increased significantly after the *Ramon Sampedro* case (1995-1998)[31], and was fuelled with new, although very different cases, such as those of *Leganés* (2005-2008), *Jorge Leon* (2006)[32] or *Inmaculada Echevarría* (2006- 2007)[33].

As a consequence of these cases in 2008 the Regional Government of Andalusia started a legal process to pass a law regulating end -of-life decisions, excluding

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kësaj të drejte referuar nenit 2 KEDNJ. **Çështjet** *e fetusit, abortit dhe eutanazisë*. Doctoral Thesis, Tirane, 2016, p.142.

[31] The *Ramón Sampedro* case, shook Spanish society between 1993 and 1998. Ramón Sampedro had been a quadriplegic patient for 25 years (1968) as a result of an accident that fractured a cervical vertebra. Sampedro began his personal fight to be allowed to die voluntarily in 1993. In 1995, he petitioned the judge to allow his doctor to administer medication that would allow him to die. His request was rejected. His case provoked a great deal of social debate, giving rise to frequent appearances of Ramón in the media. Sampedro, with the aid of the "Association for the Right to a Dignified Death", filed successive appeals before various courts, including the Constitutional Court and the European Court of Human Rights. His requests were always rejected by the courts, even when he had already died.6 In the early hours of the morning of 12 January 1998, Sampedro committed suicide by taking cyanide, assisted by an anonymous party. Criminal proceedings were initiated against the person or persons who aided his death. However, the case was dismissed as the culprit could not be found. Ramón Sampedro made a video recording of his death and took steps to have the tape delivered to television stations. Its airing caused a huge impact at both national and international levels. As a direct result, the Spanish Senate created a "Special Commission for the Study of Euthanasia", which completed its task without reaching agreement or making specific proposals.

[32] The *Jorge León* case, a 53-year-old man who, in 2000, as a result of a domestic accident, became a quadriplegic and dependent on a respirator. Via his blog — he was able to use a computer via an adaptor — he had been requesting a "helping hand" for a year that would aid him to disconnect his respirator and thereby "die with dignity". His doctors and the health administration of the Autonomous Region of Castile and Leon stated that his request constituted "euthanasia", and was therefore illegal. But the "helping hand" appeared on 4 May 2006 and Jorge León's respirator was switched off. This is a very sad case, as Jorge León could have achieved, in a tranquil manner, even publicly, the execution of an action that only proved possible in secrecy.

[33] On 18 October 2006, the patient Inmaculada Echevarría requested the permission of the Board of Directors of the San Rafael Hospital in Granada, in the autonomous region of Andalusia, where she was admitted, to give a press conference and publicly ask to be sedated and have her respirator disconnected, on which she had been dependent for approximately 10 years as a result of a degenerative muscular condition. Undoubtedly the *Echevarría* case, along with the occurrences in Leganés, marked a turning point in the debate on dignified death in Spain. Inmaculada made her request as a conscious, capable and informed adult suffering from a chronic, irreversible and progressive condition, which nevertheless was not terminal. The case was transferred to the Consultative Board of Andalusia, the highest consultative body for legal matters of the Regional Government of Andalusia. The Board finally reached the following conclusions: 1. The request for the limitation of therapeutic effort and the withdrawal of mechanical ventilation issued by Ms I.E.R. is in keeping with the law. 2. The actions of the healthcare professionals who disconnect the mechanical ventilation, (. . .) cannot be considered subject to sanction. Thus, in the opinion of the Board, the actions of the professionals cannot be classified under the criminal infractions outlined in Article 143 of the Penal Code. On 14 March 2007, Inmaculada Echevarría, having bid farewell to her friends and the healthcare team attending her, was sedated and disconnected from the respirator. In the days following her death, the extreme right-wing party *Alternative Española* lodged an official complaint before the State Prosecutor's Office attached to the High Court of Justice of Andalusia, against the doctors attending Inmaculada Echevarría and the Consultative Board. The State Prosecutor decided to close the case on the 26 September 2007.

euthanasia and assisted-suicide, which was finally enacted in 2010. Two other Spanish regions (Navarra and Aragón) passed similar laws[34]. The long road travelled to date has given rise to three important accomplishments. The first involves clarifying the precise meaning in which the word ''euthanasia'' is to be employed, accepting the definition afforded by Article 143.4 of the Penal Code.

The second involves accepting that healthcare decisions such as the limitation of futile treatments, patient rejection of treatments and palliative sedation should not be labelled as ''euthanasia''. The third involves accepting that such actions are not euthanasia, but rather actions that are completely acceptable on ethical and legal grounds, which are not subject to the aforementioned Article 143 of the Penal Code. As a result, such actions can be regulated by regional laws, as is the case in the autonomous regions of Andalusia, Navarre and Aragon.

In Spain, euthanasia and assisted suicide are the only healthcare practices related to end-of-life healthcare interventions that are prohibited to both citizens and healthcare professionals, whilst the remaining actions are legitimate[35]. Law 41/2002 for the Regulation of Patient Autonomy and Rights and Obligations with Regards to Information and Clinical Documentation represented a milestone in the configuration of the new doctor/patient relations, presenting the concept of informed consent as an act of participation in the decision-making process, as the central axis of this relationship. The law intended to remedy the deficiencies of the Bill of Rights contained in the General Law on Public Health (1986). In terms of the concept of a dignified death, this law made three important contributions: First, the central concept of informed consent, with the repercussions that this entails in terms of the right to the truth and participation in the decision-making process, such as decisions relating to palliative care; secondly, the clarity with which it established the right to refuse treatment or withdraw consent that was previously granted (Articles 2.3,2.4 and 8.5); and thirdly, the regulation of decisions relating to proxies in Advance Directives (Article 11), which had been repeatedly requested, as stated above. However, the application of this law to end-of-life decisions did not prove as clear and direct to many people as we might have assumed. The shadow of the word "euthanasia', the adjectives ''active'' and ''passive'' and the endless controversy surrounding ''action'' and ''omission'' gave rise to constant debate[36].

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[34] See Law 2/2010, of 8 April, on Personal Rights and Guarantees to Die in Dignity". The objective of this law is to regulate the various aspects of healthcare at the end-of-life, particularly, decision making in this situation. However, this law does not regulate euthanasia or assisted-suicide. Following the passing of the Andalusian law, other autonomous regions initiated their own legislative projects, taking the Andalusian text as the cornerstone. In March 2011, two autonomous regions, Navarre and Aragon, passed their own laws on "dignified death".

[35] Simón-Lorda P., Barrio-Cantalejo, *End-of-Life Healthcare Decisions, Ethics and Law: The Debate in Spain,* European Journal of Health Law 19 (2012) p. 356.

[36] See Simón-Lorda P., Barrio-Cantalejo, *End-of-Life Healthcare Decisions, Ethics and Law: The Debate in Spain,* European Journal of Health Law 19 (2012) 355-365.

Time to Legalise euthanasia in Albania?

In Albania euthanasia is illegal. It consists of the intentional killing of another person. There are no defences available to doctors who kill in such circumstances. Hence, it amounts to murder-the most serious offence in the Albania legal system. In Albania there is no political, legislative or prosecutorial interest in prosecuting doctors who killed terminally ill patients with only days or weeks to live. Quite simply doctors in Albania are not prosecuted of euthanasia. The next informed doctor who is contemplating euthanizing a patient knows (as he or she did at the time of the survey) that the chances of him or her being prosecuted (let alone convicted) should he or she proceed are about zero.

The debate on the right to die is more relevant than ever. Euthanasia and physician-assisted suicide are at the core of this ethical and legal discussion[37].While it is partly an ethical discussion, the result of this debate will lead to either end of life legislation or to refusal to legalize euthanasia, physician-assisted suicide or both. In other words, when writing about a right to die from a legal point of view- in this paper from a human rights law angle- the ethical debate cannot be ignored, since it is a necessary prerequisite to come to righteous legislation on end of life decisions. One could describe this debate as an intersection where humanities, law, medicine and also religion meet each other. Both opponents as supporters of a right to die with dignity utilize various arguments to support their case. Often these arguments are connected with each other. Sometimes the arguments are rather similar but they are interpreted in a different way.

However, in this paper we argue that euthanasia violates the right to life and, especially, socio-economic aspects in Albania are obviously not suitable to legalise euthanasia and assisted suicide. Some arguments against a right to die are sanctity of life, fear of ab use and the slippery slope legalizing euthanasia or physician-assisted suicide would cause. Proponents claim that a person has the right to choose to die because of his or her personal autonomy, their quality of life and respect and concern for others people autonomy and self-determination[38].

Sanctity of life. The sanctity of life argument is a main argument of opponents to euthanasia and physician-assisted suicide. This argument has religious fundaments. Some claim that it therefore has no place in our pluralistic society of life argument claim that a human life is scared. Life is valuable in itself, regardless of any goals you may or may not be able to pursue. People supporting the sanctity of life argument do not accept the idea that life at a certain point is no longer worth living. The

[37] Diaconescu, A.M., *Euthanasia*, Contemporary Readings in Law and Social Justice, 2012, 475.

[38] Cohen-Almagor, R., "Right to die", Encyclopedia of Global Bioethics, 2014, 5 (http://www.hull.ac.uk/rca/docs/articles/Right%20to%20Die.pdf), consulted 25 October 2017.

sanctity of life argument considers that every life has an intrinsic dignity that must be protected[39].

The illusion of autonomy, fear of abuse and the slippery slope. People who reject a right to die do not accept the main argument that the Kantian perception of autonomy enables the rational individual to make a conscious choice for death. They say that genuine autonomy is ab illusion.

A first reason why they say that there is no real autonomy is because that the choice to die is made in a context of pain and suffering. Can one really make a choice, a life ending one, fully autonomous, when in pain? In this context of sickness psychological impairment will often be the case and this may affect the autonomous thinking of the patient who wants to die[40]. Another argument that must be taken into account is the fact that some people are very susceptible to the influence of others. People might start feeling like a burden on society and on their surroundings. Some people, although they prefer life over death, will choose, some sick persons will feel a moral pressure coming from society and their surrounding family, maybe even subconsciously, to end their lives. This cannot be called a free and autonomous choice.

In the light of the concerns that a genuine autonomous decision on the end of life is not always guaranteed is the fear that end of life legislation can be abused. That a patient can feel a kind of subconscious social pressure is already mentioned. What if this pressure is more directly? Sick persons are often dependent on their family, doctor and nurses. They are in a weak positions, and if a doctor or a family member argues for euthanasia or physician-assisted suicide one can be pushed towards choosing for euthanasia. Opponents of euthanasia and physician-assisted suicide laws claim that society should protect its weakest members. They claim that allowing end of life measures opens a door for abuse that will affect the weaker members of societies. Connected to this fear of abuse argument is the slippery slope argument. This slippery slope argument means that legalizing voluntary euthanasia ,founded on the arguments of autonomy, would lead in the end to euthanasia for people who are nor capable anymore of fully exercising their autonomy. Doctors are professionals and judge on medical intervention.

The slippery slope argument argues that some doctors will use the trust and influence they have on their patients to push them towards an end of life decision. The safeguards and notions of suffering will evolve in a direction where they are interpreted more broadly. This will lead to euthanasia for newborns, people with dementia and etc... It would lead to cases of involuntary euthanasia where autonomy is no longer a decisive factor. Indeed it must be observed that for there are discussions on the fact whether or not they are still lucid or not[41].

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39 Keown, J., "The Legal Revolution: From Sanctity of Life to Quality of Life and Autonomy", Journal of Contemporary Health Law and Policy, 1998, 256-257.

40 Hartling, O.J., "Euthanasia - The Illusion of Autonomy", Medicine and Law, 2006, 192-193.

41 See Cohen-Almagor, R., "Right to die", Encyclopaedia of Global Bioethics, 2014, 5 (http://www.hull.ac.uk/rca/docs/articles/Right%20to%20Die.pdf), consulted 25 October 2017.

Dignity. This is probably the most important argument yet also the most difficult one. It is one of the most important ones because both opponents and proponents of end of life legislation use the concept of dignity. In the paragraphs above dignity is mentioned in the light of the sanctity of life argument, since dignity is considered to be an intrinsic part of life. However, dignity is also used in the light of autonomy and more specifically in the light of the notion of quality of life. Here the supporters of euthanasia and physician-assisted suicide say that life at some points loses its dignity because patients experience suffering and pain. It is up to the patient to decide whether or not his life still has dignity, it is not an intrinsic part of life as such. This, it seems like dignity is an overarching principle. Not without reason problems talk about their fight for 'dying with dignity'[42]. Moreover, the concept of dignity plays an important role in human rights law. Exploring the notion of dignity allows us to test the ethical conception of dignity to the meaning of dignity in human rights law. This relation between dignity in ethics and human rights law can be then be related to the idea of a right to die with dignity and whether such a right can be derived from human rights law[43].

In this context it is important to know that dignity is also an important concept in human rights law. Is the concept of dignity in the light of human rights comparable to the notion of dignity in the end of life debate and does, in the name of dignity in human rights law, a right to die exist?

Dignity has been a rather important concept with various meaning in the history of philosophy and ethics. However, only in the 20th century the concept became important in the domestic and international legal sphere. Human dignity is referenced and used in various human rights instrumental since the Second World War. Much like is the case with dignity in the light of ethics and specifically bioethics. The starting points of modern human rights law must be attributed to the creation of the Universal Declaration of Human Rights by the General Assembly of the United Nations[44]. This complexity surrounding dignity continues

[42] Hartling, O.J., "Euthanasia - The Illusion of Autonomy", Medicine and Law, 2006, 192-193.

[43] Cohen-Almagor, R., "Right to die", Encyclopaedia of Global Bioethics, 2014, 5 (http://www.hull.ac.uk/rca/docs/articles/Right%20to%20Die.pdf), consulted 25 October 2017.

[44] The preamble of this declaration, which is in its entirety nothing more than soft law, states in its very first sentence: "Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world". The UDHR presupposes therefore that there is an inherent dignity that every human being possesses solely because of the fact of being a member of the human species. Article 1 declares: "All human beings are born free and equal in dignity and in rights. (...)." This notion of dignity further enhances the idea that dignity is intrinsic and equal for all human beings. There is no level of dignity and the UDHR even seems to see dignity as a foundational element for human rights law. However, in two other articles human dignity is also mentioned, namely article 22 and article 23 (3). Here the context is different though. Article 22 of the UDHR is about social security and economic, social and cultural rights necessary to live with dignity, article 23 (3) is about a fair remuneration to live a dignified life. In this sense, dignity is used more on a personal level in an aesthetical context. It is not exactly the same as dignity in the sense of being the intrinsic worth of every human being. It seems that dignity, from the start, is a concept with different meanings, much like in ethics.

to exist when analyzing the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights[45]. Other international human rights treaties make reference to dignity as well. The Convention against Torture states in its preamble that human rights are derived from the inherent dignity of the human person, but does not mention dignity in any of its binding articles. The same goes for the Convention on the Elimination of All Forms of Discrimination. Only in the preamble reference is made to the dignity that is inherent to humans. Clearly, dignity became an important concept in international human rights treaties.

The Convention on the Rights of Persons with Disabilities mentions dignity multiple times, in its binding articles but also in the preamble. Again, the exact meaning of dignity remains unclear. Sometimes dignity is said to be inherent, while sometimes it is about education to foster the 'sense of dignity'.160 Also the Convention on the Rights of the child mentions dignity in an ambiguous way, both inherent and more in the sense of a personal assessment. Lastly, the International Convention on the Protection of the Rights of All Migrant Workers and Members of their families mentions dignity two times, in article 17 where it is said that the living conditions of migrant workers must respect and in article 70,where it is said that the living conditions of migrant workers must respect the principals of human dignity. Again apart from the mentioning of inherent dignity, there is no genuine definition for the concept of dignity. In the Universal Declaration on Bioethics and Human Rights of UNESCO of 2005 dignity is mentioned multiple times but again never really explained. Earlier there was also the Universal Declaration on the Human Genome and Human Rights of 1997.It is said that this instrument made the first connection between the progress in the field of science and medicine and the concept of human dignity.

While human dignity is not clearly defined in these international human rights treaties and declarations, it seems to be a fundamental aspect of human rights law.

[45] The ICCPR states in its preamble: "(...) Recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world, (...)" and "Recognizing that these rights derive from the inherent dignity of the human person". Again, the preamble is not a binding element of the treaty, but it does illustrate how dignity seems to be perceived in international human rights law. The language in the preamble of the ICESCR is very similar: "Recognizing that these rights derive from the inherent dignity of the human person". It seems that both preambles give again a foundational interpretation to human dignity. Human dignity is where human rights are derived from, according to the preambles, and every human being possesses this because of the fact they belong to the human species. However, in the binding articles of the ICCPR only in article 10 (1) 'inherent dignity' is mentioned again. This is in line with how the preamble of the ICCPR describes dignity. However, in the ICESCR also only one article, article 13 (1) about education, mentions dignity. It states that education must be directed to developing the human personality and to developing the sense of dignity of every person. In this way, this reminds of dignity as something that is a personal interpretation. Dignity, that is to say, the sense of dignity, is something that can be achieved by education. This puts dignity more on a personal level than defining it as an intrinsic quality that belongs to every human being, regardless of sex, education, race, illness and etc.

It refers to dignity in most instances as being an inherent human trait. While not a treaty and therefore not a binding instrument, there was a World Conference on Human Rights in 1993 in Vienna where 171 states adopted unanimously the Vienna Declaration and Programme of Action regarding human rights, In this declaration it is stated that: ''Recognizing and affirming that all human rights derive from dignity and worth inherent to the human person". On top of that the Vienna Declaration connects human dignity to a wide variety of human rights areas. Opposed to the other instrumental discussed above, where dignity was only sporadically mentioned in binding articles on substantive human rights, the Vienna Declaration sees dignity as an underlying principle in human rights areas, from the rights of indigenous peoples to the abolition of gender-bases violence. The Vienna Declaration also connects dignity to the area of biomedical and scientific developments, stating that these developments could have adverse effects for human's rights and the dignity of the individual. This is again a justification to discuss euthanasia and physician-assisted suicide in the context of human rights, since this bioethical discussion saw the light of day partially because of the progress of science and biomedicine.

Unfortunately, case law on the right to die debate in international and regional human rights law is limited. There are some cases at the ECTHR where end of life measures are the core of the case. Analyzing these cases allows further scrutinizing euthanasia and physician assisted suicide in the light of human rights law[46]. The most important case where the ECtHR rendered a judgment on dying with dignity is the case of *Pretty v.UK*[47]. Other case law on the matter is scarce. Only three cases where euthanasia or physician-assisted suicide was the issue have been declared admissible and a judgment was made. Two cases were against Switzerland, where assisted-suicide is legal. In *Haas v.Switzerland*[48] a man suffering from severe mental problems claimed he could no longer live in dignity. He wanted to die but was refused a prescription for medication to commit suicide, since he did not meet the requirements necessary. A last case where the ECtHR judged in the context of assisted suicide was the case of *Koch v.Germany*[49]. The applicant his wife was paralyzed and wanted to end her 'undignified' life. She wanted permission from the German authorities that, after she legally would obtain a deadly drug in Switzerland under the assisted-suicide law, she could use it in her home in Germany. This was denied by Germany and the wife committed suicide in Switzerland. Germany said allowing her to bring and use that drug in Germany violates the right to life, protected in the Basic Law.

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[46] See Tepshi, A., *E drejta e jetës. Mbrojtja e kësaj të drejte referuar nenit 2 KEDNJ.* **Çështjet** *e fetusit, abortit dhe eutanazisë*. Doctoral Thesis, Tirane, 2016, p.112.

[47] ECtHR, Pretty v. UK, 29 April 2002.

[48] ECtHR, Haas v. Switzerland, 20 January 2011.

[49] ECtHR, Koch v. Germany, 19 July 2012.

Conclusions

The debate on dying with dignity is raging in western society. More and more countries are legalizing end of life measures such as euthanasia and physician assisted suicide. Dignity is the main and overarching argument of both opponents and supporters of euthanasia and physician assisted suicide. In the name of dignity, proponents even claim that there is such a thing as a right to die.

The core of the matter is that the argumentation of supporters of a right to die claim that end of life decisions should be legal, in the name dignity based on personal authority and free choice. In Albania as well. Fear of abuse, the fear that a choice may not be entirely free, is countered by the statement that legislation can have built in safeguards that make sure each patient chooses to die, free and autonomously. In the right to die debate, opponents of legalizing physician-assisted suicide or euthanasia refute this interpretation of dignity. Opponents claim the exact opposite. Their main arguments, such as sanctity of life and a fear of abuse, can be seen under the overarching umbrella of dignity.

The main problems opponents of a right to die will invoke in favor of basic dignity are the fear of abuse and the slippery slope arguments. The fear of abuse doubts that a free and autonomous choice can always be guaranteed. Influence by their social environment as well as their physician cannot be excluded. For something as serious as choosing to die this cannot be accepted. A society where choosing to die becomes more accepted, patients, certainly patients that are 'weaker' and more subject to the influence of their surroundings, are subject to judge their quality of life by the standards of said society. This risk cannot be completely remedied, opponents of a right to die say.

However, human rights are said to be universal. Even when only focusing on human rights in Western society there is no agreement on a right to die. Not in human rights law, but also not in ethics. As long as that is not the case, a genuine human right to die dignity cannot be derived from human rights law.

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