https://doi.org/10.15360/1813-9779-2026-2-2660

Passive Euthanasia and the Withdrawal of Life-Sustaining Therapy in the Sociocultural Discourses of Western Countries and Russia: a Historical and Philosophical Analysis

Roman. E. Tarabrin*

I. M. Sechenov First Moscow State Medical University, Ministry of Health of Russia,
8 Trubetskaya Str., Bldg. 2, 119991 Moscow, Russia

For citation: *Roman. E. Tarabrin.* Passive Euthanasia and the Cessation of Life-Sustaining Therapy in the Sociocultural Discourses of Western Countries and Russia: a Historical and Philosophical Analysis. *Obshchaya Reanimatologiya = General Reanimatology.* 2026; 22 (2): 56–65. https://doi.org/10.15360/1813-9779-2026-2-2660 [In Russ. and Engl.]

***Correspondence to:** Roman. E. Tarabrin, Tarabrin_r_e@staff.sechenov.ru

Summary

Passive euthanasia and the withdrawal of life-sustaining treatment (LST) in modern Russian practice are normatively indistinguishable, leading to ethical, legal, and clinical-practical conflicts for intensive care physicians and increasing the moral distress among healthcare staff.

The purpose of this research is to clarify the distinctions between active and passive euthanasia and the cessation of futile life-sustaining treatment, as well as to demonstrate why these distinctions are not taken into account in Russian legislation and professional discourse.

Materials and Methods. The study included foreign and Russian bioethical and legal texts. A qualitative analysis of the historiography was conducted, supplemented by a structural-thematic analysis of the philosophical dilemmas associated with the end of life.

Results. The analysis identified three key lines of demarcation: 1) between active killing and allowing death through the refusal of intervention; 2) between passive euthanasia and the ethical cessation of LST; 3) between the physician's intention to hasten death and the intention to remove medical obstacles to the natural process of dying while being willing to continue assistance if the patient survives. It was shown that the Russian legal norm, which effectively criminalizes any forms of cessation of medical treatment, has developed against the backdrop of insufficient reflection on these distinctions and leads to a discrepancy between normative language and actual clinical practice, where doctors are forced to document treatment provision but often omit or alter it in practice.

Conclusion. The integration into the Russian context of more nuanced criteria for assessing intention, causality, and futility of treatment, developed in Western bioethics, combined with consideration of local sociocultural contexts and religious traditions, is a necessary condition for developing a coherent end-of-life regulation model that reduces moral distress for physicians and enhances patient trust in medical decisions.

Keywords: passive euthanasia; active euthanasia; futility of treatment; bioethics; history of medicine

Funding. The article was prepared as part of the work on the RSF grant «Russian Discourse on Bioethics in the Sociocultural Transformation of Society» (25-28-02272).

Conflict of interest. The authors declare no conflict of interest.

Information about the author:
Roman E. Tarabrin: https://orcid.org/0000-0002-5390-9205

Introduction

The prolonged existence of terminally ill patients in a coma has several socio-economic and medical consequences. Firstly, medical staff realize the futility of the interventions being performed, which provokes moral distress, exacerbates professional burnout, and leads to careless, formal care for such patients [1]. Secondly, these patients occupy scarce intensive care unit (ICU) beds, for which taxpayers spend money every day [2]. Moreover, the consideration of transferring more «promising» patients to the ICU becomes more complicated if beds are occupied. The bioethical principle of justice in the distribution of scarce medical resources requires justification for the presence of untreatable patients in intensive care units [3, 4]. Additionally, the associated complications, which are likely to lead to death, force the allocation of extra medical resources to manage the condition of these patients. Finally, the inability of relatives to communicate with unresponsive patients and the state of uncertainty become an additional source of conflict with doctors [2]. Physicians express their internal conflict as follows: «We are obligated to continue full treatment, performing cardiopulmonary resuscitation (CPR) in the event of cardiac arrest — doing everything to prevent an unfavorable outcome» [2]. They understand the futility of their actions but must provide comprehensive medical intervention [5].

The medical community is unable to implement its understanding of treating such patients due to the prevailing ethical and legal perception of halting aggressive treatment for these patients via euthanasia. For example, Article 45 of Federal Law 323 makes no distinction not only between the cessation of futile treatment for incurable terminal

patients and passive euthanasia but also between active and passive euthanasia. Specifically, it clearly prohibits all forms of hastening death: «Medical professionals are prohibited from performing euthanasia, that is, hastening the death of a patient at their request through any actions (or inaction) or means, including the cessation of artificial life support measures» (Federal Law No. 323-FZ of November 21, 2011, Article 45) [6]. Thus, according to the law, all forms of terminating life-sustaining measures, even if they do not lead to the patient's recovery, are equally prohibited as either active or passive euthanasia [7]. A physician's decision to refrain from using burdensome and futile treatment to a dying patient may be prosecuted under several articles of the Criminal Code: murder (Criminal Code of the Russian Federation, Article 105) [8]; causing death by negligence due to improper performance of professional duties (Criminal Code of the Russian Federation, Article 109) [8]; and failure to provide assistance to a patient without justifiable reason by a person obligated to provide assistance by law or special rule, if this resulted in serious harm to health or death by negligence of the patient (Criminal Code of the Russian Federation, Article 124) [8].

On the other hand, Russian legislation recognizes the right of a patient to refuse unwanted treatment: «A citizen, one of the parents, or another legal representative of a person […] has the right to refuse medical intervention or demand its cessation» (Federal Law No. 323-FZ of 2011, Article 20) [6]. Despite the seemingly legitimate opportunities for voluntary refusal of unnecessary treatment, paragraph 9 of Article 2 of the same law limits the implementation of such refusal, stating that «medical intervention without the consent of the person, one of their parents, or other legal representatives is permissible if the medical intervention is necessary for emergency indications to eliminate a threat to the life of a person» (Federal Law No. 323-FZ of 2011, Article 20, paragraph 9) [6]. Thus, this provision places exclusive responsibility on physicians for making decisions regarding the cessation of burdensome and medically futile interventions for terminal patients, including cardiopulmonary resuscitation. Similarly, Smolkova et al. (2013) provide arguments supporting the provisions of Russian legislation that stipulate criminal liability for medical professionals for actions or inactions classified as failure to provide assistance to a patient that led to the patient's death (Article 124 of the Criminal Code), even in cases of clinically ineffective and burdensome medical interventions [9]. Consequently, the legal system of the Russian Federation does not recognize the legitimacy of refusing therapeutic procedures deemed ineffective and burdensome. This normative position is reflected in academic discourse: researchers in academic publications often do not differentiate between refusing clinically inappropriate treatment and passive euthanasia [9, 10].

Some attribute this negative legal attitude towards the cessation of treatment to religious institutions in the Russian Federation, particularly the Russian Orthodox Church (ROC) [11]. However, others believe that the ROC's position is, on the contrary, aligned with legislative norms and therefore does not differentiate between various forms of euthanasia in its ethical doctrine [12, 13]. The hypothesis of our study is that at the dawn of bioethics in Russia, the lack of proper bioethical analysis regarding what the cessation of life-sustaining therapy or other active or passive hastening of a patient's death entails led to contradictory provisions in Russian legislation. This assumption is supported by several studies [14–16].

In recent years, there has been a growing interest in euthanasia. In particular, the Russian Committee on Bioethics issued a statement in 2024 proposing a broad public discussion accompanied by educational activities. «It is necessary to support the preparation of popular educational programs on television, the publication of accessible literature explaining the meaning of euthanasia as a modern «medical p ractice», and the moral values that can determine a meaningful, morally justified, and politically effective response to this urgent issue [17]». Nevertheless, within the professional community of intensive care specialists, cautious perspectives on such initiatives have been expressed [2], despite that realities of medical practice revealing the shortcomings of legislation. Intensive care physicians are forced either to resort to deception to comply with the law while discontinuing futile and burdensome treatment for terminal patients or simply to ignore all the mentioned socioeconomic and ethical issues. Besides the moral distress in intensive care units, this may overall lead to a loss of trust in the medical profession in Russia [18]. To avoid (or at least mitigate) such shortcomings in the future, suggestions have been made in academic literature that Russian society should pay more attention to the bioethical analysis of what is involved in specific forms of medical decision-making related to the treatment of terminal patients [19]. Only legal norms based on such analysis can be sufficiently consistent to determine which actions should be prohibited, encouraged, or permitted, should such initiatives be undertaken in the future [20].

Materials and Methods

The study was interdisciplinary, incorporating both international and Russian bioethical and legal texts, including: The Historiography of Ideas by A. Lovejoy [21]; The Specifics of Religious Discourse Structure by A. M. Prilutsky, L. E. Andreeva [22]; Discourse, Ethics, Public Health, Abortion, and Con-

scientious Objection in Croatia by A. Borovečki, S. Babić-Bosanac [23]. A structural-thematic analysis was conducted on the philosophical dilemmas associated with the end of life.

Results

Medical interventions that may hasten death are influenced by various motivational factors. These serve as the basis for distinguishing between active euthanasia, passive euthanasia, and the refusal or withdrawal of medical treatment in cases of clinical ineffectiveness. Based on an analysis of relevant literature and scientific discussions regarding the care of terminal patients, the following distinctions are proposed: 1) between active euthanasia and the refusal of clinically inappropriate therapy, where in the former case the physician initiates a new pathological process leading to death, while in the latter case there is a cessation (or withholding) of medical intervention that obstructs the natural course of dying.

Furthermore, 2) a demarcation is established between passive euthanasia (in which a healthcare provider intentionally hastens the patient's death by refusing to apply or withdrawing life-sustaining treatment) and the refusal of clinically ineffective treatment (even if it could potentially lead to death). Also, 3) the significance of the physician's intention is emphasized, meaning a distinction is made regarding whether the physician, while applying, refusing, or abstaining from any medical intervention, intends to hasten death, foresees it, or simply considers the risk of a fatal outcome. These three distinctions ultimately allow for an ethical differentiation between passive euthanasia and the withdrawal of life-sustaining treatment. Following Macaulay [24], p. 136, life-sustaining treatment refers to types of care that are known or reasonably assumed to be capable of prolonging life, specifically: mechanical ventilation, hemodialysis, implantable pacemakers or cardioverter-defibrillators, infusion of vasoactive drugs, extracorporeal membrane oxygenation, and in some cases, antibiotic therapy. Although nutritional support is categorized by Macaulay as life-sustaining treatment, we consciously exclude it from our analysis due to the existing controversy in bioethical debates regarding whether it should be considered a medical intervention or simply the provision of feeding to the patient.

The difference between active euthanasia and the refusal of futile medical treatment.

In the case of Vacco v. Quill (1997), the plaintiffs argued that there is no fundamental moral distinction between killing a person and allowing them to die [25]. To support Timothy Quill's position, a group of philosophers submitted a statement noting that «Whether a doctor turns off a respirator in accordance with the patient's request or prescribes pills that a patient may take when he is ready to kill himself, the doctor acts with the same intention: to help the patient die [26]». This kind of argument could also have been used in shaping Russian legislation regarding euthanasia, but with the opposite normative conclusion: all forms of intentional hastening of a patient's death have been deemed unlawful.

In addition, proponents of euthanasia argue that the distinction between killing and allowing to die does not hold independent moral significance. For instance, M. Tooley (1994) asserts that killing is considered a more serious act than consciously allowing someone to die, primarily due to external circumstances that intuitively lead us to perceive killing as more outrageous. He identifies several such circumstances: 1) motive — the intent to kill implies a more malevolent intention than the refusal to save, even if the latter is driven by laziness or negligence; 2) costs — preventing murder typically requires less risk or fewer public resources than maintaining life in the case of an incurable illness; 3) likelihood of death — in the case of murder, this likelihood is significantly higher than when opting not to intervene. In conclusion, Tooley argues that the difference in moral assessment between killing and allowing to die is influenced more by external empirical and psychological factors than by internal ethical considerations. To illustrate, he proposes a hypothetical situation involving two children, Mary and John, locked in a car with a single control button inside. If the button is pressed, Mary will be saved, and John will die; if the button is not pressed, Mary will sustain fatal injuries, and John will survive. Since there are no differences in motives, risks, and probabilities in this scenario, Tooley concludes that killing and allowing to die are morally equivalent [27].

Some authors have attempted to justify the equivalence between action and inaction, referencing the well-known example by J. Rachels of the «drowning children» [28, p. 112]. In both scenarios, two adults aim to inherit by eliminating their young nephews. The difference between the situations lies in the fact that in the first case, the adult actively drowns the child in the bathtub, while in the second, they simply do nothing, allowing the nephew to drown. According to J. Rachels, both individuals bear equal moral responsibility for the child's death, even though the distinction between direct action and passive inaction seems significant only at the level of describing their deeds.

W. Cartwright analyzes the difficulties of drawing a clear line between murder and the allowance of death, as well as the ease with which these two categories can be conflated (as in the examples of Tooley and Rachles). He argues that these are not homogeneous concepts, but rather «heterogeneous groupings containing a variety of types, such that

some of the types in one category are close to types in the other» [29]. Since individual instances from the group of murder and the group of allowing death sometimes appear similar or even overlap, it may give the impression that there is no moral difference between the groups. However, such individual coincidences cannot be generalized and unconditionally applied to all cases of murder and the allowance of death.

Such an intersection is possible because the act of killing can take both an active form — initiating a new lethal event — and a passive form — abstaining from actions that could prevent harm. Similarly, the allowance of death can occur not only passively, through non-interference in an already harmful event, but also actively — by removing obstacles that slow down the dying process. From this perspective, the case of Rachels, where an adult consciously refuses to save a drowning child, represents inaction that is effectively equivalent to murder, as the subject had the opportunity to prevent the death but chose not to. In the example of Tooley, on the other hand, pressing the button does not create a new lethal event, but merely redirects an already developing one, thereby demonstrating a visible moral equivalence between killing and allowing death.

The difference between passive euthanasia and the withdrawal of futile treatment.

Both passive euthanasia and the withdrawal (or non-initiation) of futile life-sustaining treatment share a common feature: a life-saving intervention is not undertaken. Therefore, they can both be seen as ways to «allow the patient to die». How can a moral line be drawn between them?

W. Cartwright emphasizes the importance of identifying the true cause of death by distinguishing between active deprivation of life and passive non-intervention: «Killing someone involves initiating a fatal causal sequence, whereas letting someone die involves allowing an existing fatal causal sequence to run its course. In the first case the cause of death is the person who initiated the fatal sequence, in the second it is the fatal sequence itself rather than the person who allowed it to continue» [29]. Thus, when it comes to passive non-intervention in an ongoing fatal process, the determining factor for establishing the true cause of death becomes the intent of the acting subject, rather than objective circumstances. A subject can be considered a valid cause of death if their refusal to provide assistance is accompanied by an intention to hasten the patient's death or is motivated by self-interest (for example, the desire to inherit from the dying person) when there is an objective possibility to change the course of events. In such a situation, the subject's intent becomes the decisive causal element that allows the lethal circumstances to come to fruition. The opposite case is represented by a doctor who decides to cease medical intervention based on the clinical futility of such intervention and its burden on the patient. Here, there is no intention to kill, as the doctor's goal is to refrain from clinically irrelevant procedures rather than to bring about the patient's death. The criterion for the absence of intent to kill is the doctor's willingness to accept the possible situation in which the patient continues to live even after the cessation of life-sustaining treatment — this attitude indicates that the doctor did not aim to hasten the fatal outcome. Moreover, this willingness should be reflected in the fact that the doctor continues to treat such a patient.

Therefore, the decisive moral criterion is the physician's intention. In the case of active euthanasia, the medical professional creates «a new, lethal pathophysiological state with the specific intention in acting of thereby causing a person's death» [25]. This type of action is characterized by a simultaneous directed desire for the patient's death and the execution of a new act that directly leads to death. Hence, active euthanasia should be classified as a form of murder. A different ethical framework is observed in the refusal or cessation of treatment. Various motivations are possible here: if the physician consciously acts with the intent to end the patient's life, their action may also be regarded as murder. However, if medical intervention is discontinued (or not initiated) due to its excessive burden, adverse effects, or evident futility in the terminal stage of illness, then the physician is not killing but merely allowing the natural process of dying to conclude. In this case, the cause of death should be considered the illness, not the physician's inaction.

Thus, killing always remains morally unacceptable, while refraining from intervention or discontinuing treatment can be evaluated in different ways — either as an ethically wrong act (if there is an intention and goal to end the patient's life) or as permissible (if the intention is to acknowledge human mortality and the futility of therapy in hopeless cases). In other words, if a physician intends to bring about the patient's death by stopping life-sustaining treatment, they are guilty of passive euthanasia. The intention may include specific motives related, for example, to considerations of resource allocation (needing to free up a resuscitation bed for a more viable patient) or to personal interests. On the other hand, if their decision to refrain from such interventions or to discontinue them is motivated by concern for a patient with an incurable terminal illness, and the desire to avoid the misuse of medicine when the treatment is futile, then their care is focused on the patient and the art of medicine, allowing the natural dying process to take its course. Therefore, if, by forgoing treatment and allowing the dying process to proceed, the physician finds that the pa-

tient continues to live, and the physician is not disappointed but instead pleased with this outcome and thus provides medical support in another way, it indicates that the physician had no intention to kill the patient prior to discontinuing treatment.

In this section, two more points need to be discussed. The first is whether the initial intention can be mixed with other desires or beliefs related to the plan to end unbearable suffering. The second is how to assess the abuse of medicine, closely linked to the ineffectiveness of treatment.

Regarding the first question, it is important to note that assessing intentions is an extremely complex issue. The same physician may seek to alleviate a patient's unbearable suffering, especially in cases where palliative therapy is ineffective, while not wishing for the patient's death at all. It is crucial to distinguish between desires, beliefs, and actual intentions. An intention implies an internal stance of the physician, expressed in a specific plan of action. If a physician is motivated not only by compassion but also by the intention to end the patient's suffering through death, this intention will inevitably manifest in their subsequent actions. For instance, if the cessation of overly burdensome treatment does not lead to the patient's death, a physician with such an intention is likely to act in accordance with it — perhaps by withholding necessary medical support or deliberately taking other actions to hasten death. It is in such actions that the original intention is revealed. For example, if a patient begins to breathe independently after being removed from a ventilator, a physician who does not wish for the patient's death will continue to provide treatment in another form — without the use of mechanical ventilation. In contrast, a physician who consciously desires the patient's death may take active measures to end it upon noticing spontaneous breathing, in order to see the process through to completion. A telling example is the case of Karen Ann Quinlan. If Karen's relatives had aimed not to stop excessive treatment but to hasten her death, they would have felt frustrated to see that after being disconnected from the ventilator, she continued to breathe and live. However, they continued to care for her, and Quinlan lived for several more years. This is why their action was interpreted as «allowing her to die», rather than as an act of passive euthanasia [30].

Regarding the second question about defining the futility of treatment, we need to distinguish between physiological, probabilistic, and normative futility. Although the concept of futility carries some negative connotations [31], we will use this term to indicate that a futile treatment does not benefit the patient. An example may be aggressive treatment of terminally ill patients (for instance, cardiopulmonary resuscitation for patients dying from an incurable stage of cancer).

The treatment is considered physiologically useless if it cannot achieve its therapeutic goal in principle. The concept of probabilistic uselessness implies that achieving the goal is possible only in a certain percentage of cases. According to Macauley's observation, physicians differ in their assessment of what probability of success makes a treatment justifiable [24]. Some believe that any, even minimal, assumption of success excludes the possibility of the intervention being useless. Others, on the contrary, consider treatment useless if the likelihood of a positive outcome does not exceed 1–5%, meaning that it remains possible but extremely unlikely. Finally, there are researchers for whom even a 40–60% probability of success is insufficient to deem the treatment beneficial. Thus, the decision to forgo a useless intervention can have entirely different grounds and consequences for the patient. This vagueness in defining probabilistic uselessness poses serious ethical risks. If a treatment is only potentially useless but is nonetheless discontinued or not performed at all, it may lead to hastened death for the patient, which would be unethical. However, researchers emphasize that even cases of probable uselessness — more so than cases of physiological uselessness — inevitably depend on value judgments. [32]

Normative uselessness, based on the value beliefs of the physician, is even more complex. Here, the assessment of uselessness depends on the «intrinsic value of the goal» of the medical intervention [24]. An example of normative uselessness is the continuation of resuscitation treatment for a child with anencephaly [33].

The Importance of Intention.

We have already examined many aspects of a physician's intentions, such as the intention to hasten a patient's death versus the intention to allow them to die. This section deals with the principle of double effect, which helps distinguish between unethical and ethical intentions. A physician's intention deserves careful and consistent consideration. It is important to remember that determining the intentions of individuals, including physicians who disconnect life-sustaining treatment, is certainly impossible. However, this kind of distinction is made in murder investigations to identify mitigating or aggravating circumstances, so it is not entirely futile. The principle of double effect that we present as a criterion for the ethics of withdrawing futile treatment from terminally ill patients may contribute to it's understanding.

The principle of double effect states that if an action is taken to achieve a positive, desirable effect but is accompanied by negative, undesirable risks, and if the likelihood of the positive effect outweighs the risk of the negative effect, then it is ethically permissible to undertake that risk. An example of

the double effect principle application is the prescription of opioids to a terminally ill patient whose death is inevitable when other means of alleviating unbearable pain are ineffective. In this case, if the negative effect of the opioids, respiratory depression, is not the intended goal but still occurs and ultimately hastens death, then the prescription of opioids is ethically justified according to the principle of double effect, as the negative effect was foreseen but not intended by the physician.

However, it is important to address the existing criticism of the principle of double effect, which is also related to the physician's intent definition. Opponents of the principle emphasize the significance of the purity of the physician's intentions and their responsibility for the consequences of treatment. Therefore, they argue that a physician cannot honestly claim that their sole intention is to aggressively treat the patient's pain, as they may be subconsciously or otherwise personally affected by the suffering of that patient, which could lead them to underestimate the risk of hastening the patient's death. Critics of the principle of double effect also contend that such additional intentions create a risk of indirect or unintended euthanasia.

However, this argument can be challenged. When following the principle of double effect, a doctor, even if they wish to shorten a life filled with suffering, still has the primary intention of alleviating unbearable symptoms. It is important to focus on the primary intention rather than its purity. Furthermore, as mentioned earlier, secondary intentions cannot even be called «intentions.» They pertain to the realm of desire — a compassionate desire to end the patient's intolerable suffering. The difference between intention and mere desire is that only the former involves a conscious plan of action.

Discussion

The proposal to use the physician's intent as the main criterion for distinguishing between passive euthanasia and ethical cessation of life-sustaining treatment raises two groups of issues: epistemological and institutional. The epistemological issue is related to the fact that a physician's internal motives are, by definition, inaccessible to direct observation, and can only be retrospectively reconstructed based on external actions and the sequence of clinical decisions, similar to how aggravating or mitigating circumstances are assessed in criminal proceedings. The institutional issue is that current Russian legal norms effectively encourage physicians either to mask their true motives (for example, through fictitious indications for continuing therapy) or to formally continue futile treatment to avoid the risk of prosecution under the Criminal Code of the Russian Federation.

In Western literature, criticism of the principle of double effect shows that an appeal to «purity of intent» can be psychologically and practically untenable, as a physician simultaneously experiences compassion and is subjective to resource limitations and their own moral fatigue. However, an analysis that suggests distinguishing between intentions and desires and evaluating the specific plans of action reflected in behavior (for example, a physician's reaction to a patient's unexpected survival after therapy has been discontinued) allows the concept of intent to be transformed from a purely internal category into an ethical and legal criterion. In this sense, Russian bioethics could integrate more nuanced versions of the principle of double effect and related concepts of responsibility, without reducing them to either subjective «purity of heart» or a formal prohibition of any actions that increase the risk of death.

The development of the concept of «useless» treatment is particularly significant for the Russian discussion, as it is virtually absent in domestic literature or is replaced by morally charged terms such as «refusal of assistance» or «passive euthanasia». A detailed distinction between physiological, probabilistic, and normative uselessness, as documented in international sources, indicates that the decision to discontinue therapy inevitably contains a value component. However, this component can be structured and articulated in clinical guidelines rather than left to implicit individual assessments. In the Russian legal framework, where formal discussions of the uselessness of treatment are lacking, a physician finds themselves in a position where any limitation on therapy can potentially be interpreted as criminal negligence, despite the fact that selective decisions regarding the limitation of medical procedures are already being practiced in intensive care units.

This legal silence regarding the uselessness of treatment exacerbates the moral distress of medical personnel, increases the risk of professional burnout, and pushes them to circumvent the law in one way or another, which sometimes involves creating documentary fictions and implicitly changing treatment tactics. Thus, a vicious cycle is reproduced: the absence of a conceptual and legal language for describing ethical refusal of therapy leads to legal nihilism and a decrease in public trust in medical decisions regarding end-of-life care.

The demonstrated inconsistency between the legal prohibition of any forms of hastening death and real clinical dilemmas indicates a broader tension between the Western bioethics brought in and local sociocultural conditions. On one hand, Russia finds itself included in global bioethical discussions, where criteria for distinguishing between euthanasia and the withdrawal of futile treatment have already been established. On the other hand, these criteria are introduced against a backdrop of a lack of a stable tradition of public debate about end-of-

life issues and the strong role of state and religious leaders in shaping the normative agenda.

In this situation, appealing to traditional spiritual and moral values can play a dual role. On one hand, such appeal legitimizes resistance to the legalization of euthanasia and, in conditions of economic pressure and resource shortages, expresses concerns about viewing human life as a tool that individuals possess to achieve their life goals. On the other hand, without a clear distinction between euthanasia and the refusal of futile treatment, such discourse effectively reinforces the moral and legal obligation to preserve life at all costs, which contradicts both the basic principles of beneficence and non-maleficence and traditional understandings of the naturalness of death.

Conclusion

Thus, the following criteria can be proposed to distinguish between passive euthanasia and ethical withdrawal of life-sustaining treatment as used in Western sociocultural and legal contexts: 1) if a medical professional initiates a new pathological process that leads to the patient's death, they are killing the patient through active euthanasia; 2) if they refrain from saving the patient's life by withholding or withdrawing available treatment with the intention of hastening death, they are practicing passive euthanasia. In this case, the physician would be disappointed if the patient survives after the cessation of LST. On the other hand, 3) if a physician refuses or discontinues the treatment of a patient whom they consider to be dying because they believe that treatment is medically futile and burdensome for the patient, the physician is not guilty of passive euthanasia; rather, they are simply removing a medical obstacle that interferes with the natural process of dying. In such cases, they will not be disappointed if the dying process unexpectedly reverses and the patient's life is prolonged, even for a short time.

Furthermore, the analysis conducted supports the thesis that ethical discussions should precede changes in legislation rather than serve as ideological justifications afterward. Otherwise, internally contradictory norms arise that simultaneously: 1) declare the patient's right to refuse treatment; 2) criminalize any cessation of life-sustaining treatment; 3) fail to provide physicians with a workable concept of futility. The use of the interdisciplinary field of bioethics in this context should focus not only on the theoretical deli-neation of categories but also on the analysis of the strategies that physicians actually employ to resolve conflicts in intensive care units, including their unofficial practices and moral arguments.

Only on the basis of such a «dual» analysis — philosophical-normative and empirical, grounded in practice — can a specific Russian model for end-of-life regulation be formed that, on one hand, takes into account local cultural and religious codes, and on the other, integrates international criteria of intention, causality, and futility of treatment. This would not only reduce the moral distress of medical personnel and increase patient trust but also establish a more sustainable trajectory for the development of domestic bioethics, moving beyond simple borrowing or rejection of foreign solutions.

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Received 18.02.2026
Accepted 07.04.2026
Online First 23.04.2026