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A right to die: a comparing discourse of case laws in united states of america, european court of human rights, united kingdom and albania

ABSTRACT

As human beings we are bound up with the medical profession. It is certain that at some point in our life we rely on their help. Even if such help is avoided throughout life, some life activities involve recourse to medical care.

During the exercise of its activity the medical profession is faced with many ethical dilemmas, where the solution is not in the law, where choice and decision making become difficult in terms of ethics and where they must rely on their values and judgments. That's why the involvement of the medical profession in everyone's lives makes the understanding of the law governing the medical profession extremely important. Patient rights are part of human rights.

This article's aim is to present one important patient right - the right to die. Whilst is accepted the increasing role of the medical profession in determining the shape of the law in medical care, this article focuses on understanding how different courts deal with cases involving the right to die. The article offers a framework on patient's right to die in the United States of America, Europe, United Kingdom and Albania.

Key words: assisted suicide, case law, euthanasia, right to die, right to life, physician

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1. Is there a right to die?

At the heart of liberty is the right to define one's own concept of existence, of meaning of the universe, and of the mystery of human life.¹ As Abraham Lincoln, speaking in Baltimore in 1864 said, the understanding of rights, life and liberty is different for different people.²

The right to die raises many difficult questions in medical care: What is the right to life? When life, and therefore the right to protection of life by law, begin or end? May, or must, the state protect the right to life even of a person who does not want to live any longer, against that person's own wishes? Is it acceptable to provide palliative care to a terminally ill or dying person, even if the treatment may, as a side-effect, contribute to the shortening of the patient's life? Should the patient be consulted on this? Do people have, not just a right to life and to live but also a right to die as and when they choose? Do they have the right to decide on what they consider to be a "good death"³? Can they seek assistance from others to end their lives? Can the state allow the ending of life in order to end suffering, even if the person concerned cannot express his or her wishes in this respect?

The answer to such questions might be easier in cases arising by requests of mentally fit patients, who request to die as they're unable to commit suicide themselves. The situation is very different in cases of patients who cannot express their opinions as are patients in a persistent vegetative state (PVS). In such cases the question that arises is whether they too have a right to die.⁴

The Oxford English Dictionary defines the 'right to die' as 'pertaining to, expressing, or advocating the right to refuse extraordinary measures intended to prolong someone's life when they are terminally ill or comatose.'⁵ Such right includes issues

¹ *Washington v. Glucksberg*, 521 U.S. at 727.

² <http://www.menziesvirtualmuseum.org.au/transcripts/Speech_is_of_Time/print/403_Freedom.pdf> accessed 14.11.2012.

The shepherd drives the wolf from the sheep's throat, for which the sheep thanks the shepherd as his liberator, while the wolf denounces him for the same act as the destroyer of liberty, especially as the sheep was a black one'.

³ The word 'euthanasia' derives from the Greek language meaning 'a good death', <<http://en.wikipedia.org/wiki/Euthanasia>> [accessed 04.03.2013].

⁴ Death is defined in *Chambers Twentieth Century Dictionary* as 'the state of being dead; extinction or cessation of life', <http://archive.org/stream/chambersstwentie00daviiala/chambersstwentie00daviiala_djvu.txt>, accessed 18.03.2013. *Steadman's Medical Dictionary* adds to this 'in multicellular organisms, death is a gradual process at the cellular level with tissues varying in their ability to withstand deprivation of oxygen', <<http://www.drugs.com/dict/death.html>> accessed 18.03.2013. A proper definition of death comes from United States' Uniform Determination of Death Act 1980 which, in essence, states that an individual who has sustained either: (1) irreversible cessation of circulatory and respiratory functions, or; (2) irreversible cessation of all functions of the entire brain, including the brain stem, is considered dead.

⁵ <<http://oxforddictionaries.com/definition/english/right-to-die?q=right-to-die>>, accessed 27.02.2013.

of suicide, active euthanasia (the deliberate action to hasten death), passive euthanasia (allowing a person to die by refusal or withdrawal of medical intervention), assisted suicide (providing a person the means of committing suicide), and palliative care (providing comfort care which accelerates the death process).

It is impossible to talk about a right to die without considering the acts or omissions of the physician. It's obvious that if a family member, friend or relative helps someone die, in the comfort of their own house, they will definitely face prosecution. The situation changes in medical care. Obviously it would be easy for the state to ban any sort of assistance from doctors to help their patients to release suffering and pain, and sanction punishment by law to any doctor that would commit such actions. But then, when talking about patients that can not commit suicide themselves, would such actions be considered as state interference on their right to put an end to their life? Is there such right?

A person may decide to end his or her life not only actively, i.e. committing suicide, but also passively such as refusing life saving treatment, food and water. However, even in such situations the possibility remains that another person will get involved, not to assist in suicide, but to make dying comfortable and painless. Terminally ill people or those unable to commit suicide themselves rely on their doctors to give an end to their lives.

Doctors have a duty of care which consists on diagnosing, treating and advising. These obligations are both moral and legal. Treatment ordinarily aims to benefit a patient through preserving life, relieving pain and suffering, protecting against disability, and returning maximally effective functioning.⁶ A doctor's duty of care is to take reasonable steps (as other reasonable doctors would) to save or prolong life or to act in the patient's best interests.⁷ Although in most instances doctors would prescribe the drug for the purpose of pain relief, it is arguable that at times, they may in fact do so to assist their patients to put an end to their suffering.

When deciding on end-of-life cases judges are faced with some really important questions: Do terminally ill persons have a right to avoid both "severe physical pain" and "the despair and distress that comes from physical deterioration and the inability to control basic bodily and mental functions"?⁸ Is a liberty interest implicated when the state blocks a person from seeking relief from severe pain or suffering? Is there a right to die?

⁶ James J. Walter, Thomas Anthony Shannon, *The Quality of Life: The New Medical Dilemma*, Paulist Press 1990, p.305.

⁷ <http://www.respectingpatientchoices.org.au/index.php?option=com_content&view=article&id=42&Itemid=43>, accessed 26.02.2013.

⁸ *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110).

There are two distinctive views of the right to die: the right to die as a negative right, which requires a duty of non-interference⁹ and calls for non action from others; and the right to die as a positive right, which entails not only a duty of non-interference, but also “the duty to *help*, at least in the cases where the right-holder would not be able to do the thing without help”¹⁰.

In order to benefit from the existing negative right to die, one must be competent to make a decision. Further to this, the person should be physically able to carry out the act of suicide. Therefore, a person contemplating suicide should begin and end the whole process by oneself. Any sort of assistance provided either ‘before the fact’, ‘during the process of attempt to commit suicide’ or ‘after the attempt’, would potentially render the assistant an offender and subject to prosecution.

Some judges are in favor of protecting the right to die, assisted suicide and voluntary euthanasia, while other focus on state’s interest in the protection of life. For those who support this right, it is tempting to argue that the court should recognize the right as fundamental and, under traditional fundamental rights jurisprudence, effectively stop all infringements. The problem with such an approach is that to do so would undervalue the state’s legitimate interest in preserving life in all forms when a state chooses to adopt a pro-life policy. The policy that must be adopted must balance these two interests so that they may coexist to the fullest extent possible.¹¹

There is though, arguably, a “right to die with dignity,” which includes as one of its core aspects a right to avoid “unnecessary and severe physical suffering.”¹² A successful claim to assisted suicide would require a showing of a need to avoid “severe physical pain,” and any physical pain can be avoided with either pain control medications or “sedation which can end in a coma”. Faced with the argument that assisted suicide is the only way to respond to the severe suffering of some dying patients, the courts have observed that these patients can turn to the alternative of terminal sedation.¹³ However, terminal sedation is essentially a form of euthanasia.

⁹ Childress J.F., ‘Negative and Positive Rights’, *The Hastings Center Report*, (1980) Vol. 10, No.1, p 19; *R (Pretty) v DPP (Secretary of State for the Home Department intervening)* [2002] 1 A.C. 800, p 846.

¹⁰ Prema S Matker, *Analyzing Restrictive and Approaches towards Assisted Suicide and Euthanasia*, p 17, <<https://qmro.qmul.ac.uk/jspui/bitstream/123456789/504/1/MATKERAnalysingRestrictive2010.pdf>> accessed 28.02.2013.

¹¹ Michael P. Allen, ‘The Constitution at the Threshold of Life and Death: A Suggested Approach to Accommodate an Interest in Life and a Right to Die’ [2011]. <<http://digitalcommons.wcl.american.edu/cgi/viewcontent.cgi?article=1108&context=aulr>> accessed 23.01.2013.

¹² *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997) (No. 96-110), p 2311 (Breyer, J., concurring).

¹³ *Vacco v. Quill* - 117 S. Ct. 2293 (1997).

Many are of the opinion that withdrawal of life sustaining treatment on patients in a persistent vegetative state is also another form of euthanasia. One possible justification for distinguishing between euthanasia and withdrawal of life sustaining treatment is the distinction between acts and omissions, or between killing and letting die. Treatment withdrawal, which indubitably involves doctors doing something, is a good example of conduct which lies on the boundary between acts and omissions, because it could easily be described as an action. It is by taking into account the surrounding circumstances, and not by labeling what the doctor does as an omission, that we can ascertain whether his conduct is acceptable. The morally relevant fact is not whether what the doctor does is an omission or an action, but rather whether the background against which the decision has been taken justifies the doctor's conclusion that life, in these circumstances, should not be artificially prolonged.¹⁴ Certainly there are cases where refusal of treatment is motivated by the desire to avoid a continued life of suffering and other cases where it is only the treatment itself the individual seeks to avoid.

While deciding on right-to-die cases, the courts have emphasized the distinction between withdrawal of life sustaining treatment and suicide assistance. Withdrawal of life sustaining treatment is permitted because the patient dies from the underlying disease, not from the active intervention of the physician.¹⁵

Opening the door to assisted suicide for terminally ill persons could pose too great a risk of suicide for persons who are not competent, who are not terminally ill, whose desire for suicide would abate with treatment for mental depression or with validation from others of the value of their life, or who are vulnerable to influence by family members and physicians concerned with the financial and psychological burdens of caring for the patient, nevertheless it is working for the Netherlands.¹⁶

¹⁴ Memorandum by Professor Emily Jackson, Chair of Medical Law, Queen Mary, University of London. <<http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/86we13.htm>> [accessed 03.07.2012].

¹⁵ David Orentlicher, *The Supreme Court and Terminal Sedation: Rejecting Assisted Suicide, Embracing Euthanasia*, <http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2028321> p 959.

Although treatment withdrawal is typically distinguished from euthanasia in terms of the objective component of intent, terminal sedation and euthanasia cannot be differentiated on that basis. Treatment withdrawal is distinguished from euthanasia because with the former, the physician might reasonably believe that the patient will survive the discontinuation of treatment. The physician may have misjudged either the patient's dependence on the treatment, or the chances that the patient's condition would improve.⁷ Because it is possible for treatment to be withdrawn and for the patient to survive, we can say that the physician only intends to free the patient from an unwanted treatment. We cannot make a parallel argument for euthanasia. Because euthanasia will relieve the patient's suffering only by killing the patient, the physician cannot reasonably intend for the patient not die. In terms of this distinction between treatment withdrawal and euthanasia, terminal sedation falls on the euthanasia side of the line.

¹⁶ Articles 293 and 294 of the Dutch Penal Code make both euthanasia and assisted suicide illegal, even today. However, as the result of various court cases, doctors who directly kill patients or help patients kill themselves will not be prosecuted as long as they follow certain guidelines. In addition to the current requirements physicians must report every euthanasia/assisted-suicide death to the local prosecutor and that the patient's death request must be enduring (carefully considered and requested on more than one occasion).

The majority of individuals and countries are of the opinion that ... “Legalization of physician-assisted suicide or euthanasia would “undermine the trust that is essential to the doctor-patient relationship” because physicians would be causers of death as well as healers of illness.¹⁷ A right to assisted suicide for the terminally ill inevitably leads society down the slippery slope to assisted suicide for patients, who are not terminally ill.¹⁸ Once we permit assisted suicide for some persons, we will have no principle for denying it to other persons who claim great suffering.”¹⁹

Even though the majorities of states worldwide do not accept and ban any form of assisted suicide, when it comes to decision-making the judges, themselves, are of different opinions. As a result it is very difficult to have a sharp opinion whether accept some sort of assisted suicide or be against any such form.

2. International and Albanian case law on the right to die

the case-law of many countries on the right to die is of a very large number. The legal system of different countries is different. National laws of individual countries are shaped by the history, community values, economics, culture, religious orientation, current predominant legal philosophy, etc. Countries such as The United States of America (USA), The United Kingdom (UK), Canada, Australia, etc. have common law systems in which the law is based on judge-made precedents as well as legislation. Meanwhile countries such as Italy, France, Albania, etc. base their activities primarily on national civil and criminal codes, though their higher courts do make authoritative rulings on the law. National laws of members of the European Union are subject to the European Convention on Human Rights and Fundamental Freedoms (ECHR).

2.1. *United States of America case law*

In the United States the process of dying underwent far reaching changes in the mid- and late-20th century, creating difficult ethical issues for doctors and patients, and eventually, for judges and legislators. The professionalization of the practice of medicine combined with advances in public health and medical technology to change the *when*, the *where* and the *how* of the dying process. The new technology often was seen as merely prolonging the dying process, leading some patients and families to ask courts and legislatures to recognize a ‘right to die’.

¹⁷ *ibid.* (n 12) p 2273.

¹⁸ *ibid.* p 2273-74.

¹⁹ *ibid.* (n 15) p 964.

A right to die was introduced in America since 1906 when the first euthanasia bill, which did not succeed, was drafted in Ohio. In the mid 1960's began right to die movements.²⁰

²⁰ Assisted-suicide is legal in three American states (Oregon, Washington, and Montana).

In America:

The right to assisted suicide was recognized in Washington by the U.S. 9th Circuit Court of Appeals in the case *Compassion in Dying v. State of Washington*. The U.S. Court of Appeals for the Ninth Circuit, sitting en banc, affirmed a district court judgment that ruled unconstitutional a Washington statute banning assisted suicide, as applied to competent, terminally ill adults who wish to obtain prescription medication to hasten their deaths. The statute, which was challenged by a group of patients, physicians, and the nonprofit organization Compassion in Dying, was held to be unconstitutional because it violated the due process clause of the U.S. Constitution. The court took into consideration the interests of the state in protecting life, preventing suicides, preventing undue, arbitrary, or unfair influences on an individual's decision to end his life, and ensuring the integrity of the medical profession. These interests were balanced against an individual's strong liberty interest in determining how and when one's life should end. The court recognized this interest after assessing the growing public support for assisted suicide, changes in the causes of death and medical advances, and Supreme Court cases addressing due process liberty interests. The court then determined that the state's interest, which could be protected by adopting sufficient safeguards, did not outweigh the severe burden placed on the terminally ill, and thus the statute as applied was unconstitutional.

In Oregon such right was recognized in the case *Gonzales v. Oregon* (Docket # 04-623 Jan. 17, 2006). In 1994, Oregon passed the Death with Dignity Act (passed by referendum on 9 November 1994), the first state law permitting physicians to prescribe lethal doses of controlled substances to terminally ill patients. U.S. Attorney General John Ashcroft declared in 2001 that the Act violated the Controlled Substances Act of 1970, and threatened to revoke the medical licenses of physicians who engaged in physician-assisted suicide. Oregon sued the Attorney General in federal district court. The district court and the Ninth Circuit both held that Ashcroft's directive was illegal. The U.S. Supreme Court, in a 6-3 opinion, also held that the Controlled Substances Act did not authorize the Attorney General to ban the use of controlled substances for physician-assisted suicide. "The CSA [Controlled Substances Act] does not allow the Attorney General to prohibit doctors from prescribing regulated drugs for use in physician-assisted suicide under state law permitting the procedure." "The Attorney General has rulemaking power to fulfill his duties under the CSA. The specific respects in which he is authorized to make rules, however, instruct us that he is not authorized to make a rule declaring illegitimate a medical standard for care and treatment of patients that is specifically authorized under state law." "In the face of the CSA's silence on the practice of medicine generally and its recognition of state regulation of the medical profession it is difficult to defend the Attorney General's declaration that the statute impliedly criminalizes physician-assisted suicide."

The right to die was recognized in Montana by the decision of the courts in the case *Baxter v. Montana*. *Baxter v. Montana* was a Montana Supreme Court case, argued on September 2, 2009, and decided on December 31, 2009, that addressed the question of whether the state's constitution guaranteed terminally ill patients a right to lethal prescription medication from their physicians. The original lawsuit was brought by 4 Montana physicians (Stephen Speckart, C. Paul Loehnen, Lar Autio, and George Risi, Jr., M.D.s), *Compassion & Choices* and Robert Baxter, a 76 year old truck driver from Billings, Montana, who was dying of lymphocytic leukemia. The plaintiffs asked the court to establish a constitutional right "to receive and provide aid in dying". The state argued that "the Constitution confers no right to aid in ending one's life." Judge Dorothy McCarter, of Montana's First Judicial District Court, ruled in favor of the plaintiffs on December 5, 2008, stating that the "constitutional rights of individual privacy and human dignity, taken together, encompass the right of a competent terminally-ill patient to die with dignity." Baxter died that same day. The Montana Attorney General appealed the case to the state Supreme Court. Oral arguments were heard on September 2, 2009. Amicus briefs filed on behalf of those asking the court to grant the constitutional right to receive/provide aid in dying include human rights groups, women's rights groups, The American Medical Women's Association/American Medical Students Association, clergy, legal scholars, 31 Montana state legislators and bioethicists, among others. Among the groups filing amicus briefs on behalf of the state are the Alliance Defense Fund on behalf of the Family Research Council, Americans United for Life, the American Association of Pro-Life Obstetricians and Gynecologists, and the Catholic Medical Association. The Montana Medical Association issued a statement opposing physician-assisted suicide, but has refused to file an *amicus brief* in the appeal. On Dec. 31, 2009, the Montana Supreme Court ruled in favor of Baxter. It stated that, while the state's Constitution did not guarantee a right to physician-assisted suicide, there was "nothing in Montana Supreme Court precedent or Montana statutes indicating that physician aid in dying is against public policy."

According to the USA jurisprudence, a competent person has, under the United States' Constitution a liberty interest in refusing unwanted medical treatment but, according to many US courts' jurisprudence, the US Constitution does not recognize a right to die.

In 1976 New Jersey Supreme Court was faced with the decision of the case of *Karen Ann Quinlan*.²¹ When she was 21, Quinlan became unconscious after arriving home from a party. After she collapsed and stopped breathing twice for 15 minutes or more, the paramedics arrived and took her to a hospital, where she lapsed into a persistent vegetative state and was kept alive on a ventilator. After seeing Karen like this for several months, her family finally came to the conclusion that she was beyond hope, and decided to remove her from the ventilator. Hospital officials, faced with threats from the Morris County prosecutor to bring homicide charges against them, joined with the Quinlan family in seeking an appropriate protective order from the courts, before allowing the respirator to be removed. The Quinlan family persevered, and in 1976 they took their case to the New Jersey Supreme Court, which ruled in their favor.

A nationwide controversy over an Indiana couple's 1982's decision to refuse possibly life-saving surgery for their infant son born with severe disabilities led two years later to a federal law prohibiting federally financed hospitals from withholding treatment from infants on the basis of disabilities.²²

In 1990 USA's Supreme Court was faced with the case of *Nancy Cruzan*²³, an incompetent individual who had sustained severe injuries in an automobile accident, and lived in a Missouri state hospital in what was referred to as a persistent vegetative state. Cruzan's parents requested the termination of her artificial nutrition, but hospital's staff refused to honor such request. A state trial court authorized the termination, but the State's Supreme Court reversed. USA's Supreme Court held that most courts have based the right to refuse treatment on the common law right to informed consent²⁴ or on both that right and a constitutional privacy right²⁵. According to the USA Constitution a competent person has a liberty interest, under 14-th Amendment's Due Process Clause, in refusing unwanted medical treatment.

²¹ *Quinlan v. New Jersey*, 70 N.J. 10, 355 A.2d 647 (1976).

²² *Baby Doe v The Prenatal Clinic*, <http://en.wikipedia.org/wiki/Baby_Doe_Law>, accessed 1of December 2012.

²³ *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 279 (1990).

²⁴ *Stonar v. Dillon*, 52 N.Y.2d 363 (1981).

²⁵ *Superintendent of Belchertown State School v Saikewicz*, 373 Mass. 728, 370 N.E.2d 417.

In 1997 USA's Supreme court decided on two cases: *Washington v. Glucksberg*²⁶ and *Vacco v. Quill*²⁷. In the first case, Dr. Glucksberg, along with two other physicians and three gravely ill patients brought suit to overturn a Washington law that made "promoting a suicide attempt" a felony, on the grounds that the statute violated a constitutionally-protected liberty interest under the Due Process Clause of the Fourteenth Amendment. A Federal district court ruled that the law was unconstitutional; a three- judge Court of Appeals for the Ninth Circuit reversed, but the full Circuit Court en banc reinstated the district court's conclusion: that the assisted suicide ban was unconstitutional as applied to terminally-ill, competent adults who wished to hasten their deaths with medication prescribed by their physicians.

In *Vacco v. Quill*, as in the first case, suit was brought by three physicians and three gravely ill patients, challenging the state law against aiding a suicide attempt. The district court found the law constitutional, but a three-judge Court of Appeals for the Second Circuit disagreed, ruling that the prohibition violates the Equal Protection clause of the Fourteenth Amendment. The court's reasoning was that New York law permitted terminally-ill patients to direct the removal of life-sustaining equipment in order to hasten their death, but did not allow those not attached to such equipment to hasten death by self-administering prescribed medication. The court felt that this distinction was untenable, and was not rationally related to any legitimate state interest. The Supreme Court of USA unanimously upheld both the Washington and the New York laws.

Another important case on USA's Supreme Court jurisprudence was that of *Terri Schiavo*.²⁸ Her case lasted from 1998 to 2005 and involved not only the public and the media, but also the then governor J. Bush. Terri collapsed in her St. Petersburg, Florida, home in full cardiac arrest on February 25, 1990. She suffered massive brain damage due to lack of oxygen and, after two and a half months in a coma, her diagnosis was changed to vegetative state. Even though many efforts were made during 1990-1993 to rehabilitate her, her appointed guardian ad litem stated that there was no hope for Terri.

In 1998 her husband petitioned to remove her feeding tube. He was opposed by Terri's parents who argued that she was conscious and relied on Terri's religious beliefs to continue life prolonging measures. Her parents claimed that Terri was a devout roman catholic who would not wish to violate the church's teachings on euthanasia by refusing nutrition and hydration.

²⁶ *Washington v. Glucksberg*, 521 U.S. 702 June 26, 1997.

²⁷ *Vacco v. Quill* 526 U.S. 793 June 26, 1997.

²⁸ *Bush v. Schiavo*, 125 S. Ct. 1086 (2005).

The court determined that she would not wish to continue life-prolonging measures, and on April 24, 2001, her feeding tube was removed for the first time, only to be reinserted several days later. On 2001 five doctors examined Terri Schiavo's medical records, brain scans, the videos, and Terri herself. They concluded that she was in a persistent vegetative state. On February 25, 2005, a Pinellas County judge ordered the removal of Terri Schiavo's feeding tube. Several appeals and federal government intervention followed, which included U.S. President George W. Bush returning to Washington D.C. to sign legislation designed to keep her alive. After all attempts at appeals through the federal court system upheld the original decision to remove the feeding tube, staff at the Pinellas Park hospice facility where Terri was being cared for disconnected the feeding tube on March 18, 2005, and she died on March 31, 2005.

2.2. European Court's of Human Rights case law

Meanwhile, in Europe, most of the countries ban any form of euthanasia or assisted suicide.²⁹ Assisted suicide is legal in Belgium³⁰, Luxembourg³¹, the Netherlands³² and Switzerland³³. Fundamental rights and freedoms of individuals are protected in Europe by the European Convention on Human Rights. Article 2 of such

²⁹ Article 579 of the Italian Criminal Code provides: 'Whoever causes the death of a person, with his consent, shall be punished with imprisonment from six to fifteen years. The aggravating circumstances set out in Article 61 do not apply. The provisions relating to murder apply if the offense is committed: 1) against a person under eighteen years of age; 2) against a mentally ill person, or that is in a state of mental deficiency, for another illness or abuse of alcoholic substances or drugs; 3) against a person whose consent has been convicted by extorted by violence, threat or suggestion, or taken away by stealth.

Article 216 of the German Criminal Code provides: '(1) If a person is induced to kill by the express and earnest request of the victim the penalty shall be imprisonment from six months to five years. (2) The attempt shall be punishable. Section 2 of United Kingdom's Suicide Act of 1961 provides:

'Criminal liability for complicity in another's suicide

(1) A person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be liable on conviction on indictment to imprisonment for a term not exceeding fourteen years. (2) If on the trial of an indictment for murder or manslaughter it is proved that the accused aided, abetted, counselled or procured the suicide of the person in question, the jury may find him guilty of that offence. (3) The enactments mentioned in the first column of the First Schedule to this Act shall have effect subject to the amendments provided for in the second column (which preserve in relation to offences under this section the previous operation of those enactments in relation to murder or manslaughter). (4) ... no proceedings shall be instituted for an offence under this section except by or with the consent of the Director of Public Prosecutions'.

³⁰ The Belgian parliament legalized euthanasia in late September 2002.

³¹ The country's parliament passed a bill legalizing euthanasia on 20 February 2008 in the first reading with 30 of 59 votes in favor. On 19 March 2009, the bill passed the second reading, making Luxembourg the third European Union country, after the Netherlands and Belgium, to decriminalize euthanasia.

³² The Netherlands legalized voluntary euthanasia in 2001.

³³ Article 115 of the Swiss Criminal Code, in effect since 1942, provides: 'Inciting and assisting suicide: Any person who for selfish motives incites or assists another to commit or attempt to commit suicide shall, if that other person thereafter commits or attempts to commit suicide, be liable to a custodial sentence not exceeding five years or to a monetary penalty'. Since the law provides that such acts are considered offences when committed due to selfish motives, other motives are allowed. In Switzerland assisted suicide is legal. Dignitas clinic offers assisted suicide to Swiss citizens and foreigners. Nevertheless, as the clinic's policy provides: 'In every case, for legal reasons, the patient must

Convention protects “everyone’s” right to ‘life’, where ‘life’ is understood as human life. Article 2 of the Convention requires that everyone’s ‘right to life’ be ‘protected by law’. Apart from the death penalty, it envisages only limited circumstances in which a person can be deprived of this right.³⁴ Meanwhile Article 8 of this Convention protects everyone’s right to respect his private and family life.³⁵

The consistent emphasis in all the cases before the European Court of Human Rights (ECHR) has been the obligation of the state to protect life. The Court has not been persuaded that ‘the right to life’ guaranteed in Article 2 can be interpreted as involving a negative aspect. It is unconcerned with issues to do with the quality of living or what a person chooses to do with his or her life. To the extent that these aspects are recognized as so fundamental to the human condition that they require protection from State interference, they may be reflected in the rights guaranteed by other Articles of the Convention, or in other international human rights instruments. Article 2 cannot, without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die; nor can it create a right to self-determination in the sense of conferring on an individual the entitlement to choose death rather than life. According to the ECHR no right to die, whether at the hands of a third person or with the assistance of a public authority, can be derived from Article 2 of the Convention. It is confirmed in this view by the recent Recommendation 1418 (1999) of the Parliamentary Assembly of the Council of Europe.³⁶

The 1984 case of *X v. Germany*³⁷ concerned a prisoner who had gone on a hunger strike and who was forcibly fed by the authorities. X complained of this treatment,

be able to undertake the last act – that is to swallow, to administer via the gastric tube or to open the valve of the intravenous access tube him or herself. If this is not possible, DIGNITAS is unfortunately unable to help’.

³⁴ European Convention on Human Rights, art 2: ‘1. Everyone’s right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law. 2. Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary: (a) in defense of any person from unlawful violence; (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained; (c) in action lawfully taken for the purpose of quelling a riot or insurrection.

³⁵ *ibid.* art 8: ‘1. Everyone has the right to respect for his private and family life, his home and his correspondence. 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

³⁶ *Pretty v. The United Kingdom*, App no 2346/02 (ECHR, 29 April 2002), pp 39-40.

³⁷ *X v. Germany* (1984) 7 EHRR 152, pp 153-154 state: ‘In the opinion of the Commission forced feeding of a person does involve degrading elements which in certain circumstances may be regarded as prohibited by Art. 3 of the Convention. Under the Convention the High Contracting Parties are, however, also obliged to secure to everyone the right to life as set out in Art. 2. Such an obligation should in certain circumstances call for positive action on the part of the Contracting Parties, in particular an active measure to save lives when the authorities have

arguing that it constituted inhuman and degrading treatment, contrary to Article 3 of the Convention. However, he did not argue that, under the Convention, he had a right to choose to die by starving himself. The Commission dismissed the application. Even though the intervention of forced feeding was done by the authorities of the prison where X was held, and not by physicians, in its decision ECHR held that the authorities acted solely on the person's best interest. The use of the 'best interest' in terminal cases could raise claims on the use or legalization of euthanasia. According to this decision of ECHR a healthy individual's best interest is to live and enjoy³⁸ life. Is a State acting on a terminal patient's best interest when it/the State refuses to act against this patient's wishes to help him give an end with dignity to his life?

Two more recent cases on the "right to die" were, *Sanles Sanles v. Spain*³⁹ and *Pretty v. the United Kingdom*⁴⁰. The first one concerned a man, Mr. Sampedro, who had been a tetraplegic since the age of twenty-five and who, from 1993, when he was about fifty, had tried to obtain recognition from the Spanish courts of what he claimed was his right to end his life, with the help of others (including, in particular, his doctor), without interference by the State. However, he died before the proceedings in Spain had come to an end, and the relative he appointed as successor to this claim, Mrs. Sanles Sanles, was held by the Spanish courts and by the European Court of Human Rights to have no standing in the matter, i.e., in the latter forum, not to be a "victim" of the alleged violation of the Convention.

In *Pretty v. United Kingdom*, Mrs. Pretty suffered from a progressive neurodegenerative disease. She was paralyzed from neck down and was fed from a feeding tube; however, her intellect and capacity to make decisions were unimpaired. She very strongly wished to be able to control how and when she died and thereby to be spared from the suffering and indignity that came with the disease. Although it was not a crime to commit suicide under English law, the applicant was prevented by her disease from taking such a step without assistance. It was however a crime to assist another to commit suicide (section 2(1) of the Suicide Act 1961). Intending to commit suicide with the assistance of her husband, she asked the Director of Public Prosecutions, in a letter written on her behalf, to give an undertaking not to prosecute her husband should he assist her to commit suicide in accordance with her wishes. Her request was

taken the person in question into their custody.' ... 'The Commission is satisfied that the authorities acted solely in the best interests of the applicant when choosing between either respect for the applicant's will not to accept nourishment of any kind and thereby incur the risk that he might be subject to lasting injuries or even die, or to take action with a view to securing his survival although such action might infringe the applicant's human dignity...'

³⁸ This could be disputed on the basis of the quality of life.

³⁹ *Sanles Sanles v. Spain*, admissibility decision of 20 October 2000.

⁴⁰ *ibid.* (n 36).

not approved by any of the English courts so she presented her case to the European Court of Human Rights pretending a violation of Article 2- right to life and, according to her interpretation of this article, right to die were violated.

The Court accepted that Mrs. Pretty's wish to 'exercise her choice to avoid what she considered would be an undignified and distressing end to her life' was covered by the concept of 'personal autonomy', and that the law preventing her from exercising this choice (by asking her husband for assistance, she being incapable of committing suicide unaided) thus constituted an 'interference' with Mrs. Pretty's right to respect for private life as guaranteed under Article 8 § 1 of the Convention.

Recognition of the principle of 'personal autonomy' enabled the Court to address the issue at the heart of the case: whether this principle protected the right of mentally fit individuals to choose death (if needs be with the assistance of others), or whether 'the principle of sanctity of life' could be allowed to override such 'self-determination'. The Court held that it was 'common ground [between the parties] that the restriction on assisted suicide in this case was imposed by law and in pursuit of the legitimate aim of safeguarding life and thereby protecting the rights of others.' The only issue to be determined was therefore whether the interference was 'necessary in a democratic society.'⁴¹

On its decision the Court recalled the margin of appreciation accorded to the states on several issues. The Court was careful to stress that this ruling did not mean that if a particular State did recognize such a right (as did Switzerland, for instance), that would *ipso facto* be contrary to Article 2; nor did it mean that if a State that did recognize a right to take one's own life were to be held to have acted in accordance with Article 2, that would imply that the applicant, too, should be granted that right.

In *Haas v Switzerland*⁴² the applicant lived in Switzerland, where assisted suicide is permitted. He had a long history of mental illness and wished to commit suicide. No doctor was willing to help him to do so. He complained about the refusal of the Swiss authorities to permit him to obtain lethal drugs, without a prescription, in a sufficient quantity to enable him to end his life in a dignified manner. He contended that the authorities thereby violated his right under article 8 to decide when and how to end his life. The court held that there was no violation.

The court accepted that the right of an individual to decide how and when to end his life, provided that he is in a position to make up his own mind in that respect, is

⁴¹ Human rights handbooks, No. 8, p 21; <http://echr.coe.int/echr/en/50/50_HRHHandbooks> accessed 28.02.2013.

⁴² *Haas v Switzerland* (2011) 53 EHRR 33.

one aspect of the right to respect for private life within the meaning of article 8.⁴³ The question whether there has been a violation depends on article 8(2). According to the court: ‘The Convention and the Protocols thereto must be interpreted in the light of the present-day conditions...In Switzerland, under art 115 of the Criminal Code, incitement to commit or assistance with suicide are only punishable where the perpetrator of such acts commits them for selfish motives. By comparison, the Benelux countries in particular have decriminalized the act of assisting suicide, but only in well-defined circumstances. Certain other countries only allow “passive” acts of assistance. The vast majority of Member States, however, appear to place more weight on the protection of an individual’s life than on the right to end one’s life. The Court concludes that the states have a wide margin of appreciation in that respect.’⁴⁴

2.3. *United Kingdom (UK) case law*

In the UK any form of assisted suicide or euthanasia is banned under The UK Suicide Act of 1961.⁴⁵ Even though there are many cases presented to the English courts on assisted suicide and voluntary euthanasia, the Courts have stated that these are not matters for them to decide but for the Parliament. Today these changes have still not been made.

In 1993 English courts were faced with a decision in *Airedale NHS Trust v Bland*.⁴⁶ The case concerned Anthony David “Tony” Bland born on 21st September 1970. He was injured in the Hillsborough disaster, named after the football stadium where 95 people died and many others were injured, as a result of thousands of fans being pushed and crushed against steel fencing, installed to prevent hooliganism. Tony suffered severe injuries and he stopped breathing. His brain was deprived of oxygen, and by the time breathing was restored his upper brain had been severely damaged, leaving him in a persistent vegetative state. Tony Bland was neither dead nor dying. His brain stem still functioned; he could breathe and digest food normally. He was fed by a nasogastric tube, and evacuated by catheter and enema. Both his doctor and his parents wanted to stop assisted feeding and all medical treatment so that he would die. Three years later the Airedale Hospital Trust made an application to the High Court, supported by *amicus curiae* instructed by the Attorney General, and opposed by the Official Solicitor, whose role was to represent Tony Bland’s interests.

⁴³ *ibid.* pp 51.

⁴⁴ *ibid.* pp 55.

⁴⁵ *ibid.* (n 29).

⁴⁶ *Airedale NHS Trust v Bland* [1993] 1 ALL ER 821.

Sir Stephen Brown, President of the Family Division of the High Court, granted such request to the Hospital. In his summing up he held that 'to his parents and family [Tony Bland] is dead. His spirit has left him and all that remains is the shell of his body.'⁴⁷ His decision was unanimously affirmed by the Court of Appeal and the House of Lords, the UK's highest point of legal appeal. Its findings and assumptions in the *Bland* case included that the whole purpose of withdrawing food, fluids and medicines was to end his life, that this was not authorizing euthanasia and that Tony Bland's existence in PVS was not a benefit to him.

Another particular case of assisted suicide in UK, where consent was given by the patient, was the case of *Daniel James*. Daniel was a rugby player injured in a training session in 2007, paralyzed from the chest down and with no independent hand or finger movement. The impact of his injuries on Daniel was profound. In the early months he gave his all to prove the medical prognosis incorrect, but ultimately he came to accept that his condition would never improve. He became suicidal, driven by distress at his predicament and his dependency on others. To his consultant psychiatrist, he described himself as a 'dynamic, active, sporty young man who loved travel and being independent' and that 'he could not envisage a worthwhile future for himself now'. Daniel frequently stated his wish that he had died of his injuries on the rugby field and that he was determined to end his own life. He made several attempts to do so. Daniel was assessed by a Consultant Psychiatrist on a number of occasions. His parents had stated that they had come to accept his wish to die.

Daniel planned his death at the *Dignitas* Clinic in Switzerland with the help of his parents and a close friend. On 12 September 2008 he attended the clinic with his parents where a doctor helped him to take his own life. Although Daniel James' parents and his friend played some part in the co-ordination of the arrangements, The Crown Prosecution decided that they were not 'ringleaders' or 'organizers' in the sense did not mean the Code for Crown Prosecutors; nor was the offence premeditated or a 'group' offence.⁴⁸

Another similar case on assisted suicide in UK was the case of *Debbie Purdy*⁴⁹. Ms Purdy was terminally ill with multiple sclerosis and wanted the Crown Prosecution Service to clarify whether or not an individual could assist someone to travel to another country where assisted suicide is legal and not be prosecuted on return to the UK. Ms Purdy contended that the assisted suicide prohibition in the 1961 Suicide Act constituted an interference with her rights, within the context of her

⁴⁷ *ibid.*, Sir Stephen Brown's summing up.

⁴⁸ <http://www.cps.gov.uk/news/articles/death_by_suicide_of_daniel_james/> [accessed 22.06.2012].

⁴⁹ *R (Purdy) v DPP* [2009] UKHL 45, [2010] 1 AC 345.

private life, under article 8(1) of the European Convention on Human Rights (ECHR).⁵⁰ Purdy argued that she had a right to decide to kill herself and that this right was infringed upon by the prohibitions set out in the 1961 Suicide Act.

All five Law Lords agreed that the right to respect for private life in Article 8(1) of ECHR was engaged in the case brought by Ms Purdy. Furthermore, they concluded that the assisted suicide prohibition in the 1961 Suicide Act did constitute an interference with that right, because the Director of Public Prosecutions (DPP) for England and Wales had failed to provide an offence-specific prosecution policy for assisted suicide. Owing to the absence of an appropriate policy, such interference violated Article 8(2) of the Convention and in so doing was not in “accordance with the law”. Thus, people such as Ms Purdy lacked the necessary information to inform their decision about their private lives and counter any challenge mounted by the DPP and Crown Prosecutors “in deciding under section 2(4) of the 1961 Act whether or not it is in the public interest to bring a prosecution under that section”. The law lords also ruled that changes in the law on assisted suicide could only be decided upon by Parliament.⁵¹

A recent case on assisted suicide was the case of *Tony Nicklinson and Martin v Ministry of Justice*.⁵² The claimants suffered from catastrophic physical disabilities but their mental processes were unimpaired in the sense that they were fully conscious of their predicament. They suffered from ‘locked in syndrome’. Both had determined that they wished to die with dignity and without further suffering but their condition made them incapable of ending their own lives. Neither was terminally ill and they faced the prospect of living for many years. Neither Martin’s nor Tony’s condition was capable of physical improvement.

Martin suffered a brain stem stroke in August 2008 which left him virtually unable to move. He could not speak. He could communicate only through small movements of his head and eyes and, very slowly, by using a special computer that detected where on a screen he was looking. He was totally dependent on others for every aspect of his life. He was fed by people putting food into his mouth. He was able to swallow. His medication went through a tube through his abdominal wall into his stomach. Martin was capable of physically assisted suicide, but this involved someone else committing an offence under the Suicide Act 1961, section It was possible for him to end his life at a Dignitas clinic in Zurich without an offence

⁵⁰ European Convention on Human Rights, art 8(1): ‘Right to respect for private and family life. 1. Everyone has the right to respect for his private and family life, his home and his correspondence.’

⁵¹ < <http://www.care.org.uk/advocacy/end-of-life/what-about-the-case-of-debbie-purdy> > [accessed 22.06.2012].

⁵² *Tony Nicklinson v Ministry of Justice* [2012] EWHC 2381 (Admin), Case No: CO/7774/2010; CO/7850/2011.

being committed under Swiss law; and if Martin's wife were willing to help him to do so, it was unlikely that she would have faced prosecution in England under the policy published by the Director of Public Prosecution (DPP) about prosecution for assisted suicide after the decision of the House of Lords in *R (Purdy) v DPP*. But Martin's wife, who herself was a nurse and devoted to his care, was understandably not willing to support Martin for that purpose, with which she did not agree, although she wished to be with him to provide comfort and make her final farewell, if he were to succeed in his purpose by the help of others.

Tony suffered a catastrophic stroke in June 2005. He is paralysed below the neck and unable to speak. He cannot move anything but his head and eyes. He communicates by blinking to indicate a letter held up by his wife on a Perspex board. He also now has an eye blink computer which makes word processing faster for him. The only way in which Tony could end his life other than by self-starvation would be by voluntary euthanasia. With his wife's help he could probably travel to Switzerland, but that would not help him because euthanasia is outside the scope of Dignitas' activities.

According to a statement by a doctor⁵³, it would have been technologically possible for Tony to take the final step of initiating suicide with the aid of a machine that had been invented. The machine would be pre-loaded with lethal drugs and could be digitally activated by Tony using an appropriate pass phrase, but it would be an elaborate procedure requiring the machine to be set up, tested and connected to Tony's PEG tube, but Tony wanted to be able to choose to end his life by voluntary euthanasia.

In its decision regarding the case the Court concluded: '...A decision to allow their claims would have consequences far beyond the present cases. ...It is not for the court to decide whether the law about assisted dying should be changed and, if so, what safeguards should be put in place. Under our system of government these are matters for Parliament to decide, representing society as a whole, after Parliamentary scrutiny, and not for the court on the facts of an individual case or cases. For those reasons I would refuse these applications for judicial review.'⁵⁴ 'Each case gives rise to most profound ethical, moral, religious and social issues. Some will say the Judges must step in to change the law. Some may be sorely tempted to do so. But the short answer is that to do so here would be to usurp the function of Parliament in this

⁵³ Dr Philip Nitschke, who is a doctor in North Australia.

⁵⁴ *ibid.* (n 52) pp 150.

classically sensitive area. Any change would need the most carefully structured safeguards which only Parliament can deliver.⁵⁵

2.4. Albanian case law on the right to die

In Albania, the Constitution protects the right to life and health care.⁵⁶ According to the Constitution the protection of life is an important constitutional requirement. The concepts of life and dignity are important constitutional values considered as the source of all other fundamental rights and freedoms. The individual and his life are of superior value for the state.

Regarding individual's right to die, in Albania both forms of euthanasia and assisted suicide are banned and considered a criminal offence. The problem consists in the fact that this is not literally provided by law, but it is through the interpretation of laws that such actions are considered criminal offences.

In Albania, patients' rights are guaranteed and protected by the Constitution, The European Convention on Human Rights⁵⁷, law 'On health care in the Republic of Albania'⁵⁸; law 'On public health'⁵⁹; law 'On the regulated professions in the Republic of Albania' (the part that provides duties and obligations for the health care professionals)⁶⁰ and The Ethical Code on Medical Deontology⁶¹.

Albania's Criminal Code provides criminal acts against health due to negligence.⁶² None of these articles provides limitations on the right to die or euthanasia. It is only through the interpretation of law 'On health care in the Republic of Albania'

⁵⁵ *ibid.* pp 151.

⁵⁶ The Constitution of the Republic of Albania, art 21: 'Individual's life is protected by law'; art. 55/1: 'Citizens enjoy equal right to health care'.

⁵⁷ *ibid.* art 116/1/b: 'Normative acts that are effective in the entire territory of the Republic of Albania are: ... b. ratified international agreements ...'.

⁵⁸ Law n° 10107, dated 30.03.2009 'On health care in the Republic of Albania'.

⁵⁹ Law n° 10138, dated 11.05.2009 'On public health'.

⁶⁰ Law n° 10171, dated 22.10.2009 'On the regulated professions in the Republic of Albania'.

⁶¹ Albanian Code of Ethics and Medical Deontology, adopted by Decision nr.9, dated 11.11.2011 of the National Council of the Albanian Order of Medics.

⁶² Albanian Criminal Code, section IV. Article 91 of this Code provides: 'Serious injury due to negligence constitutes criminal contravention and is punishable by fine or imprisonment up to one year'. Article 96 provides: 'Incorrect medication of patients from the doctor or other medical staff, as well as non-implementation of the therapy or the orders of the doctor from the medical staff or pharmacist, when it has caused serious harm to the health, has endangered the life of the person or has caused his death, is punishable by a fine or up to five years of imprisonment. This very act, when it has caused the patients' infection with HIV/AIDS, is punished by imprisonment from 3 to 7 years'. Meanwhile, Article 97 provides: 'Refraining from providing help without reasonable cause by the person who either legally or because of his capacity was obliged to provide, is considered criminal contravention and is punishable by a fine or to up to two years of imprisonment when, as its consequence, serious harm to the health, endangerment to life or death resulted.'

and the Albanian Code of Ethics and Medical Deontology that euthanasia is considered as a criminal offence.

The law 'On health care in the Republic of Albania' provides that, for the safeguard of the ethical rules and medical deontology by the health care professionals, Professional Orders are created.⁶³ Professional Orders' duties and activities are provided by their respective laws.⁶⁴ Such laws provide the duty of the physicians to apply the Code of Ethics and Medical Deontology.

Meanwhile, such Code provides that relief of suffering and pain is one of the fundamental duties of the physician towards its patient. This is particularly important while treating a dying patient. The physician, except treating the patient, must also offer spiritual assistance and care, in respect of patient's wishes and religious beliefs, safeguarding his dignity until the end of his life. The physician must inform the family of the patient on his condition and try to get their cooperation in relieving the suffering of the sick.⁶⁵

Acceleration of the end of life or death provocation is contrary to medical ethics. If the patient is unconscious, with no hope to live, the doctor must act according to his judgment in patient's best interest. The physician must decide on the therapeutic actions he will undertake, after consulting his colleagues and patient's closest family members.⁶⁶

As noted, the Albanian Code of Medical Ethics and Deontology allows a margin of appreciation regarding euthanasia, stressing the importance of patient's dignity and best interest, while prohibiting any form of acceleration of end of life or provocation of death.

In the Albanian jurisprudence there are neither cases of active or passive euthanasia, nor of assisted suicide. Not only there are no such cases, but there is an immediate need for the Parliament to regulate the activity of physicians on such cases. The state must also take the necessary steps to inform not only patients on their rights on medical care, but also the physicians on their rights and duties.

Even to the questionnaire prepared by the European Health Committee, followed and assembled by the Parliamentary Assembly of the Council of Europe, which led to Recommendation 1418 (1999) 'Protection of the human rights and dignity of

⁶³ *ibid.* (n 58), art 32/1.

⁶⁴ law n° 8615, dated 1. 06. 2000 'On the Order of the Physicians in the Republic of Albania'; law n° 9718, dated 19.4.2007 'On the Order of the Nurse in the Republic of Albania'; law n° 9150, dated 30.10.2003 'On the Order of the Pharmacists in the Republic of Albania'.

⁶⁵ *ibid* (n 61), art 38 'Relief of suffering of the dying patient'.

⁶⁶ *ibid.* art.39 'Non acceleration of death'.

the terminally ill and the dying',⁶⁷ Albania answered that there was no law on euthanasia, that the term was not included in the Albanian Criminal Code therefore there were no sanctions against it, that the only provisions on the Albanian Criminal Code could be found on the chapter 'On offences against life and health' and that the activity of the physician was provided only in the Albanian Code of Ethics and Medical Deontology.⁶⁸

The activities of Albanian physicians in end of life cases today aren't still regulated neither by law, nor by decision of the executive power, or any other regulation.⁶⁹ Other Albanian researchers have also suggested the immediate need for such legislative regulations.⁷⁰

The legislative reform should be coupled with a program to promote the understanding and use of procedures on end of life or terminally ill patients amongst the general public and the legal and medical professions. The patients must have greater access to information about their rights regarding medical treatment. The physicians must understand and apply not only the law but they should understand also the consequences they're faced with if they do not obey the laws in force regarding medical care. Patient's dignity and best interest should be protected, as should patient's health and life.

Conclusions

The involvement of the medical profession in everyone's lives makes the understanding of the law governing the medical profession extremely important. It is certain that at some point in our lives we are forced to rely upon the medical profession. The almost certain involvement of the medical profession in achieving good health makes the laws governing the medical profession and the rights of the patients vitally important.

Obviously the right to life is fundamental in our scheme of values. Such right, considered as the center stone of all individual rights and freedoms describes the belief that a human being has an essential right to live, particularly that a human being has the right not to be killed by another human being. Nevertheless, the interest in the preservation of human life is not itself sufficient to outweigh the

⁶⁷ <<http://assembly.coe.int/main.asp?link=/Documents/AdoptedText/ta99/EREC1418.htm>> accessed 28.02.2013.

⁶⁸ Danja Sinani '*Përkufizimi juridik i vdekjes*' (Naimi: Tirana, 1st edn, 2012) p. 116-117.

⁶⁹ This conclusion was achieved after having enquired at the legal department of Mother Teresa University Hospital, the office of statistics of Mother Teresa University Hospital, the web-site of the Albanian Ministry of Health, The Order of Albanian Doctors and after having questioned Albanian doctors.

⁷⁰ Danja Sinani '*Përkufizimi juridik i vdekjes*' (Naimi' Publication 2012) p. 161.

interest in liberty that may justify the only possible means of preserving a dying patient's dignity and alleviating her intolerable suffering.⁷¹

The right of the patient to die today should be considered in the light of the changes society is going through and of new approach towards human rights.

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