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Referendum on Euthanasia and Assisted Suicide: Between False Autonomy, Systemic Withdrawal of Treatment, and Economic Pressure

Letter from Slovenia

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Abstract

After decades of expert debate and political disagreement regarding the legalization of euthanasia and physician-assisted suicide, the current Government of the Republic of Slovenia decided in 2025 to draft and adopt (October 21, 2025) the new Law on Assistance in Voluntary Termination of Life. The rapid legislative momentum does not so much reflect moral progress, but rather a reflection of a systemic process of withdrawing treatment and concealing successful therapeutic alternatives, with a non-negligible role played by latent economic factors. The referendum question is therefore no longer just a question of mercy, but reveals whether we, as a society, will legalize the replacement of curative and holistic medicine with assisted death. On Sunday, November 23, 2025, the Act on assisted voluntary termination of life was rejected in a referendum by a narrow margin. But for other reasons that voters had, not the ones explained in this essay. The government must respect the referendum decision for one year. Then the cycle can be repeated.

Keywords: Referendum, euthanasia, physician-assisted suicide, legalizing the Right to Die

Introduction

Slovenia, an EU member state, has once again been caught up this year (2025) in one of the more important processes in the field of public health and healthcare policy, which are rapidly taking place across Europe. (1) It has thus swiftly adopted a new law seeking to legalize medical assistance in active euthanasia and assistance in "voluntary" termination of life, or assisted suicide. Slovenia was indeed very quick to prepare and adopt this law, and it is not known why the Slovenian government was in such a hurry to do so.

The public has once again not received an explanation of what the new *Act on Assistance in Voluntary Termination of Life* (2) actually entails, and what will actually be decided in the referendum (November 23, 2025). Public opinion polls suggested that the majority of voters who are going to participate in the referendum will vote in favor of the law, under the traditional circumstance that a qualified majority of voters will not participate in this referendum vote either. But the opposite happened. More voters than expected participated in the referendum. The result was close: 53.46% against (but mainly for other reasons, not those explained in this article), 46.56% in favor. An additional constitutional condition for rejecting the law was that at least 1/5 of all eligible voters had to vote against its enactment. This happened, as 369,513 voters voted against it.

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(3) Therefore, at this point, this law will not come into force in Slovenia. In accordance with the legal framework, (4) it will remain so for at least one year.

The proposed law addressing assistance in ending life and euthanasia has for decades represented a complex moral, philosophical, and legal dilemma, demanding a careful consideration of ethical values. (5) Traditional ethics conditionally limited support for active euthanasia to exceptional cases of unbearable and incurable suffering where no other solutions were available. (6) Legal-philosophical analyses then shifted to considering whether "the right to die" could be recognized as an entry into an "expanded field of freedom." (7) However, the circumstances of today's accelerated adoption of such legislation across Europe and the world differ dramatically from these classical starting points. I will try to explain this in this article.

The rapid legislative momentum does not so much reflect moral progress, but rather a reflection of a **systemic process of withdrawing treatment and concealing successful therapeutic alternatives**, with a non-negligible role played by latent economic factors. The referendum question is therefore no longer just a question of mercy, but reveals whether we, as a society, will legalize the replacement of curative and holistic medicine with assisted death.

Legal-Ethical Distinction: Not the Right to Die, but First the Right to a Dignified Life

Legal-philosophical analysis has long emphasized a crucial difference: **the right to die is neither a constitutional nor a fundamental human right.** (5–7) If it were a right, the legal system would have to enable its effective realization in practice, which is something entirely different from the mere factual possibility of a person ending their life. (8) The fundamental legal and ethical breakthrough in the debate lies (also according to the European Court of Human Rights case-law (8) in the **state's positive constitutional obligation**, stemming from the protection of the right to life and dignity. (6,9)

For several years, I have been publicly explaining, also in direct connection with the case law of the EctHR: (5,6,9) the state must do everything that can reasonably be expected of it to develop, finance, and ensure an effective, accessible, and well-managed **system of holistic palliative care and hospices**. This duty has repeatedly been highlighted in the Slovenian context as an overlooked unconstitutionality regarding dying. If the state fails to fulfil this obligation, it must be **held responsible for violating the right to life**. (10,11)

In such a context, it is impossible to speak of genuine and free **voluntariness**. If assisted death is offered as an **alternative** to non-existent or inaccessible palliative care—or, worse, inaccessible curative treatment—this is not an autonomous choice, but a forced decision between suffering and death. Legislation on assistance in voluntary termination of life in this case merely formalizes a systemic failure to act as required.

Euthanasia as a Failure of Social Policy and Economic Pressures

Critics believe that the haste to legalize euthanasia and Medical Assistance in Dying (MAiD/PAS) represents a **"failed social policy."** (12) Instead of providing the necessary support, care, and treatment, a solution that is quick and definitive is offered.

- **Economic Rationalisation.** The most alarming argument is the role of **economic factors**. The legalisation of MAiD inevitably triggers discussions about **potential savings** in healthcare systems. Studies in Canada calculated that MAiD could save millions of euros/dollars annually, mainly due to the shorter period of expensive hospitalisations and intensive end-of-life treatment. The authors of the analysis therefore focused on the potential annual savings for the healthcare system. The estimated savings resulting from a shorter period of expensive end-of-life care are estimated at between $34.7 million and $138.8 million per year. For the direct costs of implementing MAiD (such as physician fees and medications), they arrived at an estimate of between $1.5 million and $14.8 million per year. The authors also estimated (concluded) that the net savings (savings minus costs) would be between $33.2 million and $137.3 million per year. This means that the introduction of MAiD does not place an additional financial burden on the healthcare system, but rather results in significant savings. However, they cautioned that economic factors should not be a factor in individual decisions about MAiD. (13)
- **Conflict of Interest.** Despite emphasizing autonomy, critical analyses warn that this formally promotes **therapeutic killing** into a **"medical commodity"**, which becomes a legitimate "option" in the management of healthcare resources. (14,15) A serious **conflict of interest** is created between the organization that must

balance its accounts and the patient's need for expensive care.

The Danger of the 'Slippery Slope' and the Fragility of the Vulnerable

A central argument against the legalization of euthanasia is the irresolvable ethical conflict between satisfying the individual's request for therapeutic death and ensuring that vulnerable, incompetent, or powerless patients do not receive fatal therapy as a **"solution in their best interest."** (15)

The **slippery slope argument** warns of the erosion of the initial strict criteria:

- **Expansion of Criteria:** Laws that initially apply only to the terminally ill and severely suffering eventually expand to chronic and psychological illnesses, as has happened in some Benelux countries and Canada. (12)
- **Pressure on the Vulnerable:** For vulnerable groups (the poor, the elderly, those with disabilities), the pressure **"not to be a burden"** on their family or the state increases dramatically. It has been shown that vulnerable patients with low socio-economic status find it harder to advocate for their rights to holistic care, which increases the risk of choosing MAiD out of despair. (12,16)

Discussing the Question of "Incurability"

A particular issue for thoughtful and critical debate may be the concern that rushing through legislation on euthanasia and assisted voluntary termination, and consequently excessive practice of MAiD, could lead to a situation where the public health system begins to conceal or ignore the existence of potential curative or ameliorative solutions for diseases it declares to be "incurable." For example:

- **Repurposed Cancer Drugs.** The public health system usually does not include protocols based on **repurposed drugs** in care. Nevertheless, case reports in peer-reviewed publications have shown the anti-tumour potential of some affordable, non-toxic drugs, such as Ivermectin, Fenbendazole, and Mebendazole, which, when combined with other substances, achieved complete or near-complete remission in patients with advanced cancer. (17,18)
- **Pathology of Chronic Conditions.** The same applies to chronic and disabling diseases, such as "Long COVID" (PASC), which is already becoming a reason for euthanasia requests in some countries. Research has identified the pathological basis of symptoms (fatigue, "brain fog") in **fibrin amyloid microclots.** (19) Reports indicate that specifically monitored **triple anticoagulant therapy** enables the removal of these microclots and thus the resolution of persistent symptoms. (20)
- **Consequences of mRNA vaccines.** These include serious medical conditions that are either a direct or indirect result of the toxicity of mRNA vaccines (21) and effective drugs that enable the body to cleanse itself of these toxins. This includes both existing and emerging drugs. (22,23)

I ask myself whether we should think carefully, openly, and in good faith, and also raise questions about this publicly. I have no doubt that we should. In fact, I am convinced that we must do so.

If euthanasia is offered to individuals without providing them access to testing and treatment according to these—protocols, already published in peer-reviewed journals—this is not just unethical, but constitutes a systemic **withholding of vital information**. In such circumstances, the **voluntariness** of the choice ceases to exist; it is replaced by the healthcare system's failure to act as required. From a moral and ethical point of view, from the point of view of law and constitutional law in particular, as well as from the point of view of professional responsibility and the basic principles of medicine as a science "in the service of people and for the benefit of people," this should not be allowed to happen in the future.

Conclusion: Responsibility Before Death/as. Killing

The referendum question forces us to stop treating euthanasia as an isolated ethical issue. (24,25) The challenge is not whether to allow a dignified death in extreme cases, but whether we may offer it as an **alternative to treatment** which—according to critical legal analyses and some new medical sources—may be entirely achievable, yet concealed or systematically prevented.

An Act on Assistance in Voluntary Termination of Life, adopted in the current context of systemic failures, economic rationalization, and the concealment of curative options, would thus legalize systemic negligence instead of protecting autonomy. True respect for human dignity and entry into the "ex-

panded field of freedom" are only possible when all options have been exhausted and offered: from effective curative care that does not ignore new findings (about effective medicines and successful cures), to fully developed and accessible palliative care.

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