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# THE RIGHT TO DIE THROUGH THE ANALYSIS OF THE SLOVENIAN VOLUNTARY ASSISTED DYING BILL

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**Abstract** This article provides an analysis of the Slovenian Voluntary Assisted Dying Bill, in both its previous and amended versions, which is founded upon the paradigm "My life, my right". The original bill, which was regarded as highly liberal, contained numerous exceptions that effectively allowed euthanasia for all individuals with chronic illnesses or disabilities. This analysis critically examines the most controversial legal provisions of the bill and anticipates consequences should it be implemented, particularly from the perspective of vulnerable healthcare users. The analysis demonstrates that the original formulation of the right to medically assisted dying conflicts with the foundational principles of the healthcare system and is inconsistent with the Patient Rights Act. The amended Voluntary Assisted Dying Bill provides physicians with the options to both reject medically assisted dying applications and to employ safeguards to protect patients in transitional distress from premature death.

**Keywords**
euthanasia,
medical aid in dying,
legal regulation,
patient rights,
disabled persons

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## 1 Introduction

In recent years, Slovenia has been engaged in a public debate concerning the legalization of euthanasia and assisted suicide. In 2024, a civil initiative, supported by a sufficient number of voter signatures, introduced the Voluntary Assisted Dying Bill (VADB)[1] (Predlog zakona o pomoči pri prostovoljnem končanju življenja, 2023) to the National Assembly. After deliberation, VADB was rejected as unsuitable for further consideration, although a consultative referendum was subsequently held. With a voter turnout of 41.43%, 54.89% of participants supported enacting a law regulating assistance in the voluntary ending of life (Republic of Slovenia State Election Commission, 2024).[2] Despite this, the law faced significant opposition from various entities, including medical organizations, the Commission for Medical Ethics of the Republic of Slovenia, the Catholic Church, and the Islamic Community in Slovenia. The Chamber of Nursing and Midwifery did not take an explicit stance but saw many of its members support the proposal (Ažman, 2023). By early 2025, the governing coalition, in collaboration with the civil initiative, amended the bill and submitted it to the National Assembly. In July 2025, the National Assembly adopted the VADB. Opponents of the VADB submitted a request for a legislative referendum.

The debate surrounding the legal regulation of voluntary end-of-life assistance has been predominantly undertaken in very general terms, with insufficient emphasis on the specifics of the bill that served as the foundation for the proposed law. Following the results of the referendum, the governing coalition introduced amendments to the bill, modifying the most controversial provisions, notably converting the patient's right to assisted dying from an absolute right to a relative one. This change was intended to enable the adoption of sub-legislative measures aimed at protecting vulnerable individuals in distressing transitional periods.

This article systematically examines the key legal provisions of the VADB, focusing on those that pose the greatest risks of misconduct and/or abuse. It also evaluates the amendments to these provisions and their implications for patient rights. Additionally, the article presents a comparative analysis of certain provisions of the

[1] Voluntary Assisted Dying Bill – VADB (Slovene Predlog zakona o pomoči pri prostovoljnem končanju življenja – ZPPKŽ (2023, 2025)).
[2] Republic of Slovenia State Election Commission, 2024 (Slovene Državna volilna komisija Republike Slovenije).

Slovenian VADB and the Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act.[3] We have chosen to use the Dutch law for comparison, as the proponents of the VADB frequently cite it and, in certain instances, also misinterpret it (VADB, 2025, pp. 18, 19–23). It critically addresses the problematic nature of the "My life, my right" principle, which, while ostensibly promoting autonomy, may open the door to non-autonomous decisions made by individuals in transitional crises. This scenario is problematic from the perspectives of medical ethics and the Patient Rights Act (PRA).[4] The article concludes by presenting an alternative vision for regulating assistance in end-of-life decisions.

## 2 The Principle "My Life, My Right" as the Basis for Exercising Rights under Health Insurance

Upon a closer examination of the arguments proposed by opponents of euthanasia and the legal regulation of end-of-life assistance, it becomes evident that their opposition does not stem from a denial of an individual's right to a peaceful death, but from concerns regarding the broader societal implications (Ošlaj, 2018, p. 38). In the case of the previous bill, these concerns were substantiated. Proponents of the VADB, invoking the slogan "My life, my right", emphasize the patient's right to autonomy and self-determination as a fundamental principle that allows the patient to request assistance in ending their life. However, the European Court of Human Rights held in the case of *Pretty v. the United Kingdom*[5] that Article 2 of the European Convention on Human Rights[6], which protects the right to life, cannot be interpreted as conferring a diametrically opposed right, namely, a right to die.

Proponents of the VADB primarily reference Article 34 of the PRA, which they argue supports this right (VADB, 2025, p. 4). However, a closer examination of Article 34, in conjunction with Article 12 of the PRA, suggests a different understanding of the patient's right to make decisions. The right to existence and

[3] Termination of Life on Request and Assisted Suicide (Review Procedures) Act, The Dutch legal framework, which has allowed the performance of euthanasia and assisted suicide since 2002.
[4] Patient's Rights Act - PRA (Slovene Zakon o pacientovih pravicah – ZPacP): Uradni list RS, št. 15/08, 55/17, 177/20, 100/22 – ZNUZSZS.
[5] European Court of Human Rights. (2002, April 29). *Pretty v. the United Kingdom* (Application no. 2346/02).
[6] European Convention on Human Rights, retrieved from: https://www.echr.coe.int/documents/d/echr/convention_ENG (July 20, 2025).

self-determination cannot simultaneously serve as a right to demand that the healthcare system assist in ending one's life.

Article 34 of the PRA specifically safeguards the patient's right to decide which medical treatments they refuse. Although Article 34 ensures that a patient's autonomy is respected by allowing them to refuse treatment, it does not extend to granting the patient the authority to dictate medical procedures.

Proponents of the VADB, however, have extrapolated from this right a patient's correlative right to demand particular treatments, regardless of their medical validity or alignment with medical doctrine (VADB, 2025, p. 4). Notably, Article 6 of the previous version of the VADB stipulated that a patient could request assistance in ending their life if they were "experiencing unbearable suffering for which no acceptable option of relief exists." This provision could be interpreted to mean that the patient's subjective experience of suffering alone determines eligibility for assisted dying, without considering whether the relief options align with established medical practices.

This interpretation contrasts with the safeguards provided by Dutch law and conflicts with Article 12 of the PRA, which articulates that: "*A patient is entitled to treatments funded by public resources if they are deemed necessary by medical standards and are reasonably expected to benefit the patient.*" The entitlement to such treatments is contingent upon medical necessity, not solely on the patient's subjective interpretation of their suffering. In other words, a patient is entitled to treatment funded by public resources if it is necessary and justified according to medical standards, and not solely based on the subjective feelings of a patient with a chronic illness or disability. Thus, it is not the patient who determines what they are entitled to, based on their interpretation of their suffering and the interventions they wish. Demanding euthanasia solely based on the patient's experience and their acceptance of only personally acceptable options for relief is akin to a patient with occasional tachycardia having the right to demand a chest CT[7] scan with contrast from a physician, without medical indication, because an ECG[8] is not an acceptable option for the patient. Such a need expressed by patients may be the result of unsuccessful

[7] Computed Tomography.
[8] Electrocardiogram.

treatment or inadequate symptom management. To prevent such situations in palliative care, physicians should, once all options for effective symptom relief in the terminal phase of an incurable illness have been exhausted, communicate this openly to the patient and allow them to propose the possibility of assisted dying.

Furthermore, the subjective nature of suffering in the VADB contrasts sharply with the more stringent criteria in the Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act, which require that unbearable suffering must be tangible and verifiable by a physician, and that the patient hold the conviction that no reasonable alternative exists. The Dutch system also includes a comprehensive "Euthanasia Code"[9], which governs the procedures and safeguards for euthanasia and assisted suicide, ensuring that these services are delivered within a framework of strict medical and ethical guidelines, according to which a patient may choose to reject a reasonable alternative; such rejection does not automatically authorize euthanasia.

In contrast, the Slovenian proposal, by allowing euthanasia based solely on the patient's subjective experience, lacks such a regulatory framework. Additionally, this approach raises questions about the potential for misuse, as it would allow services that are not medically indicated, but rather requested purely by the patient, to be funded by public health insurance. The amended VADB addresses this issue by removing the phrase "they are experiencing" from Article 6 of the VADB, which allows suffering to be assessed objectively.

Another significant concern with the 'My life, my right' principle is that it places the right to end life above the right to receive comprehensive support for terminally ill individuals. By prioritizing access to assistance in ending life over other forms of care, such as quality palliative care, psychological support, and specialized treatments, the VADB risks depriving patients of adequate healthcare. If the legislature provides deadlines for implementing assisted dying that are more favorable than the possibility of exercising alternatives (such as a psychiatrist or palliative care), then it prioritizes assisted dying over the alternative. If patients are denied proper care, they may resort to euthanasia as a perceived solution, even when

[9] Euthanasia Code, Professional guidelines for performing euthanasia and assisted suicide, periodically reviewed by the Regional euthanasia review committees.

other viable options are available. By making such a choice a priority, we would undermine the right of patients to receive appropriate, high-quality, and safe healthcare, in accordance with established medical standards.

## 3 Access to End-of-Life Assistance

Proponents of the VADB advocate for the law as a solution to unbearable suffering during the final stages of an incurable illness (VADB, 2025, p. 3). However, the provisions of the previous bill were structured in such a way as to permit numerous exceptions, with almost no restrictions. Paragraph 1 of Article 6 in the previous VADB stipulated that a patient could claim the right to medically assisted dying (MAID)[10] if the following conditions were met: "*They are experiencing unbearable suffering, for which no acceptable relief option exists for the patient, and which is the result of a terminal illness, a severe permanent illness with persistent or recurring symptoms, or another health impairment, the treatment of which does not give a reasonable expectation of cure or improvement of the condition.*"

It is the portion of Article 6 of the previous bill, with the phrase "or another health impairment", which is, in my view, problematic. This broad categorization encompasses individuals with conditions such as hemiplegia, paraplegia, amputations, loss of vision, chronic obstructive pulmonary disease (COPD), heart failure, kidney failure, neurogenic or rheumatoid diseases, chronic intestinal diseases, and others. Essentially, the law would have allowed MAID for individuals suffering from chronic, incurable health conditions that might cause frequent or occasional exacerbations of their condition. Moreover, many elderly individuals who have at least one chronic health condition could be included in this category. The amended VADB continues to permit MAID in cases of "other serious permanent impairment of health", which affects disabled individuals. However, even the amended VADB is deficient because it fails to define what severe health impairments mean. If we consider that severe health impairments only mean 100% disability, then in addition to the impairments mentioned above, we can also include patients who have received transplants of the heart, liver, lungs, after amputation of fingers, or both tibias. However, if we include patients with 90% or 80% disability among the severe health impairments, this list is much more exhaustive. The amendment places limitations

[10] Medical aid in dying- MAID (pomoč pri končanju življenja - PPKŽ).

on the absolute right of the patient by requiring a physician to assess the patient's suffering and the extent to which all potential treatment options for serious illnesses have been exhausted. Additionally, point 9 of Article 2 in the amended VADB further defines "intolerable suffering" as: *"A condition with no possibility of improvement when the patient endures severe and intense physical pain, extreme psychological distress, or both."*

This definition allows for psychological distress, not necessarily only physical suffering, to be considered as a basis for requesting MAID. All patients falling under this definition can request MAID if they suffer from extremely severe psychological distress due to a medical condition. However, the physician may refuse the request if they determine that the psychological distress is reversible or expected to improve. The first judicial decision will likely determine the adequacy of this safeguard.

The previous VADB, by providing such broad exceptions, effectively extended the right to MAID to a significant portion of the population. In combination with Article 28, or Article 26 of the amended VADB, which states that "the death insurance contract also covers death that occurs as a result of the MAID procedure, regardless of how much time has elapsed between the conclusion of the contract and the implementation of the MAID procedure", the law not only provided a medical justification for MAID but also implicitly included a social rationale (Bračič, 2023). Thus, there is a risk that the possibility of a financial windfall from life insurance will give some chronic patients an additional incentive to request MAID. So, a patient who does not see a prospect for himself, who is unable to support his family or his children in school, who has a severe chronic illness or is disabled, can help his loved ones by asserting the right to MAID, even though he could live with his illness or condition for years. Proponents of the VADB argue that insurance companies would adjust their actuarial calculations accordingly (Mišič et al., 2023), although this could result in chronic patients and disabled individuals being excluded from obtaining life insurance, given the VADB's provision that these individuals are entitled to MAID under certain conditions.

Furthermore, Paragraph 3 of Article 26 in the previous VADB states: *"The death of a patient, which occurred as a result of the MAID, shall not be considered as a direct cause of death. The direct cause of death shall be considered as a serious incurable disease or other serious permanent impairment of health ..."* This provision raised further concerns (Zwitter, 2025), as it allowed a disability that was not a direct cause of death but could lead to death over

time to be classified as the "cause of death". This provision conflicted with Paragraph 2 of Article 21, which defined the cause of death for the purposes of medical certification as "assisted suicide".

## 4 Limitation of the Right to Medical Aid in Dying

The drafters of the VADB assumed that MAID would not be widely applied (VADB, 2025, p. 18). Rather, their entitlement would be subject to fulfilling specific legal conditions, which would be assessed and determined by the attending physician, an independent physician, and the competent Commission for Assistance in Voluntary Termination of Life in Slovenia ("Commission"). Under the previous VADB, physicians were merely required to confirm the patient's experience rather than assess it substantively. However, the amended VADB introduced the opportunity for physicians to more thoroughly assess the patient's condition. Whether physicians will actually be able to protect patients in transitional distress remains to be seen with the legal precedent.

Proponents of the VADB believe that any potential issues related to the standardization of the law would be addressed through by-laws developed by the medical profession (Mišič et al., 2023). However, if a law explicitly defines rights, those rights cannot be reinterpreted or altered by an executive actor's arbitrary interpretations of legal provisions. There is also a decision of the Constitutional Court[11] which, among other things, in paragraph 8 stipulates: *"... that the rules are adopted for the purpose of enforcing the law, which presupposes that they are substantively bound to the law. The rulebook must not stipulate anything in the substantive sense without a legal basis and outside the substantive frameworks that must be explicitly set out in the law or at least ascertainable from it by interpretation ..."*

The previous VADB would have allowed a young individual with paraplegia to request MAID during the mourning phase, when the individual had not yet come to terms with their condition. Under the previous bill, such a patient would have been entitled to MAID, even without a reasonable expectation of recovery. The amended

[11] Decision annulling the Rules on the Methodology for Setting Rents in Non-Profit Apartments, issued by the Constitutional Court of the Republic of Slovenia, adopted 17. 12. 1998 (Slovene Odločba o razveljavitvi pravilnika o metodologiji za oblikovanje najemnin v neprofitnih stanovanjih; Uradni list RS, št. 4/99).

VADB, however, gives physicians the ability to challenge requests for MAID in such cases.

## 5 Limitations of the Right to Medical Aid in Dying Due to the Patient's Inability to Make Independent Decisions

Both proponents and opponents of euthanasia place a strong emphasis on human autonomy. In contrast, opponents highlight the complexities and potential external pressures that could diminish autonomy, particularly if euthanasia were legalized.

Some authors (Velleman, 1999; Wright, 2017) contend that the ability to make autonomous decisions in the face of severe pain or mental illness is often compromised, as the capacity for rational decision-making can be severely limited by suffering.

The previous VADB did not limit the exercise of the right to MAID solely to individuals who have an acute mental disorder. Instead, it allowed patients who experienced mental distress due to chronic conditions to assert their right to MAID. As we have already written, according to the provisions of the previous VADB, the right to MAID could also be exercised by a young injured person with paraplegia, during the mourning phase, when he or she has not yet accepted their health condition. According to the provisions of the previous VADB, it would not have been possible to prevent MAID for such a patient. Namely, paragraph 2 of Article 6 in the previous VADB stated that *»the right to MAID could not be exercised solely on the basis of suffering caused by an acute mental disorder.*« This meant that MAID could not be accessed *solely on the basis* that the patient had an acute mental disorder; in order to exercise this right, an additional condition was required. In other words, in addition to the mental disorder, the patient would also need to have a chronic illness or disability. Paragraph 2 did not impose any limitations beyond those already specified in Paragraph 1 of Article 6 of the VADB. This lack of restriction raised questions about whether individuals undergoing significant mental distress following a serious illness or injury would be able to make autonomous decisions, especially during the mourning phase or periods of denial.

Paragraph 12 of Article 4 of VADB states: *"The psychiatrist shall state in his opinion whether the patient is capable of making decisions about himself."* There are also chronic depressions and anxiety disorders with suicidal tendencies, which, due to the inaccessibility and stigmatization of psychiatric treatment in Slovenia, are not treated, diagnosed, or treated at all in many patients (Rifel et al., 2008; Jerala & Selič-Zupančič, 2021; Ropret et al., 2023). A psychiatrist might judge that a patient is incapable of making decisions about himself only based on acute mental distress. Yet, many patients, after a serious injury or after being diagnosed with an incurable disease, are incapable of making completely rational decisions, even if these distresses are transient. In times of hardship, in the process of grief and coping with new life circumstances, a person's ability to make rational judgments is significantly limited (Velleman, 1999; Wright, 2017). However, the distress of patients due to a serious medical condition cannot be considered a mental condition that could deprive them of the right to MAID. A patient who is diagnosed with disseminated lung cancer and is in a phase of denial or anger is no more capable of making decisions (McFarland et al., 2020; Ungvari et al., 2025) about himself than a patient who has been involved in a car accident with consequent spinal cord injury and is in a phase of denial or anger (Mayou et al., 1993; Usta Sağlam et al., 2023). This is the case because if the patient's mental distress is considered a reason for denying the right to MAID, then no one who actually suffers would be entitled to MAID. This result is contrary to the fundamental purpose of passing such a law. If, on the other hand, seriously ill people in distress are able to make decisions about themselves and thus also about MAID, then young injured people in distress (paraplegia, amputations), but who temporarily do not see prospects for recovery during their mourning phase, are capable of making decisions about themselves, and yet would be entitled to MAID (paragraph 1 of Article 6).

## 6 Possibility of Patient Complaint

Proponents of the VADB assert that Slovenian physicians, in accordance with the VADB, can be as critical of the conditions necessary to implement MAID as their Dutch counterparts, and therefore, they will be able to issue a negative opinion that will be considered (Pleterski, 2024). While the amended VADB allows this, the original version explicitly stipulated that physicians and the Commission should only provide an opinion on whether the patient met the conditions of Article 6 of the VADB. If a physician offers an opinion contrary to this provision, it would be

considered a violation and grounds for judicial protection. Article 13 of the VADB states that an appeal against the Commission's decision is not allowed; however, judicial protection before a court is permitted within thirty days of the notification of the decision. In the event of a rejected application for MAID, in accordance with Article 14 of the VADB, the patient may seek judicial protection at the social court and challenge the decision of the Commission. Additionally, the patient may refer to Article 27 of the Administrative Dispute Act[12] if the law was either not applied or incorrectly applied during the procedure that led to the issuance of the administrative act, and if procedural rules were not adhered to, affecting the legality or correctness of the decision.

It is conceivable that patients suffering from renal failure on hemodialysis, visual impairments, deafness, paraplegia, or amputation, for whom most physicians would reject a MAID application, might still seek judicial protection if they meet the conditions outlined in Article 6 of the VADB. These patients may argue that they endure unbearable suffering, that no suitable relief options are available (such as being ineligible for kidney transplantation), and that their health impairment does not offer a reasonable expectation of recovery. In these instances, the amended VADB makes it more challenging to implement MAID for chronic patients, as it requires a physician's assessment under Article 6 of the VADB, which was absent in the previous version. Without this amendment, a judge would only be able to adhere to the explicitly stated conditions of the original VADB.

## 7 The Right to Euthanasia and the Expected Frequency of Its Exercise

Proponents of the VADB have removed the provision for euthanasia from the previous Bill. Paragraph 2 of Article 5 of the previous VADB stated: *"Euthanasia is performed if the patient is unable to administer the lethal substance themselves, due to religious, moral, or other justified reasons, or if other justified reasons exist."* The previous VADB therefore, allowed euthanasia instead of assisted suicide based on the patient's religious or moral objections, which are subjective and unchallengeable. That is to say, because moral and religious reasons are entirely subjective, they cannot be objectified, the patient only has to refer to them. Furthermore, the previous VADB

[12] Administrative Disputes Act (Slovene Zakon o upravnem sporu – ZUS-1: Uradni list RS, št. 105/06, 107/09 – odl. US, 62/10, 98/11 – odl. US, 109/12, 10/17 – ZPP-E in 49/23.

included undefined "justified reasons" for euthanasia to apply, essentially equating the right to euthanasia with the right to physician-assisted suicide. This distinction is significant when considering the anticipated scope of such services, which proponents of the VADB have miscalculated. In the Netherlands, where euthanasia and assisted suicide are treated similarly, the majority of patients choose euthanasia. In 2022, the Netherlands saw 8,501 euthanasia procedures and only 166 assisted suicides, with 33 assisted suicides eventually leading to euthanasia due to complications (Annual report, 2022).[13] Were one to wish to estimate the number of MAID requests in Slovenia on the basis of Dutch data, the calculation would need to include both requests for euthanasia and requests for assisted suicide, rather than only requests for assisted suicide, which are rare in the Netherlands but represent the sole option under the proposed amended VADB. It follows that the number of MAID requests would likely be significantly higher than anticipated by the proponents of the draft law. If we used Dutch data, where 5.1% of all deaths occur pursuant to the Termination of Life on Request and Assisted Suicide, we could extrapolate approximately 1,147 MAID procedures annually in Slovenia, which accounts 5.1% of 22,492 deaths in Slovenia in 2022 (source: SURS).[14] This refers only to approved requests, but we must also take into account that two-thirds of applications in the Netherlands are rejected (Expertisecentrum Euthanasie, 2024).[15] The Dutch experience suggests that theoretically, Slovenia could expect as many as 3,450 applications annually. These figures indicate that MAID would likely be requested more frequently in Slovenia - more than 33, as projected by the proponents of VADB. The removal of the option of euthanasia from the VADB is also likely to significantly reduce the number of applications for MAID. However, a direct comparison with the Netherlands is also problematic due to differences in social standards, healthcare accessibility, and cultural attitudes toward life termination.

[13] Annual report is a report on the procedures performed for Termination of Life on Request and Assisted Suicide, issued each year by the Regional Euthanasia Review Committees.
[14] SURS - Statistični urad Republike Slovenije (Statistical Office of the Republic of Slovenia, 2022).
[15] The Expertisecentrum Euthanasie, a regional center specialized in assisted dying, received 4,508 requests for euthanasia in 2023, of which 1,269 were granted. This means that approximately 72% of the requests were rejected.

## 8 A Proposal for the Integration of Additional Safeguards into the Existing VADB or Beyond

Given the concerns and examples discussed above, I believe that amendments or additional safeguards are needed within the VADB, especially regarding the definitions in Article 2, Article 6, and Article 28. To ensure the appropriateness of MAID, the patient's suffering should be deemed irreversible in the terminal phase of progressive disease. Palliative care methods exist to reliably determine the irreversibility of certain symptoms or conditions when they fail to respond to treatment. The intensity of these symptoms can also be measured. A significant concern turns on the difficult question of at what point we can definitively say that no reasonable alternatives remain, and the patient is entitled to MAID. Patients have the right to refuse medical care, including palliative treatments, especially if the side effects outweigh the benefits. However, a refusal of reasonable alternatives cannot justify claiming that the patient's suffering is irreducible if, from the healthcare provider's perspective, these alternatives offer no real relief. Therefore, a balanced approach is necessary, one that considers both the patient's experience and the judgment of healthcare professionals, using objective measures to assess the intensity and frequency of physical suffering (pain, nausea, difficulty breathing) and also the intensity of these symptoms.

This shift in paradigm could not be accomplished by the VADB alone but may require a comprehensive palliative care law in Slovenia or amendments to the Healthcare Services Act and PRA. Under such a framework, medical interventions already performed in healthcare could be more clearly defined, including certain cases where treatment should be withdrawn. For example, in intensive care, physicians, without the consent of an unconscious patient, but with the consent of relatives, decide to withdraw hemodynamic and ventilatory support for patients, which sustains them and with which they could live for an indefinite period. This decision to withdraw is also MAID in cases of medical conditions that are not the result of a chronic terminal illness. Upon withdrawal, to prevent suffering, patients are prescribed doses of opiates that would cause respiratory arrest and death. It is hard to avoid the presumption that, by the current definition, this constitutes euthanasia, though the word is avoided in healthcare, due to its negative connotations. In summary, patients in the final stages of terminal progressive

diseases like cancer, motor neuron disease, cardiovascular diseases, or obstructive lung diseases should be eligible for MAID.

## 9 Conclusion

The previous VADB contained unacceptable proposals.. The amended VADB still carries unnecessary risks for disabled and chronically ill patients in transitional distress, who may have many years of relatively high-quality life despite their conditions. However, the amended VADB provides physicians with the option of rejecting MAID applications in such cases and the possibility of introducing safeguards to protect patients from premature death. Whether the amended VADB poses a real risk to patients in transitional distress is an imponderable. This question likely will not be resolved until the first lawsuit is filed for refusing to perform MAID on a disabled person, and the court decides the matter. This risk, however, could be avoided if the previously discussed provisions of the law were amended.

While euthanasia and physician-assisted suicide are often considered ethically unacceptable from a medical ethics perspective, the paradigm where MAID is based on the patient's demonstrated need and is objectified by healthcare professionals appears ethically acceptable. This would apply primarily to patients in the final stage of terminal illness with no possibility of improvement through palliative care. This paradigm, along with other medical interventions already used in healthcare, could be defined in the law on palliative care. From a comparative law standpoint, it appears that many countries (most recently the United Kingdom's Assisted Dying for Terminally Ill Adults Bill) will adopt laws directly regulating MAID.

In conclusion, patients who are not objectively suffering, or who are not yet in the final stage of a terminal illness, should not be eligible for MAID within the framework of public healthcare. If society permits MAID for patients who are not suffering unbearably from terminal illness, it would be preferable to offer this service outside of public healthcare to avoid violations of medical ethics, palliative care principles, and patient rights under the existing law.

**Note**

This article is the outcome of private and partially public discourse between the author and the proponents of the proposed Slovenian Voluntary Assisted Dying Bill.

**Legal Acts**

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**Povzetek v slovenskem jeziku**

Ta članek ponuja analizo slovenskega predloga zakona o prostovoljnem končanju življenja, in sicer v njegovi prvotni ter spremenjeni različici, ki temelji na paradigmi »Moje življenje, moja pravica«. Prvotni predlog zakona, ki je veljal za zelo liberalnega, je vseboval številne izjeme, ki so dejansko omogočale evtanazijo za vse osebe s kroničnimi boleznimi ali invalidnostjo. Analiza kritično obravnava najbolj sporne pravne določbe predloga zakona ter predvideva posledice njegove morebitne uveljavitve, zlasti z vidika ranljivih uporabnikov zdravstvenih storitev. Pokaže se, da prvotna formulacija pravice do medicinske pomoči pri končanju življenja nasprotuje temeljnim načelom zdravstvenega sistema in je v neskladju z Zakonom o pacientovih pravicah. Spremenjeni predlog zakona o prostovoljnem končanju življenja zdravnikom omogoča tako zavrnitev vlog za medicinsko pomoč pri končanju življenja kot tudi uporabo zaščitnih ukrepov za varovanje pacientov v prehodni stiski pred prezgodnjo smrtjo.