REVIEW ARTICLE

CONTENTS

Patient autonomy and the right to refuse medical intervention: Medical and legal aspects

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ABSTRACT

Aim: To examine the right to refuse medical treatment and resuscitation as a component of somatic rights, to analyze comparative legal frameworks in the USA, EU member states and Ukraine, and to identify criteria for distinguishing lawful refusal of treatment from violations of medical and legal obligations.

Materials and Methods: The study employs a comparative legal method to analyze legislation across multiple jurisdictions, formal legal analysis of national and international normative acts, and case-law analysis of key ECtHR decisions, including *Arskaya v. Ukraine*, *Pindo Mulla v. Spain*, and *Lambert v. France*. Doctrinal legal sources on patient autonomy, informed consent, and advance directives were also examined.

Conclusions: The right to refuse medical treatment constitutes a fundamental somatic right grounded in personal autonomy and human dignity. Ukraine requires systemic legislative reform to introduce legally binding advance directives and DNR orders, accompanied by safeguards including competency verification, centralized registries, and guaranteed access to palliative care.

KEY WORDS: patient autonomy, advance directives, do-not-resuscitate order, somatic rights, informed consent

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INTRODUCTION

The right to refuse medical treatment and resuscitation is one of the key elements of somatic human rights, which concern control over one's own body and physical integrity. This right stems from the principles of personal autonomy, respect for dignity and freedom from unwanted interventions. In today's world, where medical technologies allow for the prolongation of life even in critical conditions, this right is becoming the subject of intense debate at the intersection of jurisprudence, ethics and morality.

Somatic rights, or the right to the physical integrity of the body, are a component of fundamental human rights enshrined in international instruments such as the Universal Declaration of Human Rights and the European Convention on Human Rights. The right to refuse medical treatment stems from the principle of autonomy, which provides that a competent adult has the right to make decisions about his or her body without coercion. This right is considered a "negative" right – that is, a right to non-interference, in contrast to the "positive" right to receive medical care [1].

In the context of resuscitation, the right to refuse encompasses situations where a patient may refuse measures such as cardiopulmonary resuscitation, ventilation, or other life-sustaining measures. It is based on the doctrine of informed consent, where the patient must be fully informed of the risks and alternatives. However, somatic rights are not absolute: they are limited if the refusal threatens public health, for example in cases of infectious diseases, or if the patient is incompetent, for example due to mental disorders.

In a somatic rights system, this right is related to the right to die with dignity, but differs from euthanasia or assisted suicide in that it focuses on passive refusal rather than active action. In many jurisdictions, such as the United States, it is protected by the Fourteenth Amendment, which guarantees freedom from unwanted medical intervention. In Europe, the ECHR interprets this as part of the right to private life, emphasizing that the freedom to accept or refuse treatment is key to self-determination [2].

AIM

The aim of this study is to examine the right to refuse medical treatment and resuscitation as a component of somatic rights, to analyze comparative legal frameworks in the USA, EU member states and Ukraine, and to identify criteria for distinguishing lawful refusal of treatment from violations of medical and legal obligations.

MATERIALS AND METHODS

The study employs a comparative legal method to analyze legislation across multiple jurisdictions, formal legal analysis of national and international normative acts, and case-law analysis of key ECtHR decisions, including *Arskaya v. Ukraine*, *Pindo Mulla v. Spain*, and *Lambert v. France*. Doctrinal legal sources on patient autonomy, informed consent, and advance directives were also examined.

Number of acts analyzed. The following regulatory acts were directly analyzed: Patient Self-Determination Act 1990 (USA); the decision of the US Supreme Court in the case of Cruzan v. Director (1990); Advance Directives Act 2009 (Germany); Mental Capacity Act 2005 (Great Britain); Medical Assistance in Dying Act 2016 (Canada); relevant legislation of the Netherlands, Belgium and Turkey; profile acts of the legislation of Ukraine on health care and medical assistance; Constitution of Ukraine; ECHR and the practice of the ECtHR in the cases of Arskaya v. Ukraine, Pindo Mulla v. Spain, Lambert v. France.

Excluded acts. The following acts were deliberately excluded from the scope of analysis: acts regulating exclusively active euthanasia (since the study focuses on passive refusal of treatment, not active assistance in death); general codified acts (civil codes, criminal codes) without special norms on advance directives; acts of countries outside the EU/USA/Canada, where the legal mechanism is either underdeveloped or unavailable for verification.

ETHICS

All sources used in this literature review are publicly available.

REVIEW AND DISCUSSION

The analysis revealed a significant asymmetry in the legal protection of patient autonomy across jurisdictions. The USA has the most formalized system of advance directives and DNR orders, the EU demonstrates progressive but variable implementation, while Ukraine lacks a statutory mechanism for legally binding advance medical directives, creating legal uncertainty for patients, physicians, and families of incapacitated persons.

The right to refuse medical treatment is enshrined in law in many countries, with emphasis on advance directives - legal documents that allow a person to specify in advance the medical care they want or do not want if they become incapacitated - and advance directives about not resuscitating. In the United States, since 1990, after the case of Cruzan v. Director [3], Missouri Department of Health, the Supreme Court has recognized the constitutional right to refuse life-sustaining measures, including nutrition and hydration, provided that the will is clearly expressed. Each state has laws on advance directives such as living wills and durable powers of attorney for medical decisions [4].

In the EU, approaches vary. In Germany, the 2009 Advance Directives Act allows patients to record a refusal of treatment, including refusal of resuscitation, with a mandatory competency test. In the UK, the Mental Capacity Act regulates advance decisions to refuse treatment, with a focus on best interests for incompetent patients. In the Netherlands and Belgium, the right has been extended to euthanasia for terminally ill patients, but the basic right to refuse is enshrined in patient rights laws. In Canada, the 2016 Medical Assistance in Dying Act allows for refusal and active assistance in dying for terminally ill patients, with criteria to be expanded in 2021. In Turkey, the right to refuse exists, but with limitations, and needs reform to better protect [5].

Refusal of resuscitation measures. The right of a person to refuse medical intervention, including resuscitation measures, is a complex moral and legal issue, in which the principles of autonomy, humanity and the professional duty of a doctor intersect. In most legal systems of the world, resuscitation measures are considered urgent and aimed at preserving life under all conditions. However, the right of a person to self-determination also includes the ability to refuse measures that continue biological existence without hope of restoring vital functions or consciousness. From a moral point of view, forced resuscitation of a patient who has consciously refused it can be considered a violation of his dignity. This is especially true in cases where such actions only prolong suffering or maintain life in a state incompatible with human consciousness [6].

Legally, the problem lies in the lack of clear procedures that allow recording a person's will to refuse resuscitation. In many countries, this is resolved through a document known as a Do Not Resuscitate Order, a written statement of the patient's will that obliges medical personnel to refrain from resuscitation in the event of clinical death. In Ukraine, a similar mechanism is not enshrined in law, so a doctor who does

not perform resuscitation may be held liable, even if he acted in accordance with the patient's wishes. The ethical dilemma in this case lies in the contradiction between the doctor's duty to save life and respect for the person's will [7].

Recognition of the right to refuse resuscitation does not mean the devaluation of life, on the contrary – it is the recognition that life has meaning only when it retains dignity and a conscious dimension. If medical intervention only prolongs the process of dying, and does not restore health, it can turn into a form of violence against a person. Therefore, in a state governed by the rule of law, it is necessary to provide a mechanism that will allow the patient to determine in advance the limits of permissible intervention. This does not deny the humanism of medicine, but on the contrary – gives it a moral meaning, turning the doctor into a partner in preserving human dignity even at the moment of death [8].

Patient refusal of treatment for fatal diseases. The patient's refusal to treat an incurable or terminal illness is a manifestation of the autonomy of the individual, who recognizes the right to make decisions about his or her own body, suffering, and life expectancy. From a moral point of view, such a decision can be perceived as a desire to preserve dignity in a situation where medicine is no longer able to cure, but only prolongs agony. Legally, this issue is related to the right to informed consent, because a person can consciously refuse treatment only when he or she fully understands the consequences of his or her choice. The doctor is obliged to provide the patient with all information about his or her health condition, treatment options, prognosis, and potential suffering that both treatment and its absence can cause. Such transparency ensures freedom of choice and relieves the doctor of some of his or her moral responsibility. However, in practice, conflicts often arise when doctors, guided by professional ethics or fear of legal liability, continue treatment against the patient's wishes. From a legal perspective, this is a violation of personal autonomy, as no one can be forced into medical intervention without their own consent [2].

The ethical side of the problem is that refusing treatment is not always a manifestation of hopelessness. It is often a conscious choice of a person who wants to live the rest of his life peacefully, next to his loved ones, without pain and forced procedures. Such a decision requires great inner courage and should not be perceived as a denial of the value of life. On the contrary, it can be an expression of respect for it - an understanding that life is not measured by duration, but by dignity and meaning. It is important to establish mechanisms in the legal system that would allow a person to officially refuse treatment so that medical personnel are not faced with a choice between the law and conscience. At the same time, the state must guarantee access to palliative care, psychological support and pain relief so that refusal of treatment is not forced due to pain or hopelessness. This approach combines humanism, freedom and respect for human dignity [8].

Relatives' decisions regarding the treatment of incapacitated persons. Situations where the decision to treat or terminate treatment is made by the relatives of an incapacitated person are among the most complex in both legal and moral terms. The lack of willpower on the part of the patient creates the risk that the relatives' decision will be determined not by the interests of the patient, but by their own beliefs, emotions, or even material motives. From a legal point of view, such decisions should be based solely on the principle of "the patient's best interests" – that is, on what corresponds to his dignity, state of health, and real chances for improvement [9].

The moral dilemma is that even close people cannot fully feel the line between the struggle for life and the continuation of suffering. Often, relatives seek to "keep" a person at any cost, because they are not ready to accept the loss. However, this position may be controversial if the patient is in a vegetative state or in a state of irreversible brain damage. From an ethical point of view, continuing treatment in such cases can be considered a violation of the human right to a dignified death [6].

Legally, it is necessary to establish control mechanisms that would ensure that the decisions of relatives are made objectively, with the involvement of doctors, ethics committees or the court. Ideally, each person should be able to designate a trusted person during life who will make decisions about medical intervention in the event of their loss of capacity. This practice, common in developed countries, allows for the avoidance of conflicts and ensures respect for the will of a person even when they cannot express it. Morally, society must cultivate respect for the dignity of even helpless individuals, recognizing that prolonging life at any cost is not always a manifestation of love or care. Sometimes the most humane decision is to allow a natural end to life without pain and humiliation. The balance between compassion, law and morality in such situations determines the true maturity of society and its ability to respect not only life, but also the humanity in its end.

The United States has a well-developed system of advance directives and DNRs, which allow a person to determine medical decisions in advance in the event of loss of capacity. For example, the federal Patient Self Determination Act (PSDA) of 1990 requires medical institutions to inform a patient of their right to draw up such docu-

ments when they are hospitalized. Advance directives include a "living will", a "health-care proxy" or other forms of document. Specifically, a DNR is a written order that states that a patient does not want to be resuscitated in the event of cardiac or respiratory arrest. Different states have their own forms and rules; for example, the state of California has a regulation that when hospitalized, a medical institution must allow a patient to draw up a "Request to Forego Resuscitative Measures / Advance Health Care Directive / DNR". Legally, all of these documents are valid, but their implementation depends on whether all formal requirements have been met, whether the document is in the medical record, and whether the doctor or medical staff has received a copy of it. Thus, in the USA, the patient has wide opportunities to record his will in terms of medical decisions, and state/medical legislation gives this status [10].

In the European Union, the development of the advance directive mechanism is also underway, but with a lower level of unification at the European level. Studies show that in the EU countries there are different approaches to "advance medical directives" - some states have fully recognized them legally, while others leave them at the level of recommendations or ethical standards. The European Court of Human Rights has recognized in a number of decisions that the patient's right to express his/her preferences regarding medical intervention should be taken into account as an element of autonomy, but member states independently determine the forms of execution. For example, directive studies show that the "advance directive" document should be clear, understandable, and intended for a situation when a person has already lost the ability to make decisions. At the same time, in many cases, the legal force of such documents depends on whether there is an appropriate legal mechanism in a particular country, how the document is recorded, whether it is included in the medical record, and whether there is a possibility of revision or cancellation. So, in the EU, the mechanism exists, but with great variability: sometimes it is legally binding, sometimes it is recommendatory, and sometimes it is applied only in the context of ethics committees. [5].

In Ukraine, the situation is significantly different. Currently, there is no legally established mechanism that would allow a patient to record in advance in writing their wishes regarding medical intervention when they lose their ability to make decisions. Ukrainian legislation establishes that decisions regarding medical intervention are made by the patient himself or by a legal representative in the event of loss of legal capacity, but there are no clear rules for "advance directives". For example, legislative acts on healthcare do not contain provisions that allow a patient to fill out a document in advance that obliges doctors to unconditionally fulfill his wishes in the future. At the same time, the Constitution and laws establish the right to medical care, voluntariness of treatment, and protection of dignity, but the mechanism for exercising the will regarding refusal of treatment or resuscitation is significantly limited. For example, the legislation on healthcare and medical care contains general provisions, but does not specifically define the form and legal force of such a declaration of will. In practice, this means that doctors, medical institutions, or relatives may face legal uncertainty in cases where a patient has left a "medical will." Scientific and legal research in Ukraine emphasizes that the institution of a "living will" (medical will) in the country has theoretical discussion, but does not have clear legal regulation [11].

Comparatively, several key differences between the approaches can be identified: first, in the USA, the mechanism for formalizing the expression of will is highly developed, is drawn up in writing, often has special forms or templates, is valid in medical institutions, includes DNR and advance directive. For example, a doctor can enter a DNR order into the medical record, which significantly increases the practical implementation of the patient's will. In EU countries, there is a movement in this direction, but the variability is great - it depends on the jurisdiction, and even where the document is legally recognized, the practice can be, for example, voluntary and not forced. In Ukraine, the lack of a regulatory framework means that the patient has rights, but the mechanism for implementing them regarding a pre-formulated expression of will is limited and less protected.

Secondly, from the point of view of legal force: in the USA, advance directives and DNR have significant legal force, although depending on the state. Medical institutions are obliged to inform, accept documents, and take them into account during treatment. In the EU, the legal force varies: where it is enshrined in law, the effect is stronger, but a situation is possible when the document is of a recommendatory nature. In Ukraine, the legal consequences of such documents are absent or not defined, which creates legal uncertainty.

Thirdly, from the point of view of practice and implementation: the USA has a wide practice of consulting patients, using such forms, and including them in the healthcare system. The EU emphasizes autonomy and ethics, but implementation depends on the member state. Ukraine does not yet have an established practical mechanism: the patient can express a wish, but the medical institution or doctor is not obliged to follow a written directive formed in advance [4].

This situation has important consequences. On the one hand, the high level of development of the mechanism in the USA means that the patient has a significant degree of control over his medical future. On the other hand, the

absence of such a mechanism in Ukraine means that the patient's will may remain legally unrecorded and will not be guaranteed to be fulfilled. This creates risks: medical decisions may be made without taking into account the wishes of the person, ethical dilemmas arise for doctors, relatives and the healthcare system. In conclusion, the analysis shows that the mechanisms for recording the patient's will in the USA, the EU and Ukraine differ significantly: the USA has the most formalized and practically implemented approach, the EU is intermediate, with great variability, Ukraine is poorly formed legislatively and practically. If the goal is to ensure patient autonomy and protect the will of the person in critical situations, then the Ukrainian legislation and medical system should develop mechanisms that would ensure the legal force of previously drawn up medical orders, as well as their practical application [12].

In this context, it will be appropriate to consider several judicial precedents.

Arskaya v. Ukraine (application no. 45076/05). The case raises a classic problem of the State's positive obligations to protect life in the field of medical care and the procedure for investigating a death resulting from possible medical negligence. The facts of the case indicate that the applicant's son was admitted to hospital with a severe lung infection and abscess, and was offered surgical and diagnostic interventions, but he refused many of the procedures. During the treatment, there were operational and organisational shortcomings – inadequate supervision, errors in the interpretation of diagnostic data and late transfer to intensive care, which together gave rise to well-founded suspicions of inadequate care. The family initiated a criminal and disciplinary investigation, but the domestic authorities failed, in the applicant's view, to ensure an effective investigation of the circumstances and the prosecution of those responsible. The ECtHR in this case emphasizes the two-component nature of the state obligations under Article 2 of the Convention: first, the state must refrain from arbitrary deprivation of life, and second, it has positive obligations to ensure an effective medical system and mechanisms for investigating deaths. The Court carefully examined the medical materials and found that the national investigation practice in this case did not meet the requirement of effectiveness: there was no proper, independent and prompt clarification of the causes of death and an assessment of the actions of medical personnel. On this basis, the ECtHR found a violation of the procedural aspect of Article 2, since the victims could not obtain a real legal answer to the question of possible negligence in the provision of medical care. The decision emphasizes that in the health care system, the state not only guarantees the formal right to life, but also has organizational and procedural responsibilities: proper clinical supervision, diagnostic standards, protocols for transferring patients to intensive care units and, in the event of a fatal outcome, effective investigation procedures and the possibility of prosecution. In practice, the ECHR decision called for an update of approaches in national practice: to improve medical control systems, standardize death investigation processes in medical institutions and ensure victims effective access to justice in order to prevent the recurrence of such tragedies [13].

Pindo Mulla v. Spain (application no. 15541/20, Grand Chamber, 17.09.2024). This case raises a difficult balance between the State interest in protecting life and the guarantees of the autonomy and freedom of conscience of the individual; the alleged issues were advance written refusals to specific medical procedures (in particular blood transfusions) and the ways in which they were taken into account by doctors in emergency situations. In the case, the applicant, motivated by religious beliefs, issued a written and documented refusal to receive a blood transfusion, which was placed in her medical file and had to be taken into account by the medical staff. In a subsequent emergency, when a blood transfusion was administered due to a threat to life, the doctors did not follow the fixed written refusal or, at least, did not establish a procedure for adequately verifying and documenting the reason for not complying with the wishes. The Grand Chamber examined the issue under Article 8 (right to private life) in conjunction with Article 9 (freedom of thought, conscience and religion) and concluded that, while the State has a duty to protect life, it must also ensure that the religious beliefs and wishes of the patient are respected by means of reliable procedures that allow for the timely and accurate identification and compliance with advance directives. The Court emphasised the State's procedural obligation: it is required to establish such mechanisms, organisational algorithms and instructions for staff (including control over the availability of documents, marking in the medical record, algorithms for action in emergency situations) to avoid situations where religious or written refusals are ignored. The Grand Chamber judgment sets the standard: a state cannot reasonably rely solely on the "need to save life" without simultaneously providing guarantees that the providers of medical care acted in accordance with clear procedures for verifying voluntary refusals and documenting them. The Court recalled that the possibility of restricting freedom of conscience stems from a legitimate and proportionate aim (protection of life), but such restrictions must be minimally invasive and compensated by mechanisms ensuring respect for autonomy. The ECtHR judgment recognized a violation of the applicant's rights and set the task for the state to improve national procedures so that in future the will of patients in matters of critical treatment would be reliably protected and could be implemented even in emergency conditions [14].

Lambert v. France (application no. 46043/14, Grand Chamber, 05.06.2015). The case of Vincent Lambert was pivotal in interpreting the relationship between the right to life and the right to a dignified death in situations of a patient's long-term and irreversible condition, highlighting the "margin of appreciation" of States in regulating medical decisions to withdraw artificial support. Following a severe brain injury, Mr Lambert was in a stable state of dependence on long-term artificial nutrition; the clinical team and the French national authorities, guided by domestic legislative and ethical approaches, concluded that the continuation of mechanical life support was "obstination déraisonnable" – unreasonable obstinacy – and decided to withdraw life support in accordance with the established procedure. The relatives objected, relying on the patient's previously stated wishes, and the case underwent complex national and international proceedings. The Grand Chamber, examining the case under Article 2 of the Convention, found that France had not violated the Convention: the national legal framework and procedure, which provided for the participation of doctors, ethical consultations and consideration of the opinions of relatives, were sufficiently clear and provided guarantees to protect the patient's interests. The Court emphasised that the resolution of such issues fell within the margin of appreciation of the Member State, as it was rooted in national ethical, legal and medical traditions; however, such a margin of appreciation was not absolute – national procedures had to be thorough, transparent, include medical justification, the involvement of independent experts and due consideration of the patient's expressed wishes. The Lambert judgment confirmed that the termination of "futile" treatment could be compatible with the Convention provided there was a well-founded, documented clinical argument and sufficient procedural guarantees; This position has since become a guideline for states regulating the termination of artificial life support, combining the protection of life with respect for human dignity and clinical common sense [15].

CONCLUSIONS

The study shows that the right to refuse medical treatment and resuscitation is an integral element of the system of somatic human rights, based on the principles of personal autonomy, respect for human dignity and freedom from unwanted interference. An analysis of international legal standards, in particular the practice of the ECHR in the cases of Arskaya v. Ukraine, Pindo Mulla v. Spain and Lambert v. France, convincingly demonstrates that the right to refuse treatment is not absolute, but its implementation must be ensured by appropriate procedural guarantees from the state. The above decisions have formed a clear standard: the state is obliged not only to formally recognize the autonomy of the patient, but also to create organizational mechanisms that allow for reliable recording, verification and implementation of advance medical directives even in emergency conditions. A comparative analysis of the legislation of the USA, EU countries and Ukraine revealed a significant asymmetry in the level of legal protection of patient autonomy: if in the USA the system of advance directives and DNR orders is legislatively developed and practically implemented, and in EU countries there is a gradual unification of approaches, provided that significant variability between jurisdictions remains, then in Ukraine the corresponding institution is at the initial stage of theoretical understanding and is devoid of clear regulatory regulation. The absence of a legally enshrined mechanism in Ukraine for the implementation of the right to refuse medical intervention creates serious legal and ethical problems for both patients and medical personnel. Doctors find themselves in a situation of legal uncertainty, when compliance with the patient's will may contradict their legal obligation to take all measures to preserve life, and relatives of incapacitated persons are deprived of a clear regulatory basis for making decisions on the termination or limitation of treatment. The problem is exacerbated by the fact that the right to informed consent, enshrined in healthcare legislation, is not supported by effective mechanisms for recording and legal recognition of advance medical directives. On the other hand, the ECHR decision in the Pindo Mulla v. Spain case clearly indicates that the state cannot legitimately refer to the protection of life as a basis for ignoring the patient's documented will without simultaneously introducing appropriate organizational standards and algorithms for verifying such documents. This indicates an urgent need for systemic reform of Ukrainian legislation in this area, taking into account both international standards and domestic legal traditions.

In view of the above, the introduction in Ukraine of the institution of advance medical directives and DNR-directives is not only theoretically justified, but also a practically necessary step towards establishing real patient autonomy and compliance with European standards for the protection of human rights. At the same time, the introduction of an appropriate mechanism should be accompanied by appropriate safeguards against abuse: mandatory verification of a person's capacity when drawing up a directive, the creation of a centralized register of such documents, the involvement of independent medical and ethical consultants in controversial cases, as well as ensuring access to quality palliative care so that refusal of treatment is not forced due to pain or lack of alternatives. The implementation of these measures will allow balancing the state interest in protecting life with respect for the dignity and freedom of each person, turning the Ukrainian medical system into a partner in preserving humanity even in the most difficult moments - up to the dignified end of life.

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CONFLICT OF INTEREST

The Authors declare no conflict of interest

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