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DISCUSSION PAPER

SHIFTING EUTHANASIA'S GOALPOSTS

SHOULD NZ CREATE PATHWAYS FROM DISABILITY TO DEATH?

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About the author

Maryanne Spurdle holds a Master of Public Policy from the University of Auckland, a BA in Communications from California State University at Fullerton, and is a World Journalism Institute Fellow. One of her early roles was at a charity that supports vulnerable and homeless adults in the north of England. That experience informed and fuelled her desire to discover and communicate the best ways that families, communities, and governments can encourage human flourishing in a complex world.

The paper in summary...

New Zealand's End of Life Choice Act specifies a prognosis of six months or less for eligibility—a safeguard in keeping with the Act's original intention to restrict euthanasia to people who are near death. However, a member's bill proposes extending eligibility to people who could have years or decades to live.

The End of Life Choice Amendment Bill, submitted by ACT MP Todd Stephenson, would leave eligibility mainly dependent on the presence of irreversible decline and unbearable suffering. While this would remove the challenge of predicting life expectancy, it leaves subjective criteria and introduces questions more difficult to answer than the one being removed. Physicians would then need to predict how someone is likely to continue living, taking into account not just disease progression but the health system's provisions and limitations.

Additionally, health practitioners would have to decide whether someone who wants to end their life should first receive suicide prevention efforts and treatment, or be referred for euthanasia without further attempts to alleviate their suffering. A consumer-provider view of healthcare favours the latter, even though both physical and mental suffering may be remediable with care or even with time.

Such subjective judgements risk disadvantaging vulnerable patients. People with disabilities, chronic illness, and declining physical capability already face the highest barriers to receiving care. Canada expanded eligibility to patients who are not near death in 2021—called "Track 2"—and the reporting there bears this out. Track 2 patients are far more likely than Track 1 patients to be experiencing disability, poverty, loneliness, and isolation. The "choice" this presents many patients is summed up in the words of one 44-year-old woman who wrote her own obituary before dying by euthanasia: "Ultimately it wasn't a genetic disease that took me out, it was a system. ... I could have had more time if I had more help."

From a disability rights perspective, there is a grave concern that legalizing euthanasia and assisted suicide could put at risk the lives of persons with disabilities. If assisted dying is made available for all persons with a health condition or impairment, regardless of whether they are terminally ill or not, a social assumption might follow that it is better to be dead than to live with a disability.

– UN Human Rights Council[1]

1 UN Human Rights Council, *Rights of persons with disabilities: Report of the Special Rapporteur on the rights of persons with disabilities,* United Nations General Assembly (2020), 9-10.

This bill does not account for the fact that requests to die are likely to be precipitated by people being unable to receive the support and treatment they need.

Overseas reporting also reveals that dependence, loss of autonomy, and the fear of being a burden are among the most common reasons people apply for euthanasia—cited more frequently than fear of pain. These experiences are common among people with disabilities, who—without the additional safeguard of the six-month prognosis—would find themselves living within or close to the bounds of eligibility for assisted suicide.

The UN has called for a repeal of Track 2 euthanasia in Canada. Even before it was approved, its Special Rapporteur on the Rights of Persons with Disabilities said the provision "perpetuated the idea that living with a disability is a life not worth living" and has criticised the expansion's "eugenic aspirations." Removing the prognosis safeguard in New Zealand would open us up to identical criticism.

Our health system's priorities only amplify the message that disabled lives are less worthy of care. Euthanasia is fully funded in New Zealand, while access to treatment, support, and palliative care is limited. Expanding access to this inexpensive option opens it up to the very people who are most likely to need care that is costly, long-term, and time-intensive. This creates perverse incentives socially and institutionally that no policy can eliminate.

A lack of true choice also weakens trust in the health system. No patient should find, when they are at their most vulnerable, that death is an option, but care is not.

A six-month prognosis is an imperfect safeguard, but removing it would create suffering despite all intentions to the contrary. It would also erode trust in the health system for those who are most reliant on it. To protect vulnerable patients and provide meaningful choice, we recommend:

- Retaining the six-month prognosis requirement
- Increasing training for and access to specialist palliative care
- Improving access to treatment, disability support, and services that make life more bearable

1. EXPANDING THE EOLCA

Aotearoa New Zealand's End of Life Choice Act (EOLCA) came into force in November 2021. It followed a 2020 public referendum on legislation that Parliament had approved the year before, dependent on passage of the binding referendum.

The Act amended sections of the Crimes Act that deal with aiding and abetting suicide, removing criminal liability for medical practitioners who follow processes created by the EOLCA to end someone's life.

The legislation that voters approved has these criteria for patient eligibility:[2]

- 18 years or older
- New Zealand citizen or resident
- Suffering from a terminal illness with a prognosis of 6 months or less
- In an advanced state of irreversible decline in physical capability
- Experiencing unbearable suffering that cannot be relieved in a way the person considers tolerable
- Competent to make an informed decision

The methods approved include both assisted suicide, where a physician prescribes lethal drugs that the patient self-administers, and voluntary euthanasia, where the physician both supplies and administers the lethal dose. Unless specified, "euthanasia" here refers to both practices.

a. Eligibility for non-terminal patients

In September 2025, ACT Party MP Todd Stephenson lodged a reworked End of Life Choice Amendment Bill. As a member's bill, it would need to be drawn by lottery. For it to pass into law, a majority of MPs would have to approve it on a conscience vote.

In addition to proposing that the recommendations from the Ministry of Health's 2024 euthanasia review become law, this bill would remove the requirement for patients to have a prognosis of 6 months or less.[3] The bill's stated reasons for this change are:

1. To align New Zealand with newer overseas models,
2. To recognise that prognoses are medically unreliable,
3. To end prolonged, irreversible suffering in patients who are not near death, and
4. To reverse a safeguard that was, for the authors of the legislation, a political compromise.

The purpose of this paper is to evaluate the impact of removing the terminal prognosis. As Canada is five years further down the track, both in legalising euthanasia and then extending it to non-terminal patients, its experience is highly instructive. We will also look at where New Zealand currently sits in comparison to the handful of other jurisdictions that have legalised various forms of euthanasia, and where it would sit with the proposed expansion.

b. International norms

Until about a decade ago, very few jurisdictions allowed assisted suicide or voluntary euthanasia.

Switzerland was an early exception. Since 1942, nonprofits independent of the state have been allowed to provide assisted suicide—but not voluntary euthanasia—as long as there is no evidence the assistance was done with "selfish motives."

The US state of Oregon legalised assisted suicide in 1994. Over the next three decades 11 US states and Washington, D.C. have followed suit. All require a terminal prognosis with life expectancy of fewer than six months, and none have legalised voluntary euthanasia.

In 1997, Colombia decriminalised euthanasia without creating legislation. Since then, a combination of court decisions, government regulations, and administrative protocols have guided the practice.

In 2002, the Belgian Act on Euthanasia created eligibility and procedural criteria with scope for interpretation by clinicians. It has one of the most liberal applications;

2 New Zealand Government, "End of Life Choice Act 2019," (New Zealand, 16 November 2019). https://www.legislation.govt.nz/act/public/2019/67/en/latest/#DLM7285905.

3 *End of Life Choice Amendment Bill*.

pathways exist for vulnerable populations such as minors and those with psychiatric conditions, and patients can access both voluntary euthanasia and assisted suicide.

The Netherlands also legalised both forms in 2002, with similarly wide criteria and the provision for advance directives that allow people to request euthanasia at a later date if they lose competence. Unlike Belgium, which only allows this for patients who are essentially comatose, patients in the Netherlands may be euthanised while conscious and without needing to understand that their life is about to be ended.

Both Belgium and the Netherlands have a strong tradition of oversight by the medical community itself. Doctors are expected to exhaust all treatment options before approving patients for euthanasia, Belgian doctors are advised not to raise the topic with patients lest it be interpreted as medical advice, and both countries have monthly commissions that review cases that might signal problems.

When Canada's euthanasia legislation came into effect in 2016, it diverged from the handful of jurisdictions that allowed the practice in a few key ways. First, the legislation was precipitated by a Supreme Court ruling. *Carter v Canada (Attorney General) 2015* determined that the blanket prohibition on aiding or abetting suicide violated the Canadian Charter of Rights and Freedoms.[4]

The legislation was in response to this ruling, and medical practice sat downstream from both—not directly guiding or overseeing it, but adapting to satisfy new requirements.

The legislation appeared to limit eligibility to patients whose natural death was imminent with the phrase "reasonably foreseeable death." However, the absence of any time frame has allowed physicians to interpret what is generally understood to be within six months or a year as within the next decade. The lack of accepted norms within medical practice and the legislation's vague wording meant that, from the start, its practice in Canada was more liberal than the five US jurisdictions where assisted suicide was then legal. It had more restrictive eligibility requirements than Belgium or the Netherlands, but lacked the Netherlands' emphasis on ensuring patients are first offered alternatives.

Another court case led to extending the scope of Canada's "Medical Assistance in Dying"—or MAiD. The Superior Court of Québec ruled in *Truchon v Canada (AG) 2019* that the reasonably foreseeable natural death criterion for eligibility was unjust and discriminatory. So in 2021, legislation for "Track 2" MAiD created a path for those whose deaths are not foreseeable to end their lives.

Most Australian states enacted legislation similar to Canada's original law between 2019 and 2026. Assisted suicide—where the physician prescribes but does not administer the drugs—is supposed to be the default option, but voluntary euthanasia is more common.[5]

In 2021, Spain legalised both assisted suicide and voluntary euthanasia, choosing the more liberal route of allowing it for "severe, chronic, and debilitating conditions." Legislation also passed in Uruguay in 2025, and in France in 2026. Slovenia also passed legislation, but then reversed it by referendum in 2025. Five other jurisdictions have decriminalised one form or another or provided for exceptions to criminal law.[6]

c. No longer a last resort

Of the few jurisdictions that have legalised euthanasia, most require a terminal prognosis. New Zealand's End of Life Choice Act draws the line at six months—a horizon too distant to predict with great certainty, but one that narrows eligibility to people who are likely to be near death. This was included in the 2020 public referendum because, without this line, large segments of society would immediately be eligible. Suffering and decline are common experiences for those with disabilities, chronic illness, and advanced age.

Of those who support legalising euthanasia, some are committed to this safeguard because they believe euthanasia should be an option of last resort. They see a place for it when a person is near death and suffering. Others, however, believe that if someone is suffering

4 Carter v. Canada (Attorney General), No. 35591 (Supreme Court of Canada 2015).

5 Voluntary Assisted Dying Board Western Australia, *Annual Report 2024–25* (28 October 2025), 31.

6 Rebecca Vachon and Étienne-Alexandre Beauregard, *An International Comparison of Assisted Dying Regimes: Part 1—Eligibility Criteria*, Cardus (25 May 2026), 6.

enough to want their life to end, then denying that wish is unjust.

A Curia poll following the 2020 referendum reveals that among the roughly two-thirds of New Zealanders who supported it, 38% would have voted "no" had they understood that terminally ill people "for whom treatment exists that could relieve their suffering" would be eligible.[7] If the majority of New Zealanders do not support euthanasia for terminal patients who still have treatment options, it is unlikely they would support it for patients who are not near death.

A Canadian survey asked this question explicitly, and 64.4% of respondents said that euthanasia should be either a last resort or in exceptional circumstances.[8] In fact, those in the highest income bracket—who also were the most supportive of euthanasia in general, at 83%—were the ones least supportive of allowing it in cases where patients had limited access to medical care. Their support plummeted to just 8% for such cases.[9]

An absolutist view of autonomy, which would enable euthanasia for anyone who has capacity to consent, clashes with perspectives geared to protect vulnerable patients and improve their access to care. Suicide prevention efforts, for instance, begin with the premise that suicide "can be prevented with the right support and care."[10] Providers create firm lines between the definitions of euthanasia and suicide, clarifying that one is "an end-of-life choice" and the other is a choice between life and death.

If euthanasia is not an option of last resort, available only to those with a limited prognosis, then we affirm that some lives are not worth living.

d. Clinician opinions

In New Zealand, euthanasia is centred on medical practitioners. They are the ones who assess eligibility, the ones who administer the drugs in most cases and prescribe them in all. A committee of three practitioners reviews the records. Medical practitioners must know and implement relevant legislation.

Their opinion of potential legislation is highly relevant.

A 2025 Australian survey of 142 clinicians who work in palliative care found that support for legal euthanasia fell from a slim majority—52% in cases of symptomatic terminal illness—to 34% for patients who were chronically ill and 24% for those with disabilities. In other words, a significant majority are opposed to allowing euthanasia for patients whose deaths are not imminent.[11]

Determining eligibility in such cases is not straightforward. Assessors surveyed in Canada called decisions about whether patients qualified for Track 2 "morally and legally complex."[12] For clinicians, the complexity is particularly acute when potential treatments exist but may not be accessed, as in a lack of appropriate pain management; when suffering is driven by existential fears about future suffering, and not physical pain; and when unmet social needs contribute to suffering.[13]

The consensus is that the six-month prognosis is a weak criterion for eligibility.[14] If euthanasia is designed to prevent protracted suffering for those who are near death and exclude those who might live years longer, the prognosis needs to be no more than a few weeks. Beyond that, for most conditions, a coin toss is more accurate at predicting

7 Curia Market Research, "Euthanasia Poll October 2020," (October 2020).

8 William J W Choi et al., "When medical assistance in dying is not a last resort option: survey of the Canadian public," *BMJ Open* 14, no. 6 (2024): 1.

9 Choi et al., "When medical assistance in dying is not a last resort option: survey of the Canadian public," 5-6.

10 Go Gentle Australia, "Joint statement by Australia's suicide prevention leaders," news release, November 2023.

11 GL Grove et al., "Shaping a knowable event or embracing a mysterious journey: A mixed methods study on palliative care clinician views on voluntary assisted dying," *Palliative and Supportive Care* 23, no. 153 (22 July 2025): 3.

12 Barbara Pesut et al., "Assessors' decision-making regarding applicant eligibility for Track 2 medical assistance in dying in Canada: a qualitative study," *Canadian Medical Association Journal* 198, no. 1 (2026).

13 Janine Penfield Winters et al., "Conduit or conductor? Physician providers' descriptions of their role as MAiD assessors in the first years after legalisation in Canada," *Journal of Medical Ethics* 52 (2026): 157.

14 Aida Dehkhoda et al., "Early experiences of the End of Life Choice Act 2019 amongst assisted dying practitioners in Aotearoa New Zealand," *BMC Palliative Care* 24, no. 149 (24 May 2025): 6.

life expectancy.[15] Neurodegenerative conditions, for example, cause irreversible decline but the extent and timing of the decline is rarely predictable.

Consensus breaks down when it comes to choosing an alternative to this criterion, revealing different intentions for euthanasia. Some physicians do not believe that it should be restricted to those who are dying, so they see no need for such criteria. Others see both the complexity of evaluations and the risk to vulnerable patients increasing if that somewhat arbitrary line is removed.

In *Interrogating Choice,* we addressed the risk and complexity inherent even in cases where the patient is expected to live less than six months.[16] Without that safeguard, physicians are left to make subjective judgements about current suffering and patients' likely futures. They may not have to guess when someone is likely to die, but they still have to guess the way someone is likely to live.

Palliative care physicians are used to hearing patients express a wish to die. Prior to the legalisation of euthanasia, this was an open invitation to explore the underlying causes of suffering and find ways to address them. Patients could express this wish safely, expecting a doctor to help remove it rather than fulfil it. In 80% of cases, palliative care providers can relieve physical pain and in nearly every case reduce it substantially.[17] They also have many tools at their disposal to ease psychosocial suffering.

Euthanasia for patients near death and the prospect of eligibility for patients who are not near death further complicates physicians' roles. One New Zealand physician put it this way: "One of the major symptoms we look out for is suicidal ideation. Ordinarily, I would come alongside someone and say, 'Why are you thinking like that?' What am I supposed to do now?"[18]

The goal used to be clear: address the suffering so it's no longer unbearable. Now, the goal is uncertain. Should the physician aim to untangle the reasons for a patient's hopelessness and suffering, or begin a process that they know could easily end the patient's life within a fortnight?[19]

15 M. Orlovic et al., "Accuracy of clinical predictions of prognosis at the end-of-life: evidence from routinely collected data in urgent care records," *BMC Palliative Care* 22, no. 51 (2023).

16 Maryanne Spurdle, *Interrogating Choice: Euthanasia and the illusion of autonomy*, Maxim Institute (May 2025).

17 Christel Hedman et al., "Pain prevalence and pain relief in end-of-life care – a national registry study," *BMC Palliative Care* 23, no. 1 (2024).

18 Voice For Life, *Senior Hospital Clinician Speaks Out on Assisted Dying* (10 March 2026).

19 Alex Penk, "New data suggests people are moving from application to assisted death more quickly," 27 February, 2025, https://www.ethosalliance.nz/articles/new-data-suggests-people-are-moving-from-application-to-assisted-death-more-quickly.

2. PHILOSOPHICAL CONSIDERATIONS

a. The 'right' to euthanasia

The doctor-patient relationship has shifted over the past few decades. It was once centred on one human caring for another; now there is a commercial, provider-customer dynamic. Aotearoa New Zealand's own Ministry of Health uses terms like "consumer" and "service provider" to describe patients and physicians, signalling a transactional relationship like those in retail or hospitality. Health care is largely funded by and governed by the state. Patients access it as a right of residency, and medical staff are the intermediaries who meet consumers' needs.

For centuries, the Hippocratic Oath's avowal to do no harm provided an ethical foundation for medical decisions. But now patients' autonomy, which expresses their personal definitions of good or harm, takes precedence.[20] In this context, a person's desire to end her own life might be considered "good" provided legislated criteria are met—even if the physician can offer alternatives, and even if they believe the alternatives are better than ending the patient's life.

Under a traditional care model, exploring ways to address suicidal ideation would always be best practice. In our consumer model, offering alternatives to a patient who wants to die—if they meet eligibility criteria—infringes on patient autonomy. Contemporary conversations in medical academia call such care "paternalistic."[21]

Every health system has both economic and regulatory limitations on what services patients can receive. In New Zealand, euthanasia is fully funded and offered in every corner of the country. This means that if two physicians agree that a person is eligible, the health system all but guarantees that they will be helped to die that way.

The risk in this consumer model is that pharmacists, GPs, and surgeons are reduced to vending machines that exist to provide consumer products. This view obscures the fact that they are ethical beings who, at their best, use both their professional expertise and their moral judgement to provide what they consider to be the best care. In a future discussion paper, we address conscience rights and how the EOLC Amendment Bill introduces new ethical tensions.

Legislation has created an expectation that medical practitioners will end the life of any eligible adult who requests it. Any expansion in euthanasia legislation will extend that expectation to more people, and create more "fringe cases"—people who are not eligible by most interpretations of the law, but who some doctors will say are. Eligibility is a subjective call; no diagnostic tests exist. The pressure from those who believe they have a right to euthanasia will continue to push the boundaries of the legislated criteria, while the doctor-patient relationship increasingly resembles service providers who set aside ethical considerations in order to serve the customer.

Expanding access to euthanasia is not the same as expanding human rights. Objections from bodies such as the UN Human Rights Council to widening eligibility highlight the absence of a consensus over any "right" to euthanasia. The difference between advocates and opponents is not a commitment to protecting individual autonomy, on the one hand, and a disregard for it on the other. Each side is equally able to point to instances where, if they had their way, a person's autonomy would have better protection.

The real point of difference is whether euthanasia should be normalised in the health system and available to address various forms of suffering, or whether (assuming it is to be legal) it should be rare and exceptional. Ethicist Heidi Janz references the shift in language through Canada's experience, from "assisted suicide" to "assistance in dying" and then, officially, MAiD. She said that "this shift was very much welcomed by proponents of AS&E [assisted suicide and euthanasia] because it served to destigmatize and normalize the practice of physicians killing patients. Indeed, the term Medical Assistance in Dying (MAiD) functions to transform the killing of patients by physicians into

20 Winters et al., "Conduit or conductor? Physician providers' descriptions of their role as MAiD assessors in the first years after legalisation in Canada," 158.

21 Ibid, 159.

'legalized, compassionate end-of-life care,' in the words of MAiD proponent and provider, Dr. Stefanie Green."[22]

No one disagrees that suffering should be addressed and that the health system should be well equipped to do so. However, some people believe that embedding the option to end one's life in the health system creates new, unjust forms of suffering. Others deny this or believe that the benefits outweigh that cost.

b. Suffering as the main criterion

With the proposed changes, physicians will need to conclude that the patient suffers from at least one condition that "is advanced, progressive and expected to cause death." However the condition, or conditions, may not themselves be terminal—even though the criteria bring to mind people whose lives are restricted both in breadth and length.[23]

Patients may live for years or even decades longer, and there may be potential yet to treat and improve their symptoms.

The most common conditions for patients who die under Track 2 MAiD in Canada include Parkinson's disease, COPD, multiple sclerosis, vasculopathy, and diabetes.[24] Cancers, pulmonary fibrosis, congestive heart failure, kidney failure, liver failure, and atrial fibrillation are also common diagnoses.[25] In Colorado, which legalised assisted suicide in 2016, at least 12 people have been eligible because of anorexia.[26]

Members of Ontario's MAiD Death Review Committee (MDRC) have raised the need for integrated psychosocial care, given that psychosocial suffering is prevalent in Track 2 applications and patients may otherwise live for years.[27] They observed that the primary drivers for applications they reviewed include potentially transient and remediable suffering, such as grief and isolation.

Unlike New Zealand's proposed legislation, Track 2 in Canada has a 90-day assessment period during which alternatives may be explored. There is no minimum assessment time included in the amendment, nor a requirement that the physician have expertise in the patient's conditions—safeguards that exist in other jurisdictions.

An additional wrinkle, observed in one survey of Canadian practitioners, is that "assessors' interpretations of the law had evolved over time."[28] The experience in every jurisdiction with assisted suicide and voluntary euthanasia is that the most common forms of suffering involve grief over loss and fear of future loss. Grief and fear cause suffering that can be addressed, yet policies do not ensure that patients have these needs addressed before joining the same path as terminal patients.

Physical pain is often complex, and psychological suffering no less so. Treatment requires energy and resources, and the best outcome might be reduced rather than eliminated suffering. The *Journal of Medical Ethics* reported on euthanasia providers' view of their role in patient care in Canada. Some "described how successfully qualifying for MAiD gave their patient a sense of control, and this essentially 'cured' their suffering."[29] This leads to the obvious question: might there be other, non-terminal options that provide patients with that needed sense of control?

If it becomes the norm to offer euthanasia to any patient experiencing suffering, whether or not they are nearing a natural death, then the easiest and least expensive option will become the default. If death is an option when healing is out of reach—an option that does not have the wait

22 Heidi Janz, *For Such a Time as This: Articulating a Christian Ethic of Disability in the Context of MAiD*, Cardus (30 April 2026), https://www.cardus.ca/research/health/perspectives-paper/for-such-a-time-as-this/?

23 *End of Life Choice Amendment Bill*.

24 Office of the Chief Coroner of Ontario, *MAiD Death Review Committee (MDRC) Report: 2025 – 1 (Evaluating Incurability, Advanced State of Irreversible Decline in Capability, and Reasonably Foreseeable Natural Death)* (2025), 8.

25 Office of the Chief Coroner of Ontario, *MDRC Report: 2025 – 1*, 26.

26 Eric Schulzke, "A terminal calculus," *Deseret News*, 15 April 2026.

27 Office of the Chief Coroner of Ontario, *MDRC Report: 2025 – 1*, 27.

28 Pesut et al., "Assessors' decision-making regarding applicant eligibility for Track 2 medical assistance in dying in Canada: a qualitative study."

29 Winters et al., "Conduit or conductor? Physician providers' descriptions of their role as MAiD assessors in the first years after legalisation in Canada," 154.

times and access issues that most treatments do—then those who are disabled or elderly or dealing with chronic conditions become even more vulnerable. The relief of those who do not want to endure any longer appears merciful in isolation, but the negative impact on vulnerable people who want support through their suffering remains.

Finally, any calculus that balances the effects of potential physical suffering against the impacts of its remedy must address them honestly. The reality is that little is known about what patients experience when euthanasia does go to plan, and record-keeping when it does not proceed smoothly is patchy.

One challenge to gauging euthanasia's predictability is that the various protocols employ drugs that were created for therapeutic purposes. They were not developed to be used in lethal doses, and have never been tested for such use. Autopsies are rarely conducted on patients who die by voluntary euthanasia or assisted suicide, so apart from general knowledge—the doses for successful paralysis and doses for successful death—little is known about what patients are, or are not, experiencing.

Not all deaths by voluntary euthanasia and assisted suicide go according to plan. New Zealand is not among the handful of jurisdictions that collect and publish this data.

Complications reported elsewhere include:[30]

- Difficulty accessing veins or IV line failure
- Vomiting up oral drugs
- Delayed loss of consciousness
- Pain
- Coughing or choking
- Seizures

A 2023 report from Oregon recorded a complication rate of 10% in deaths where a physician was present. (Since patients must self-administer the drugs in Oregon, they are not always attended by a doctor.) The report does not describe what most complications were. However, the varying time for drugs to take effect reflects the inexact nature of lethal prescriptions. The time from ingestion to unconsciousness ranges from one minute to more than eight hours. From ingestion to death, the range stretches from three minutes to more than five days.[31]

In Western Australia, where physicians administer the drugs in 94% of cases, the complication rate was 4% in 2024–2025. The longest time to death for IV administration was 45 minutes, and for ingested drugs it was 4 hours 44 minutes.[32]

As with natural death, most euthanasia deaths appear to be peaceful. However, for a significant minority of those who choose euthanasia, the intervention will cause suffering that is distinct from and in addition to the suffering that they seek relief from.

To have informed consent, patients and their loved ones should understand that there is the possibility that they will not retain control of the process or die peacefully. They should understand the capabilities of palliative care and have access to it. They should also understand that even among those who need pain management at the end of their lives, 80% are able to receive complete relief and 99.8% at least partial relief.[33]

Do some people reject a natural death, convinced it will be unbearable, and choose lethal drugs without understanding that they might be trading one form of suffering for another?

c. Diminishing alternatives

Medical interventions and pathways of care often require significant expenditure of money and time. Euthanasia is quick and inexpensive. But eligibility for euthanasia—regardless of whether or not a patient desires it—comes with a singular side effect: the need to justify *continuing* one's existence.

British philosopher Kathleen Stock expresses it this way: "We are potentially changing the attitude of a population to their healthcare providers, particularly people who are already frightened of going to the doctor. … now they

30 Manuela Callari, "Is Assisted Death Always Peaceful? Lack of Data Means We Simply Don't Know," Medscape, 3 February, 2026.

31 Oregon Health Authority, *Oregon Death with Dignity Act 2023 Data Summary* (20 March 2024), 14-15.

32 Voluntary Assisted Dying Board Western Australia, *Annual Report 2024–25*, 34, 38, 40.

33 Christel Hedman et al., "Pain prevalence and pain relief in end-of-life care – a national registry study," *BMC Palliative Care 23*, no. 1 (2024).

have to make a choice that was socially unacceptable to think about before, but now it's there—it's in the waiting rooms, it's on the posters, it's in the news—and they have to explain to themselves or others why they're not taking that choice."[34]

Without being eligible for euthanasia, patients who would benefit from dialysis, chemotherapy, mobility aids, prescription drugs, insulin therapy, or any number of interventions may assume that health professionals will recommend whichever is most appropriate, and the health system will ensure they receive it.

When euthanasia becomes an option, legislation does not make it a *preferred* option but "the system sorts cases on its own." Eric Schulzke wrote in Utah's *Deseret News* that "Patients encounter delays, denials and exhausted alternatives, while assisted death remains reliably available. When eligibility turns on subjective suffering, loss of dignity, dependence or being a burden, the line between medical judgment and social failure blurs. What begins as a choice in extremes becomes the option of least resistance."[35]

The options available directly impact euthanasia uptake, as illustrated by the differences between those accessing Track 1 (death reasonably foreseeable) and Track 2 (death not reasonably foreseeable) euthanasia in Canada. Track 2 patients were overwhelmingly more likely to live alone and come from areas of residential instability. Female patients in the lowest quintile of income were twice as likely to die from Track 2 than females in the highest quintile.[36]

Even with the six-month prognosis, New Zealanders who are eligible for euthanasia may face different pathways simply because of where they live. Palliative care, a holistic approach that improves the quality of life for those facing life-threatening illness and provides support for their whānau, is not universally available despite the World Health Organization naming palliative care in its "human right to health."[37] Only about half of those who are eligible for palliative care each year receive support through Hospice New Zealand's network, and parts of the country have few or no specialists.[38] Hospices themselves receive only about half of their funding from the government, relying on donations and fundraising for the rest.[39]

British MP Ashley Dalton—while suffering from terminal cancer herself—made this statement during the UK's 2026 debate on a failed assisted suicide bill: "None of this takes place in a vacuum. Unless we can say that everyone that needs it has access to high-quality palliative care, then we're offering nobody a choice. A terrible death or an assisted death is not a choice; it is a threat."[40]

Palliative care access is a crucial factor in end-of-life choices. Expand euthanasia eligibility to those who are not near death, and access to other interventions for those who are suffering will also become a determining factor in the manner of some patients' deaths.

In addition to widening eligibility, the EOLC Amendment Bill proposes allowing physicians to *offer* euthanasia as an option to those who may be eligible: the ill, disabled, and elderly. They are the people with the greatest reliance on the health system and demand for its limited resources.

New Zealand often has wait lists for screening, testing, and treatments. A constant queue of drugs awaits approval for funding. Into this context, the bill introduces an inexpensive, one-off alternative.

Even though the *intention* of presenting euthanasia as an option is not to disincentivise healthcare provision, no safeguard can prevent it. Euthanasia is exceptional in that it is fully funded and available anywhere in the country. When one option is dramatically cheaper, faster, and less complicated than any alternative, stakeholders have multiple incentives to favour it. The result is that some patients who face years or even decades of dependence will experience internal and external pressure to decline

34 Yascha Mounk, "Kathleen Stock on the Case Against Assisted Death," *Yascha Mounk*, 7 April, 2026.

35 Schulzke, "A terminal calculus."

36 Health Canada, *Fifth Annual Report on Medical Assistance in Dying in Canada 2023* (December 2024).

37 Merryn Gott, Jackie Robinson, and Stella Black, *The Voices of Underserved Communities in Palliative Care* (The University of Auckland: Te Ārai Palliative Care and End of Life Research Group, 2024).

38 Catherine D'Souza, "The Need for Palliative Care in Aotearoa New Zealand," *New Zealand Medical Journal 138*, no. 1619 (25 July 2025): 14–21, https://doi.org/10.26635/6965.6933.

39 Hospice New Zealand, *Fund Hospice fairly and make dying better and taxes lower* (January 2025), 4.

40 UK Parliament, "Terminally Ill Adults (End of Life) Bill," (Hansard, 11 September 2026).

the care they need and choose a procedure that costs no more than a root canal.

Of those who applied for Track 2 MAiD in Canada in 2023, 49.2% listed being a "perceived burden on family, friends and caregivers" as a reason for applying.[41] One of the people who considered applying is a woman named Rachel, who has a condition that causes chronic pain. She also suffers from depression and has a history of PTSD.[42] She said that before Track 2 existed, "If I said that I wanted to die or that I couldn't hack it anymore, I was met with, 'Here's some coping skills and let's talk about it,' and various forms of therapy and resources being brought to bear."

Since euthanasia has become legal for non-terminal conditions, when seeking help for suicidal thoughts, she has been advised how to access euthanasia. Mental health professionals have encouraged her to visit Dying with Dignity's website. This has damaged her confidence in the health system and she now avoids going to hospital: "I was afraid that if any doctor either brought up MAiD themselves or met my kind of ambivalent desire for MAiD, all I needed was a push and I would be dead right now." She said she is thankful to have found a health care provider that does not endorse euthanasia for mental illness: "All I needed was health care and pain care."

41 Health Canada, *Fifth Annual Report on Medical Assistance in Dying in Canada 2023*.

42 Alexander Raikin, "How Death Care Pushed Out Health Care," *National Review*, 14 September, 2023.

3. RISKS OF EXTENSION

"What is good for one patient can be bad for the whole community—that's a very difficult thing."
– Dr Menno Oosterhoff, Dutch euthanasia provider

In the Netherlands, euthanasia is governed largely by the medical community itself, which foregrounds personal autonomy and the elimination of suffering. Dr Menno Oosterhoff embodies the Dutch approach as he works on euthanasia's frontiers: patients with mental illness and those who are too young to vote. *The Atlantic* summed up his operating principle: "Some lives are better not lived."

"In performing euthanasia, he said, he looked 'to the individual patient,' adding that public policy is 'not my work.'"[43]

Those who are in charge of policy, however, must evaluate the risks to society at large. The EOLC Amendment Bill would create a broad category of people who, if they wished to end their lives, would be offered suicide assistance while all others with an identical desire would be offered suicide prevention.

a. Disability and discrimination

Not all disabled people will be eligible for euthanasia under the proposed changes. However, everyone who is eligible will, by definition, be disabled. Having a condition that is "advanced, progressive and expected to cause death," and "being in an advanced state of irreversible decline in physical capability" ensure this.[44]

The UN's Special Rapporteur on the Rights of Persons with Disabilities, in one of its statements opposing Track 2 euthanasia in Canada, wrote that "there is a real risk that those without adequate support networks of friends and family, in older age, living in poverty or who may be further marginalized by their racialized, indigenous, gender identity or other status, will be more vulnerable to being induced to access MAiD."[45]

The Special Rapporteur also "asserted that outdated notions about 'normality' still dominate medical, legal and philosophical deliberations," including discussions about euthanasia. Legislation allowing euthanasia due to disability—not imminent death—"may support a social assumption that 'it is better to be dead than to live with a disability.' It is easy to imagine but impossible to quantify the damage this does to those with lifelong disabilities, those who are in the vulnerable position of adjusting to a new impairment, and anyone dealing with the cumulative effects of aging."

The Committee on the Rights of Persons with Disabilities (CRPD) pointed out that equality is grounded "on a recognition of the inherent equal worth of each person with a disability—equal personhood."[46]

It was one of many voices expressing concern as Canada prepared to extend euthanasia to patients who were not near death and whose suffering is "largely caused by lack of support and societal inequality."[47] People who require mobility ramps, treatment, or physical support to maintain health or independence are already more likely to have unmet needs.

The *World Medical Journal* said that the introduction of a lethal alternative sends them this message: "we are not needed." This has been backed up by surveys of affected populations. When British disability charity Scope polled disabled people in 2014, it found that most of them feared the legalisation of euthanasia would create pressure to end their lives prematurely.[48]

Attitudes about the lives and experiences of those who are disabled impact policies, care pathways, and the decisions of those treating patients. In the words of Heidi Janz, a Canadian ethicist who is herself disabled, "virtually everyone who applies for and receives MAiD under either

43 Charles Lane, "When mentally ill teenagers ask to be put to death," *The Atlantic*, 15 March, 2026.

44 *End of Life Choice Amendment Bill*.

45 "Mandates of the Special Rapporteur on the rights of persons with disabilities; the Independent Expert on the enjoyment of all human rights by older persons; and the Special Rapporteur on extreme poverty and human rights," updated 3 February, 2021.

46 Ibid.

47 Leonie Herx, Margaret Cottle, and John Scott, "The 'Normalization' of Euthanasia in Canada: the Cautionary Tale Continues," *World Medical Journal* 66, no. 2 (2020): 30.

48 Wendi Wicks, "The Consequences of Euthanasia Legislation for Disabled People," *Policy Quarterly* 11, no. 3 (August 2015): 39.

Track 1 or Track 2 will, to varying degrees, have been affected by ableism—that is, prejudice and discrimination on the basis of disability—at systemic, interpersonal, or internalized levels."[49]

Janz references disability scholar Fiona Kumari Campbell, whose definition of ableism identifies "a particular kind of self and body (the corporeal standard) that is projected as the perfect, species-typical and therefore essential and fully human."

Benign phrases such as "quality of life" mask both professional and public assumptions about whose lives are "worth" living given the cumulative weight of resources, suffering, and loss required to continue that life. Ableist judgements do not begin with the assumption that all lives are equally valuable; they factor in changeable characteristics such as utility, absence of suffering, autonomy, and mental health.

The risk of this logic, according to the UN's Human Rights Council, is the most damaging type of discrimination: "a social assumption might follow that it is better to be dead than to live with a disability."[50]

(i) Lack of access to necessary treatment

For those with disabilities, all choices are not weighted evenly.[51] In Canada, those with disabilities are four times as likely as those without to have unmet healthcare needs.[52] If they apply for euthanasia, there is no protocol in place to ensure that, prior to being approved, they have been offered viable alternatives.[53]

Records from Ontario, Canada, show that patients who die from Track 2 MAiD are more than twice as likely to have a disability than patients who die from Track 1 MAiD. Between January 2023 and December 2024, 24.3% of MAiD patients whose death was reasonably foreseeable (Track 1) reported having at least one disability. But among those who were not near death, 67.9% reported one or more disabilities—which, for four out of five, affected their mobility.[54] They also reported higher rates of being "unable to do most activities of daily living"—92.1% compared to 79.3%—reflecting a greater need for support.[55] Seven of the 237 disabled patients who died from Track 2 MAiD in Ontario needed disability services but could not access them.[56]

Assessment for euthanasia there, as in Aotearoa New Zealand, takes place in isolation from health services that the patient could benefit from but may not be receiving. Assessments can be completed by people who do not have expertise in relevant areas.

During the debate on the End of Life Choice Act, New Zealand disability rights activist Dr Huhana Hickey pointed out that "[w]e say this is all about someone's choice, but disabled people often aren't given good choices around healthcare at all and the sector is majorly underfunded. ... Until we address issues around funding of disability and palliative care there is no such thing as choice."[57]

Ramona Coelho, a Canadian doctor and former member of Ontario's MAiD Death Review Committee (MDRC), says that she has seen patients approved "without a deep dive of their suffering or without offering evidence-based medicine that could offer them solutions to live well."[58] She said that many have been offered it repeatedly, and some feel pressured to book an assessment. She also wrote that "For

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49 Janz, *For Such a Time as This*.

50 UN Human Rights Council, *Rights of persons with disabilities: Report of the Special Rapporteur on the rights of persons with disabilities*, 9-10.

51 The meaning of "disability" in the following statistics, being self-reported, reflects patients' own understanding of their level of ability. Nearly one quarter of Track 2 patients report not having a disability despite being "unable to do most activities of daily living." Being disabled typically means having an impairment, so anyone with "irreversible physical decline" and experiencing "unbearable suffering" would be disabled.

52 Rebecca Vachon, *Disability and MAiD: A Discussion Paper of Public Opinion Polling*, Cardus (February 2026), 18.

53 John Keown, "The Value of Autonomy," in *The Reality of Assisted Dying: Understanding the Issues* (Maidenhead, UK: McGraw Hill, 2025), 13–14.

54 Office of the Chief Coroner of Ontario, *MDRC Report: 2025 – 1*, 10.

55 Ibid, 13.

56 Ibid, 15.

57 Caralise Trayes, *The Final Choice* (Capture and Tell Media, 2020), 124-25.

58 Government of Alberta, "MAID protections for Albertans with mental illness," news release, 18 March, 2026, https://www.alberta.ca/release.cfm?xID=958511A2CE817-A924-E2A6-0D101236984ADB16.

many disabled, elderly, and marginalized patients, trust in the system is fragile, and discrimination risks are real."[59]

Those with disabilities have well-documented barriers to care. Most have a greater need for resources that are often limited in supply; some have communication challenges due to vision or hearing impairments, intellectual disabilities, or mental illness; physical access is difficult for those with limited mobility; and patients are not always able to find practitioners who are highly experienced in their condition.[60]

(ii) Physician bias

> *"If I, in good health, wanted to die and attempted to kill myself, physicians would have the ability, by law, to restrain me against my will and ensure that I receive treatment for this desire to die. But if I was handicapped or ill, then the same physicians could help me end my life. The MAiD system says that the healthy are worthy of suicide prevention, and the disabled and ill are not."*[61]
> *– Jeremy Bannon*

Approval for euthanasia depends on individual physicians' opinions, as there are no objective tests for "advanced state of irreversible decline." And while that phrase does describe people nearing a natural death, that language also applies to people who were born with disabilities such as cystic fibrosis, muscular dystrophy, and cerebral palsy. People who develop conditions such as multiple sclerosis and diabetes could also easily be eligible—as the experiences of many Canadians have shown.

Members of Ontario's MDRC have raised concerns that physicians who approve someone based on a "grievous and irremediable condition" are themselves liable to have ableist assumptions.[62] They pointed out that presumptions about the quality of life for people who need assistance in daily life "could unduly influence eligibility decision." Understanding "the personal and social meanings assigned to living with a disability … is essential for exploring alternative approaches to alleviating suffering that do not rely on assumption rooted in ableism."

Determining euthanasia eligibility is unlike a medical test with a positive/negative outcome and clear treatment pathway. There are limits to what an assessor can know. Relevant information may be missed, and assessors' biases regarding quality of life may predispose them to value some kinds of information and disregard others: [63]

- There is no reliable way to measure "decision-making capacity."
- Capacity may be variable, particularly for people dealing with serious illnesses.
- Capacity is impacted by mental illness and psychiatric conditions. For some patients, suicidal ideation may appear or vanish, even in short timeframes.
- Strong emotions, such as fear and grief, can interfere with capacity temporarily. This is particularly common for patients suffering spinal cord injuries or other life-changing illnesses or injuries.
- Believing oneself to be a burden on others can influence patients' decisions.[64]
- Circumstances that are "unjust or overwhelming" can limit patients' choices.
- Coercion is, by virtue of the way it twists another's will, difficult to detect. Undue influence and manipulation, which patients themselves may be unaware of, is even more so.

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59 Ramona Coelho, "Alberta bill restricting assisted suicide reaffirms that care comes first," *National Post*, 20 March 2026.

60 Tara Lagu et al., "'I Am Not The Doctor For You': Physicians' Attitudes About Caring For People With Disabilities," *Health Affairs* 41, no. 10 (3 October 2022).

61 Jeremy Bannon, "I'm Sorry My Colleague Killed Your Sister," *First Things*, 2025.

62 Office of the Chief Coroner of Ontario, *MDRC Report: 2025 – 1*, 30-31.

63 Winters et al., "Conduit or conductor? Physician providers' descriptions of their role as MAiD assessors in the first years after legalisation in Canada," 155.

64 Records by the Oregon Health Authority show that 42% of patients who accessed euthanasia in 2024 feared "being a burden." Oregon Health Authority, *Oregon Death with Dignity Act Data Summary 2024* (27 March 2025), 9.

(iii) Social bias

> *"The fear that able-bodied people have about terminal illness is often about pain, incapacity, loss of bodily function, inability to move around—things that disabled people live with now, and which are not necessarily terminal. As soon as you say those things are fundamentally undignified—so undignified that if the person wants it, we'll kill them to get them out of that position—it is impossible to take that attitude and inject it into society in a way that's sequestered from the rest of it, without having knock-on effects for disabled people. Effectively you are saying, you are in a fundamentally undignified position, and great that you want to carry on, but lots of people don't, so we're going to kill them or help kill them. That's just a terrible message to send to disabled people."*
> *– Kathleen Stock*[65]

Discussions about euthanasia may assume that dependence is beyond the "normal" human experience—that dependence undermines dignity, diminishes the worth of one's life, or is inconsistent with exercising autonomy. This starting point further entrenches ableist assumptions about the lives of those with disabilities.

We are all highly dependent on others for care during our earliest years. Some are dependent throughout life, and many are again in old age. Whether through age, disability, or injury, dependence is part of being human.

Western society has become less tolerant of dependence as technology and the creation of wealth allow greater expressions of individualism. We are still dependent, but now cars, software, machines, and commerce provide what whānau, neighbours, and beasts of burden once did. The others we depend on are faceless, their contributions mediated by technology.

Conflating independence with dignity feeds people's fear of various forms of disability. This is reflected in surveys of the primary driver for people's euthanasia applications. Fear of "losing dignity" contributes to 70% of applications in Oregon and Track 2 applications in Canada.[66] If all people are equal in fundamental dignity, then loss of abilities cannot diminish it. One inquiry into dignity narratives in Canada's provision of euthanasia explicitly stated that such equality exists, and that "this basic value remains undiminished even at the end of life, even in the midst of suffering." So "physical disability should not be itself an indignity. Rather, the indignity is a product of the social stigma that society carries toward people living with physical disabilities."[67]

The UN Human Rights Council has called for a repeal of Track 2 euthanasia in Canada, largely because of the way it perpetuates this stigma.[68] Its reports maintain a perspective wider than one of personal autonomy in isolation, recognising that people's decisions take place in the context of social norms, structures, and attitudes. One 2020 report even acknowledged the presence of "eugenic aspirations":[69]

> *The hegemony of ableism in society has perpetuated the idea that living with a disability is a life not worth living. There is a deep-rooted belief, carved with fear, stigma and ignorance, that persons with disabilities cannot enjoy a fulfilling life, that their lives are incomplete and unfortunate, and that they cannot attain a good quality of life. … While the eugenic programmes of the late nineteenth and early twentieth centuries have disappeared, eugenic aspirations persist in current debates related to medical and scientific practice concerning disability, such as prevention, normalizing therapies and assisted dying. Notwithstanding all the progress achieved over recent decades concerning the rights of persons with disabilities, embracing disability as a positive*

65 Mounk, "Kathleen Stock on the Case against Assisted Death," *Yascha Mounk*, 7 April, 2026.

66 Oregon Health Authority, 2024 Oregon Death with Dignity Act Data Summary (27 March 2025); Health Canada, *Fifth Annual Report on Medical Assistance in Dying in Canada 2023*, 32.

67 Kristie Serota et al., "Dignity Narratives in Complex MAiD Bereavement Stories: A Critical Qualitative Analysis," *Narrative Inquiry in Bioethics* 15, no. 3 (2025): 3.

68 United Nations Convention on the Rights of Persons with Disabilities, *Concluding observations on the combined second and third periodic reports of Canada* (21 March 2025).

69 UN Human Rights Council, *Rights of persons with disabilities: Report of the Special Rapporteur on the rights of persons with disabilities*, 17.

aspect of humanity remains the final frontier to be conquered.

No safeguards can protect vulnerable people from cultural messages, from passively absorbing expectations from whānau, or from outright coercion.[70] Physicians who would have been expected to find ways to alleviate suffering in disabled patients will, if we permit the changes proposed, be expected to facilitate access to euthanasia for disabled people who are not near death.

Dr Coelho writes that, "Over time, this changes professional identity. Medicine traditionally demands persistence with patients through uncertainty, slow recovery and complex suffering. MAiD introduces a different model, asking clinicians to decide when suffering should no longer be treated and when life may be ended instead. The deeper danger is cultural and professional. With MAiD's integration into our system, medicine may shift from asking, 'How do we treat suffering?' to 'When is suffering severe enough to justify death?'"[71]

This attitude reflects wider cultural values that, when seen to affirm suicidal ideation, deserve to be questioned. As the authors of "Illusion of choice?" wrote:

> *"[V]alues that shape the western mind, prioritising autonomy, self-sufficiency and control may implicitly frame dependency as failure, and death as a means of restoring agency. Commonly reported motivations for Assisted Dying, such as feeling like a burden and the loss of autonomy or control, can be understood as appraisals shaped by prevailing cultural norms about independence and self-sufficiency, rather than as purely individual preferences that signify personal choice and autonomy."*[72]

Autonomy—operating independently and in our own best interests—is necessarily dependent. If what we prefer is not an available option, our autonomy is eroded. If people we depend on are making decisions that run counter to our desires, our autonomy is challenged.

In the words of disability ethicist Heidi Janz, "disability ethics problematizes and reframes autonomy, placing it within a relational context and redefining it from an act carried out in total isolation to an act which necessitates interdependence and has communal consequences."[73]

For health professionals involved with euthanasia, upholding autonomy is a minefield. Those who recognise remediable factors influencing the decision by disabled candidates often struggle to affirm their wish to die.[74] Not affirming it, however, violates the principles of patient-centred care.

b. Undermining suicide prevention

"Suicide prevention research shows that normalizing death as a response to life suffering, combined with access to lethal means, increases suicide risk."[75]
– Dr Ramona Coelho

Applications for euthanasia are precipitated by loss or the threat of loss. In jurisdictions where patients are asked why they apply, nine out of ten fear losing autonomy or losing the ability to do the things they enjoy. Fear about inadequate pain control—not necessarily the experience of pain—is a factor for only one third of applicants.[76]

The primary driver of applications is a fear of experiencing disability. In places where eligibility includes people who are suffering but not near death, many who live with disabilities

70 Ibid, 9-10.

71 Ramona Coelho, "Assisted Dying Is Changing Medicine More Than We Realize," 31 March, 2026, https://goodmenproject.com/featured-content/assisted-dying-is-changing-medicine-more-than-we-realize/?

72 Ruslan Zinchenko and Sheila Hollins, "Illusion of choice? Implicit coercion and assisted dying in clinical practice," *BMJ Supportive & Palliative Care* 16 (23 February 2026): 6.

73 Janz, *For Such a Time as This*.

74 Maria Cheng and Angie Wang, "Private forums show Canadian doctors struggle with euthanizing vulnerable patients," *AP News*, 17 October 2024.

75 Ramona Coelho, "Euthanasia can allow structural coercive forces to push people toward death," 15 April 2026, https://alexschadenberg.blogspot.com/2026/04/euthanasia-can-allow-structural.html.

76 Oregon Health Authority, *Oregon Death with Dignity Act 2023 Data Summary.*

now find that, legally and medically, their peers are free to choose death rather than to live as they have been living.

End-of-life concerns for euthanasia applicants in Oregon:

Losing autonomy	92%
Less able to engage in activities making life enjoyable	88%
Loss of dignity	64%
Losing control of bodily functions	47%
Burden on family, friends/caregivers	43%
Inadequate pain control, or concern about it	34%
Financial implications of treatment	8%

Oregon Health Authority data summary, 2023

The common experience of patients being unable to access support, treatment, and expertise can exacerbate patients' lack of agency, difficulty adjusting to physical limitations, and the feeling of being a burden. In Canada, where patients are now offered euthanasia in every setting from aged care facilities to emergency departments, those with disabilities are at heightened risk of feeling like they should "choose" to end their own lives.

Contrary to assumptions that legalising euthanasia would reduce the number of suicides, international research has observed increases—particularly for the elderly and females.[77] Conversely, efforts to discourage suicidal behaviour do have an impact; suicidality is rarely persistent. A review of 90 studies that followed suicidal patients over time found that 70% did not make further attempts, and 90% did not die by suicide.[78]

Normalising euthanasia is not compatible with strengthening suicide prevention efforts. Education campaigns that try to draw a clear line between suicide and euthanasia cannot mitigate the damage, because the two will always be bound by a core belief: death is an acceptable remedy for suffering.

Those who work in suicide prevention are particularly sensitive to the impacts of this narrative. Le Va is a suicide prevention charity that works with Māori and Pasifika communities in New Zealand. Chief Executive Elizabeth Mati warns that when assisted dying becomes more visible, "it can influence how people experiencing distress make sense of their own situation." She writes:[79]

> *In prevention, we're very mindful of how exposure to certain ideas can shape thinking and attitudes, especially for people who may already feel overwhelmed or like a burden. ... Broadening eligibility beyond those who are imminently dying does introduce more ambiguity into the system. It becomes harder to maintain a clear boundary between end-of-life care and suicide prevention, particularly for people living with ongoing illness or complex needs over a longer period of time.*

The International Association for Suicide Prevention (IASP) has weighed in on the risk to suicide prevention efforts. In response to the growing number of jurisdictions legalising euthanasia and assisted suicide, in 2025 it wrote: [80]

> *There is a strong potential for overlap or equivalence between what we consider to be suicide and euthanasia and assisted suicide (EaAS), particularly when EaAS is provided not at the end of life and instead to those with chronic conditions for whom death is not imminent. Research and clinical experience indicate that when a person has an irremediable illness or life situation, steps can still be taken to remediate the suffering and reasons motivating their desire to die. Even when it may convincingly appear to be hopeless, premature deaths can be prevented.*

In order to mitigate risk, the IASP recommends engaging with suicide prevention experts and ensuring services such as palliative care, material supports, and mental health care are accessible. It would like everyone who applies to be able to receive "high quality suicide prevention assessments and interventions, regardless of their problems, circumstances

77 Sourafel Girma and David Paton, "Is assisted suicide a substitute for unassisted suicide?" *European Economic Review* 145 (2022).

78 "Attempters' Longterm Survival," 2026, accessed 20 April, https://hsph.harvard.edu/research/means-matter/means-matter-basics/attempters-longterm-survival/.

79 Elizabeth Mati, email, 22 April 2026.

80 International Association for Suicide Prevention, "IASP Position Statement on Assisted Suicide and Euthanasia," news release, 1 December, 2025, https://www.iasp.info/2025/12/01/iasp-position-statement-on-assisted-suicide-and-euthanasia/.

and status of their eligibility." It rejects an absolutist view of autonomy, where even self-destructive wishes should be affirmed. It observes that "[d]eath should never be a substitute for adequate care and support."

In the handful of places where non-terminal patients can access euthanasia, the boundary between euthanasia and suicide care has become so obscured that people seeking help while suicidal have been offered help to end their lives. Kathrin Mentler, who has disabilities and chronic pain, went to Vancouver General Hospital in 2023 during a suicidal crisis. After they told her that the unit had no beds available, they asked if she had considered euthanasia. *The Atlantic* reported that Mentler "left the hospital in a 'panic,' and that the encounter had validated many of her worst fears: that she was a 'burden' on an overtaxed system and that it would be 'reasonable' for her to want to die."[81]

In 2023, pro-euthanasia organisation Go Gentle Australia published a "Joint Statement by Australia's Suicide Prevention Leaders." It draws a firm line between the categories of euthanasia and suicide, saying each should be discussed separately: "Confusing these terms can delay access to suicide prevention services for people in distress, and complicate or delay care for people with terminal illness who are seeking an additional choice at the end of life."[82]

The statement clarified that suicide "can be prevented with the right support and care, including the crisis support and counselling services that our organisations provide."

Euthanasia, on the other hand, "is not a choice between life and death. It is an end-of-life choice available to eligible terminally ill people who are already dying. It offers an element of control and comfort over how they die when death becomes inevitable and imminent."

What happens when euthanasia becomes a choice for those who are *not* already dying? How does a society maintain its efforts to prevent suicide?

Five years after Canada began permitting patients without foreseeable deaths to be eligible for MAiD, the Canadian Association for Suicide Prevention expired. In April 2026, the 40-year-old organisation announced it would cease to operate due to "significant and sustained funding challenges."[83]

c. Bias against more time- and resource-intensive options

The speed with which some people receive euthanasia undermines the narrative that safeguards protect vulnerable people, and that death remains the last resort. In New Zealand, at least one patient has died within 48 hours of applying.[84] In Canada, dozens of people a year die the same day.[85] In significant numbers of cases in both countries, attending physicians are making little or no effort to involve psychiatric or palliative care, speak to caregivers and family, or consult with specialists who may recommend treatment for specific conditions.

Initially, Canada required a 10-day assessment period for patients whose death was foreseeable, but scrapped it in 2021. The failed assisted suicide bills in England and Scotland would have required nine days and two days, respectively. New Zealand's legislation has no assessment safeguard and the Ministry of Health is actively seeking to reduce wait times and reduce safeguards. It would make a referral to a psychiatrist—which current legislation only directs in cases where mental capacity is in question—optional, allowing assessments by those who are not specialists in mental health.[86]

In Canada, a growing number of patients are speaking out after their efforts to access health care and disability support are being met with the offer of MAiD.

81 Elaina Plott Calabro, "Canada is Killing Itself," *The Atlantic*, 11 August, 2025.

82 Go Gentle Australia, "Joint statement by Australia's suicide prevention leaders."

83 Canadian Association for Suicide Prevention, "Canadian Association for Suicide Prevention Announces Planned Closure After More Than Four Decades of National Leadership," news release, 15 April, 2026.

84 Penk, "New Data Suggests People Are Moving from Application to Assisted Death More Quickly," 27 February, 2025, https://www.ethosalliance.nz/articles/new-data-suggests-people-are-moving-from-application-to-assisted-death-more-quickly.

85 Fleur Metson, "When Citizens Can Request to Die in the Morning and Be Gone by Supper, Surely That Is a Step Too Far?," LBC, 17 May 2026, https://www.lbc.co.uk/article/assisted-dying-canada-right-to-life-5HjdZHQ_2/.

86 Ministry of Health, *Review of the End of Life Choice Act 2019* (Ministry of Health, November 2024), 17-18.

This self-authored obituary in the *Winnipeg Free Press* is from a 44-year-old woman who died from euthanasia:[87]

"Living with ALS has not been easy. … Ultimately it was not a genetic disease that took me out, it was a system. There are not enough supports and services promoting quality of life and independence for those who are not healthy and able-bodied. … Vulnerable people need help to survive. I could have had more time if I had more help."

New Zealand shares much in common with Canada, where wait times for general surgery are about five months, more than a year for orthopaedic surgery, and sometimes longer for mental health services.[88]

As one New Zealand physician pointed out, after he provides diagnoses that require ongoing support, "I know I'm sending people home to a system that is completely overwhelmed."[89] Many face long waits for tests and for treatment while their fear and anxiety grow. Euthanasia, however, is universally accessible to patients with a six-month prognosis. If the eligibility is extended, it will become one of the few guaranteed options for thousands of patients needing complex care.

Approving euthanasia for someone who would otherwise need long-term care and support "lets everyone else off the hook"—stretched services, medical professionals, family members, budgets. "I'm worried that it's actually reducing people's choices," the physician said.[90] Ethical questions may seem inconvenient and even irrelevant when fiscal and temporal equations are so clear-cut.

We cannot be naïve to financial pressures. In 2017, French modelling based on Quebec's legislation estimated savings of approximately €26,000 per patient for the final year of life. The prospect of legal euthanasia translated to annual savings of €1.4 billion a year in health costs alone, without factoring in retirement payments and other entitlements.[91]

These incentives are worrying a growing number of people. Some physicians in Canada who were initially happy to participate in euthanasia have since stopped, according to Columbia University doctor and ethicist Lydia Dugdale. Speaking to *The Free Press*, she said, "Hastening death becomes the path of least resistance. It is efficient, and it results in substantial healthcare savings. Once the state and the medical profession legitimize what's easy, efficient, and cheap, it's hard to blaze a different path."[92]

d. Incentivising patient refusal of care

"One of the things we hear, not infrequently, is that I'm not going to take palliative care medication in case I become incompetent and can't have the assisted death that I want. So, I'm prepared to increase my suffering, which is insane, so I can die when I want to."[93]
– Physician surveyed in New Zealand

For patients who have lost the will to improve their condition, neglecting health care or even food may allow them to qualify as being in "irreversible decline." This is a criterion proposed in the End of Life Choice Amendment Bill, and one that Canada adopted for Track 2 MAiD eligibility. Documented cases in Canada show that this can result in patients ensuring their eligibility for euthanasia rather than accepting psychological support and medical intervention.

Ontario's MDRC reported cases such as that of "Mr B," who suffered from cerebral palsy and "profound psychosocial suffering and loneliness due to limited social relationships and isolation from community." In preparation for his evaluation for euthanasia, he restricted his diet to a glass or two of caloric fluid a day. He continued this diet through consultations and his second assessment, at which point he was bedbound and in "an advanced state of decline"—

87 Sathya Dhara Kovac, "Sathya Dhara Kovac," (2022). https://passages.winnipegfreepress.com/passage-details/id-311052/KOVAC_SATHYA.

88 Calabro, "Canada is Killing Itself."

89 Voice For Life, *The Hidden Truth About Euthanasia: A Doctor's Perspective on Loneliness, Pressure, and the Illusion of Choice* (6 May 2026).

90 Ibid.

91 Yves-Marie Doublet and Pascale Favre, *Les non-dits économiques et sociaux du débat sure la fin de vie*, Fondation pour L'innovation Politique (January 2025), 23.

92 Rupa Subramanya, "Death in One Day: Inside Canada's Assisted-Suicide Machine," *The Free Press*, 5 March 2026.

93 Dehkhoda et al., "Early experiences of the End of Life Choice Act," 7.

not primarily because of the cerebral palsy, but because he had starved himself to ensure eligibility for euthanasia.[94]

The MDRC's report on evaluating incurability and irreversible decline also involved a woman, "Mrs A," suffering from obesity who had developed comorbidities.[95] She declined management and treatment of her conditions and was found eligible due to "advanced and irreversible" decline.

Some members of the committee identified that this is inconsistent with a "care-first" approach. They are of the opinion that "MAiD assessments and discussions should not proceed until a consistent and supportive healthcare relationship has been re-established. This approach is intended to ensure that persons are making informed decisions within the context of comprehensive care, rather than as a result of unmet medical or social needs."

Such physicians recognise that their patients' health could improve—often by non-invasive and standard care. They appeal to recognised standards and argue that cases such as "Mrs A" should not progress the way they did. However, physicians who disagree are free to allow patients who are not near death to access assisted suicide and euthanasia by neglecting their health, precipitating physical decline.

As in New Zealand, Canadian patients aren't required to have mental health support or be referred for evaluations. Despite signs that both Mrs A and Mr B could have benefitted from interdisciplinary support, neither received a psychiatric referral. Evaluations and interventions are at the discretion of the attending physician in both countries, despite recommendations (such as one contained in the MDRC report) that all complex conditions and questions regarding capacity result in psychiatric assessments.[96]

Patients contributing to their own decline has become a disturbing side effect of Canada's euthanasia expansion. Short of infringing on patient autonomy, the only ways to reduce such perverse incentives are to restrict eligibility to those whose death is already foreseeable (as Alberta recently chose to do), or to create even wider eligibility criteria so that people who are not declining physically may also qualify—thus removing the motivation some patients have to avoid effective treatments.

e. Subjectivity, irremediability, and uncertainty

> *"Wide variability may include outer margins of practice, in either direction, that exceed the intention of the legislators and society."*[97]

The handful of jurisdictions that have legalised euthanasia for patients whose death is not imminent create a veneer of certainty over questions that cannot be answered.

Which patients, given time and support, would change their minds?

Do physicians have all the relevant information?

Are the patient's sources of suffering remediable?

Physicians in these contexts cannot merely recommend treatment based on objective criteria. They are bound by a patient's subjective, untestable measure of their suffering—and, frequently, not even present suffering but the anticipation of suffering in the future.

Dr Sonu Gaind, former president of the Canadian Psychiatric Association, said that while "pretending to provide MAiD for an irremediable condition, we actually end up taking the lives of non-dying people—who could get better—for all sorts of other psychosocial suffering. That's not compassion."[98]

Those applying for euthanasia are frequently in a time of adjustment, whether near the natural end of life or not. New Zealand's lack of an assessment period increases the risk that they will never have the opportunity to adjust, and the expansion of criteria would magnify that risk. As Professor Roderick MacLeod points out, "If you take a poll of people who first arrive at palliative care thinking about

94 Office of the Chief Coroner of Ontario, *MDRC Report: 2025 – 1*, 21-22.

95 Ibid, 16-17.

96 Ibid, 20.

97 Winters et al., "Conduit or conductor? Physician providers' descriptions of their role as MAiD assessors in the first years after legalisation in Canada," 159.

98 Rupa Subramanya, "Scheduled to Die: The Rise of Canada's Assisted Suicide Program," *The Free Press*, 11 October, 2022.

euthanasia it would actually be moderately high. After a couple of weeks that number will drop significantly."[99]

Canada has illustrated how vague eligibility criteria—with the definitions of "suffering," "progressive condition," and "expected to cause death" all open to interpretation—have led people who have treatable health conditions to end their lives because it's too hard to access social or medical provisions. A physician interviewed by *The Free Press* spoke about the disconnect she experienced between a patient's technical eligibility and her unease in approving him, when she knew treatment he was refusing would help. She said that "many people have no ethical or clinical qualms about this—that it's all about a patient's autonomy, and if a patient wants this, it's not up to us to judge. We should provide."[100]

However she "regretted her decision almost as soon as the man's heart stopped beating. 'What I've learned since is: Eligible doesn't mean you should provide MAID,' Li told me. 'You can be eligible because the law is so full of holes, but that doesn't mean it clinically makes sense.' … 'There's no standard here; it's just kind of up to you.'"

The public discourse around euthanasia has not caught up to the medical and political reality in jurisdictions like Canada. Commenting in 2015 on the shift in language from "assisted suicide" to "assisted dying," Kevin Yuill observed that "it appears to be a shift away from the emphasis on autonomy and self-determination towards a demand that death become a medical choice, completely divorced from moral responsibility."[101]

f. Effects on safeguards

"It becomes like an assembly line. But it is very helpful to have specialized providers and a pool of expertise … The worry is that one person might develop a different practice to what's [standard] and would then repeat itself many, many times."
– Canadian physicians' views of their role as euthanasia providers[102]

Ultimately, legalising physician-provided euthanasia embeds a pathway within the health system allowing one person to intentionally end another's life. Every criminal code that protects the right to life prohibits this. The argument for creating an exception is that the death was imminent; the individual is merely choosing how to bring about the inevitable. When death is not imminent, eligibility rests on even thinner criteria. "Unbearable suffering" is one that providers of euthanasia themselves say is "not clinically measurable."[103]

Without agreeing on a moral standard, patients and practitioners alike have no way to reach a consensus regarding criteria. Dr Ellen Wiebe, one of Canada's most prolific MAiD providers, has had multiple complaints filed against her by people who believe she has violated the principle of protecting human life. However she has not been found guilty of wrongdoing, and she does not expect to be.

Wiebe has explained why: "'… if a lawyer says, 'Oh—I disagreed with some of those things,' I'd say, 'Well, they didn't put lawyers in charge of this.' She laughed. 'We were the ones trusted with the safeguards.' And the law was clear, Wiebe said: 'If the assessor'—meaning herself—'believes that they qualify, then I'm not guilty of a crime.'"[104]

Despite 428 cases of possible criminal violation in Ontario, none have been referred to law enforcement for possible

99 Trayes, *The Final Choice*, 95.

100 Calabro, "Canada is Killing Itself."

101 K. Yuill, "The unfreedom of assisted suicide: How the right to die undermines autonomy," *Ethics, Medicine and Public Health* 1 (19 November 2015).

102 Winters et al., "Conduit or conductor? Physician providers' descriptions of their role as MAiD assessors in the first years after legalisation in Canada."

103 Dehkhoda et al., "Early experiences of the End of Life Choice Act," 7.

104 Calabro, "Canada is Killing Itself."

Miriam Lancaster's story:

Moments after they wheeled me into the emergency ward, a young female doctor approached my bed. After running through the usual questions about what was hurting and how much, she said, as casually as one might offer a cup of tea: "Do you want MAiD?"

She sounded eerily like the doctor who had offered it to my husband—as if she was reading from a script.

I said, as firmly as I could manage: "No, thank you."

She heard my refusal, took one look at my daughter's and sister's faces, and swiftly changed the subject. …

I was stunned. No one had even told me what was wrong with me. All I knew was that I was in tremendous pain and that a stranger had just suggested I might want to end my life.

Miriam Lancaster, "Never Kill Yourself," The Free Press, 28 March 2026.

breaches of MAiD guidelines. Subjective and relative criteria cannot ensure that those who are eligible for euthanasia receive protection of life equal to that ineligible persons receive. Whatever our hopes for medical practitioners, the reality is that they will not all, and not always, provide what is expected: equal access to alternative treatments, rigorous investigations to ensure that coercion is not a factor, accurate diagnosis and prognosis, or thorough treatment of issues driving the desire to die.

We need only note the shortest time from application to death in New Zealand—two days—to dispel any illusions to the contrary.[105]

"The stark reality," according to ethicist John Keown, "is that some doctors would fail to ensure that requests for VAE [voluntary active euthanasia] were free, informed and competent and that there were no alternatives."[106]

g. Loss of trust

In addition to these observable harms, extending euthanasia to people who could live for years, or even decades, creates an invisible cost. Trust suffers as soon as we know that the health system we fund, and from which we have the expectation of care when we need it, actively ends some lives. Even more damaging—these lives are the ones that require the greatest support.

A Canadian survey that recorded people's expectations of the health system found stark differences between those with severe disabilities and those without.[107] Among the general population, 27% were "worried about financially or socially vulnerable people considering MAiD because they can't access adequate, quality care." The percentage rose to 49% when those living with severe disabilities were asked. Of that subset, 57% reported discrimination, 31% believed they had worse access to healthcare in general, 24% worse quality healthcare in general, and 21% difficulty finding a primary care doctor.

There is a rationalisation, openly voiced in some circles, which says that euthanasia leaves more resources for people who have greater needs and who want to live. This approach prioritises utility over care and devalues the lives of the very people who need their value affirmed.[108]

105 Penk, "New Data Suggests People Are Moving from Application to Assisted Death More Quickly."

106 John Keown, *Euthanasia, Ethics and Public Policy: An Argument against Legislation*, Second ed. (Cambridge: Cambridge University Press, 2018), 72.

107 Vachon, *Disability and MAiD*, 12, 14.

108 Yves-Marie Doublet and Pascale Favre. *Les Non-Dits économiques Et Sociaux Du Débat Sure La Fin De Vie*. Fondation pour L'innovation Politique (January 2025). Some in favour of this expansion have not only expressed this "advantage," they have even calculated how much the system will save.

Euthanasia is not "another" option, in the sense that chemotherapy or surgery might be for a cancer patient. It is the termination of options. The more likely a patient is to opt for euthanasia, the less likely they are to need palliative care, physiotherapy, psychiatric care, dialysis, or aged care. Even without utilitarian calculations, euthanasia embeds utilitarian incentives in every hospital ward and GP clinic.

This is Canada's experience. Despite court rulings that foreground compassion and policies designed to be fair, a constant stream of reports illustrates how distrust of Canada's system has grown—particularly among those who are disabled or elderly. Many of these people suspect that there are bureaucrats, legislators, and health care workers who view them as an unnecessary burden now that they qualify for euthanasia. This materially changes their relationship with the health system. It actively undermines trust.

4. INTERNATIONAL COMPARISONS

Aotearoa New Zealand's current six-month prognosis is aligned with legislation in most Australian states and in the US states that have legalised assisted suicide. Aside from the Australian Capital Territory, which does not specify a timeframe, Australian states and territories require a prognosis of less than either six months or a year.

Removing the prognosis safeguard would create a system more in line with Canada, which removed the requirement for a "reasonably foreseeable death" in 2021.

The other countries that lack this safeguard are Austria, Luxembourg, the Netherlands, Spain, Uruguay, and Belgium—the last of which requires death to be "in the near future" only for children and relies on medical consensus, not legislation, to govern euthanasia's practice.

Of Belgians euthanised in 2025 who suffered multiple chronic conditions, 57.3% were not terminally ill. Despite being legal since 2002, this represented a near tenfold increase from 5.9% just five years prior. The recent, steep increase has led the European Institute of Bioethics to ask (translated from French), "[H]as old age become a reason to resort to euthanasia?"[109]

In the same report, it noted that a small but growing percentage of patients receiving euthanasia have psychiatric conditions (1.6%), cognitive disorders (1.7%), and no physical suffering (1.9%).

An additional six countries have provision for euthanasia but no laws governing criteria such as prognosis.[110]

a. Canadian experiences

One of the bill's rationales for the suggested changes is that they align with what Canada has been doing since 2021. This prompts us to ask: how has Canada's approach worked? We have already looked briefly at individuals whose stories raise concerns.

Some of the most detailed reporting comes from the Office of the Chief Coroner in Ontario. It reveals that safeguards are not preventing deaths precipitated by factors that include caregiver burnout, mental illness, and inadequate housing.[111]

The MDRC's 2024 report on same-day and next-day provisions, using information from the coroner's office,

Criteria for euthanasia eligibility for patients whose death is not imminent

Canadian "Track 2" eligibility	NZ EOLC Amendment Bill
Have a serious and incurable illness, disease, or disability	Diagnosed with a condition that, either on its own or in combination with one or more other diagnosed conditions, is advanced, progressive, and expected to cause death
Be in an advanced state of irreversible decline in capability	*Unchanged criteria:* in an advanced state of irreversible decline in physical capability
That illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable.	*Unchanged criteria:* experiences unbearable suffering that cannot be relieved in a manner that the person considers tolerable

New Zealand Government, "End of Life Choice Act 2019"; Criminal Code of Canada, (R.S.C., 1985, c. C-46) 241.2(2).

109 European Institute of Bioethics, "+50% increase in euthanasia cases in three years in Belgium: death on request as a remedy for old age and dependency?" 25 March, 2026.

110 Vachon and Beauregard, *An International Comparison Part 1*.

111 Vachon, *Disability and MAiD*.

recounts the experience of the elderly "Mrs B."[112] Someone in her family said that she was interested in MAiD, so an assessor met with her. Their report records a change of mind, "citing personal and religious values and beliefs." However the next day—at her husband's request—she was assessed for MAiD once again. This time the assessor declared her eligible despite noting concern about "the possibility of coercion or undue influence ... due to caregiver burnout." That didn't stop a third evaluator, who assessed her online, from providing the required second approval. She was killed one day after explicitly declining MAiD.

The report also described the death of "Mr C." He had requested MAiD after his hospital admission with cancer, but he soon became delirious and then unresponsive—unable to consent. However the euthanasia provider chose to "vigorously rouse" him, recorded that the patient "opened his eyes and mouthed 'yes,'" and proceeded to end his life.

Reports like this are not exceptional. In Canadian hospitals, 23% of those who receive MAiD die the day of or the day after being assessed.[113] Far from being an option of last resort, ending a life is considered standard treatment.

Alan Nichols had a history of depression. He had been previously hospitalised due to suicidality, but successfully applied for MAiD due to hearing loss.[114]

Roger Foley has a degenerative brain disorder and has been declined care that would allow him to remain in his own home. Hospital staff offered him euthanasia so often that he began recording conversations. In one, the hospital's director of ethics told him that continuing his care would cost "north of $1,500 a day." He has spent most of the past decade hospitalised and believes staff are trying to coerce him into applying for MAiD.[115]

Patients aren't the only ones caught off guard by the new normal. Conversations on private forums reveal how conflicted many Canadian physicians are as they determine whether or not people's disabilities qualify them for euthanasia. One asked whether others had approved people for blindness; the answer was yes, with one reporting multiple cases approved. In one of those instances, the physician also approved the patient's wife—who only consented after several assessments—because the husband wanted them to die together.[116]

b. Alberta's reversal

Bill 18 in Alberta would

- **Restrict provision where the sole condition is mental illness** (even if federally permitted in future)
- Limit **how and when clinicians can raise MAiD with patients,** shifting away from proactive discussion and reinforcing conscience protections
- Create stronger **institutional and practitioner-level constraints** on access
- Return **eligibility to those with a terminal condition**, going further than specifying a foreseeable death (as in Track 1) by specifying a one-year prognosis

In April 2026, Alberta's government passed the Safeguards for Last Resort Termination of Life Act to "introduce safeguards for medical assistance in dying (MAID) to ensure it is not used in place of care or support for mental illness or disabilities." In practice, it reverses the 2021 expansion of eligibility requirements and will restrict euthanasia to people whose natural death is "reasonably foreseeable."[117]

To date, it is the most significant piece of legislation intended to reverse expansion of euthanasia. Despite being out of step with federal laws, Alberta's legislature passed it with a comfortable margin. Bill 18 comes five years after Canada adopted expansions like those the

112 Office of the Chief Coroner of Ontario, *MAiD Death Review Committee (MDRC) Report: 2024 – 4: Complex Same Day/Next Day Provisions* (2024).

113 Subramanya, "Death in One Day."

114 Calabro, "Canada is Killing Itself."

115 Maria Cheng, "'Disturbing': Experts troubled by Canada's euthanasia laws," *AP News*, 12 August 2022.

116 Cheng and Wang, "Private forums show Canadian doctors struggle with euthanizing vulnerable patients."

117 Government of Alberta, "MAID protections for Albertans with mental illness."

EOLC Amendment Bill proposes. Alberta has legislated to restrict eligibility to patients whose deaths are reasonably foreseeable, specifying a prognosis of death within a year.

In anticipation of new federal legislation, Bill 18 rules out allowing provision for mental illness alone (set to come into effect in 2027) and providing euthanasia to minors. It also limits how and when clinicians can raise MAiD with patients and protects both individual and institutional conscientious objection rights.

Before New Zealand signs up for the same experiment, we should honestly evaluate the impact it has had on Canadians' end-of-life care, health system, medical professionals, people with disabilities, the elderly, and those battling mental illness.

CONCLUSION

A six-month prognosis cannot reliably identify which patients' deaths are imminent and which patients may continue to live for years. However, if we are to limit euthanasia to those who are near death, then it is the best of the imperfect safeguards currently employed.

The alternative is to offer euthanasia to patients with a variety of disabilities—chronic illnesses, degenerative conditions, and congenital diseases such as cerebral palsy. Such a policy sends two harmful messages. First, it signals that death is an appropriate response to suffering. Second, the health system is no longer committed to preserving the lives of those with disabilities. Everyone eligible for euthanasia is, inevitably, dealing with a disability.

Without the safeguard of a six-month prognosis, physicians are left to make subjective judgements about which patients' lives are "worth" living—who should be referred for mental health support when they are suicidal—and which patients should be affirmed in a wish to die. Since the EOLC Amendment Bill recommends no assessment period, someone with remediable suffering and years to live could, by this bill's standards, die the same week as their consultation.

Patients' decisions are made in a context where treatment, disability support, specialist referrals, housing, and other forms of care may be delayed or unavailable. For some disabled patients—who already face the greatest barriers to care—euthanasia may not merely be one additional option, but the most accessible option.

Canada teaches us what this change looks like in practice. Since 2021, when eligibility was extended to patients whose deaths are not reasonably foreseeable, there have been documented cases of people who could have lived for years choosing euthanasia due to isolation, lack of disability support, and mental illness.

The backlash in Canada has begun. In 2026, Alberta easily passed legislation that runs counter to federal law. Once in effect, the law will restrict access to patients expected to live no longer than a year and wind back other expansions that mirror the EOLC Amendment Bill's aims. Its rationale was, simply, patient safety.

RECOMMENDATION

We do not recommend loosening the six-month prognosis requirement in the End of Life Choice Act. Patient safety is not enhanced when people whose natural death is not imminent are supported to end their life during times of suffering. All patients experiencing suffering and disability face a greater risk of being diverted away from suicide prevention, away from reasonable treatment, and towards a terminal conclusion.

The referendum that New Zealanders voted on was explicit in its intention to allow only those who are near death and experiencing suffering to end their lives. Most voters and health practitioners oppose embedding the option to end a life prematurely in the health system.

For those exceptional cases where suffering persists, the health system should be equipped to increase training for and access to specialist palliative care and better access to other treatments and services that make life more bearable. No patient should find, when they are at their most vulnerable, that death is an option but care is not.

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