RIGHT TO MEDICAL AUTONOMY: REFUSAL OF TREATMENT AS AN ELEMENT OF PERSONAL FREEDOM

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Annotation. The right to refuse medical treatment represents one of the most complex intersections of personal freedom, medical ethics, and legal regulation. This article examines the theoretical and legal foundations of the patient's right to refuse medical intervention, tracing its evolution from paternalistic medical practice to the modern autonomy-centered paradigm. Drawing on international legal instruments, including the Oviedo Convention and the Charter of Fundamental Rights of the European Union, as well as the case law of the European Court of Human Rights, notably the Grand Chamber's decision in Pindo Mulla v. Spain, the article establishes that the right to refuse treatment constitutes an independently recognized subjective right rooted in the principles of personal autonomy, bodily integrity, and human dignity.

The article analyzes the doctrine of informed consent as the legal foundation upon which the right to refuse is built, emphasizing that genuine informed refusal presupposes both awareness and voluntariness. Particular attention is paid to the limits of this right, which are determined by the patient's legal capacity, the nature of the medical situation, and the legal validity of advance directives. The study further addresses the theoretical tension between patient autonomy and the physician's duty of beneficence, arguing that these principles are not mutually exclusive: in situations involving a competent patient, autonomous will takes priority, while beneficence is realized through ensuring the quality of the decision-making process rather than overriding the patient's choice.

A comparative dimension is incorporated through analysis of regulatory approaches in France, Germany, the Netherlands, Italy, the United Kingdom, and Japan, revealing a pan-European doctrinal convergence toward recognizing informed refusal as a legally enforceable right. The article concludes that the absence of a unified legislative mechanism in Ukraine for implementing the right to refuse treatment, coupled with vague legality criteria and gaps in defining medical professionals' liability, necessitates systematic legal reform aligned with European standards.

Key words: medical autonomy, right to refuse treatment, informed consent, patient rights, bodily integrity, beneficence, European Court of Human Rights.

1. Problem statement.

The right to medical autonomy is one of the fundamental manifestations of personal freedom of a person, which organically combines constitutional guarantees of personal integrity, the right to health care and the right to free development of the personality. At the same time, the implementation of this right in the area of refusal of treatment gives rise to a number of acute legal conflicts: a clash of interests between the patient and the medical institution, competition between the principle of respect for personal autonomy and the state's obligation to protect the life and health of citizens, as well as the issue of the legal consequences of such a refusal for all participants in medical legal relations.

This problem becomes particularly acute in cases where refusal of treatment may lead to the death of the patient or serious consequences for his health, as well as when it comes to persons with limited legal

capacity, minors or patients in critical condition, unable to consciously express their will. In such situations, law enforcement practice is faced with the lack of clear legislative mechanisms that would allow balancing patient autonomy with medical, ethical and legal requirements. Despite the fact that Ukrainian legislation formally enshrines the patient's right to refuse medical intervention, the legal regulation of this institution remains fragmentary and lacking in systematization. The lack of a unified mechanism for implementing the right to refuse treatment, the vagueness of the criteria for its legality and the gaps in determining the responsibility of medical professionals necessitate a comprehensive scientific study of the above-mentioned issues.

2. Analysis of recent research and publications.

The issue of patient medical autonomy and the right to refuse treatment is at the intersection of medical law, bioethics and constitutional law, which determines the interdisciplinary nature of its study. In domestic legal science, certain aspects of the legal regulation of medical legal relations were studied by S. Stetsenko, V. Stetsenko, I. Senyuta, who considered the rights of patients in the context of the general concept of medical law of Ukraine. The issues of informed consent and its reverse side, informed refusal, were partially covered in the works of Y. Shatkovska, N. Bolotina and O. Yaroshenko within the framework of the study of civil law regulation of the provision of medical services.

In foreign doctrine, the right to medical autonomy has received much more thorough development. The conceptual foundations of patient autonomy are laid down in the works of T. Beauchamp and J. Childress ("Principles of Biomedical Ethics"), who formulated the principle of respect for autonomy as one of the four basic principles of biomedical ethics. The legal aspects of refusal of treatment are actively studied in Anglo-Saxon legal doctrine - in particular, in the works of J. Muller, R. Fayden, etc., as well as in the practice of the European Court of Human Rights, which in its decisions has repeatedly addressed the issue of the relationship between Article 2 (right to life) and Article 8 (right to respect for private life) of the Convention for the Protection of Human Rights and Fundamental Freedoms in the context of medical decisions.

3. The article aims to explore the theoretical and legal foundations of the patient's right to refuse medical intervention, determine its legal nature and place among the subjective rights of a person, and clarify the regulatory basis and limits of the implementation of this right in the light of modern approaches to the doctrine of medical law and the case law of the European Court of Human Rights.

4. Presentation of the research material.

The origins of the patient's right to refuse treatment should be sought in the formation of the concept of personal autonomy as the basis of the legal status of a person. For a long time, a paternalistic approach dominated medical practice, in which the doctor was considered the only competent subject for making decisions about treatment. This concept was based on the presumption: it is the doctor's medical knowledge that determines what is best for the patient, and therefore the patient should obey the medical decision [10, p. 1974]. The turning point occurred in the 1950s–1970s, when public attention to human rights, the Nuremberg Code, and subsequent legal reforms significantly changed the nature of the relationship between the doctor and the patient. The key doctrinal premise of the modern right to refuse was the requirement of informed consent. Kim H.W. and Lee A. note that case law, in particular common law precedents, has established the doctrine of the priority of patient autonomy over medical paternalism even when refusal of treatment may result in the patient's death [1, p. 84]. Lewis J. and Holm S. in their theoretical study emphasize that the recognition of the patient as an autonomous subject in the context of clinical decision-making sets the limits within which the patient must be protected from paternalistic medical intervention: informed consent is the standard mechanism through which the patient exercises his sovereignty over his own body [7, p. 617].

In the English common law tradition, the right to refuse treatment is conceptually based on the principle of bodily integrity. Horn R. and Kerasidou A. establish that William Blackstone introduced this principle

into legal practice as early as 1765, and modern common law establishes that, provided that the patient is properly informed, he is not obliged to give reasons for refusing treatment [9, p. 406].

A parallel evolution has taken place in the continental legal tradition. The author of a comparative study, Varahala S., notes that France legislated the patient's right to refuse treatment in 2002 through the adoption of the so-called "Kushner Law", and the Netherlands has developed one of the world's broadest concepts of patient autonomy, encompassing both advance directives and the right to euthanasia [8]. In Germany, the individual right to refuse exists alongside a strong tradition of social and state responsibility and mutual trust between doctor and patient [8].

It should be noted that the international legal dimension of the patient's right to refuse treatment was formed primarily through the 1997 Council of Europe Convention on Human Rights and Biomedicine (Oviedo Convention). Article 5 of this document enshrines the principle of autonomy of will through informed consent as one of the main rights of the patient: medical intervention may be carried out only after the person concerned has given his free and informed consent. This norm also covers the reverse side - the right to withdraw such consent at any time.

The practice of the ECHR has also significantly influenced the doctrinal understanding of this right. The Court has consistently interpreted Article 8 of the ECHR (the right to respect for private and family life) as encompassing the right to self-determination and personal autonomy, including the freedom to consent to or refuse medical interventions. As established in a study of the ECtHR's practice on informed consent, complaints related to the lack of proper consent now concern not only a possible violation of Article 8, but also Article 3 of the ECHR (prohibition of inhuman treatment), when the treatment is particularly invasive [11, p. 489].

Of particular importance is the decision of the Grand Chamber of the ECtHR in the case of Pindo Mulla v. Spain, which is considered one of the most important in this area in recent years. The applicant, a Jehovah's Witness, had drawn up an advance directive before hospitalization with a categorical refusal of blood transfusion in any medical situation, even life-threatening. However, during the surgical treatment, the doctors, having received permission from the judge on duty, carried out a blood transfusion without the patient's knowledge and against her documented will [12]. The Court analysed the conflict between Articles 2 and 8 of the ECHR, the right to life and the right to personal autonomy, and found that compulsory medical intervention contrary to the clearly expressed and legally established will of a competent person is a violation of the Convention. This decision confirms that even the protection of the right to life cannot automatically justify ignoring the patient's right to refuse treatment [12].

The Charter of Fundamental Rights of the European Union also serves as an important normative reference point, Article 3 of which guarantees the right to physical and mental integrity of the person and, in the context of medicine, the right of the person to informed consent in accordance with the conditions established by law. In fact, these provisions form a normative minimum below which no Member State may fall in regulating medical relations.

The doctrine of informed consent is the legal foundation on which the right to refuse treatment is built. This doctrine itself has undergone a long evolution: from simply informing the patient about the planned intervention to the requirement to ensure his full understanding of the risks, alternatives and consequences of treatment. Fry M. in a 2024 study emphasizes that informed consent combines the right to be sufficiently informed with the right to agree to or reject medical intervention; at the same time, the researcher identifies three key limitations to the real autonomy of the patient: the "information gap" - a situation when the patient cannot fully comprehend the medical information provided due to its complexity; limited cognitive capacity; and the tendency to over- or under-estimate the risks of treatment [14].

A comparative study of the regulation of informed consent in Italy, France, Great Britain, Scandinavian countries, Germany and Spain, conducted in 2024 and published in the Journal of Forensic and Legal Medicine, found that in all the legal systems studied, informed consent is recognized as a mandatory requirement; the common standard is clear information about treatment, therapeutic alternatives and significant risks - mostly documented in writing [15]. In fact, this conclusion indicates the formed pan-

European doctrinal convergence on issues of informed consent. The distinction between voluntary and informed consent is fundamentally important. Abraham J. A. and Abraham S. P. emphasize that although the patient may be informed about his health condition, he will not always be able to make a free decision: pressure from family, medical staff or material circumstances can hinder the realization of autonomy [5, p. 126]. Thus, true informed consent and, accordingly, informed refusal, presupposes the simultaneous observance of two conditions: awareness and voluntariness.

In a broader doctrinal context, Lewis J. and Holm S. reveal that the practice of assessing the patient's capacity has formed a specific approach to autonomy, based on cognitive indicators: the ability to understand the information provided, assess the consequences of different options and formulate and communicate one's decision [7, p. 618]. These criteria become crucial precisely in situations of refusal of treatment: when a patient refuses life-saving therapy, verification of his capacity becomes a legally binding element of a legitimate refusal.

Thus, as we see, the right to refuse treatment and the right to informed consent are two sides of the same legal phenomenon. Refusal is the exercise of the right to not consent after receiving proper information. That is why the doctrine of informed consent is not only a procedural mechanism, but also a substantive legal basis for the patient's subjective right to refuse medical intervention.

Despite the established nature of the right to refuse treatment, its implementation in practice often faces complex legal conflicts. Central among them is the issue of patient capacity: the right to refuse is recognized only for those individuals who are able to independently understand and realize the consequences of their decision.

Pirotte B. D. and Benson S. argue that the first step in any situation of refusal of medical care is to establish the patient's capacity, which they define as the ability of a person to process information and make an informed decision in accordance with their own beliefs, values and wishes [2]. At the same time, they emphasize that the four principles of medical ethics, autonomy, beneficence, non-maleficence and justice, are not equivalent in each specific situation, and their balance depends on the circumstances of the case [2].

Marshall K.D. and co-authors in a 2024 paper (The American Journal of Bioethics) insist that competent adults have the legal right to make their own medical decisions, including refusing medical care even when the outcome would be death. The forcible confinement or physical or chemical restraint of a patient who has been found to have capacity is a documented violation of the law, both in tort and criminal law [16]. This conclusion is particularly relevant in the context of refusing treatment after resuscitation measures. The issue of advance directives is a separate doctrinal layer. Andoh B. examines a case where a patient's advance directive regarding blood transfusion was found to be legally invalid due to failure to comply with formal requirements. The author argues that while the right to refuse and the advance directive are important legal instruments, both have limitations in practical application [4]. In the study by Leal-Adorna M., it is established that if the patient is capable at the time of the proposed treatment, his or her currently expressed will (regardless of a previously drawn up directive) will always have priority. If the patient is incapable, advance directives or decisions of the legal representative come to the fore [13].

A separate category is emergency medical care situations. The recommendations of the European Society of Emergency Medicine state that if a doctor in an emergency situation establishes the patient's lack of capacity, the right to refuse treatment cannot be exercised: in such a case, the law presumes that a reasonable person would agree to treatment in order to avoid serious consequences [17]. At the same time, the recommendations emphasize that informed refusal is a process, not just a signature on a form [17], and therefore, even in conditions of urgency, medical professionals are obliged to take the patient's expressed will into account as much as possible.

Thus, the right to refuse treatment is not absolute. Its limits are determined by: the patient's capacity (in the absence of which substitute mechanisms are applied - advance directives or decisions of a representative); the nature of the medical situation (emergency narrows the scope for the implementation of the refusal); as well as the rights of third parties and the public interest. However, the above restrictions are of an exceptional nature and cannot be transformed into a general rule of disregard for the patient's will.

It should be noted that the central theoretical conflict of medical law is the confrontation between the patient's right to autonomy and the doctor's duty to act in the patient's best interests (the principle of beneficence). This tension has deep doctrinal roots and is often manifested in the practice of clinical decision-making. Conceptually, patient autonomy is often contrasted with doctor's beneficence in such a way that they seem to exclude each other: if the doctor is guided by beneficence, he "knows best" and can override the patient's decision; if autonomy dominates, the doctor is obliged to carry out the patient's will, even if he considers it harmful. However, such a binary construction is an oversimplification. Lewis J. and Holm S. in the study we have already cited advocate a phenomenological approach, according to which autonomy is not only a cognitive phenomenon, but includes the patient's practical identity - his values, cultural context and way of interacting with the world [7, p. 622]. This means that the full realization of autonomy requires the doctor not to be neutral, but to actively assist the patient in making an informed decision.

The author of a comparative study, Varahala S., proposes a "relational" model of autonomy, which recognizes that a patient's decisions are formed in a certain social and family context, and therefore, medical law must take into account both individual will and the network of relationships in which a person lives [8]. The same study provides a comparative illustration: in Japan, in the absence of advance directives or the need for life-saving intervention, hospitals usually provide treatment if it is absolutely necessary to save life, although a Japanese court has at the same time recognized the right of a Jehovah's Witness patient to refuse a blood transfusion on the basis of personal autonomy [8]. This example illustrates that even in systems with a strong paternalistic tradition, the right to refuse treatment is gradually gaining normative recognition.

The confrontation between autonomy and beneficence is particularly acute in psychiatry. A study in the British Journal of Psychiatry emphasizes that patient autonomy and beneficence are not polar principles, but should be considered as equivalent guidelines: society has a legitimate interest in the "good outcome" of treatment, and therefore a simple slogan of "more autonomy" cannot automatically solve complex clinical situations [18, p. 97]. At the same time, the authors insist: the patient should be an equal participant in decision-making, not a subordinate subject.

Thus, legal theory does not oppose autonomy and beneficence as incompatible values, but rather builds a hierarchy between them: in situations with a competent patient, his autonomous will is a priority; at the same time, the doctor retains the obligation to ensure the conditions for the formation of this will - by providing comprehensive information and eliminating pressure factors. Beneficence is realized not through the cancellation of the patient's decision, but through the quality of medical support for the process of making this decision.

5. Conclusions.

Thus, in our opinion, the patient's right to refuse treatment is an independent subjective human right, derived from the fundamental principles of personal autonomy, bodily integrity and human dignity. It is not exclusively a medical-ethical phenomenon, but has a clearly expressed legal nature and regulatory enshrined in international and national legal acts.

The doctrine of informed consent is the legal foundation of the right to refuse: refusal of treatment is the flip side of the right to informed consent. The full implementation of this right is possible only if both components of informed consent are observed: awareness and voluntariness.

The right to refuse treatment is not absolute. Its implementation depends on: the patient's legal capacity; the nature of the medical situation (ordinary or emergency); the availability and legal validity of advance directives. Lack of capacity does not deprive the patient of legal protection, but redirects decision-making to substitute mechanisms: advance directives or an authorized representative.

The practice of the ECHR confirms that refusal of treatment is a conventionally protected right under Article 8 of the ECHR, and even the protection of the right to life (Article 2) does not give the state the automatic right to forcible medical intervention contrary to the clearly documented will of a capable patient.

The theoretical conflict between patient autonomy and the doctor's beneficence is not insoluble: the modern doctrine of medical law establishes a hierarchy according to which the autonomous will of a capable patient is a priority, while the beneficence is implemented in the form of high-quality informational and procedural support for making this decision.

References:

1. Kim H. W., Lee A. How patient autonomy drives the legal liabilities of medical practitioners and the practical ways to mitigate and resolve them. Postgraduate Medical Journal. 2023. Vol. 99, No. 1168. P. 83–88. DOI: 10.1093/postmj/qgad003.

2. Pirotte B. D., Benson S. Refusal of Care. StatPearls. Treasure Island (FL): StatPearls Publishing, 2026. URL: https://www.ncbi.nlm.nih.gov/books/NBK560886/

3. Andoh B. The "Right" to refuse treatment. Medicine, Science and the Law. 2023. DOI: 10.1177/00258024221140660.

4. Andoh B. Right to refuse treatment upheld while advance directive failed. Medicine, Science and the Law. 2025. DOI: 10.1177/00258172241280435.

5. Abraham J. A., Abraham S. P. Patient Freedom to Choose or Refuse Treatment: Is Autonomy Upheld? IJSRM. Human. 2021. Vol. 19, No. 1. P. 124–134. URL: https://www.researchgate.net/publication/353854998_Patient_Freedom_to_Choose_or_Refuse_Treatment_Is_Autonomy_Upheld

6. Kim C. J. Ensuring Patients' Well-Deserved Right to Refuse Treatment, Not Jumping to an "Assisted Death With Dignity". Journal of Korean Medical Science. 2024. Vol. 39, No. 2. Art. e30. DOI: 10.3346/jkms.2024.39.e30.

7. Lewis J., Holm S. Patient autonomy, clinical decision making, and the phenomenological reduction. Medicine, Health Care and Philosophy. 2022. Vol. 25, No. 4. P. 615–627. DOI: 10.1007/s11019-022-10102-2.

8. Varahala S. Autonomy on Trial: Trust, Capacity, and the Doctor-Patient Divide in US Bioethics and Law. Voices in Bioethics. 2025. Vol. 11. DOI: https://doi.org/10.52214/vib.v11i.13957

9. Horn R., Kerasidou A. The Concept of Dignity and Its Use in End-of-Life Debates in England and France. Cambridge Quarterly of Healthcare Ethics. 2016. Vol. 25, No. 3. P. 404–413. DOI: 10.1017/S0963180116000050.

10. Kilbride M. K., Joffe S. The New Age of Patient Autonomy: Implications for the Patient-Physician Relationship. JAMA. 2018. Vol. 320, No. 19. P. 1973–1974. DOI: 10.1001/jama.2018.14382

11. Buelens W., Herijgers C., Illegems S. The View of the European Court of Human Rights on Competent Patients' Right of Informed Consent. Research in the Light of Articles 3 and 8 of the European Convention on Human Rights. European Journal of Health Law. 2016. Vol. 23, No. 5. P. 481–509. DOI: 10.1163/15718093-12341388

12. Pindo Mulla v. Spain [2024] ECHR 753: Grand Chamber judgment, 6 June 2024.

13. Leal-Adorna M. Informed Consent vs. Refusal of Treatment from a Legal Perspective: Spain and the Case of Adult Jehovah's Witnesses. Religions. 2025. Vol. 17, No. 1. Art. 7. DOI: 10.3390/rel17010007

14. Fry M. Autonomy and Its Limits: A Discussion of the Shortcomings of Informed Consent. Voices in Bioethics. 2024. Vol. 10. DOI: 10.52214/vib.v10i.12507.

15. Bolcato V., Franzetti C., Fassina G., Basile G., Martinez R. M., Tronconi L. P. Comparative study on informed consent regulation in health care among Italy, France, United Kingdom, Nordic Countries, Germany, and Spain. Journal of Forensic and Legal Medicine. 2024. Vol. 103. Art. 102674. DOI: 10.1016/j.jflm.2024.102674.

16. Marshall K. D. et al. Hospitals Are Not Prisons: Decision-Making Capacity, Autonomy, and the Legal Right to Refuse Medical Care, Including Observation. The American Journal of Bioethics. 2024. Vol. 24, No. 5. DOI: 10.1080/15265161.2024.2327293.

17. Recommendations on Informed Consent for European Emergency Departments. European Society for Emergency Medicine (EUSEM). URL: https://eusem.org/images/Patient_Informed_Consent_in_the_ED-FINAL.pdf.

18. Lepping P., Palmstierna T., Raveesh B. N. Paternalism v. autonomy — are we barking up the wrong tree? The British Journal of Psychiatry. 2016. Vol. 209, No. 2. P. 95–96. DOI: 10.1192/bjp.bp.116.181032

19. Bielov D. M., Hromovchuk M. V., Hretsa Ya. V., Tymchak V. V. Essence of somatic human rights in the process of biomedical research. Wiadomości Lekarskie. 2021. Vol. 74, No. 10. P. 2663–2667. DOI: 10.36740/WLek202110226

20. Myroslava V. Bielova, Viktoria I. Fridmanska, Viktoriia Yu. Svyshcho, Lesia V. Leshanych. Legal regulation of biomedical research: key principles and their implementation. Wiadomości Lekarskie Medical Advances, Volume LXXVII, ISSUE 10, October 2024. S. 2070-2076.

21. Bielov D., Hreca Ya., Shandra B., Bodnar S. The right to health care in the system of constitutional human rights: Theoretical and legal analysis of content and structure. Wiadomości Lekarskie Medical Advances. 2025. Vol. LXXVIII, Iss. 10. P. 2173–2179. DOI: 10.36740/WLek/213595. URL: https://www.wiadomoscilekarskie.pl/pdf-213595-133160?filename=The%20right%20to%20health%20care.pdf

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