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Impact of Palliative Care/Medicine on Realization of "Right to Life" and "Right to Dignity" in The Context of Human Rights Protection

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Abstract

This study aims to define the content, interpretation and understanding of palliative care / medicine in the context of the development of modern biomedicine with the priority of the role of protection and respect for human rights, while focusing on the categories of seriously ill and their implementation of "the right to life", "the right to health", and "The right to death".

The study was conducted on the basis of the analysis of normative legal acts, jurisprudence, relevant scientific and statistical data that regulate the issues of palliative and hospice care, euthanasia and their interconnection. Comparative palliative care in different countries was based on theoretical sources, legislation of the countries and the "Quality of Death Index". The overview of the laws of the world was done and it was found that the country in which the euthanasia is legally possible; countries where it is not prohibited and the countries criminal law which establishes the prohibition of euthanasia with further punishment for its implementation.

The statistics of recent years show that the majority of diseases, which in the future lead to incurable diseases, in which both patients and relatives find themselves in the path of despair and fear. In such circumstances the need for palliative care constantly ascending aye. In this context, questions arise as to the understanding of the nature of palliative care / medicine as a combination of therapeutic measures or a decent completion of life linking these two areas with the realization of such rights as the right to life, health, and death. In the context of the latter, the understanding of the role and place of euthanasia is becoming apparent not only for the severely ill, but also for healthy people, based on the desire for a decent completion of life and the impossibility of committing suicide, which is a punishable act.

That is why the importance of palliative care/medicine is necessary, first of all, from the legal point of view and the protection of human rights, which is the priority of every democratic state.

In the study, it was concluded that palliative care/medicine must have a clear understanding and legal consolidation at both the international and national levels, based on the concept of essence "pain" through a set of measures to right ted for rehabilitation or worthy end of life, in a speech last activity search effective ways to avoid future life-threatening cases. Therefore, palliative aid/medicine serves some basis for the rights to a decent life worthy of death of people with the prospect of an overall strategy of healthy and decent life for future generations.

Keywords: Palliative care, Palliative medicine, Hospice assistance, Right to life, Right to health, Right to death, Euthanasia.

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INTRODUCTION

Modern development of society, technology and science determines not only the need for human rights, but also becomes the basis for the emergence of new rights that are directly related to the progressive development of mankind. One of the most progressive branches is biomedicine that develops precisely in order to meet the needs and human rights of the whole world community as well as of each individual. It is the development of modern medicine that has led to significant changes not only in scientific, but also in legal circles, in particular as a result of the emergence and formation of a new fourth generation of human rights.

Human Rights decided to distribute the force generation time of their occurrence and the circumstances that led to it. Generally recognized are three generations of human rights. They developed for a long time and under the influence of various historical events. The first generation of human rights is called civil and political rights, the need of which arose in people, along with the origins of constitutionalism. The first attempts at their normative consolidation date back to the XIII century, but their acute need and the basic formation occurred in the XVIII century. Having received their inalienable rights of the first generation, people had the need to fulfill their other needs, which led to the formation of the second generation of human rights. In fact, by consolidating respect for the right to life and the avoidance and arbitrary deprivation of liberty, a person needed the guarantee of the other rights that would enable her to secure this life, and namely: to be able to work effectively under normal conditions, receive social assistance, have access to education, receive decent wages and pensions that can provide a standard of living. The second generation of human rights included economic, social and cultural rights and took place around the XIX century. The final stage was the formation in the XX century. the third generation of human rights - collective rights. That is, every generation of human rights expresses the minimum of rights that mankind needs at different stages of its development.

However today as a result progress and development of mankind scholars are talking about the emergence of new generations of human rights, in particular the so-called "fourth generation of human rights". It includes such rights as: the right to change gender, the right to surrogate motherhood, the right to artificial insemination, the right to euthanasia, the right to transplant organs, the use of virtual reality, cloning, etc. In general, most of these "newly created" rights arose from the development of medicine (genetics, biomedicine, etc.) but certainly taking into account those new "needs" that are facing a human today.

Due to the fact that most of the rights of the fourth generation relate to the sphere of medicine, it became necessary to ensure the rights of such persons who seek medical treatment, which are the patients of such specialized institutions. This is confirmed by the Council of Europe Convention on the Protection of Human Rights and Dignity in Connection with the Advancement of Biology and Medicine in accordance with Art. 2 of which: "The interests and welfare of an individual prevail over the exclusive interests of the whole society or the auctions." In addition, according to Art. 5 of the aforementioned Convention, any interference with health may only be carried out after the volunteer and informed consent of the person concerned. Such person is provided in advance with relevant information about the purpose and nature of the intervention, as well as about its consequences and risks. The appropriate person at any time can freely withdraw his consent (Convention on Human Rights and Biomedicine, 1997). That is, in any case, the development of medicine is aimed at improving human life, protecting its rights, which in no case can be violated.

However, when analyzing the rights of the fourth generation of human rights, there is an urgent question: where is the boundary between the observance of the rights of the fourth generation and the violation of human rights in general? Due to such a rapid development, human rights have been mixed up and at present one of them has led to a violation of another. One such controversial right is the right to euthanasia or, as it is called "the right to death". Today euthanasia is officially authorized only in a few countries of the world. The first of these countries was the Netherlands, where in 2001 a law was passed that allowed the use of euthanasia and also regulated its components from the use.

The most liberal laws in this regard are in Switzerland under the law of which a doctor has the right to prescribe a lethal dose of a drug to a patient who is hopelessly ill in the event that the latter is able to make the decision on its own and to inject a drug (112. Ua, 2018). In general, the experience of Switzerland is very

interesting in the issue of euthanasia. There is no separate law in the territory of this country that would allow the use of euthanasia, but along with this in the Criminal Code of the Swiss, in particular, in accordance with Art. 114 states that a person who committed a killing from condolence to a victim is not punishable (Miroshnichenko, 2012). However, today there are countries where euthanasia (active) received broad "legal rights": the existence of a special law, no criminal liability for the assistance so the first activities (Canada, Switzerland, Mexico, Benelux, some US states, etc.).

In the majority countries of the world, including Spain, Italy, Ukraine, Russian Federation, Brazil, Peru, Romania, Chile, Cuba, etc. euthanasia is prohibited. It is considered to be a murder and punishable under criminal law. This is confirmed, for example, in the seventh paragraph Art. 52 of the Law of Ukraine "Fundamentals and legislation on the health care of Ukraine" of 1992: "Medical workers are prohibited from euthanasia - the intentional acceleration of death or death of the incurable patient in order to stop his suffering" ("The Fundamentals of Ukrainian Legislation on Health Care", 1992). It should be noted that in the Criminal Code of Ukraine since 2001 there is no article that would impose a punishment for euthanasia. Therefore, in view of the above law, euthanasia is not allowed in any way, form and under the current Criminal Code, it is equivalent to a simple murder (murder without mitigating and aggravating circumstances) (The Criminal Code of Ukraine, 2001). It is quite possible to agree with this provision, but to consider this socially dangerous act, as a simple composition of the murder, in our opinion, it is impossible.

Another interesting example is Australia, in whose territory for some time euthanasia was explicitly prohibited by the legislation of the state. However, in 2019, the Australian Parliament decided to allow euthanasia in one of the states of Australia (Victoria). Parliament even adopted a separate law regulating the implementation of euthanasia in the specified territory. According to him, the physician will be allowed to introduce a fatal injection to the patient in those cases where incurably diseased patients are physically incapable of doing it on their own. However, the law provides for certain conditions. First, for euthanasia, it is necessary for the patient to stay live for less than six months. In addition, he must reside in the state for at least a year, that is, in this way the Australian authorities have made it impossible for this territory to resort to so-called "suicidal tourism", which is a process where incurable ill people travel to the territory of countries where euthanasia is authorized to complete your life. Thus, it can be argued that euthanasia begins to be legalized around the world, which indicates the urgency of the problem of the suffering of incurably sick people.

However, in this case, it will not be about the permission or prohibition of euthanasia in the legal context but about euthanasia, which becomes new in the context of the development of palliative care for patients, which is aimed at alleviating their suffering. It is in this context that it is necessary to study the connection and meaning of "palliative care", "the right to life", "right to health", and "right to death" and "euthanasia". Thus, the issue of "the right to death" requires a more detailed analysis in terms of ensuring human rights in the case of serious, incurable illnesses.

MATERIAL AND METHODS

Materials were Ukrainian and foreign scientific literature, international and normative legal acts of different countries, medical and statistical data. Such research methods as information-analytical, statistical, comparative, systemic approach are applied.

The scientific study concerned the use of palliative care in the world, as well as the study of its features, in particular the relationship with the implementation of the "right to death" (euthanasia). The analysis of the statistics of fatal diseases in the world, according to which it was concluded that, for example, during the period of 2000-2011, the most frequently caused death were the following diseases: lung cancer (along with tracheal and bronchial cancer) in 2011 killed 1.5 million people. persons (2.7%), compared with 1.2 million people (2.2%) in 2000, 1.4% of diabetes mellitus (2.6%), compared with 1.0 million (1.9%) in 2000. However, according to these data, it was determined that by 2020, the ranked causes of death will be divided as follows: ischemic heart disease; impaired cerebrovascular flow, including stroke; chronic obstructive pulmonary disease; infections of the lower respiratory tract; lung cancer, trachea and bronchi. The number of cancer patients has doubled in the period from 1975 to 2000, and will double by 2020, and three times by 2030.

It should be noted that the WHO notes that the two largest "environmental" killers in the world are strokes and heart attacks (2.5 million per year). Further there are heart diseases (2.3 million) and cancer (1.7 million), respiratory diseases (1.4 million) and diarrhea (846 thousand). In relation to diseases caused by environmental pollution, among the deaths associated with external pollution: 40% - cardiovascular diseases; 40% - stroke; 11% - chronic obstructive pulmonary disease (COPD); 6% - lung cancer; 3% are acute infections of the lower respiratory tract in children. Deaths associated with contaminated air in single rooms: 34% – stroke; 26% - cardiovascular diseases; 22% - COPD; 12% - acute infections of the lower respiratory tract in children; 6% - lung cancer.

According to the latest "death rate index", the level of palliative care is distributed as follows (1-5): Great Britain, Australia, New Zealand, Ireland and Belgium. The last places (75-80), in turn, occupy the following countries: the Dominican Republic, Myanmar, Nigeria, the Philippines, Bangladesh, Iraq. Regarding directly the level of palliative care, the first five countries are the United Kingdom, the Netherlands, Australia, Ireland and Taiwan. The worst level is recorded in the following countries: Guatemala, Romania, the Philippines, the Dominican Republic, Egypt and Iraq.

In studies and assesses the situation with the issue of palliative/care medicine and taking into account the statistical indicators of disease, legal analysis address this issue and factual circumstances in different countries, allowing us to build a comprehensive approach to meaningful understanding of the issues and strategies work in this sphere.

DISCUSSIONS AND RESULTS

According to the report of the Special Rapporteur on Health in GA OON A/65/255 of 2010, palliative help is the set of measures aimed at improving the quality of life of patients with a diagnosis that threatens their lives by preventing and alleviating their suffering (General Assembly, 2010). British researchers B. O'Neill and M. Fallon have identified palliative care as an active, absolute help to sick people whose disease cannot be cured (O'Neill and Fallon, 1997). Some Ukrainian researchers, such as Yu. I. Gubsky, V. V. Lazorishinets and D. D. Diachuk proposes to consider palliative care, not as a complex of measures, but as a branch of scientific medicine and health care. Thus, in their opinion, palliative care is a branch of scientific medicine and health, the main task of which is to improve the quality of life and relieve the suffering of patients with different nosological forms of chronic incurable diseases, mainly in the terminal period of their progression, when the possibilities of specialized treatment of the underlying disease are limited or, from the point of view of modern scientific representations, are hopeless. Under these conditions, the axiom of the modern health system in the developed countries of the world is increasingly becoming the notion that patients with incurable diseases at the terminal stage are necessarily subject to professional palliative medical, social and psychological supervision (Gubsky, n.d.).

Another interesting view is the opinion of the Ukrainian researcher G. A. Mironov, who defines palliative care as an active general care for patients whose illness does not respond to treatment. By definition The World Health Organization (WHO), palliative care is an approach that improves the quality of life of patients and their family members in a situation associated with a patient's life-threatening illness through the prevention and alleviation of his suffering through early identification and accurate assessment and treatment of pain and relief of other physical, psychosocial and spiritual problems (WHO Definition of Palliative Care, n.d.). The main goal of palliative care is to support the quality of life in its final period, maximizing the physical and moral suffering of the patient and his relatives, preserving the human dignity of the patient on the threshold of the inevitable - the end of human biological life (Mironova, 2016).

Indeed, on the one hand, palliative care is a real step in the relief of the suffering of people suffering from incurable diseases. However, on the other hand, palliative care is unnatural remedy for modern medicine, which, in addition to the benefit of incurable people, also brings a major recession to medical science, which can be characterized as follows: easier to apply to a patient with palliative medicine than to make maximum efforts to treat it. So, to date, there is a large number of diseases that modern medicine cannot cure. However, in our opinion, it is necessary to look more broadly not at illness and its treatment, but on the circumstances that cause these diseases, for example: poor nutrition, air pollution, reservoirs and soils, destruction of living organisms, etc. All these factors are more global and provoke the appearance of many endemic diseases in humans. First of all, we must fight these phenomena so that they do not cause the

development of incurable diseases in humans. That is, it is necessary to solve the problem of incurable diseases, and not to emphasize the use of palliative medicine. Consequently, the situation should develop as follows. First of all, measures should be taken to protect nature and the environment, to control the quality of food product, medicines and cosmetics in order to avoid provoking in the population of incurable diseases. WHO notes that the two largest "environmental" killers " in the world are strokes and heart attacks (2.5 million per year). Then there are heart diseases (2.3 million) and cancer (1.7 million), respiratory diseases and (1.4 million) and diarrhea (846 thousand). The WHO report identified a number of environmental causes and their link with mortality, namely: environmental pollution, exposure to chemicals, climate change and ultraviolet radiation, more than 100 diseases and injuries, etc. (Doschich, 2016). For example, according to official WHO data, As of 2016, about 3.3 million people died as a result is disease related to indoor air pollution and 2.6 million. - as a result of diseases associated with atmospheric air pollution. Deaths associated with external contamination: 40% - cardiovascular disease; 40% - stroke; 11% - chronic obstructive pulmonary disease (COPD); 6% - lung cancer; 3% are acute infections of the lower respiratory tract in children. Deaths sewed with contaminated air inside the premises: 34% –stroke; 26% - cardiovascular diseases; 22% -COPD; 12% - acute infections of the lower respiratory tract in children; 6% - lung cancer (Briggs G. (2014). The given statistics really show disappointing data on the growth of the number of diseases related to environmental problems.

But along with the above problem, one should also pay attention to the context of the development of modern medicine and try to provide effective treatment to those who are already seriously ill. That is, in our opinion, it is necessary to use palliative medicine for persons suffering from serious illnesses, but not to wait for natural death of a person, and to take all measures to the last to cure it. That is, palliative care / medicine should not be the "beginning of the end", it should be one of the stages of the treatment of a person directed not to a decent completion of the patient's life, but to facilitate the stage of exacerbation of the disease with further attempts to cure it.

However, attention should be drawn to the Report of the United Nations Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health from 2010 which states that patients suffer from severe and moderate pain where there is virtually no palliative care, and they would prefer to die than to continue to live with severe pain that we cannot treat (General Assembly (2010). This once again confirms the need for palliative care that is needed around the world today. Every year, about 60% of people who die are incurably ill and need help with palliative care/medicine. Its availability can improve the lives of at least 80% of people with incurable illnesses, but for most patients, such programs are unattainable.

For example, WHO state that about 90% of patients with the disease of cancer can receive adequate therapy against pain as opioid analgesics, but most patients have no access to such drugs. In addition, they require treatment for psychological disorders associated with cancer, which are manifested in severe stress and constant anxiety. Even people who have been cured of this disease can have psychological problems and need their effective solution.

Regarding HIV / AIDS, indicate the city at that UN estimated 36.9 million. People in the world living with HIV and approximately 670 thousand. - 1.3 mln people die of AIDS each year. Of these, 15, 8 % of patients in the last stages of AIDS suffer from unbearable pain, but only a small percentage of them have access to pain medications or to palliative care. In addition, in the less developed countries, the highest rates of HIV/AIDS transmission are noted but there is only limited access to opioid drugs for pain relief (United Nations Program on HIV/AIDS (UNAIDS). The progress of AIDS is variable and unpredictable, and people have a wide range of complications. People living with AIDS face potential opportunistic infections, and also have different side effects from the treatment of infections and AIDS itself. That is why the palliative care for AIDS patients should be adapted to the different needs of patients.

Particular attention deserves the elderly and children, because they are a vulnerable category of people. Older people have elevated rates of chronic and incurable diseases. Age-related changes in the body result in a deterioration in the physical and mental state of elderly people, an increase in the number of people with disabilities and those who need extra care (Gerasimova, 2013). In Europe and the United States, the trend towards an increase in the proportion of elderly people suffering from severe chronic diseases is in

specialized medical facilities, where this contingent of patients receives high-qualified assistance from specially trained specialists in palliative medicine. In particular, in Australia and Germany, every 15th of the elderly lives in boarding houses and in the UK, each in the 20th, in the United States, almost half of the people over the age of 80 are periodically in specialized institutions for the elderly. The relevant question is relevant also for Ukraine: today, the number of people over 60 years old is 20.4%, and the corresponding figure will continue to grow. According to the existing expert assessments in our state, the number of people in need of professional medical care in the terminal stage of life (patients at the terminal stages of oncological and cardiovascular diseases, AIDS and tuberculosis, patients with severe heart failure, persons with motor and intellectual disorders after the postponed stroke, with severe degenerative disease of the brain, including diseases as Alzheimer's, along with the elderly age who require palliative care professional), has annual Dr. 500 thousand. People (Gubsky, Lazoryshynets, & Dyachuk, 2008).

WHO also provided a definition of palliative care for children, which is a special, albeit palliative care related to the adults. Therefore, palliative care for children is an active full concern for the physical condition, mental faculties and mental state of the child, which also includes providing support to the family. Palliative care for children begins with the diagnosis of the disease and continues, regardless of whether the child receives the appropriate treatment or not. A person who provides palliative care to a child should monitor and try to eliminate or reduce as much as possible its physiological and psychological suffering and ensure appropriate social conditions. Effective palliative care requires an integrated multidisciplinary approach involving family involvement and makes available public resources; it can be successfully implemented even if resources are limited. Palliative care for children may be provided for limited resources of specialized medical care in the institution of the general medical network and even at the child's home.

It should be noted that, in accordance with the Declaration of the Rights of the Child in 1959, the child is physically and mentally immature, as well as mentally and socially inalienably (Declaration of the Rights of the Child, 1959). In addition, the child does not have full civil capacity, which occurs differently in different countries of the world. That is why the child needs special protection and care, including proper legal protection, before and after birth. In this context, the question is not the possibility, at its own discretion (the child) to make decisions about their health, treatment and, including, decision on the application of palliative medicine. The problem of the use of palliative care for children is also that, unlike adults who need such help as a result of a serious illness, children are often born with such diseases and diseases, which from the very beginning of birth implies the use of palliative medicine. This leads to a deadlock in the future generation and the related illnesses are often also caused by environmental problems, environmental disasters, poor nutrition of the parents of the child, etc. Instead of solving the problem at its root, it is easier to use palliative care in modern medicine for such children.

Children with incurable diseases and exhausting illnesses suffer from pain but often are not provided with palliative care. Children's pain is often underestimated or even ignored, particularly because of the lack of appropriate knowledge.

The International Children's Palliative Care Network, established in 2005, estimated that 20 million children around the world can benefit from palliative care. For children, this also includes supporting optimal child development, formal education, stimulating development, in order to enable a child of any age to live decent lives.

At the same time, attention should be paid to the state of affairs regarding the use of palliative care/medicine in the case of countries such as Ukraine, the United States and Great Britain, which differ in their approaches. Starting from 2000 to modern times Ukraine characterizes ARE decreasing birth rate, an aging population and high rates of morbidity and mortality from cancer and serious complications of chronic non-communicable diseases, including cerebro-Vascular malformations and lesions of the cardiovascular system, kidney, respiratory, diabetes , as well as an increase in the number of elderly people age, suffering from cognitive impairment and neurodegenerative diseases of the brain, in particular Alzheimer's disease, age-related lesions of the musculoskeletal system, the peripheral nervous system and connective tissue, endocrine, genetic and allergic diseases, which, in particular in the decompensated and terminal stages of the course, are accompanied by pronounced pain syndrome and other severe disabilities (Voronenko, Gubsky, & Tsarenko, 2014). By the rate of malignant neoplasm incidence, Ukraine ranks 2nd in Europe. Over the past 5

years, this figure has increased from 333 to 349 people per 100 thousand population. According to projected estimates, by the year 2020, the incidence of malignant neoplasms in Ukraine may increase to 370 per 100,000 population. If in 1990 in accounting for diagnosed oncological diseases there were 670 thousand people, now their number exceeds 1 million (State Statistics Service of Ukraine (Demographic and social statistics). Population incidence (1990-2017). Consequently, such statistics clearly indicate the need for sweeping palliative medicine in Ukraine. However, with and according to the expert data of the NGO "Ukrainian League for the Development of Palliative and Hospice Care", as of the beginning of 2017 there are only 7 hospices, 2 centers for the provision of palliative care (Ivano-Frankivsk, Kharkiv), as well as more than 60 specialized palliative departments with cumulative the number of about 1,500 beds for the maintenance of palliative patients with a minimum requirement of 4,000 inpatient beds set by the WHO. At the same time, according to WHO standards, the minimum required is 100 beds for palliative patients with 1 million people. First of all, it should be noted that the issue of the provision of palliative and hospice medicine is regulated by the Order of the Ministry of Health of Ukraine "On the organization of palliative and hospice care" from 2011, which in its provisions establishes the procedure for the provision of palliative care. In accordance with it, palliative care is defined as a complex of measures aimed at improving the quality of life of the patient and members of their families, prevention and relief of emotional and emotional suffering. the patient by means of the early detection and diagnosis of symptoms of pain and disorder of life, carrying out adequate medical treatment, symptomatic therapy and care, providing psychological, social, spiritual support or medical and psychological rehabilitation, regardless of disease, age, social status, nationality, religious or political beliefs, place of residence of the patient, etc.

Palliative care is based on complex multidisciplinary analysis of the physical condition of the patient, the degree of pain and limitation of livelihoods, psycho-emotional, cognitive and cultural peculiarities, the maximum possible and comprehensive consideration of the needs and wishes of the patient and his family, the prognosis of progression of the disease and life expectancy. The provision of palliative care begins with the diagnosis of an incurable progressive disease and a limited life expectancy and continues until the end of the period of family grief.

At the same time, according to the same Order, a palliative patient is a patient of all age groups with a limited life expectancy that suffers from incurable progressive diseases that cannot be cured by modern and accessible methods and means and accompanied by severe pain syndrome, severe disorders life, need medical care, care, psychological, social, spiritual support or medical and psychological rehabilitation.

In general, the relevant Order regulates the issues of provision of palliative care, indications and contraindications for the provision of such assistance, the legal regulation of the hospice activities and their main tasks, the peculiarities of the activities of outpatient brigades of palliative care and the conditions for providing it at home with the patient, especially the establishment and operation of palliative units and their main tasks (Order of the Ministry of Health of Ukraine "On the organization of palliative and hospice care", 2011). Thus, at the level of by-laws in the form of the Order of the Ministry of Health of Ukraine, the main features of provision of palliative and hospice care are defined on a legal level. However, in our opinion, taking into account the acute need for palliative and hospice care in Ukraine, it is necessary to create a separate law at a regulatory level that will thoroughly and comprehensively regulate this concept, as well as to create and adopt a Palliative and Hospice Pathology Reform Strategy help. Such a Strategy should be based on an analysis of the current challenges and needs of the incurably sick population of Ukraine and to provide effective assistance to the population concerned, fully protecting their right to dignity and in line with European standards in this area.

Another interesting example is the United States, where palliative care financing is multichannel. First, at the expense of the state program of medical insurance for the elderly - Mediker, which began to cover hospice care for terminal patients to 80.0% since 1982. Secondly, at the expense of private insurance companies and at the expense of the Medicaid program, which provides for the insurance of the poor, at the expense of the patients' own funds and from various charitable foundations. Interesting is the four-level structure of palliative medicine, which is constructed as follows: 1) ordinary home help (95.6%); 2) Continuous home help. It involves mainly nursing care. It is provided only during the period of crisis of the patient or in the case when the terminal patient needs to be at home (0.9%); 3) hospital assistance in the hospice. Conducted for

control of pain syndrome and other acute and chronic symptoms (3.3%); 4) temporary hospitalization for hospice, which is conducted in order to give a "respite" to relatives of the patient and temporarily alleviate their life (Gerasimova, 2013). That is, the development of palliative care in the United States at a high level. In addition, in some states of the United States, euthanasia is permitted, which is also evidence that the country is in a progressive development in the matter of realizing human rights, including the "right to death".

Palliative care in the UK for many years is recognized as a medical specialty and has academic status, but the bulk of its funding is still coming from the private sector. In this country, there are a large number of day care units that provide daytime assistance one or more times a week for patients at home. Functions and methods of activity of employees of such departments are diverse. The organization of daytime departments is carried out in order to assess the symptoms, the implementation of various forms of treatment in a favorable environment, providing the opportunity to rest the patients themselves, their relatives, who are constantly caring for the patient. All this allows to facilitate the stay of the patient at home and avoid hospitalization, provide psychological support, in addition - to hold other measures aimed at improving the quality of life of the patient and his relatives. The British Council for Specialist Hospice and Palliative Care recommends that palliative care services, other than palliative and hospice professionals, include palliative care professionals who can work full time and part-time, but on a regular basis, such as: physical therapist, social worker, cons Religious issues and so on (Gerasimova, 2013).

In the UK, people aged 65 and over will be automatically paid if a person is considered to be terminally ill without having to comply with the "6 month" criterion. In this case, such a person can get different equipment, for example, elevators in the stairs, elevators with a fixture to the ceiling, electric or manual multifunction beds, etc. But for this all equipment must be paid. In the case of a limited solvency, a sick person may receive a "grant" from the state (Standards of Medical Care for Older People Expectations and Recommendations (2000)).

In analyzing the whole right question in the context of the issue of palliative and hospice care, it should be noted that The field of palliative care has the following rights, such as: reduction of pain; assistance in overcoming physical and psychological suffering; obtaining the necessary medicines in the field of palliative care; receiving spiritual and moral support; family support; assistance provided by qualified palliative care specialists; getting help at home, dying, and, if desired, dying at home; treatment of the disease and refusal from the initiated treatment or refusal from the proposed treatment methods; medical information, including diagnosis, predictions and medical interventions, including palliative interventions; determination of the trustee who will make decisions about her health and provision of medical care; equal access to medical care and provision of services (including non-discrimination in obtaining qualitative and timely palliative care regardless of age, sex, socio-economic status, nationality, life forecast or ways of infection); a system of support to help patients live as active as possible until their death; legal services for rendering assistance in matters of real estate and other property, child care, the issuance of a power of attorney or other legal services required for the patient; a system of support to help the family during a patient's illness and during a heavy loss; services to meet the needs of patients and their families, including help patients live as actively as possible before their death; legal services for rendering assistance in matters of real estate and other property, child care, the issuance of a power of attorney or other legal services required for the patient; a system of support to help the family during a patient's illness and during a heavy loss; services to meet the needs of patients and their families, including help patients live as actively as possible before their death; legal services for rendering assistance in matters of real estate and other property, child care, the issuance of a power of attorney or other legal services required for the patient; a system of support to help the family during a patient's illness and during a heavy loss; services to meet the needs of patients and their families, including cultivation after severe loss.

It should be noted that the lack of access to palliative care for patients leads to a number of violations of the human rights recognized by the international community: the right to life, health, freedom from discrimination and equality, and violates the prohibition of torture and degrading treatment and indictment. The respective rights are enshrined and guaranteed at the universal and regional level of international law. To begin with, you must consider the right to life, which is the fundamental right of everyone. The right to life is guaranteed by a number of international legal acts. Yes, according to Art. 3 of the General Declaration of

Human Rights (hereinafter - ZDPL) of 1948, to which a person has the right to life, to liberty and to personal integrity (Universal Declaration of Human Rights (1948). According to the Art. 6 p. 1 of the International Covenant on Civil and Political Rights of 1966 (hereinafter ICCPR), the right to life is an inalienable right of every person. This right is protected by law. No one can be arbitrarily deprived of life (International Covenant on Civil and Political Rights (1966). The corresponding right is also enshrined in Art. 12 of the International Covenant on Economic, Social and Cultural Rights (hereinafter referred to as the International Covenant on Economic, Social and Cultural Rights), which states that States have a duty to recognize the right of everyone to the highest attainable standard of physical and mental health (International Covenant on Economic, Social and Cultural Rights (1966).

The right to life is enshrined in the documents of the main regional international human rights organizations, among them: the European Convention on Human Rights of 1950 (hereinafter referred to as the ECHR), the American Convention on Human Rights from 1969, and the Frikani charter of human rights and peoples since 1987 (European Convention on Human Rights (1950). Overall, providing palliative care course is associated with the right of everyone to life, because palliative care provides support life of seriously ill persons in their last days, while keeping it decent standard of living persons. So, without receiving the necessary painkillers, a person with an incurable illness cannot adhere to the treatment regimen, which, as a result, leads to a decrease in the life expectancy.

Another indisputable human right associated with palliative care is the right to health. Their ratio in general is like the right to life, because the right to health is that the state must ensure that every person has the opportunity to maintain a high level of health and provide medical care. In the same cases, when it is impossible to help a person, it is the duty to support her life to the last, facilitating suffering. From this, the main task of palliative care pays off. Note that support for human health is guaranteed by ZDPL and IPESC. Similar provisions are contained in the Convention on the Elimination of All Forms of Discrimination against Women of 1979, the International Convention on the Elimination of All Forms of Racial Discrimination of 1965 and the Convention on the Rights of the Child of 1989 (Convention on the Elimination of All Forms of Discrimination against Women. (1979), Indian Penal code (1860).

Particular attention is paid to the issue of palliative care in the context of non-discrimination and the prohibition of torture. As to the first one, we note that according to the norms of international law, no person can be discriminated against on any grounds, including for health reasons. Equality and non-discrimination are guaranteed in virtually every one of the above acts of international law, with the exception of the IPECL, which concerns a slightly different set of human rights. Persons in need of palliative care are incurably ill, in particular often with such illnesses that are difficult to accept in a society, in particular HIV/AIDS. The task of each individual state and the international community as a whole is not only to maintain a decent standard of living for the dying person, but also to ensure equal treatment of patients at the level of the healthy, providing them with the same rights and obligations, protection against discrimination and violation of their rights.

That is, palliative medicine, as mentioned earlier, consists not only in the medical provision of the patient, but also includes psychological and, if necessary, legal assistance. It is these components of palliative care, on the one hand, to ensure the psychological stability of persons with incurable illnesses, in particular in keeping them from suicide, as well as normal life, and on the other hand, in knowledge and understanding of their rights and the ability to protect themselves from discrimination on the basis of I will be health. Thus, the high level of palliative care in the state directly affects the provision of basic human rights. That is, we can conclude that without giving patients adequate level of palliative care, the state thereby violates their fundamental rights.

In the context of the prohibition of torture, palliative care also plays a special role. Despite the fact that torture is not associated with incurable illnesses, they still have a direct connection with palliative medicine. First of all, consider what constitutes torture. According to Art. 1 Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment of 1984, "torture" means any act that intentionally inflicts intentional pain or suffering on any person, whether physical or mental, in order to obtain from him or a third person information or recognition, to punish her for acts committed by her or a third person or in the commission of which she is suspected of, intimidating or compelled by her or a third person, or for any

reason based on discrimination of any kind, when such pain or suffering is caused by public officials or other persons acting as official or with their incitement, and with their knowledge, or their tacit consent. This term does not include pain or suffering that has arisen as a result of only legal sanctions, inseparable from these sanctions or accidentally caused by them (Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984)). That is, at first glance, palliative and hospice care is not related to torture. However, if we analyze the failure to provide such assistance through the prism of international human rights law, we can generally emphasize that a person who does not receive palliative care suffers physically or psychologically. Such suffering is caused by the failure of the state to provide necessary support, which is palliative care. Torture as a whole includes not only the physical, but also psychological, suffering of man. That is, taking into account the foregoing, it can be argued that the refusal to provide palliative care to a mortally ill person, refusal of access to it or the complication of such access may be interpreted as torture and inhuman treatment. Thus, it once again confirms the need for the state to ensure the high efficiency and availability of palliative and hospice care.

Examples of human rights violations in the context of the prohibition of torture include the refusal of doctors to prescribe morphine, which could weaken the patient's pain due to fear of legal liability. Also, people who have previously used drugs are forbidden to prescribe drugs. Because of this, former drug addicts suffering from AIDS suffer severe illness at the last stage of the disease and suffer from severe pain. In addition, national legislation generally prohibits and restricts access to opioid drugs, forcing cancer patients and AIDS to suffer from a pain that could be alleviated. Thus, on the basis of the above-analyzed facts, the value of palliative and hospice care for seriously ill people has been reaffirmed.

In accordance with current international approaches and concepts, palliative medicine must be an integral part of the medical care. The WHO Declaration of 1990 and the Barcelona Declaration of 1996 call on all states of the world to include palliative care in the structure of national health systems (Wolf, 2011). The Council of Europe made a significant contribution to the legal regulation of palliative and hospice assistance at the international level. So, in 1999, the Parliamentary Assembly of the Council of Europe (hereinafter - the PACE) issued a recommendation 1418 on the rights of sick and dying people in 1999. Resolution 1418 states that dying patients often lack a reduction in mental suffering, and their psychological, social and spiritual needs are not taken into account. The document, in particular, noted the need to provide appropriate additional training for healthcare professionals working with incurably ill. In accordance with the said Resolution, the duty to respect and protect the dignity of the incurably sick or dying person derives from the inviolability of human dignity at all stages of life. This respect and protection are expressed in providing a suitable environment that allows a person to die decently (Recommendation 1418, 1999).

The Resolution 1418 also noted that today there are certain factors that threaten the basic rights of deriving from the dignity of terminally ill or dying, including: lack of access to palliative care and effective treatment of pain; often lack of treatment for physical suffering and non-fulfillment of psychological, social and spiritual needs; artificial prolongation of the dying process by using disproportionate medical measures or continuing treatment without the consent of the patient; lack of continuing education and psychological support for medical staff working in palliative medicine; inadequate care and support for relatives and friends of terminally ill or dying patients who otherwise could alleviate human suffering in its various dimensions; the fear of patients losing their autonomy and becoming a burden for their relatives or institutions; the lack or inadequacy of the social and institutional environment in which someone can leave their relatives and friends; insufficient allocation of funds and resources for the care and support of incurably sick or dying; social discrimination .

The Council of Europe also called on the Member States to ensure in their internal legislation the necessary legal and social protection against these particular dangers and fears that could be encountered by an incurably sick or dying person in the internal law of the States (Recommendation 1418. (1999).

In 2001, the European Federation of International Pain Relief Associations published the "Declaration of Pain", which urged EU national governments and institutions to raise awareness about the social significance of pain.

It should be noted that in 2002 in Rome (Italy) the European Charter on Patient Rights was adopted. It, among other things, focuses on the right to be deprived of unnecessary suffering and pain in the patient a.

Using the right to participate in the development of health policy, as proclaimed in the Charter, patients can contribute to the fact that the process of dying of the incurable patient is not accompanied by pain syndrome (European Charter of Patients' Rights (2002).

In 2008, a joint Declaration was issued by the International Association of Palliative and Hospice Assistance and the World Palliative Care Alliance for the Identification of Palliative Care and Human Poverty Control. Among the organizations that have signed it, there are both global and regional and national organizations. The list of medicines needed for palliative care is another document that regulates the humanization process for the world's most incurably ill. It was prepared by the International Association of Hospice and Palliative Care in 2009-2010 with the participation of a number of international organizations.

Among the recent developments, it should be noted the adoption in May 2018 of the Maya Declaration, adopted by the European Federation of International Pain Relief Associations. It enshrines the right of any person to have access to the best pain medications in any part of the world. The Declaration states: "Currently there is limited access to adequate treatment of acute and chronic diseases in many parts of the world. Governments and even health workers are not well aware of chronic pain as a health problem. Many health workers are not well-educated and familiar with the best practice of pain relief. We demand that pain medicine be a specialty due to its unique set of knowledge necessary for the treatment of patients suffering from persistent pain" (Declaration of Miami (2018). That is, in this Declaration, the European Association for the Study of Pain, the European Federation of Associations, emphasizes the need to give special attention to the issue of facilitating the suffering of the sick and the establishment of a separate area of medicine that would deal exclusively with pain research and methods for its relief and elimination.

Thus, internationally, palliative care and hospice care has been discussed and reflected in international legal instruments directly or indirectly, for example, in the 1997 Convention on the Protection of Human Rights and Dignity regarding the Use of Biology and Human Beings; European charter of patients' rights by 2002 , the Declaration on pain of 2001 r. ; The Joint Declaration of the International Association of Palliative and Hospice Assistance and the World Palliative Care Alliance for the Identification of Palliative Care and Human Rights Poverty Control from 2008 ; Miami Declarations from 2018 and others.

It should be noted that, apart from the legal side, the issue of palliative care also has a practical aspect of implementation. It manifests itself in the direct protection of the rights of persons to palliative care. There are some vivid examples of solving the problem. First of all, let's pay attention to the case that was considered in India and concerned access to morphine by cancer patients. In 1998 Dr. Ravindra Ghooi and (Dr. Ravindra Ghooi), filed a lawsuit on behalf of cancer patients in India. He asked the court to streamline the procedures for the supply of morphine for medical purposes. Dr. Ghooi sued after his mother's death. His mother suffered from breast cancer, but due to the fact that in the past she suffered a stroke and had diabetes, she was contraindicated in aggressive cancer therapy. However, she suffered from severe pain. Her doctors were not able to get even 1 mg of morphine for her treatment. Dr. Ghooi himself spoke on behalf of his mother, facing bureaucratic barriers and spending time and money meeting with government officials, but as a result, they were unsuccessful.

Having exhausted all administrative remedies, Dr. Ravindra Ghooi sued Delhi High Court. After reviewing the case in 1998, the Supreme Court upheld: "The patient has the right to receive any medication he needs, in particular morphine." The court then ordered the state administration to provide as soon as possible the need for morphine and to meet the expectations of hospitals in obtaining morphine licenses. The court also addressed the patients with a request to go to court if they do not get needed medications.

In the context of this, consideration should be given to addressing the State Commission on Human Rights to ensure the availability of palliative care in India. So, in India, medical workers are not sufficiently trained in the field of palliative care, which should be part of their medical education. In addition, there is no policy on palliative care in India, and most states continue to enforce strict drug control laws, even with palliative care medicines. For example, ill patients in Kerala (India) were not able to obtain the necessary palliative care from qualified specialists or analgesics.

Oncologists and director of the Institute of Palliative Medicine, appealed to the State Commission for Human Rights to introduce palliative care in state hospitals in Kerala. Recommendations provided by the Commission contain basic guidelines for palliative care education, indicating that training should ensure that

healthcare workers are informed about: communication; the process of making legal decisions; pain in cancer patients; medical complications in patients at the terminal stage of the disease; neuropsychiatric problems of patients with incurable illness, and spiritual support of terminal patients in the terminal stage of the disease. The government has adopted a number of measures to develop a palliative care program in Kerala. The palliative care program in Kerala has become a model for palliative care programs in developing countries. Today, there are over 200 public organizations that provide palliative care services, and more than 300 government initiatives.

It should be noted that the growing need for palliative care, the provision of decent care for incurable patients at the end of their lives, caused by the general aging of the population and the spread of severe chronic diseases, is a challenge for health systems in many countries. Probably the only comprehensive tool that compares the state of providing palliative care in different countries of the world is the so-called "Death Quality Index", developed and first in 2000. In 2015, the second edition of the Index, which compares data between 80 countries the world using 20 separate indicators, grouped into five categories: the palliative care and healthcare environment; human resources; availability of assistance; quality of care; and the level of community involvement. The first place in the 2015 ranking (the best "Quality of death" - the best quality of death) is occupied by the United Kingdom. Then the next 2-5 places will occupy Australia, New Zealand, Ireland and Belgium. The last places according to the Index are countries such as Iraq, Bangladesh, Nigeria, Philippines, Botswana, China, Ukraine, India mentioned earlier and many other countries (A report by The Economist Intelligence Unit (2015).

In general, the use of palliative medicine should be treated with great care, so that its continued use does not become a barrier to the development of biomedicine in general. Because human nature is such, why look for new ways to cure a disease if you can simply use palliative medicine. This approach is wrong and regressive. Palliative care should be provided at the time of diagnosis and in tandem with any curative therapy, that is to try to cure a person, and not just to relieve her suffering caused by the disease. Palliative care should be adapted to the needs of the patient as the patient progresses to the final phase. Palliative care should include psychological and spiritual services and other support. Palliative care programs should also consider the needs of the family during the progression of the disease to a severe loss. Some programs include legal services for the issue of a power of attorney or health care order and assistance in fulfilling the will.

The state-administrative essence of the notion of "palliative" can be disclosed because of its connection with the health and social protection industry, namely: the process of allocation and provision by the state of certain categories of patients with drugs, chemicals and medical devices, the use and application of which leads to reduce their pain, suffering from which they suffer; activity, taking certain measures to temporarily reduce the patient's sensation of pain, to create social and domestic conditions of care. It is clear that these categories of patients have, under certain circumstances, a disease that threatens them with imminent death. These types of diseases detected by doctors can not be cured, that is, they are incurable, fatal or deadly. Mortally ill patients at the last stage of such diseases are placed to live in special medical institutions - hospices (Daniluk, 2018). On this basis, hospice care can be defined as a wide range of medical and social and psychotherapeutic measures provided to a person at the last stages of the disease, that is, dying, at the end of his life - usually in the last six months. Hospice care can also be considered as one of the organizational forms of palliative medicine. Therefore, in our opinion, it is advisable to share palliative and hospice care as follows. The first should be the stage of treatment for the sickly patients, on which doctors make every effort to save the patient. In turn, hospice care can be considered as the final stage of a person's life, in those cases in which it is really impossible to take any measures to save it. Hospice assistance, in our opinion, should not act as an organizational element of palliative care, but adventure after the use of palliative medicine by a doctor and after all attempts to save a person's life.

The main thing to note is that palliative care in no way affects the duration or termination of a patient's life. That is, palliative care should not be used to carry euthanasia through a doctor or suicide. The value of life, the natural process of death, and the fact that both of these factors contribute to personal growth and self-awareness must be recognized. As previously noted, in our opinion, palliative care should be an intermediate stage in the treatment of severely ill persons, and not a kind of sentence imposed on such a person. In this context, palliative medicine does not affect the realization of a person's "right to death". However, it should

be considered what in general is such a concept as "the right to death". Based on the title of this right, one can conclude that it includes the ability of a person to dispose of his life at his own discretion. In the context of this, particular attention should be paid to doctrinal approaches to understanding the right to death. In the context of bioethics, the right of every person to the uniqueness and the primary value of his own life and death, the discovery of the will of an independent, unique person is recognized [5]. After examining the general approach of scientists to studying this issue, it can be noted that there are two approaches to understanding the right to death today. In accordance with the first - the right to death is identified with euthanasia, that is, the ability of a person on his own accord to end his life under the pressure of severe incurable illness. This is done to relieve the trauma of the patient, which once again confirms the understanding of the direct communication of palliative medicine with the realization of the right to death through euthanasia. The majority of scholars, such as Ukrainian researchers such as I. V. Kachur, K.O. Polonska. Recall that euthanasia is a practice of stopping or reducing the physician's life of a person suffering from an incurable disease, experiencing unbearable suffering, with a view to their termination (Grischenko, 2005). An American researcher H. Papeira identified euthanasia as an act committed only by a physician who deliberately ends with human life at her request (Pereira, 2011). Therefore, only the doctor and only by the decision of the individual patient or, in some individual cases, by the decision of its closest relatives, can conduct the procedure of euthanasia. As for the second approach, it should be noted that the right to death, in addition to the right to euthanasia, may still include the "right" to suicide. For example, Representative of this theory is the Ukrainian researcher G. B. Romanovsky who considers euthanasia and suicide as elements of the right to death (Romanovsky, 2009). That is, in general both rights meant by the right person at the discretion of her own life, but this decision may depend not on unavoidable circumstances, manifested in the form of incurable diseases, and etc. at stations based on the desire people to carry out certain actions that lead before the termination of her life. However, we do not agree with the opinion of G. B. Romanovsky regarding the attribution of suicide to the right to death, and we consider that this category should be exclusively euthanasia.

Indeed, at first glance, euthanasia and suicide can be interpreted as synonyms, since these acts have the following common features: firstly, the common goal is the desire to prematurely depart from life; secondly, the free expression of the person and, thirdly, the result of both actions is death. However, according to a number of other factors, euthanasia and suicide should be considered as separate phenomena that have different motives, causes, degrees of responsibility. However, the essential difference between suicide and euthanasia lies in the perception of the fact of the death of a person with his relatives. For example, when a person acts in a state of affection under the influence of depression or other impulse, it is always a tragedy for the suicide family, leaving them feeling guilty; Moreover, as statistics show, the cause of most suicide cases remains unknown. When it comes to euthanasia, the patient of the terminal stage of life gets a chance to minimize the pain of his relatives, having met a decent death along with his close friends.

The act of committing suicide is mainly an impulsive action caused by a number of negative factors manifested in human life, regarded as the only way out of the "deadlock" situation. While euthanasia is a complex procedure that involves the passage of a number of medical examinations (including psychiatric) only in order to obtain a permit for the right to take advantage of it. This means that, unlike suicide, a person must have a healthy psyche, clearly understand his actions and be responsible for their consequences.

An important aspect of the delineation of categories of suicide and euthanasia is the degree of criminal liability for a committed act. There is no country in the world where suicide is allowed. So the criminal codes of such countries as: India (Article 309), Malaysia (Article 309), Sudan (Article 215), Singapore (Article 309), - note, that suicide is a criminal offense; that is, in the case of a failed attempt, a person may be sentenced to a year imprisonment (Kapinus O. S. (2006). Other countries do not include punishment for suicide, but they contain a norm about the occurrence of responsibility for bringing suicide, in particular in Ukraine in accordance with Art. 120 of the Criminal Code of Ukraine provides for the punishment of up to three years of imprisonment (if the consequence of suicide is the ill-treatment of a person, coercion, systematic humiliation of human dignity); for a term up to five years (if the suicide was materially or otherwise dependent on the accused) or for a term up to seven to ten years - if the unlawful actions were committed against the minor.

Such a norm is contained in the Criminal Code of Azerbaijan (Article 125); Albania (Article 99); Bulgaria (Article 145); Latvia (Article 124); Moldova (Article 150); Of the Russian Federation (Article 110).

In general, the views of researchers in medicine, law, religion, philosophy is very different and controversial, generating a large number of arguments "for" and "against". However, supporters of such an idea believe that the ability of a person to exercise the right to death is, in a way, a realization of the guaranteed constitutional right to life (Zaborovsky VV (2017). In particular, the Russian researcher A. A. Malinovsky notes that by giving a person a refusal to exercise the right to death, thus the state and society restrict its freedom (Malinovsky, 2002). In this regard, it should be noted that the realization of the right to death, for example, through euthanasia, is the most humane end of the life of the young man as an opportunity to destroy suffering, patience which is no longer bound. However, in our opinion, no way in this context can be considered suicide as a way to end life. Ukrainian scientist V. V. Zaborovsky noted that the right to dignity should include the right to treatment by means of humane methods, which should be aimed at alleviating suffering and helping to die calmly ill person (Zaborovsky, 2017).

From a religious point of view, the relation to euthanasia is rather negative. Believers adversaries of euthanasia, as the rules of law, emphasize that this immoral practice prohibited by this covenant should be prohibited in any of its forms, and it is forbidden by law, that is, from the language of faith, into the language of state and law. Representatives of the largest religious organizations condemn the practice of euthanasia and claim the exclusive right of God to determine the moment of death of man. They also remind of miraculous healings and warn about the dangerous temptation to get rid of euthanasia from "unproductive" citizens.

Despite the fact that the article earlier stated that euthanasia and palliative medicine do not have the same features, since palliative care is aimed exclusively at a decent completion of the patient's life but does not affect the acceleration of such an end, nevertheless, in our opinion, between these phenomena have a causal relationship. The Bidwa phenomena are aimed at alleviating suffering. If palliative care is applied to a person, this means that her life is in danger. Therefore, in the event that at the stage of providing palliative care the person will still not be able to cure, the death of a person in any case will be the end of such assistance. However, such death can be either biological or due to euthanasia in those cases where human suffering is already intolerable, and the chance to cure them is absent. In this way, it is a mistake to assure that these two phenomena are not interconnected. It can be argued that in general euthanasia can be qualified as the last stage of palliative medicine, since euthanasia is also aimed at ending the suffering of the patient. However, in our opinion, because of the circumstances u about euthanasia is not permitted today in most countries, it is not referred to under palliative care.

It should also be noted that euthanasia is used in practice not only by incurably sick individuals, but also by elderly people who have lost their thirst for life. An example of this is the decision of a 104-year-old Australian scholar to take euthanasia. David Gooddall, who was called Australia's oldest scholar, has been fighting for the legalization of euthanasia around the world for the last few years. In Australia, "assistance in committing suicide" is prohibited, and Goodall had to go to Switzerland, where such a way to depart from life is permitted by law. He was not sick, simply, as he himself said: "Life no longer brought him pleasure". If he considered his decision from the point of view of human rights, he had the full right to do so in that he had the full right to dispose of his own life. Such "healthy eunuch tangibia" is very rare and causes very controversial views. However, in any case, the completion of life under the supervision of specialist medical personnel, without pain and suffering, is the best way out of committing suicide. The appropriate case is evidence that suicide cannot be attributed to the fourth generation of human rights and it is a mistake to consider it an integral part of the right to death.

A striking example of the difference between suicide and the onset of euthanasia is the case that occurred in 1973 in the Netherlands, when the Dutch doctor "killed" (stopped suffering) his incurably sick mother and was imprisoned for 1 week of imprisonment. After that, the process of legalizing euthanasia in the Netherlands began. In 1984, euthanasia was recognized as acceptable if the doctor followed the instructions of the Royal Medical Association. Already in 2001, euthanasia was closed at the level of law (Miroshnichenko, 2012).

It is in this context that one should refer to the practice of the European Human Rights Organization (hereinafter - ECHR) regarding the use of euthanasia in the context of palliative care. Note that in Art. 2 ECHR guarantors and not everyone's right to life. However, this is not at all a testimony to the prohibition of euthanasia. The ECHR of 1950 includes all fundamental human rights and freedoms. The most important, but at the same time, the most common disclaimer of the above-mentioned Act is that which regulates the right to life. After all, if a person takes the right to life, then other rights generally lose their meaning.

The right to life is enshrined in Article 2 of the ECHR, which provides that no one may be deprived of life intentionally, however, in accordance with paragraph 2 of this article, the right to life will not be violated if there is a use of force directed at the protection of other persons; to avoid mass disorder; for the purpose of arrest on legal grounds or to prevent the escape of a person already in lawful arrest, but at the same time, this article does not prescribe all problematic aspects of the right to life, and thus leaves room for court practice. In particular, from what moment comes the right to life (the moment of conception or birth); the issue of abortion and the question of "right to death" - all these aspects raise many questions and encourage legal debate.

With the proliferation of euthanasia and the legalization of it in a number of European countries, the question arose whether the person has the right to address to the EPL to protect such a controversial right as "the right to death". It should be noted that already in 2002 there was an SPL for the first time faced with such issues. In *Pretti v. United Kingdom* (*Prétty v. United Kingdom*, 2002), the applicant, Diane Pretti, who suffered constant pain and suffering due to an incurable illness, as a result of which she wished to die, asking her husband to bring her a lethal injection (because of the illness was paralyzed) thus worrying about his actions being qualified as a crime (Khimyak Yu.B. (2009). Given the fact that in the United Kingdom euthanasia is prohibited and such actions by the applicant's husband may be a criminal offense, the national courts refused to grant Diana Prietti's request for immunity from prosecution against her husband (Mokoseeva, 2013). After exhausting all national remedies, the applicant applied to the ECtHR to declare that such a refusal by the domestic courts was a direct violation of a number of ECHR articles 2, 3, 8, 9 and 14. In particular, according to the applicant, Article 2 of the ECHR seeks to protect against the violation of the right to life by third parties, and the essence of the notion of "right to life" is that it also automatically includes the "right to death", since the latter is the regular final stage of the right to life (Chervyatsova, 2012).

It is advisable to draw attention to the fact that the ECHR uses in its decisions such a notion as "the right to death", but is it appropriate to precisely this term? Such a wording may include the right not only to euthanasia, but also to suicide, which in its turn, of course, is beyond the legal framework of all countries of the world. Also, taking into account the physiology of human life - death is the final stage of biological life and an inevitable phenomenon that does not require any legal and moral consolidation. But, in this case, under certain circumstances, this stage of life can be approximated with the help of euthanasia. That is, in our opinion, it will be more correct to speak not about "the right to death", but about the right to stop life without torment and suffering, that is, the right to euthanasia.

In its decision, the ECtHR noted that the right to life cannot be interpreted as having a diametrically opposed meaning, that is, as including the right to death. Thus, the Court rejected the applicant's request for a violation of Article 2 of the ECHR (Case «*Pretty v. The United Kingdom*» (2002). The applicant also alleged that there had been a violation of Article 3 - freedom from cruel or degrading treatment. As the woman's disease progressed, the terminal stage of Diane Pretti's life would be accompanied by respiratory failure and pneumonia (caused by increased weakness of the swallowing muscles). This clinical picture a priori implies that the applicant will suffer severe pain and die in unbearable torment, that is, there will be a violation of Article 3 of the ECHR. There is an SPL disagreed with the interpretation of this article by the applicant and noted that the suffering naturally generated (as a result of mental or physical illness) would be a violation of the above article only if they were related to the conditions of detention, the consequences of expulsion or other measures, responsibility for which lies in the state (Senyuta, 2013). The Court also considers that there were no violations of other articles referred to by the applicant's party. In deciding on this case, the judge of the ECHR was guided not only by practice, but also by the Council of Europe Parliamentary Assembly Recommendation No. 1418 "On the Protection of the Rights and Dignity of Deadly Ill Persons" (1999), paragraph 9

of which stipulates that the desire of the deadly patient to put an end to life prematurely under no circumstances is a legal claim to death by another person.

The Pretti case against the United Kingdom laid the foundations for considering other cases of euthanasia and pointed to the lack of regulation of this somatic right at the international level. In turn, the Parliamentary Assembly of the Council of Europe examined the issue of euthanasia on the European continent, and its findings were contained in a document titled "Questions and Answers on euthanasia" (2003), and subsequently adopted Resolution No. 1859 "Protection of Rights and Dignity taking into account the patient's wishes expressed earlier" (2012), which considers euthanasia as a deliberate killing and insists on its prohibition (Resolution 1859/2012. (2012).

Two weeks after the final decision was made by the CPD in the case of Diana Pretti, the applicant died in terrible torture, which she so wished to avoid. At the same time, the decision on this case and the loud publicity of the sad history of a paralyzed woman influenced the British authorities, which in another court decision considered it possible to turn off completely paralyzed, but able to speak and thus express Mrs. N.'s will (for ethical reasons, the name of the applicant not specified) from the device of artificial respiration support.

On July 19, 2012, the PLL made a decision on another noisy case - Koch v. Germany (2012), like Diana Pretti, the plaintiff's wife was almost completely paralyzed and had a desire to end her life with sodium phenobarbital (Research Report. Bioethics and the Case-law of the Court. (2016). In order to obtain this drug, a woman turned to the Federal Institute of Medicines and Medical Equipment, who denied Ms. Koch to meet her request. After some time, a woman went to Switzerland, where she carried out the euthanasia procedure with the help of Dignitas, and her husband appealed to the ECtHR complaining of violations of Articles 2, 3, 8 and 13 of the ECHR. The court's decision was in favor of the defendant, in particular, the provisions on the non-dissemination of Articles 2 and 3 to the exercise of the right to death (in this case, the transfer of drugs to a paralyzed wife) were confirmed (Case «Koch v. Germany» (2012).

Interesting is the fact that not always the defendants in cases of "right to death" are countries where euthanasia is beyond the legal framework. There have been cases where the applicants defended the right to euthanasia in Switzerland, the country with the most lenient legislation on the issues of self-election of their own death date. In particular, in 2011, Haas v. Switzerland (Haas vs. Switzerland, 2011) was dealt with where the applicant insisted on violation by the state of his right to respect for private life, which includes the right to independently elect their own date of death. Since active euthanasia in Switzerland was permitted, there was no violation of Article 2 of the ECHR, but according to the applicant, the refusal to provide him with a means of implementing euthanasia constitutes a violation of the positive rights of Switzerland and the interference with his private life and as a result of a violation of Article 8 The ECHR. Mr. Haas (the applicant) has suffered from bipolar affective disorder for over 20 years and wished to end the problem with his life with the help of a special drug - sodium phenobarbital, which can be purchased at a regular pharmacy, but exclusively by the prescription of a doctor. The problem was that the euthanasia practice in Switzerland has clear limits to regulation, in this case. To get this medication you need a recipe. The applicant was refused more than one 170 doctors in the delivery of this recipe, arguing that the illness of Mr. Haas is curable. In its decision, the ECtHR was in solidarity with the decisions of Swiss national courts and supported the defendant's right to establish a framework for the issuance of a lethal drug in order to avoid abuses by those who seek "easy death" and to protect the health and safety of the population (Case «Haas v. Switzerland» (2011).

The legal position of the Court with regard to the legislation on euthanasia in Switzerland was expressed in the judgment of May 14, 2013 against Gross vs. Switzerland (Gross vs. Switzerland, 2013) , where 82-year-old Aldy Gross complained of violating her right to euthanasia because of the refusal to issue a recipe for the purchase of phenobarbital sodium, but she was not deadly ill, and her decision to purchase a deadly drug was justified by the deterioration of health due to age and reluctance to wait for natural death. In its decision, the ECHR did not consider the material aspect of the case, that is, it did not determine whether the applicant had the right to euthanasia, but drew the defendant's attention to the gaps in national legislation, namely the lack of clear criteria for the possibility of euthanasia on grounds such as those of the applicant (Case «Gross v. Switzerland» (2013). Another case that was the subject of a decision on euthanasia by the European Court of

Human Rights is Lambert and others v. France (Lambert and others vs. France, 2015). The applicants were the parents of Vincent Lambert, a paralyzed man who was 8 years old in a vegetative state with a minimum level of consciousness. After prolonged treatment, which did not produce any positive results, the physician was asked to stop the artificial support of the patient's life, which was to provide artificial nutrition and hydration of the body. Under French law, the doctor's proposal was not illegal under the Law "On Passive Euthanasia" (2005), better known as the "Law of Leonetti" (Alekseev M. (2011). This doctor's proposal was supported by his wife and six of the eight brothers of Vincent, but the patient's parents were categorically determined.

Mr Pierre and Mrs. Vivian Lambert (parents of a sick person) appealed to the French State Council to ban doctors from passive euthanasia regarding their son; As a result, the Council for the Evaluation of the State of Vincent appointed three medical examinations. As each of the surveys showed a less satisfactory state of the brain, and the physiotherapists advocated euthanasia, the Council's decision was not on the side of the applicants who appealed to the ECtHR to refer to the violation of Article 2 of the ECHR. At the time of the Court's review, Vincent's shutdown of the device was postponed. By the final decision of June 5, 2015, the ECtHR takes into account the desire of Vincent himself expressed to his wife before the tragedy (in particular, not to leave him in a vegetative state and, in the case of negative circumstances, not to prolong his life artificially), and also relying on judicial practice which points out that in matters of euthanasia, the Court gives greater autonomy to the national laws of the countries, the Court made a decision in favor of the defendant and did not see in the actions of state authorities in certain circumstances the violation of Article 2 The ECHR. To the ECHR were submitted and other similar applications but not all of them have been considered, for example: Sanles Sanles v. Spain 2000, Ada Rossi and Others v. Italy 2008, Nicklinson and Lamb v. United Kingdom 2015, Gard and Others v. United Kingdom 2017, Afiri and Biddarri v. France 2018 etc. (End of life and the European Convention on Human Rights. Press Unit. Factsheet. (2019).

Consequently, there is an SDL considering cases of euthanasia more and trying to be dynamic in its decisions, as the ECHR is a living mechanism, and every new euthanasia case is a precedent. Also, the ECtHR pays great attention to the attitude of each individual respondent country to the realization of the right to euthanasia and gives the state the right to regulate issues of its permission or prohibition on its own discretion. The purpose of the Court's consideration of the case is to identify those factors which violate or do not violate Article 2, 3 or 8 of the ECHR in conjunction with the norms of the national legislation on the euthanasia of a particular country.

CONCLUSION

Thus, it is necessary to define palliative medicine as a stage of treatment of seriously ill persons, the ultimate goal of which is not the death of the patient but its recovery. In general, palliative care should be taken in two directions: in the first place, it is a temporary help on the path to the choice of treatment since the new treatment of any kind is the salvation of man - life, not death. In the second direction, it should be considered as a real supportive therapy, the result of which will be the death of the patient. Therefore, palliative care is directly linked with the right to die, but it can be implemented in two directions due to biological or patient death or euthanasia is when a person can no longer bear the suffering (pain). On this basis, the term "palliative medicine" should be defined as a complex of actions aimed at working with seriously ill persons for the purpose of carrying out measures for the relief of patient suffering and the search for ways of its treatment.

Considering the modern challenges, the doctors and patients face worldwide, it is reasonable to develop a unified concept of palliative medicine/care that will have universal effect and will be applicable in all countries. Particular attention in the provisions of the Convention specified should be paid to understanding the concept of pain (both physical and mental with emphasis on the fact that the main aim of the strategy should be the treatment of disease.

In those cases where treatment is generally unfeasible, the sick person should be entitled to euthanasia as the final stage of the use of palliative medicine in order to end its suffering. Today's euthanasia is becoming widespread in more and more countries, precisely because of its ability to make human death easy and humane. Euthanasia cannot be equated with suicide despite the fact that at first glance, these phenomena are similar. It is in this context that euthanasia is carried out by appropriate specialists, in the first place, in order to avoid the person being diverted from suicide. However, in the absence of incurable illness, the

achievement of a retirement age, medical commission and conduct, other measures, you can try to put a question about the use of "healthy euthanasia" if this is needed by a person in the implementation of the right to "worthy death". But in general, suicide cannot be output from certain first situation because it implies the impossibility of precisely the state to provide people a decent life in any age and situation in which it found itself.

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