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End-of-Life Decisions in Albania: The Call for an Ethical Revision

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Abstract

While in Western European countries, the end-of-life decisions have become a matter of public policy, this paper provides a detailed analysis of end-of-life decisions in Albania by focusing on instructional medical directives. The manuscript investigates the Albanian legal system, the documents published by the National Ethics Committee and the National Committee of Health, as the two main advisory public bodies on health issues, as well as the national medical jurisprudence and the Code of Medical Ethics. After emphasizing the importance of instructional medical directives and considering the international literature that has underlined the ethical principle of patient autonomy, this paper provides some policy suggestions. In the conclusion, this contribution highlights the importance of *ad hoc* rules governing instructional medical directives as well as the ethical principles and international literature as an instrument to fill the gap in the national system. In addition, particular attention is given to the application of ethical principles in end-of-life decisions in the current pandemic situation.

Keywords Albania · End-of-life decisions · Instructional medical directives · Code of medical ethics · Patient autonomy

Introduction

In recent decades, the patient-physician relationship has been transformed in Albania. From a communist ideology, also expressed in medicine, to a neoliberal approach to the ethical principle of patient autonomy where the main focus is the broader concept of wellbeing (Swetz et al 2014; Tibaldi et al 2011), which is considered in this paper as conceptually broader than just the notion of physical

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health since it includes the subjective idea of what constitutes health (Veshi 2017), without including the political function of it.

In Europe, while withholding or withdrawing treatment from a conscious patient is considered legal (ECtHR, Pretty v. the UK, application no. 2346/02, par. 63), different approaches have been applied for withholding or withdrawing treatment from an unconscious patient, physician-assisted suicide (PAS), or euthanasia (or "mercy killing"). The majority of the members of the European Council (Andorno 2008) as well as all the English-, German-, and Romance-speaking countries (Koka and Veshi 2019) recognize the right to also not be treated (the right to withhold or withdraw medical treatment) by unconscious patients. Furthermore, several Western European countries—such as the Netherlands, Belgium, and Luxemburg, Germany, or Switzerland—have legalized forms of PAS or euthanasia. More recently, in September 2019, the Italian Constitutional Court has recognized some type of PAS by declaring the unconstitutionality of parts of Article 580 of the Italian Penal Code (PC) (Italian Constitutional Court, R.O. 43/2018). In addition, on February 26th, 2020, the German Constitutional Court has declared the unconstitutionality of Session 217 German PC (StGB) that prohibits assisted suicide, if conducted "on business terms" (*geschäftsmäßig*) since this is not aligned with the combined interpretation of Article 2(1) with Article 1(1) German Basic Law (German Constitutional Court, 2 BvR 2347/15).

In Albania, while euthanasia and PAS are deemed criminal offences (Articles 76, 79, and 99 PC) and in violation of rules established in the Code of Medical Ethics (Article 39) (Boçari et al. 2010), Albanian law has acknowledged that withholding or withdrawing treatment from a conscious patient is considered legal since the patient can and does, in fact, consent to withholding or withdrawing medical treatment. This has also been codified in Article 6(2)(ç) Law no. 107 of March 2009. The legal and bioethical discussion regarding withholding or withdrawing of treatment from an unconscious patient is quite complicated and it is directly correlated with the absence of an *ad hoc* law ruling on advance directives (ADs).

The importance of ADs has been recognized by several national and international scholars (Dudley et al 2019; Koka and Veshi 2019; Veshi and Neitzke 2015b; Burlá et al. 2014; Winter 2013; Vyshka and Kruja 2011; Alfonso 2009). With the recognition of the importance of ADs, a patient's position evolves from a passive role of personal, physical, and mental protection to an active role of freedom and quality of life (Veshi and Neitzke 2015b). However, Albania does not have a specific law governing ADs.

This paper provides a general overview of end-of-life decisions in Albania by focusing on instructional medical directives. The paper also investigates the Albanian medical jurisprudence on this issue without finding any evidence of case-law dealing with end-of-life situations (Bara and Vyshka 2014). In addition, the authors consider the two main public bodies, the National Ethics Committee and the National Committee of Health, established as advisory bodies for medical issues without finding any specific document ruling end-of-life situations or ADs. Particular attention is given to the Code of Medical Ethics since this is the only legal document that includes some reference to the end-of-life decision process. The authors

also consider ethical principles and international literature as instruments to fill this gap.

The manuscript has the following sections: The importance of "instructional medical directives" section underlines the importance of instructional medical directives by briefly examining some of the main critiques done for its implementation. It also investigates the Albanian legal framework governing instructional medical directives by focusing on the Code of Medical Ethics. "Instructional medical directives": policy suggestions section proposes some policy suggestions after considering the implementation of the ethical principles of patient autonomy. In the conclusion, the authors argue that the current absence of an *ad hoc* law ruling end-of-life decisions does not protect patient autonomy. Suggestions regarding an ethical revision of the Code of Medical Ethics are included. However, until the moment that the Albanian Parliament rules on-end-life decisions, physicians and judges should apply ethical principles as well as the international jurisprudence and literature promoting patient autonomy. In the cases of withholding or withdrawing medical treatments from unconscious patients, the authors propose an innovative interpretation of the ethical principles in the current pandemic situation.

The Importance of "Instructional Medical Directives"

Patients can express their medical declaration through ADs. An AD should be considered a medical declaration, which, based on the principle of extended autonomy, gives directives for future medical care in case of future incapacity. Citizens can express their medical declarations in two different forms: the "instructional medical directives" or the "surrogate will", both explained below. From a medico-legal perspective, these types of ADs should be complementary.

In the case of instructional directives, commonly known as instructional medical directives (or "living will"), citizens express their preferences regarding specific medical treatments that they want (to permit or) to reject in case of future unconsciousness. The second form of ADs, the surrogate will, gives enduring power for health care affairs to another competent citizen: the "surrogate". Surrogates must understand patients' wishes and values.

This paper focuses only on the analysis of "instructional medical directives". The term "living will" is confusing for people because the will takes effect only after an agent's death, and is directed to other people (Spoto 2011). Instructional medical directives are intended for a physician's acts to conform to a living patient's wishes. To avoid this confusion, it would be better to use the term *instructional medical directives* or *treatment directives*.

Instructional medical directives are written expressions of citizens' preferences regarding specific medical treatments that they want (to consent to or) to reject in case of future incapacity, which should be assessed by an impartial expert. It is thought that the origin of instructional medical directives could be the "Do Not Resuscitate" orders that physicians used to write in patients' case histories after discussing it with them and their families (Rabkin et al. 1976). Therefore, the instructional medical directive should be considered as the document in which the citizen

expresses his or her preferences regarding specific medical treatments that he or she wants (to consent to or) to reject in the case of absence of future capacity.

It should be noted that in case of clear instructional directives that correspond perfectly in concrete medical situations, they should always have more weight in the decision-making process (Council of Europe 2014). These could be cases of chronic illnesses or neurodegenerative diseases affecting cognitive faculties. In these cases, the patient has received all medical and legal information regarding his future (probable) incapacity. But, unfortunately, these are rare cases.

Although instructional medical directives are recognized as an important instrument to enshrine patient autonomy, some authors have underlined the risks of their implementations: life has an intrinsic value (or there is a principle of sanctity of life); they distort the patient–physician relationship; and they misunderstand the social role of physicians.

First, some bioethicists claim that life has an intrinsic value. Catholic bioethicists would state that instructional medical directives, which are directed at refusing life-sustaining intervention, infringe on the principle of the sanctity of life. It should be pointed out that the concept of the "sanctity of life" has a religious connotation that should not be used by a secular State (Brock 2009). One objection derived from this principle is that if patients have the right to decide about their end-of-life, life will be less valued. Sick people could be considered less important than healthy citizens (Spoto 2011). People with disabilities and old patients without families could ask for treatment to be withdrawn because they do not have families or relatives to take care of them.

The second main criticism focuses on the patient–physician dialogue. A competent patient can make a decision and can reconsider it after taking into account physicians' advice. However, an incapacitated patient cannot revise his/her medical declarations. Furthermore, if instructional medical directives are general or vague or include only specific treatments that cannot be applied by analogy to a given medical situation, there will be difficulties in interpreting patients' wishes (Teno et al. 1997).

Physicians' social role could be considered as professionals who want to keep their patients alive, even through aggressive treatment. Physicians' perceptions of patients who could have written instructional medical directives, but did not, could be that these patients want to undergo aggressive treatment, or that these patients "did not want treatment withheld under any circumstances" (Kelly 2006).

Although these problems exist, it should be suggested that the benefits of the instructional medical directives still outweigh the risks. Further, in case of incapacity, the instructional medical directives can create a bridge between patients and physicians (Italian National Bioethical Committee 2003; British Medical Association 1995). Moreover, instructional medical directives—especially if they were expressed through an intensive dialogue with doctors—enhance patient's autonomy (Hunt and Ells 2011). In addition, only the recognition of instructional medical directives leads to the equal treatment of competent and incompetent patients, which entails an application of the principle of equity, also protected in the Albanian constitution (Article 18). Instructional medical directives are based on the solid moral ground of the principle of autonomy. As Buchanan and Brock state (1989),

instructional medical directives are acts "of self-determination" which are based on the so-called extension view of autonomy. They could be stated as follows: "just as we have a moral right of autonomy to effect our preferences over our interests in the present, so we have a moral right of precedent autonomy to effect (in advance) our preferences over our surviving interests".

From a strict Albanian legal point of view, instructional medical directives should be considered as unilateral legal transactions that produce legal effects in the non-pecuniary individual sphere: their aim is to (consent to or) reject future medical treatment in case of an agent's incapacity. They should be viewed as an application of the right to self-determination recognized by Article 27 of the Albanian Constitution since there exists a right to life, but not a duty to live. The right to self-determination regarding health may be narrowed only in cases where a public intervention aims to protect the community (Article 6 Law 107/2009). However, the public intervention shall aim not only the protection of others' health but also shall not damage, but (eventually) improve patient's health. This interpretation is similar to that of the European Court of Human Rights (ECtHR) which has stated that "therapeutic necessity cannot be regarded as inhuman or degrading…[when] … the medical necessity has been convincingly shown to exist" (par. 82) and this medical treatment improves patient's health (ECtHR, Herczegfalvy v. Austria, Application no. 10533/83, par. 81). Although this legal decision deals with the interpretation of Article 3 ECHR (Prohibition of Torture), it is included here since this case underlines the patient's wellbeing even in situations where for public safety (eg. a patient with Covid-19) physicians do not respect patient's right to self-determination.

By considering the general legal framework, in particular Articles 6-11 Albanian Civil Code (CC), instructional medical directives can be written only by people with full competency, reached at the age of 18 years old. Furthermore, simple opinions or declarations that do not aim to produce a legal effect on relationships with physicians must not be considered. Physicians must pay close attention to patients' medical declarations because on the one hand they should not take simple opinions into consideration, but on the other, they must be aware that patients' preferences change during the course of a disease (Berger and Majerovitz 1998). This could be achieved with a process of only four steps: understanding, appreciation, reasoning, and communicating a choice (Moye et al. 2007). It is fundamental that the agents comprehend diagnostic and treatment-related information (understanding). After understanding the risks and benefits of a particular medical treatment, patients must have the ability to relate them to their own future eventual particular situation (appreciation) by comparing alternative treatments in a logically consistent manner (reasoning). In the end, they should convey a treatment choice (communicating a choice).

Although the Albanian legal framework does not establish specific rules regarding end-of-life decisions, the Albanian Code of Medical Ethics of November 2011 should be examined. The Code of Medical Ethics was published by the Albanian Order of Physicians[1] and is legally binding for all the physicians affiliated with it (Article 3). In other words, disciplinary sanctions may be applied in cases of its

[1] The Order of Physicians was formed for the first time in 1993.

infringement (Article 68 Code of Medical Ethics and Article 1 Regulation of 08.04.2016 of the Albanian Federation of Physicians).

Clearly, Article 39 Code of Medical Ethics states that in the case of an unconscious patient with a terminal illness, the physician must act on his judgment by considering the patient's best interest. He, in consultation with other colleagues and with patient relatives, decides on the therapeutic treatment. Thus, instructional medical directives are not considered at all. In addition, physicians shall also consult other colleagues as well as patient relatives. All of them must seek to serve the patient's best interests rather than follow the patient's wishes. This rule does not protect patient autonomy and his right to self-determination. Physicians, the medical staff, and the patient's relatives should consider the patient's wishes, and only act according to the patient's best interests when those wishes are unclear. This is the only policy that safeguards patient autonomy.

The current paternalistic formulation of Article 39 Code of Medical Ethics might be considered unconstitutional since it violates the fundamental principle of equity, established in Article 18 of the Albanian constitution. Accordingly, Article 39 makes a distinction between conscious and unconscious patients by allowing the right to refuse medical treatments only to the first group. This means that an unconscious person may not be considered a person and all previous wishes may lose validity. Further, the instructional medical directive protects patient dignity, which is also the core principle of modern democratic constitutions. In 1998, for the first time in the Albanian legal history (Omar and Aurela 2008), dignity has become one of the main constitutional principles, also recognized in the preamble of the current constitution.

Moreover, Article 39 Code of Medical Ethics is also in contrast with international law, which Albania has ratified. In concrete, Article 9 of the Oviedo Convention states that "the previously expressed wishes relating to a medical intervention by a patient who is not, at the time of the intervention, in a state to express his or her wishes shall be taken into account". Although according to it, "previously expressed wishes" are not legally binding, Article 39 of the Albanian Code of Medical Ethics does not include at all the importance of them. As a result, Article 39 is also unconstitutional since the Albanian constitution recognizes that laws and other normative acts of the Council of Ministers shall be aligned not only with the constitution but also with ratified international agreements (Article 116 Albanian Constitution). Since July 2011, the Oviedo Convention entered into force also in Albania.

In addition, the formulation of Article 39 Albanian Code of Medical Ethics is also in contrast with *soft*-law documents published by the Council of Europe. Judges can also apply these *soft*-law documents since part of the doctrine has underlined that even non-binding international documents may influence State behavior. The application of *soft*-law documents as a main source of law has also been done by the ECtHR (Veshi 2015). For instance, the ECtHR has applied the Convention on Human Rights and Biomedicine of 1997 towards the UK that has not ratified it yet (ECtHR, Glass v. the UK, Application No. 61827/00) or towards France that at that time had not ratified this convention (ECtHR, Vo v. France, Application No. 53924/00). In more concrete terms, Article 39 Code of Medical Ethics is in contrast with the principle 15 Recommendation REC(2009)11, which states that instructional medical directives that do not have a binding force should be treated

as statements of wishes to be given due respect. The use of the term "due respect" is stronger than the phrase "shall be taken into consideration", used in Article 9 of the Convention of Oviedo.[2]

To sum up, instructional medical directives are an important instrument to highlight patient right to self-determination since according to the majority of the bioethicists agree that, in case of a patient's incapacity, medical decisions at end-of-life must be made according to the so-called *three-step hierarchy* in the following order: (1) patient's wishes, (2) substitute judgments and only at the end (3) patient's best interest (Buchanan and Brock 1989), understood as objective medical criteria.

"Instructional Medical Directives": Policy Suggestions

The complexity of legal and ethical issues concerning withdrawing treatment from an unconscious patient arises from the need to reconstruct the patient's will. The absence of an *ad hoc* Law ruling instructional medical directives creates legal uncertainty since doctors and the medical staff are not aware of what to do in the case of a request to withhold or withdraw medical treatments by unconscious patients.

Part of the legal doctrine believes that withdrawing treatment cannot be punished because despite the facts being similar to criminal offences—such as homicide by request of the victim or homicides committed in other specific circumstances, also recognized in the Albanian Penal Code in Articles 99 and 79[3] respectively—there is the exculpation act of fulfilling a duty (Article 21 PC) (Canestrari 2003). However, a part of the legal community argues that humans do not have the moral right to die and therefore in the case of an unconscious patient, even if the patient has during some point of his life given consent to withhold or withdraw medical treatments, there is the necessity to save the patient's life. In these cases, the doctor is neither liable for kidnapping nor unlawful detention (Articles 109 and 110 PC) since there exists the exculpation act of extreme necessity (Article 20 PC) (Iadecola 2003).

The *ad hoc* Law ruling instructional medical directives should not be part of public law: it may be part of the Civil Code—as it has happened in the German-speaking countries[4]—or as a distinguished legal text, as it has happened in the English-speaking countries (Koka and Veshi 2019; Veshi and Neitzke 2015a, b). Notably, the political decision to include the end-of-life decisions in either the public code or the civil code is in itself an important political choice: public codes regulate citizens' activities in connection with the organs of the State, and the civil law rules citizens' dealings with each other. The decision to include the regulation of ADs in the public law (i.e. in France) expresses some kind of external control of citizens'

[2] However, it must be mentioned that the French version of this recommendation uses the same expression that appears in the Convention of Oviedo.

[3] Article 79(1)(c) states Deliberate homicide committed: against physical or psychic handicap persons, very ill persons or pregnant women, when the victim's attributes are evident or known is punished by imprisonment not less than 20 years or by life in prison.

[4] The Austrian parliament has modified its civil code only with respect to the nomination of a surrogate.

healthcare decisions. On the contrary, the modification of the civil code (i.e. in Germany, Austria, and Switzerland) demonstrates that end-of-life decisions are considered a private matter for the individual sphere.

The Law should recognize the importance of instructional medical directives by highlighting their legally-binding force. Otherwise, as established in the Oviedo Convention, instructional medical directives should—at least—be considered or given due respect by the medical staff. This may be the result of the fact that they have been written by competent patients. In addition, the Law should not limit their execution in time or the object of medical treatment.

More specifically, instructional medical directives should, at least, be considered or given due respect by the medical staff. This approach would align with the Article 9 Oviedo Convention of 1997. Moreover, the authors believe that ADs should be legally binding. This approach is in harmony with national policies established in other Western European Countries (Koka and Veshi 2019). Even in countries such as Italy and France that did not recognize the binding force of ADs, in recent years, they have, since they modified their national policies (Koka and Veshi 2019; Veshi 2017). In these cases, physicians shall follow the patient's wishes and accept they are not contrary to legal provisions. For instance, instructional medical directives shall have the ability to impose on physicians a legal obligation of "not acting" or to withdraw medical treatment, but cannot include an obligation to act, understood as an obligation to commit euthanasia or PAS.

The focus on instructional medical directives is a direct result of the fact that individual autonomy requires as a pre-condition the mental capacity (Department of Health 2008). Since the agent should have all the adequate information regarding future incapacity, it is recommended that the end-of-life decisions are made within 12 months from the moment of their executions (Gardiner et al. 2011). This is due to the fact that the patient's participation in the end-of-life decisions during palliative care becomes tense because two different preferences (ie. wanting control over life and wanting to be cared for) contrast between them (Seymour et al. 2004). It follows that the "instructional medical directives" written in rehabilitation centers (where the patients have had several conversations with various physicians) are more precise regarding the future actual medical condition.

Nevertheless, instructional medical directives should not have a time limitation. Currently, in Austria (article 7(1) Law of 8 May 2006),[5] and in Portugal (article 7(1) Law of 16 July 2012)[6] a time restriction has been established. In addition, time restriction was required in the old version of the French law (Article 1111-11 CSP),[7]

[5] In Austria, ADs could be legally-binding or not. In case of legally binding AD, the interested party must receive complete medical information by the physician and legal information by the public Notary. In addition, this document is valid for 8 years; if not renew with the same formalities, it will have only an advisory power. This document may be registered in the Austrian Chamber of Nataries.

[6] In Portugal, ADs are valid for a period of 5 years.

[7] The old version of the French law established that advance directives have a validity of 3 years. Nevertheless, they could be renewed by a simple signature of the existing document (article 1111-18 CSP). On the contrary, the new version of the French Law of 2015 does not establish any time-limited of these documents.

and also in the Italian Bill 2350, which was never passed into law. The time limitation policy is in harmony with the idea of some scholars who consider the renewal of instructional medical directives to be crucial. According to them, this review should occur every 1–5 years (Erin and Harris 1994). Further, the periodic renewal of directives makes it possible to keep up with the situation encountered. The renewal of instructional medical directives features the philosophy of Derek Parfit (1984), who believes that personal identity is not continuous over time and place.

To avoid problems that could arise from the long-time between the formulation of instructional medical directives and their execution, by considering the experience of other Western European countries, two suggestions could be made. The first case deals with the medical discoveries: previous wishes are valid until the moment there is a medical discovery or a change in the patient's pathological conditions that if the patient had known them, they would have changed his or her medical instructions. This solution is applied in both the international framework and in the different national laws.[8] The second solution considers the power of legal proxies: the uncertainty of personality changes may be resolved by giving broader control to the surrogate who must verify whether the instructions given in the living will address the actual medical situation accurately. This solution was adopted for the first time in Germany (Article 1901a(1) BGB). In addition, it seems that this policy has been also implemented by the new French policy of March 2015—also emphasized in January 2018—in article 1111-6(2) *Code Santé Publique* (Public Health Code; CSP) as well as in Article 4(5) of the Italian Law no. 219 of December 2017.

Furthermore, instructional medical directives should not have an object limitation either. The paternalistic approach embraced in the Code of Medical Ethics may limit the object of instructional medical directives by not recognizing the withholding or withdrawing of life-supporting medical equipment; in particular, artificial nutrition and hydration or artificial ventilation. While the medical community agrees that artificial ventilation is a medical treatment, controversial arguments have been stated in the case of artificial nutrition and hydration; in particular, in the case of abatement of artificial nutrition (Schmidt et al. 2000). However, scholars who do not recognize nasogastric feeding as a medical treatment agree that nasogastric feeding should be considered as general medical management (Hoppe and Miola 2014).

It should be noted that in both these cases, the ECtHR has underlined that it is lawful to withdraw these types of life-supporting medical equipment (Hendriks 2019). In other words, the Strasbourg Court has recognized the right to not be treated by ruling that there would be no violation of Article 2 (right to life) of the ECHR if life-supporting medical equipment were to be withdrawn from a patient in a vegetative state. This is an important step in the recognition of patient autonomy since in the absence of this medical jurisprudence, physicians could have been liable

[8] Paragraph 62 of the Explanatory Report on the Convention on Human Rights and Biomedicine of April 1997; Paragraph 180 Explanatory Report on the Recommendation CM/Rec (2009) 11 of the Council of Europe; Article 4(5) of the Italian Law no. 219 of December 2017; Article 25(4)(c) Mental Capacity Act of 2005 in England and in Wales; and article 10, section 1, nr. 1 of 8 May 2006, *Patientenverfügungs-Gesetz – PatVG* in Austria.

for intentional homicide (Article 76 PC), homicides committed in other specific circumstances (Article 79 PC), or for homicide by request of the victim (Article 99 PC).

The Law should detail the formalities that the instructional medical directives must contain. While in the Italian Law of December 2017, the importance of adequate medical information is emphasized (Article 4), in Germany, citizens can write living wills even without preventive medical information (Article 1901a BGB). Since the Albanian society is not aware of the importance of instructional medical directives or other forms or end-of-life situations (Organ and Rama 2016; Rama and Sallaku 2012; Vyshka and Kruja 2011; Boçari et al. 2010), adequate medical information might be considered a better policy. Nevertheless, this information, since it deals with the legal effects of a personal decision, shall be given by the public Notary, as it is also provided in the Austrian policy (Article 7(1) Law of 8 May 2006), or by legal documents available on-line free of charge. This policy will also avoid the eventual paternalistic approach of Albanian physicians, which was expressed in Article 39 of the Code of Medical Ethics.

In addition, the Law should specify whether instructional medical directives could be communicated only in a written form or any form of medical declaration is to be considered legally valid. While the Italian Law of December 2017 limits somehow the validity of ADs to a written form (Article 4(6)), in Germany, oral declarations are legally binding: they are considered as treatment wishes (*Behandlungswünsche*) in the case of a specific oral declaration that matches the patient's actual medical situation, or as a presumed wish (*mutmaßlicher Wille*) in case of general statements (article 1901b(2) BGB).[9]

In Albania, a similar notion to the instructional medical directive is the notion of "amanet". This notion derives from the Turkish language and translates to "a supplication for God's sake". "Amanet" are oral declarations given to the closest family member that generally include concern about property, internment and funeral arrangements (i.e. place to be buried, the funeral ceremony) as well as advice for the future (i.e. taking care of the spouse or for his/her children). However, the Albanian society is not aware of the importance of instructional medical directives or other forms or end-of-life situations (Organ and Rama 2016; Rama and Sallaku 2012; Vyshka and Kruja 2011; Boçari et al. 2010). Thus, the Albanian Law should limit the form of instructional medical directives to only written forms. This strategy will differentiate the traditional notion of "amanet" with the concept of "instructional

[9] In 2009, the law *Drittes Gesetz zur Anderung des Betreuungsrechts*, Law no. 593 of 19 June 2009, fixed a clear order within ADs in Article 1901b BGB, which states that in case of patient's unconsciousness this order must be followed: 1) living will 2) *mutmaßlicher Wille* or treatment wishes (this is a specific German concept that refers to specific oral declaration that matches the patient's actual medical situation) 3) presumed wishes 4) patient's best interest (which in Germany is understood according to objective medical criteria). Although living wills are considered the primary way to determine patients' wishes, the law is entirely dedicated to the role of legal proxy (surrogate and guardian). Moreover, the legal proxy "must examine whether these determinations correspond to the current living and treatment situation" (Article 1901a, section 1 BGB).

medical directives". Additionally, before their compilation, adequate medical information should be given in advance.

The written form of the declaration is an exception of the Albanian legal system because the legal system is based on the liberty of forms (Article 663 CC). It should be noted that this exception has been justified in two main ways. First of all, the written form requires a higher evaluation compared to oral declarations, it gives more legal certainty, and it avoids the challenge of establishing the patient's wishes. Furthermore, instructional medical directives are considered as unilateral acts that produce a legal effect in the non-pecuniary sphere and the Albanian system has always established them in a written form *ad substantiam*—the act must be in a written form; otherwise, it is invalid.[10]

Thus, by considering these two reasons, the Albanian Law should limit the form of instructional medical directives to only written forms. This strategy will differentiate the traditional notion of "amanet" with the concept of instructional medical directives. Nevertheless, the Law should also recognize the right to write living wills through private acts. This avoids the costs for the Notary needed in the case of deed or private notarized acts.

In addition, in the case of people who are incapable to write, living wills could be expressed through video recording. This approach will demonstrate the principle of equity established in Article 18 of the Albanian constitution by considering citizens who are incapable to write as full members of the Albanian society. Moreover, in cases of emergency and urgency, revocation can also be done through oral declaration delivered or a video recording delivered to the physician and transcribed witnesses since in these cases there is no time for formalities. This policy is similar to the Italian Law of December 2017 (Article 4) and the French approach valid until January 2016 (Article 1111-17 CSP).

Conclusion

In Western European countries, the end-of-life decisions have become a matter of ethical debate and public policy (Veshi and Neizke 2015a, b). However, the Albanian society is not aware of the patient autonomy in end-of-life situations (Organ and Rama 2016; Rama and Sallaku 2012; Vyshka and Kruja 2011; Boçari et al. 2010).

This paper focused only on the analysis of the "instructional medical directives". After briefly considering their advantages and disadvantages, this manuscript uncovered some of the most important benefits of the application of "instructional medical directives". The authors reviewed the national legal system by also considering the medical jurisprudence as well as the position of the medical and biomedical communities. While this paper investigated the absence of medical case-law as well as of biomedical documents, the authors analyzed different rules, by paying particular attention to the Code of Medical Ethics. The authors underlined that Article 39

[10] An example of this principle is the recognition of a natural child (Article 181 Family Code) or its legitimacy (Article 176 Family Code).

Code of Medical Ethics has applied a paternalistic approach, which is in contrast with the protection of the ethical principle of patient autonomy.

The authors highlighted that Article 39 Code of Medical Ethics is in contrast with international law, which Albania has ratified. Article 39 is not only in contrast with international *soft*-law, principle 15 Recommendation REC(2009)11 of the Council of Europe, but also with international legally-binding documents, Article 9 of the Oviedo Convention. Thus, Article 39 of the Code of Medical Ethics is unconstitutional since according to Article 116, national laws and bylaws shall be aligned not only with the constitution but also with ratified international agreements, as, since July 2011, it is the case of the Oviedo Convention.

In addition, to increase the implementation of ethical principle of patient autonomy in end-of-life decisions, the paper suggested some policy recommendations. The need for *ad hoc* rules governing end-of-life decision is fundamental to underline patient dignity since the medical community has applied a paternalistic approach to end-of-life decisions. By considering the international literature that has promoted patient autonomy, the authors asserted that the instructional medical directives in written forms should have legally-binding force (or at least be highly considered by the medical staff), and should be without time or object limitations. Furthermore, particular rules should be established in the case of citizens who are incapable to write or in the cases of revocation when a situation of emergency and urgency exists.

In conclusion, *ad hoc* rules governing end-of-life decisions will enforce the ethical principle of patient autonomy. Until that moment, Albanian physicians as well as judges should apply the ethical principle of patient autonomy. The authors also suggest the application of the principle of human dignity in end-of-life decisions. Human dignity is one of the most important values crystallized in the Albanian constitution of 1998, which is mentioned not only in Articles 3 and 28 but also in the preamble. This value has already been applied by the Albanian Constitutional Court in case law (e.g. Albanian Constitutional Court no. 25 of 28 April 2014 and no. 33, of 10 April 2017). Furthermore, respect for human dignity has been codified in the European Charter of Medical Ethics, of which the Order of Physicians of Albania takes part.

In other words, the previously expressed wishes relating to a medical intervention by a patient who is not, at the time of the intervention, in a state to express his or her wishes shall be taken into account (Article 9 Oviedo Convention). Moreover, by applying the medical jurisprudence of the ECtHR, the withdrawal of life-supporting medical equipment should be considered legal. Therefore, physicians should not be liable for intentional homicide (Article 76 PC), homicide committed in other specific circumstances (Article 79 PC), or for homicide by request of the victim (Article 99 PC).

During Covid-19, the application of ethical principles has been challenged. Several countries have underlined the lack of intensive care beds and ventilators for patients. If the epidemic curve of infected individuals is flattened over a long period, the Albanian health care system will also suffer. The principle of justice is the main ethical principle that should guide the fair allocation of scarce medical resources during a pandemic. Although there should not be a distinction between patients with Covid-19 and others that need the same medical devices, priority should be given to

younger patients (thus, maximizing benefits) (Emanuel et al. 2020; Vergano, et al. 2020; Biddison et al. 2014; Rosenbaum 2011) as well as health care workers and others who care for ill patients (thus, promoting instrumental value) (Emanuel et al. 2020).

While others might not have access to needed medical treatment, access to care should be guaranteed. This recommendation is also aligned with Principle 8 of the European Charter of Medical Ethics, which states that "while respecting personal autonomy, the physician will act in accordance with the principle of treatment efficacy, taking into consideration the equitable use of resources". Therefore, during this pandemic, physicians should protect human dignity and guarantee care to all patients (Principle 3 of the European Charter of Medical Ethics) while prioritizing some groups of patients without being liable for criminal charges.

In other words, considering the scarce medical resources during a pandemic as well as the application of international law, in the cases of withdrawal or withholding of life-supporting medical equipment of unconscious patients who have previously expressed their autonomy via instructional medical directives even in absence of specific rules governing ADs, physicians should not be liable for intentional homicide (Article 76 PC), homicide committed in other specific circumstances (Article 79 PC), or for homicide by request of the victim (Article 99 PC).

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References

Alfonso, Heather. 2009. The importance of instructional medical directives and advance directives. *Journal of gerontological nursing* 10: 42–45.

Andorno, Roberto. 2008. The previously expressed wishes relating to health care Common principles and differing rules in national legal systems. In *Steering Committee on Bioethics 35th meeting*.

Bara, Brunilda, and Gentian Vyshka. 2014. A right to die: a comparing discourse of case laws in United States of America, European Court of Human Rights, United Kingdom and Albania. *JAHR* 9: 135–156.

Berger, Jeffrey T., and Deborah Majerovitz. 1998. Stability of preferences for treatment among nursing home residents. *The Gerontologist* 2: 217–223.

Biddison, Lee Daugherty, et al. 2014. Ethical considerations: Care of the critically Ill and injured during pandemics and disasters: CHEST consensus statement. *Chest* 4: e145S–e155S.

Boçari, Gëzim, Elmaz Shaqiri, and Gentian Vyshka. 2010. The actuality and the historical background of covert euthanasia in Albania. *Journal of Medical Ethics* 12: 842–844.

Brock, Dan W. 2009. Medical decisions at the end of life. In *A companion to bioethics*, ed. Helga Kuhse and Peter Singer, 263–273. Oxford: Wiley-Blackwell.

Buchanan, Allen E., and Dan W. Brock. 1989. *Deciding for others: The ethics of surrogate decision making*. Cambridge: Cambridge University Press.

Burlá, Claudia, et al. 2014. Alzheimer, dementia and the living will: A proposal. *Medicine, Health Care and Philosophy* 3: 389–395.

Canestrari, Stefano. 2003. Le diverse tipologie di eutanasia: una legislazione possibile. *Rivista Italiana di Medicina Legale* 5: 751–775.

Dudley, Katerina M., et al. 2019. Understanding service usage and needs for adults with ASD: The importance of living situation. *Journal of Autism and Developmental Disorders* 2: 556–568.

Emanuel, Ezekiel J., et al. 2020. Fair allocation of scarce medical resources in the time of Covid-19. *The New England Journal of Medicine* 382: 2049–2055.

Erin, Charles A., and John Harris. 1994. Instructional medical directives: Anticipatory decisions and advance directives. *Reviews in Clinical Gerontology* 3: 269–275.

Gardiner, Clare, et al. 2011. Exploring the transition from curative care to palliative care: A systematic review of the literature. *British Medical Journal of Supportive & Palliative Care* 1: 56–63.

Hendriks, Arend Cornelis. 2019. End-of-life decisions. Recent jurisprudence of the European Court of Human Rights. *Era Forum.* 19 (4): 561–570.

Hoppe, Nils, and José Miola. 2014. *Medical law and medical ethics*. Cambridge: Cambridge University Press.

Hunt, Matthew R., and Carolyn Ells. 2011. Partners towards autonomy: Risky choices and relational autonomy in rehabilitation care. *Disability and Rehabilitation* 1: 961–967.

Iadecola, G. 2003. Note critiche in tema di "testamento biologico". *Rivista Italiana di Medicina Legale* 3–4: 473–483.

Kelly, David F. 2006. *Medical care at the end of life a catholic perspective*. Washington: Georgetown University Press.

Koka, Enkelejda, and Denard Veshi. 2019. A new law of 'living will' in Italy: A critical analysis. *Liverpool Law Review* 40: 113–130.

Moye, Jennifer, et al. 2007. Assessment of capacity to consent to treatment: Challenges, the "ACCT" approach, directions. *Clinical Gerontologist* 31 (3): 37–66.

Omar, Luan, and Anastasi Aurela. 2008. *Constitutional law*. Tirana: ABC.

Organ, Helen, and Rudina Rama. 2016. Approaches to end-of-life care: A comparison between the UK and Albania. *Future Hospital Journal* 2: 134.

Parfit, Derek. 1984. *Reasons and persons*. Oxford: Oxford University Press.

Rabkin, Mitchell T., et al. 1976. Orders not to resuscitate. *New England Journal of Medicine* 7: 364–366.

Rama, Rudina, and Agim Sallaku. 2012. Perception and attitude toward end of life in Albania. *Advances in Palliative Medicine* 1: 1–5.

Rosenbaum, Sara J. 2011. *Ethical considerations for decision-making regarding the allocation of mechanical ventilators during a severe influenza pandemic or other public health emergencies*. Centers for Disease Control and Prevention, Office of the Associate Director for Science.

Schmidt, P., R. Dettmeyer, and B. Madea. 2000. Withdrawal of artificial nutrition in the persistent vegetative state: a continuous controversy. *Forensic Science International* 1–3: 505–509.

Seymour, Jane, et al. 2004. Planning for end of life: the views of older people about advance care statements. *Social Science and Medicine* 1: 57–68.

Spoto, Giuseppe. 2011. Questione di Fine Vita tra modelli adottati in Europa, negli Stati Uniti e Proposte Interne. *Europa e diritto privato* 4: 1175–1196.

Swetz, Keith M., et al. 2014. Advance directives, advance care planning, and shared decision making: Promoting synergy over exclusivity in contemporary context. *Journal of Pain and Symptom Management* 3: e1–e3.

Teno, Joan, et al. 1997. Advance directives for seriously ill hospitalized patients: Effectiveness with the patient self-determination act and the SUPPORT intervention. *Journal of the American Geriatrics Society* 4: 500–507.

Tibaldi, Giuseppe, Luis Salvador-Carulla, and Juan Carlos Garcia-Gutierrez. 2011. From treatment adherence to advanced shared decision making: New professional strategies and attitudes in mental health care. *Current Clinical Pharmacology* 2: 91–99.

Vergano, Marco, et al. 2020. Clinical ethics recommendations for the allocation of intensive care treatments in exceptional, resource-limited circumstances: The Italian perspective during the COVID-19 Epidemic. *Critical Care* 24: 165.

Veshi, Denard, and Gerald Neitzke. 2015a. Advance directives in some Western European countries: A legal and ethical comparison between Spain, France, England, and Germany. *European Journal of health law* 4: 321–345.
Veshi, Denard, and Gerald Neitzke. 2015b. Living Wills in Italy: Ethical and comparative law approaches. *European Journal of Health Law* 1: 38–60.
Veshi, Denard. 2015. Studio relativo alla Raccomandazione CM / Rec (2009) 11 in merito agli Stati di lingua latina (Italia, Francia, Portogallo e Spagna), tedesca (Austria, Germania e Svizzera) e inglese (Irlanda e Regno Unito di Gran Bretagna e Irlanda del Nord). *Rivista Italiana di Medicina Legale* 3: 1277–1294.
Veshi, Denard. 2017. Comments on the Lambert case: The rulings of the French Conseil d'État and the European Court of Human Rights. *Medicine, Health Care and Philosophy* 2: 187–193.
Vyshka, Gentian, and Jera Kruja. 2011. Inapplicability of advance directives in a paternalistic setting: The case of a post-communist health system. *BMC Medical Ethics* 1: 12.
Winter, Laraine. 2013. Patient values and preferences for end-of-life treatments: Are values better predictors than a living will? *Journal of palliative medicine* 4: 362–368.

Other documents

Albanian Constitutional Court no. 25 of 28 April 2014.
Albanian Constitutional Court no. 33 of 10 April 2017.
Albanian Law no. 107 of March 30th, 2009.
British Medical Association. 1992. Statement on Advance Directives.
British Medical Association. 1995. *Advanced Statements about Medical Treatment*. London: BMJ Publishing Group.
Council of Europe. 2014. Guide on the decision-making process regarding medical treatment in end-of-life situations.
Decision of the Council of Ministers Nr.595 of Septermber 21st, 1998.
Department of Health. End of life care strategy: promoting high quality care for all adults at the end of life.
ECtHR, Glass v. the UK, Application No. 61827/00, 9 March 2004.
ECtHR, Pretty v. the UK, application no. 2346/02, 29 April 2002.
ECtHR, Vo v. France, Application No. 53924/00, 8 June 2004.
German Constitutional Court, 2 BvR 2347/15.
Italian Constitutional Court, R.O. 43/2018, 29 September 2019.
Italian National Bioethics Committee. 2003. Advance directives. Roma.

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