REVIEW ARTICLE

CONTENTS

The right to die: Legal analysis of end-of-life decisions in Ukraine

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ABSTRACT

Aim: To analyze medical and legal aspects of end-of-life decision-making in Ukraine, focusing on euthanasia, assisted suicide, withdrawal of life-sustaining treatment, and advance directives. The objective was to evaluate arguments for and against legalization and to examine their relationship with patient autonomy and human rights.

Materials and Methods: An interdisciplinary qualitative approach was applied, combining medical, ethical, and legal perspectives. A systematic review of publications was conducted in PubMed, Scopus, and Web of Science. Ukrainian legislation, including the Civil Code, Criminal Code, and Health Law provisions, was analyzed alongside International Human Rights instruments and relevant jurisprudence of the European Court of Human Rights. When searching for information for this study, the following combinations of keywords were used: "euthanasia", "assisted suicide", "end-of-life decisions", "palliative care", "terminal illness", "patient rights", "right to life", "right to die", "advance directives", "withdrawal of life-sustaining treatment", "DNAR/DNR", "legal regulation in Ukraine", "European Court of Human Rights", "human rights and medicine". 37 sources were selected that fully corresponded to the results of the request.

Conclusions: Ukrainian law prohibits active euthanasia, while assisted suicide and withdrawal of life-sustaining treatment in unconscious patients remain unregulated and may fall under criminal liability. Withdrawal of futile therapy and opioid-based symptom management are permitted forms of terminal care. Comparative analysis shows that judicial practice of European court of human rights increasingly recognizes patient non-property rights and self-determination in end-of-life decision-making. Clarifying the legal status of assisted suicide and advance directives, with appropriate safeguards, may enhance patient rights and harmonize national law with European standards and will also make the legal status of medical workers more certain.

KEYWORDS: Euthanasia, Assisted Suicide, Terminal Care, Patient Rights, Advance Directives

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INTRODUCTION

Currently, most diseases are treatable even if they cannot be completely cured, therefore patients can continue their lives even with some compromises. However, some functional conditions can significantly impact on a patient's life quality, moreover, eventually resulting in death, that is called terminal illness. The term "terminal illness" is defined as an irreversible or incurable disease from which death is expected in the foreseeable future [1]. Terminal illness is associated with wide variety of complications such as physical and psychological symptoms of current disease which are significantly impairing and gradually disrupting life of patients [2]. The most common complications affecting quality of life are anorexia and cachexia, constipation, anxiety and depression, dyspnea, fatigue, nausea and vomiting, pain and pain-related symptoms [3]. Moreover, patients with terminal illness can experience not only physical pain but also emotional and spiritual, thus severe and multifaceted pain is one of the greatest fears among such patients [4]. Systematic studies have shown that pain is the most prevalent increasing distressing symptom during last period of life, moreover, a "good death" among most of respondents is considered as a being pain-free [5]. It is crucially important to manage pain, other symptoms, psychosocial and psychiatric problems by end-of-life care which is a part of palliative care [6]. For all that, as WHO estimated that about 56,8 million patients need end-of-life care, but only 14% received it, thus such patients met poor quality of life and even traumatic death [7]. On the one hand, achievements in medicine made it possible to improve treatment of seriously ill patients and to prolong their life, however, on the other hand, as number of untreatable diseases shows that prolongation of life might not be a goal for all cases of terminal illnesses, thus the goal must be pointed at improvement of life quality and prevention and relief of suffering. In palliative care physicians may sometimes get a request for nontreatment decisions, therefore, such decisions lead to a life end. Request for life end is quite complicated including personal, psychological, social, legal, cultural, religious

and demographic factors, moreover, each request needs individual approach to patient and family with respect, attention, and sensitive communication [8].

The legal framework of the topic under consideration includes the personal non-property rights of an individual, in particular the right to life, which is a natural and inalienable human right. The right to medical care is also the subject of this study. Another important aspect of the issue of ending the life of a terminally ill persons at their request is the aspect of legal consequences that may arise for individuals who are participants in relations connected with the termination of life. First and foremost, this refers to medical professionals, but the subjects of the aforementioned relations may also include the relatives of the terminally ill person or other individuals. Thereby, end-of-life decisions and ways of death hastening are challenging topics, which clearly receives varying degrees of acceptance or lack of acceptance in different countries and relevant legal regulation.

AIM

The aim of the study was to provide an overview of the common end-of-life decisions with primary and secondary intentions, including actions and omissions, to analyze existed arguments and counterarguments for legalization in Ukraine. The study also aims to develop legal approaches to understanding the legal nature of end-of-life decisions and how they relate to the right to life and the right to medical care.

MATERIALS AND METHODS

This article is based on a comprehensive interdisciplinary analysis involving legal and medical dimensions of end-of-life decision-making in the context of Ukraine. The research methodology included a qualitative review of relevant scientific publications and legal documents. To ensure the objectivity and completeness of the analysis, a systematic search of peer-reviewed literature was conducted using international scientific databases such as PubMed, Scopus, and Web of Science. The search focused on studies addressing euthanasia, assisted suicide, palliative care, and patients' rights related to end-of-life decisions. Additionally, the research involved a doctrinal (normative) analysis of Ukrainian legislation, including the Civil Code, Criminal Code, and relevant health laws, as well as a review of international human rights instruments (e.g., the Convention for the Protection of Human Rights and Fundamental Freedoms) and jurisprudence of the European Court of Human Rights. This methodological approach allowed for a detailed examination of both existing legal frameworks and scientific discourse, contributing to a balanced understanding of the current status and challenges related to the right to die in Ukraine. When searching for information for this study, the following combinations of keywords were used: "euthanasia", "assisted suicide", "end-of-life decisions", "palliative care", "terminal illness", "patient rights", "right to life", "right to die", "advance directives", "withdrawal of life-sustaining treatment", "DNAR/DNR", "legal regulation in Ukraine", "European Court of Human Rights", "human rights and medicine". 37 sources were selected that fully corresponded to the results of the request.

ETHICS

All sources used in this literature review are publicly available.

AI STATEMENT

The author states that no AI tools were used in writing this article.

REVIEW AND DISCUSSION

Rights of patients with terminal illness or end-stage disease to make decision about end of life is a debatable question around the world, despite that, a growing number of countries support and legalize assisted dying of such patients [9]. Assisted dying is defined as «The involvement of healthcare professionals in the provision of lethal drugs intended to end a patient's life at their voluntary request, subject to eligibility criteria and safeguards. It includes healthcare professionals prescribing lethal drugs for the patient to self-administer («physician-assisted suicide») and healthcare professionals administering lethal drugs («euthanasia»)» [10]. Assisted suicide and euthanasia are the most discussed among medical end-of-life decisions, however, in this review we examine other ways potentially hastening death by direct or indirect actions or omissions of physician, patient or other individuals. Such end-of-life decisions will be discussed and classified in groups. From the one hand, regarding to a physician, the ending life decision can be based on certain actions or omissions depending on the reasons and intentions hastening the death of patient. From the other hand, relatively to a patient, end-of-life decision can be made on preference of the patient or his family, in this case it is important to assess the competence of patient or family to clarify the awareness in making such decision.

Table 1. End-of-life decisions

Ways of enactment	**1. Administration of life-terminating drugs with primary intention to end life** **2. Withdrawal or withholding of life-sustaining therapy** **3. Opioid-based therapy** **4. Assisted suicide** **5. Disconnection from life-support devices** **6. Advance refusal of resuscitation**					
Groups	**Euthanasia**		**Assisted suicide**	**Withdrawal of life-sustaining treatment in unconscious patients**		**Advance refusal of resuscitation**
Subgroups	Active	Passive	-	Proxy-directed withdrawal of life-sustaining treatment	Clinician-directed withdrawal of life-sustaining treatment	-
Content of the decision	Administration of life-terminating drugs with primary intention to end life	Withdrawal or withholding of life-sustaining therapy; Opioid-based therapy without primary intention to end life	Provision of life-terminating drugs; Prescriptions of life-terminating drugs	Withdrawal initiated by a legal representative or surrogate decision-maker, based on presumed will or best interests of the patient	Withdrawal initiated by medical personnel due to treatment futility or excessive burden, in line with legal or ethical standards	An individual's pre-determined decision to forgo life-restoring interventions in the event of clinical death, typically motivated by considerations related to organ donation or religious beliefs

Source: compiled by the authors of this study

In our view, end-of-life decisions can be implemented in several ways: administration of pharmacological agents or other substances leading to death, withdrawal or withholding of life-sustaining therapy, opioid-based palliative treatment, physician-assisted suicide, termination of mechanical life support, or advance refusal of resuscitative measures (Do Not Resuscitate order). These approaches can, in turn, be classified into four groups: euthanasia, assisted suicide, withdrawal of life-sustaining treatment in unconscious patients and advance refusal of resuscitation. This classification is grounded in a comprehensive criterion that considers both the decision-making subject and the purpose for which the decision is made (Table 1).

Euthanasia is defined as the intentional termination of life of a terminally ill patient at their own request, with the aim of alleviating suffering. Assisted suicide – in other words provision of life-terminating drugs or prescriptions. Withdrawal of life-sustaining treatment in unconscious patients is the termination of life of an individual who, due to objective medical conditions, is unable to make an independent and conscious decision to end their life (e.g., brain death, irreversible incapacitated states incompatible with life), based on the decision of third parties, in order to prevent existence under conditions deemed incompatible with human dignity. Advance refusal of resuscitation (or Do not attempt cardiopulmonary resuscitation – DNACPR (DNR)) – a preemptive decision made by an individual to forgo resuscitation in the event of clinical death, typically for the purpose of organ donation or based on religious or ethical beliefs [11].

1. Regarding euthanasia, several subtypes can be distinguished: active euthanasia, passive euthanasia.

1.1. Active euthanasia or administration of lethal drugs is commonly defined as an direct action of physician terminating life of a patient with uncurable disease in terminal phase and performed at the voluntary request of the patient with the purpose of ending of situation the patient considers intolerable, important to add, that physician is not only giving the way to end the life but also is an agent of death [12].

1.2. Passive euthanasia – the withholding or withdrawal of life-sustaining treatment, allowing the patient to die naturally; in certain cases, this may also include the administration of opioids aimed at relieving suffering, even if it may potentially hasten death. Considering decisions of withholding/withdrawing treatment before the death in most of cases are made because of the following: firstly, aggressive treatment in terminal stage of disease is often impairing a quality of life, secondly, there is a little or there is no chance of improvement and are commonly met in a very old patients or patient with dementia. However, the time when treatment of current disease or life-sustaining treatment should be cancelled is still debatable with strong intercultural differences. Results of conducted research have shown that treatments with potential high impact on life quality is rarely continued till death [13]. According to the rule of double effect, an action with the intent of benefits achievement

is morally acceptable even if an action brings a harmful side effects, if benefits outweigh the harm. The intent of withholding/withdrawing treatment reflects freedom from unwanted intervention thus hastening the natural death, which will occur because of the current disease. European Association for Palliative Care stated "Withdrawing/withholding ineffective, futile, burdensome, and unnecessary life-prolonging procedures or treatments doesn't constitute euthanasia or assisted suicide because it is not intended to hasten death but indicate the acceptance of death as a natural consequence of the underlying disease progression" [14]. From the other point of view, withdrawing the measures to support the patients' life and thus hastening the death can be considered as a passive euthanasia [15]. Based on the cited statement, it is possible to conclude that withholding/withdrawing treatment is not intended primarily to hasten death but does have secondary intention. Regarding pain alleviating treatment, then opioids are commonly used drugs for this purpose, however the doctrine of double effect should be taken in account as drugs which are possibly shortening the life of patients, in addition, existing court cases draw attention to use of morphine as "slow euthanasia" [16]. Indeed, opioids provide a good symptoms control, but along with that, opioids have many side effects, moreover, opioids use can result in respiratory suppression, analgetic tolerance, hyperalgesia and dependence [17]. Thus, on the one hand, pain and symptoms control using opioids, even if risk for shortening of life exist, is ethical [18], but, from the other hand, on the line with beneficial effect there is, with no intention, death hastening.

With regard to Ukrainian legislation, the definition of euthanasia can be found in Part 7 of Article 52 of the Law of Ukraine "On the Fundamentals of Health Care Legislation of Ukraine" (Law of Ukraine on Health Care) dated November 19, 1992, No. 2801-XII, which states: "Medical workers are prohibited from performing euthanasia – the deliberate acceleration of death or the mortification of a terminally ill person in order to end their suffering." [19].

Firstly, from the wording of the law, it is clear that euthanasia is explicitly prohibited. Secondly, based on the legal norm, the following characteristics of euthanasia can be distinguished:

(a) intentional nature of the act – euthanasia involves a person's awareness that their actions or inaction will result in death or mortification;

(b) purpose – the act is aimed at ending the suffering of a terminally ill person;

(c) subject – euthanasia is performed in relation to a terminally ill individual, i.e., someone whose illness is incurable;

(d) means – involves the acceleration of death or deliberate killing, rather than the natural course of dying;

(e) actors – the law directly refers to medical professionals, but the concept may be broader in practical or ethical discussions.

These elements define euthanasia in Ukrainian law and underscore its current prohibition, irrespective of the patient's consent or request.

2. Assisted suicide – the provision of means or information by a physician or other party, enabling a patient to end their own life voluntarily [20].

In our opinion, assisted suicide could involve several forms of action, first is providing the patient with a prescription for medications intended to end life, or pharmacologically-assisted suicide is generally defined as a practice when physician prescribes a lethal dose of medication, which a patient intends to use to end own life. It is essential to consider that physician only provides prescription to hasten death, but it is the patient who decides to use drug to end the life, therefore voluntary self-administration of drugs producing lethal effect by a patient, but also a patient is free to decide against self-administration, thus the responsibility for the final action lies with the patient who requested assistance [12]. Second, supplying the patient with life-ending medications; and third one refers to cases when a patient with terminal ill has voluntary will to end life but unable to do its own because of certain disability, thus patient requires physician to perform the ending life action [15]. In certain instances, assisted suicide is nearly indistinguishable from active euthanasia.

3. Withdrawal of life-sustaining treatment in unconscious patients includes disconnection from life-support equipment based on the decision of legal representatives and disconnection from life-support equipment based on the decision of medical professionals. This is often regulated through advance directives or substitute decision-making laws. In turn, disconnection by medical professionals may also be classified as withdrawal of life-sustaining treatment in unconscious patients, depending on the intention, for instance, to relieve suffering or to end life. In many jurisdictions, withdrawal of life support in cases of brain death or medical futility is not legally defined as euthanasia, but rather as allowing natural death especially when brain death equals legal death.

4. The last category related to end-of-life decisions is DNACPR – do not attempt cardiopulmonary resuscitation, sometimes called DNAR – do not attempt resuscitation or DNR – do not resuscitate or AND – allow natural death, but all these notions refer to the same purpose, in other words in case of cardiac arrest the physician should not try to restart heart function

or breathing, therefore resulting in death, thus this is about CPR only and it doesn't mean that patients will not get care, treatment and support [21]. DNAR decision can be made by person's own or by physician in case when CPR will cause physical or psychological harm or case history states about polyorganic pathology leading to end of life. In contrast to other end-of-life options, decision about DNAR order can be made at any time either when person is healthy or when approaching the end of life, secondly, DNAR decision can be written either for a short time or with no end date, in this case DNAR decision must be periodically reviewed [22].

Consequently, relatively to action/omission and intention, the end-of-life decisions made by physicians can be with primary and secondary intentions in case of withholding and withdrawing treatment when action or omission will hasten death. In turn, treatment which is directed only to relief pain or other symptoms can be considered as hastening of death with secondary intention, but administration/prescription of lethal drugs and DNAR order considered as with primary intention of death hastening.

The characteristics of the actor's actions as having a primary or secondary intention to hasten death may be taken into account in two distinct legal areas: (1) the legal regulation of relations related to the end-of-life decisions, and (2) the legal qualification of the actor's actions in case of investigation needed.

An analysis of the aforementioned end-of-life decisions in the context of Ukrainian legislation allows the following conclusions: active euthanasia is explicitly prohibited by law, and actions of medical professionals exhibiting characteristics of active euthanasia may be classified as criminal offenses under Articles 137 and 140 of the Criminal Code of Ukraine [23]. However, the situation regarding passive euthanasia is less obvious. Ukrainian law permits both the withholding or withdrawal of treatment and the administration of opioid-based therapy.

According to Part 4 of Article 284 of the Civil Code of Ukraine: 'An adult capable individual who is aware of the significance of their actions and able to control them has the right to refuse medical treatment' [24]. In turn, Part 4 of Article 43 of the Law on Health Care establishes that: 'A patient who has attained full civil capacity and is aware of the significance of their actions and able to control them has the right to refuse medical treatment' [25]. At the same time, a physician bears no liability for the patient's health in the event of the patient's refusal to follow medical instructions or failure to comply with a prescribed regimen [26].

The possibility of using opioids in medical care is provided, for example, by the Order of the Ministry of Health of Ukraine "On Approval of Medical Care Standards for Chronic Pain Syndrome in Adults and Children" dated 06 April 2023, No. 643 [27]. Thus, passive euthanasia, as a form of euthanasia and one of the methods for implementing end-of-life decisions, finds its legal basis within the current legislation of Ukraine.

Assisted suicide is not allowed under the Ukrainian legislation. Provision of life-terminating drugs and prescriptions of life-terminating drugs by medical or pharmaceutical worker can be punished according to Article 140 of the Criminal Code of Ukraine [28].

Withdrawal of life-sustaining treatment in unconscious patients is not permitted in Ukraine. In particular, according to Part 2 of Article 52 of the Law on Health Care: 'Active measures to sustain the life of a patient shall be discontinued if the patient's condition is determined to be irreversible death' [29]. Accordingly, advance refusal of resuscitation is currently outside the scope of Ukrainian law, and the failure to provide, without valid reasons, medical assistance to a patient by a healthcare professional who is obliged, according to established rules, to provide such care, and who is aware that omission may result in serious consequences for the patient, is punishable under Article 139 of the Criminal Code of Ukraine [30].

ARGUMENTS FOR LEGALIZATION END-OF-LIFE DECISIONS

For the specific group of people, a life is not always highest achievable value that should be protected and supported, that underlines the importance of personal autonomy and self-determination of end-of-life decisions. The autonomy of patients with uncurable disease in terminal phase that is conception in living own life, rights of self-determination [18]. An Article 8 of European Convention on Human Rights enshrines the right to bodily autonomy, although this is a rather extended interpretation of the said article, which states: «Everyone has the right to respect for his private and family life, his home and his correspondence. 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 wellbeing 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.» [31]. In paragraph 51 of the Haas v. Switzerland case, the European Court of Human Rights emphasized that one of the aspects of the right to respect for private life (Article 8 of the Convention) is the individual's right to decide in what manner and at what point their life will

end, provided that they are capable of freely making such a decision [32]. The favor of such decision is to relief the severe unbearable suffering and when there is no prospect to relief, moreover when avoiding or ending suffering cannot be achieved in any other way that is acceptable to the patient. Important to add, as experience of some countries shows that diagnosis of terminal ill must be confirmed at least by two doctors and life-expectancy of 6 month or less [33].

The lack of moral demarcation between direct actions leading to death as assisted suicide or euthanasia and indirect actions such as withdrawal/withholding treatment, treatment of pain and other symptoms, if these actions are not to be in the best interest of patient and, moreover, shorten life or hastening death.

Ukraine is currently undergoing a reform of its civil legislation, within the framework of which the Concept for the Renewal of the Civil Code of Ukraine (hereinafter referred to as "the Concept") was submitted for public discussion. According to the Concept, specifically § 2.9 of Book Two entitled Personal Non-Property Rights, the potential legalization of euthanasia and assisted suicide is being considered. It is proposed to re-evaluate the issue of legalizing passive euthanasia and assisted suicide, taking into account the jurisprudence of the European Court of Human Rights (ECHR), alongside the introduction of corresponding amendments to the Criminal Code of Ukraine [34]. This indicates a normative trend toward the liberalization of legal relations associated with the conscious termination of life in terminally ill individuals [32]. Such a direction aligns with broader pan-European legal trends and the established case law of the ECHR. Nonetheless, as of the time of this study, the proposed amendments have not yet been enshrined in national legislation.

COUNTERARGUMENTS FOR LEGALIZATION END-OF-LIFE DECISIONS

From the moral point of view, which is based on the religious beliefs, no person can have rights to end life, therefore all actions or omissions with primary or secondary intentions are against human nature and reflect degradation of humanity. An Article 2 of European Convention on Human Rights enshrines the *right to life*, where is stated that: «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. 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.» [31]. In particular, the European Court of Human Rights has emphasized that the right to die is fundamentally opposed to the right to life and cannot be derived from it. Accordingly, Article 2 of the Convention cannot be interpreted as guaranteeing a right to die. This position was clearly articulated in Pretty v. the United Kingdom case, where the Court stated that "Article 2 cannot, without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die" [35].

Additionally, palliative care provides alternatives to relieve severe suffering in most of cases thus legalization of end-of-life procedures may lead to the lack of development and devaluation of palliative care. Legalization of end-of-life procedures may cause tendency of physicians to choose ending of life more frequently and easier to avoid suffering for unconscious patients, patients with dementia or mental diseases and infants that is a category of patients who are incompetent. Also, scientific data shows that up to half of patients with cancer have symptoms of depression, in turn, depression often manifests somatically, thus enhances symptoms of current disease, hence, it is hard to assess the competence of patient and real degree of suffering from terminal illness with sufficient certainty [36]. The main principle of medical education is the patient as the main value of the medical system; therefore, physicians are trained to protect quality and quantity the lives of patients, thus physicians' involvement in the ending life goes against primary principles and will affect ethics of medical practice. Death certificate requires to indicate the cause of death, thus in case of assisted suicide or euthanasia the cause of death is defined because of lethal dose of drugs but not the underlying illness. As statistical data shows that in countries where assisted suicide is legal the total suicides number has been increased compared to period when such procedures were illegal [37].

The initial point for end-of-life decision making can be a prognosis of the patient's current disease, quality and quantity of remaining life and perspectives of possible treatment, also how much the treatment is harmful and could more affect remaining life, consideration of possibilities of alternative treatment and its impact, analysis of similar clinical cases and statistical data in order to compare the effectiveness of treatment and life expectance, also degree of accompanied suffering. Finally, if patient or physician tent to come to end-of-life decision, thus important to specify the ways of death hastening between possible and certain end of life, which depends on patients' condition, action or omission, primary or secondary intention.

COMMON PROPOSALS FOR REGULATION

From the perspective of regulating relations connected to end-of-life decisions under civil law of Ukraine, it should be noted that certain measures, such as the withholding or withdrawal of treatment and the administration of opioids, are provided for under current Ukrainian legislation. Although these measures are not directly aimed at ending a patient's life, they may, to some extent, hasten death. Such decisions exhibit characteristics of passive euthanasia, which has been recently proposed for legalization in the Draft Concept for the Revision of the Civil Code of Ukraine. The same Draft Concept also proposes the legalization of assisted suicide as encompassed by the right to life, which generally corresponds to the current practice of the ECHR and the philosophical-legal ideas of the perception of natural human rights.

At the same time, it appears appropriate to supplement civil legislation with the right to refuse resuscitation. Clearly, such a refusal must be expressed by a legally competent individual in an unequivocal manner and documented appropriately (potentially with notarization). Unlike withdrawal of life-sustaining treatment in unconscious patients for individuals who, due to their medical condition, are unable to express their end-of-life decision, raising doubts about the validity of such a decision, "Do Not Resuscitate" order allows for a clear and verifiable expression of the individual's prior will regarding the non-application of resuscitative measures. The legalization of DNR would allow individuals to make an autonomous choice in favor of consciously terminating life rather than persisting in a state of helplessness or existence in conditions compromising human dignity, which may result from clinical death, coma, or brain injuries associated with these conditions. Furthermore, the legalization of DNR would define the limits of legal liability for healthcare professionals involved in such practices.

CONCLUSIONS

Through the study of legal regulations and scientific literature, we have delineated the primary methods for the realization of life-termination decisions: 1) administration of life-terminating drugs with the primary intention of ending life; 2) withdrawal or withholding of life-sustaining therapy; 3) opioid-based therapy; 4) assisted suicide; 5) disconnection from life-support devices; 6) advance refusal of resuscitation. The identified methods can be systematized into four groups: (1) euthanasia (active and passive); (2) assisted suicide; (3) Withdrawal of life-sustaining treatment in unconscious patients (Proxy-directed withdrawal of life-sustaining treatment; clinician-directed withdrawal of life-sustaining treatment); (4) advance refusal of resuscitation.

We determined that certain end-of-life decisions are expressly prohibited by the current legislation of Ukraine (active euthanasia), some, although not explicitly prohibited, but fall within the scope of criminal law by creating or constituting elements of specific offences (assisted suicide, withdrawal of life-sustaining treatment in unconscious patients, advance refusal of resuscitation), and others are the part of existing medical practice within the legal framework (passive euthanasia).

In scope of modern philosophical and legal views on natural human rights and prevailing judicial practice, we consider that legalization of assisted suicide and advance refusal of resuscitation is justified, insofar as these measures can be verified in accordance with the valid will of the person and are directed toward a dignified termination of life as an element of the content of the right to life.

Further research within this topic will be focused on the medical, ethical, legal, technological, and organizational prerequisites for the legalization of the aforementioned end-of-life decisions.

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CONFLICT OF INTEREST

The Authors declare no conflict of interest

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