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DISCUSSION PAPER

INTERROGATING CHOICE:

EUTHANASIA AND THE ILLUSION OF AUTONOMY

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EXECUTIVE SUMMARY

New Zealanders who meet certain criteria have been able to end their lives since the End of Life Choice Act (2019) came into effect in November 2021. Three years on, a Ministry of Health review required by law highlighted gaps in the legislation but also advocated for loosening some restrictions. The rationale for its recommendations is that making one choice easier for patients to access will improve the overall quality of end-of-life care. However, free choice is largely dependent on the quality of options and information available. Clearing the path to a single option does not automatically improve the quality of people's choices.

New Zealanders do not have equal access to end-of-life care. While euthanasia is fully funded, palliative care is not. Palliative care addresses varied needs such as pain and symptom management, support for whānau before and after death, in-home care provision, and psychological and spiritual support. Fewer than 30% of patients who die each year benefit from hospice care, but an estimated 90% of us will be eligible for it at some point. Many regions are served by few or no palliative care specialists, and the hospice services available—limited as they are—are not fully funded by the government.

Offering euthanasia to any patient who doesn't also have access to a hospice bed or in-home palliative care prioritises utility over compassion. Unlike other options, euthanasia eliminates alternatives. It introduces risks that the normal provision of health care (access to a cancer treatment, for instance, or new diagnostic equipment) does not.

While the risk of coercion is addressed in the legislation, the safeguards in place are inadequate to consistently identify or prevent it. There are other risks that are also impossible to eliminate, and which go unaddressed by the Ministry and the legislation. Studies show that significant diagnostic errors occur at least 10% of the time, and prognoses of 6 months or less are even less accurate. Additionally, patient autonomy is undermined by the soft coercion of societal and systemic norms.

The Ministry's review favours removing barriers to access over increasing euthanasia safeguards wherever the two are in tension. It acknowledges that a cooling-off period improves safety but rejects the idea of implementing one because that would delay access. This is despite the shortest time reported from application to death being just two days, and the most common wait time being two weeks. The emphasis on an efficient death undermines the kind of consideration and care that an informed choice requires.

Patients should have good information about what a natural death would entail, in addition to understanding and being able to access alternatives to euthanasia. Palliative care specialists recognise that most people have a limited understanding of dying and a natural fear of the unknown. It is possible to alleviate some of this anxiety with good information and practical support. If people are free to choose to end their life without first understanding the stages of natural death, the quality of that choice is necessarily compromised.

Currently, doctors must wait for patients to request euthanasia before discussing it with them. However, the Ministry of Health recommends that doctors be allowed—and even encouraged—to offer it to eligible patients. The Ministry considers it on par with treatments designed to heal or to manage pain and symptoms. **A patient's approach to care and treatment would inevitably be impacted by the knowledge that their doctor considers death as good an option as others.**

Finally, the provision of euthanasia involves the choices of both doctors and care facilities. The Ministry of Health recommends limiting conscientious objection rights for doctors who don't want to refer patients for euthanasia, and requiring care facilities to provide access to euthanasia on site. Further to that, it states that communities whose values "are not aligned with or supportive of assisted dying"—specifically, Māori communities—have "a lack of awareness" of the practice and that there is "an urgent need for assisted dying to become familiar, understood, and accepted."

Neither this stance by the Ministry nor the legislation as it stands support independent, informed, and free patient choice. **To improve the quality of end-of-life care in New Zealand, and to ensure meaningful choice, we make a number of recommendations. They aim to:**

- Improve public awareness about both death and end-of-life options.
- Ensure universal access to palliative care.
- Improve palliative care training for healthcare professionals.
- Fortify protections around euthanasia.

INTRODUCTION

New Zealand's End of Life Choice Act (2019) is predicated on the belief that people should be free to choose how they die. Three years after patients began accessing euthanasia, the Ministry of Health completed a statutory review that recommended improving areas that lack clarity and closing gaps in oversight, while making euthanasia a more appealing, accessible option. But can the Ministry close gaps while widening access?

This paper evaluates the quality of choice that this legislation and the health system at large provide those at the end of their lives. We consider pillars of genuine autonomy: good information, reliable prognosis, equitable access to end-of-life support, and protection from external influences. We also address more subtle forms of coercion, the problem of predicting future suffering, and the challenge of balancing competing choices.

THE CHOICE FOR PATIENTS

> *"There's no chapter about the final stage of illness. And that's what's missing. ... There is a gap and I think that relates to our society not being very open about death."*[1]

What do we know about dying? The picture we have of the way our lives may end will influence the choices we make leading up to it. In order to choose well, patients need good information about what natural death involves, the specifics of their own disease and its progression, and what care they may receive.

New Zealand is one of ten countries that now provide legal access to both assisted suicide (where a physician provides lethal drugs) and voluntary euthanasia (where a physician administers lethal drugs). For our purposes, "euthanasia" will refer to both practices.

The End of Life Choice Act (2019) came into effect on 6 November 2021, a year after 65% of voters approved a public referendum. To be eligible, patients must be diagnosed with an illness with a prognosis of no more than six months, and found by two physicians to be experiencing unbearable suffering that cannot be relieved in a manner that the patient considers tolerable.

The Ministry of Health offered 25 recommended changes to the legislation in its 2024 review. Some identify gaps in oversight and implementation, but most reflect the Ministry's intention to make euthanasia easier and faster to access.[2] We do not know which of these recommendations will be introduced as amendments, or when.

An existing private member's bill, if drawn, would give Parliament the option to remove the eligibility requirement of a prognosis of six months or less.[3] Such changes will be debated in years to come, and when they are, we must decide what true "choice" looks like. Fast-tracking access to one option will not improve the quality of choice while other pathways remain neglected.

The process of dying

The central message of *With the End in Mind: Dying, Death and Wisdom in an Age of Denial*, a book by palliative care specialist Dr Kathryn Mannix, is that we need to get better at talking about dying. Her decades of experience in caring for patients at the end of their lives have taught her the importance of having healthy conversations about death and dying. Her stories illustrate the power of understanding how dying normally progresses. This knowledge reduces anxiety for patients and their whānau, opens space for important conversations, and gives people the tools to die well:[4]

> *The process of dying is recognisable. There are clear stages, a predictable sequence of events. In the generations of humanity before dying was hijacked into hospitals, the process was common knowledge ... . The art of dying has become a forgotten wisdom, but every deathbed is an opportunity to restore that wisdom to those who will live, to benefit from it as they face other deaths in the future, including their own.*

Mannix is not alone in spreading this message. Hospice New Zealand has produced a short animation describing

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[1] 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), 50.

[2] Ministry of Health, *Review of the End of Life Choice Act 2019* (Ministry of Health, November 2024).

[3] Todd Stephenson, "Bill lodged to improve access to End of Life Choice," news release, 12 September 2024.

[4] Kathryn Mannix, *With the End in Mind: Dying, Death and Wisdom in an Age of Denial* (London: Harper Collins, 2017), 145.

normal dying to "support people to talk about it more, in the hope that they might worry about it less."[5]

A good death

A few, core desires unite us as we face the end of our lives. We don't want to be alone. We want to be able to retain agency, being able to evaluate and choose options that align with our values and personality. We don't want to experience pain or uncomfortable symptoms. We don't want anxiety about the unknown. Desires that flow on from these include avoiding dependency, which may be felt as "being a burden" on others, or lacking the ability to care for oneself. Mannix addresses these needs as she describes what good care looks like—finding the root of people's fears, offering solutions, ensuring they never feel alone.

A survey of those who accessed assisted suicide in Oregon in 2024 showed that the most common concern, influencing 89% of respondents, was losing autonomy. Being less able to engage in activities that make life enjoyable came second at 88%, then loss of dignity at 64%. Nearly half feared losing control of bodily functions. Being a burden worried 42%, and 34% were concerned about inadequate pain control. More than 9% were under pressure from the cost of treatment.[6]

Dying will inevitably bring about some of the conditions that people fear. However, a "good death" employs ways to ease them. Loss of physical abilities, for instance, need not equate to a loss of dignity. Care that continues to treat the patient as a whole person confers dignity. That could mean addressing someone who is nonresponsive with the assumption that they can still hear greetings, or giving someone who has lost physical capabilities a say in what they do and when. Good care also helps the patient reframe attitudes that can be reframed. Old activities may not be feasible, but new ones can bring joy. Everyone is deserving of care and might discover, with the right caregivers, that they can continue to contribute to others' lives even in simple ways. It is no more shameful to be "a burden" at the end of life than it is at the beginning.

Unfortunately, as we will see, many people aren't offered a good death. Without access to those who can provide resource-intensive physical and psychological care, their needs may fall on just one or two other people—which will feel like a burden—and they may find themselves without adequate pain or symptom relief. Good deaths are usually possible, but with our health system's provision they aren't always accessible.

> *"Things will sometimes go wrong. We know this for a simple reason: things go wrong all the time in health care, in our best attempts to protect and preserve life. If we are fallible in every other attempt to care for people through illness and the end of life, we will be fallible in our provision of assisted dying. We have no rational grounds to expect otherwise. And the consequences of our fallibility, however rare, can only be wrongful deaths."*[7]

The problem of prognosis

One of the main reasons that most countries have abolished the death penalty is that it risks executing an innocent person. The inability to prove guilt in all cases and the permanence of the punishment have contributed to widespread opposition for its use in any context.[8]

Uncertainty and permanence are core features of euthanasia, too. Studies show significant diagnostic discrepancies—ones that are potentially life-altering—in 10–15% of autopsies.[9] Less critical errors are found about a quarter of the time. And prognoses that estimate lifespan beyond a few weeks in the future will be inaccurate not just some of the time, but *most* of the time.[10]

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[5] "What is it like to die," updated 18 June 2024, https://www.hospice.org.nz/what_is_it_like_to_die.

[6] Oregon Health Authority, *Oregon Death with Dignity Act Data Summary 2024* (27 March 2025), 9.

[7] Emilie Yerby, "Guernsey was right to reject assisted dying," *The Economist*, 20 August 2018.

[8] Ilora Finlay and Alex Carlile, *A Question of Public Safety*, Living and Dying Well (2010).

[9] Julian L Burton and James Underwood, "Clinical, educational, and epidemiological value of autopsy," *The Lancet* 369, no. 9571 (14 March 2007).

[10] 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), https://doi.org/10.1186/s12904-023-01155-y.

There will always be patients who are told they are gravely ill when they are not. Some will believe that they have only months to live and yet they will be cured or have their lives extended for years. One high-profile example is psychologist and media personality Nigel Latta who, seven months after being told that cancer would kill him within the year, revealed that he had all but recovered.[11]

Bleak and inaccurate prognoses will alarm patients unnecessarily. Those errors are unfortunate, but they are impossible to eliminate. Entering the pathway to euthanasia, on the other hand, carries risks that other options do not. Time and treatment may prove that hope, and not resignation, should inform our choices.

Access to expertise

Doctors have different specialties. Yet the Ministry of Health declined to recommend "that either the attending practitioner or independent medical practitioner must have expertise in, and experience of the disease, illness, or medical condition of the person being assessed"—which some Australian states require—because requiring this expertise would "create a significant barrier to access."[12]

This goes against the advice of The Australian and New Zealand Society for Geriatric Medicine: "Practitioners must have adequate experience in general medical conditions, older people's health, the interaction of comorbidities and oncology to be able to determine life expectancy, and they must be aware of reversibility and treatable issues. They need good training in cognitive and capacity assessment. Many health practitioners work in fields where these skills have not been obtained (e.g. pathology, paediatrics and radiology)."[13]

Few medical practitioners specialise in end-of-life care, either. A palliative care review found "junior doctors still report that [palliative care] is the area in which they feel most unprepared and which causes them the greatest distress," and that remains true two decades later.[14]

As Maxim's previous research into palliative care access found,[15] "undergraduate medical students will receive several weeks' training in women's health, compared to approximately one week in palliative and end of life care training across their six-year degree." The London Royal College of Physicians pointed out that "in medical school curricula, great emphasis is placed on seeing a set number of births and engaging in other procedures," concluding, "there should be an equivalent for end of life care training."

The quality of end-of-life choices is eroded when patients can apply for euthanasia without consulting a practitioner who specialises in the medical conditions they are experiencing or one who specialises in end-of-life care.

> *"In a healthcare system that focusses on a narrative of curing illnesses and injuries as a measure of success, palliative care is often overlooked. Through this narrative, death is seen as an extraordinary event that should be avoided at all costs, rather than something that can be anticipated and prepared for."*[16]

Access to palliative care

A select committee report in the UK pointed out that "if a future bill is to claim with credibility that it is offering assistance with suicide or voluntary euthanasia as complementary rather than alternative to palliative care, it should consider how patients seeking to end their lives might experience such care before taking a final decision."[17]

The variance in both understanding of and access to palliative care creates an inequitable system. Those who, for instance, know their options related to pain relief, family support, and dying at home are far more equipped to make choices than those who think that hospice is just "a place to die," or who have an understanding but cannot access care.

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[11] "'Very, very good': Nigel Latta gives update on his cancer treatment," 1News, 16 March 2025, https://www.1news.co.nz/2025/03/16/very-very-good-nigel-latta-gives-update-on-his-cancer-treatment/.

[12] Ministry of Health, *Review of the End of Life Choice Act 2019*, 109-10.

[13] Ministry of Health, *Review of the End of Life Choice Act 2019*, 102.

[14] Mari Lloyd-Williams and Rod D. M Macleod, "A systematic review of teaching and learning in palliative care within the medical undergraduate curriculum," *Medical Teacher* 26, no. 8 (December 2004): 683.

[15] Danielle van Dalen, *Ending Well: The urgent case for accessible palliative care*, Maxim Institute (November 2021), 18.

[16] van Dalen, *Ending Well*, 7.

[17] Finlay and Carlile, *A Question of Public Safety*.

Defining palliative care

Palliative care takes a holistic approach to improving the quality of life for people facing life-threatening illness. Physical care includes pain and symptom relief, which can be offered either by palliative care specialists or by physicians with other specialties that have received some specialised training in end-of-life care.

Recognising that suffering is usually psychological as well as physical, specialists offer psychosocial, spiritual and practical support, both to patients and their whānau. This equips family members to better care for their loved one. Palliative care also extends to bereavement counselling after the patient's death. The WHO recognises palliative care under the "human right to health."[18]

Dr Kathryn Mannix, who has worked in palliative care in the UK for decades, has helped train others in the specialty. She described her role this way in an interview on RNZ:[19] "You meet someone who just feels awful, and who thinks that between now and when they die they will never not feel awful. And you help restore their physical wellbeing, their emotional wellbeing, their sense of being okay in the world."

Maxim's 2021 paper *Ending Well: The Urgent Case for Accessible Palliative Care* delved into the purpose and availability of palliative care in New Zealand. It is aligned with the well-known and widely accepted *te whare tapa whā* model of health, which "uses the image of the four walls of a house, each of which is essential for the building to stand: wairua (spiritual well-being), hinengaro (emotional and mental health), tinana (physical well-being), and whānau (family and one's wider social network)."[20]

Euthanasia cannot offer the same level of choice that palliative care does because it generally focuses on just one "wall"—physical well-being.

Palliative care ensures that people are not alone or without options. It improves quality of life and, often, life expectancy. It is also likely to reduce hospital costs, particularly for non-cancer diagnoses.[21] If someone wants to die at home (which many do), it provides support for the family as they care for their relative. Specialists help whānau have conversations that are helpful but often difficult to broach at the end of life.

Barriers to accessing palliative care

In Health New Zealand's own words, "All people in NZ should have access to a range of person and whānau centred quality palliative care health services, when and where needed, that are accessible and culturally, linguistically and spiritually appropriate. This includes services that support whānau-family in their caring and bereavement."[22]

The reality, however, is that New Zealand has a postcode lottery for end-of-life care. Health New Zealand's report goes on to say that "there is inequity in access to, experience of, and outcomes from palliative care services." Of the 37,884 who died in New Zealand in 2023, 10,860 received support through New Zealand's hospice network.[23] An estimated 23,000 more would have been eligible for palliative care, but many regions have few or no specialists.[24]

The End of Life Choice Act (2019) requires attending physicians to "ensure that the person understands their other options for end-of-life care," but those options vary significantly across the country.[25] In 2010, New Zealand had about half the palliative medicine specialists needed, and demand has only increased. People with disabilities, local Māori health providers, and those who live rurally are among those who are less likely to have access to that support.[26] Starship Hospital is the main publicly funded provider for paediatric palliative care; only three other providers exist outside of Auckland, and not all receive public funding.[27]

The Ministry of Health's 2017 forecast for the palliative care workforce identified several issues: an aging workforce;

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[18] Gott, Robinson, and Black, *The Voices of Underserved Communities*.

[19] Kathryn Mannix, "Kathryn Mannix: the importance of being frank about death," interview by Jim Mora, *Sunday Morning*, 9 March 2025, https://www.rnz.co.nz/national/programmes/sunday/audio/2018978080/kathryn-mannix-the-importance-of-being-frank-about-death.

[20] van Dalen, *Ending Well*, 5.

[21] van Dalen, *Ending Well*, i.

[22] Health New Zealand, "Position statement on palliative care in Aotearoa New Zealand, National Palliative Care Steering Group," (September 2024), 1.

[23] Hospice New Zealand, *Annual Report 2024* (2024), 12.

[24] "Deaths in New Zealand 1991–2024," 2025, https://figure.nz/chart/1WdlzLBouoRzmBrp-iPkoB20BRqtLT8qU.

[25] Ministry of Health, "End of Life Choice Act 2019," (New Zealand, 16 November 2019), 8.

[26] Salina Iupati et al., "Community specialist palliative care services in New Zealand: a survey of Aotearoa hospices," *New Zealand Medical Journal* 135, 1566 (2022): 37.

[27] Paediatric Palliative Care NZ Rei Kōtuku, *Unheard Cries: New Zealand's Neglect of Palliative Children* (November 2024).

difficulty recruiting and retaining palliative care medicine specialists; a shortage of general practitioners with an interest in palliative care; and a shortage of nurses with specialist palliative care skills.[28] None of these problems have improved, and currently only two people are employed by Health New Zealand to coordinate a national palliative care strategy. Even their roles have been in jeopardy.[29]

This neglect restricts the choices available to a large proportion of Kiwis. Euthanasia is fully funded and accessible everywhere in the country, but palliative care is not. Dr Dana Wensley, one of the original members of New Zealand's board reviewing assisted deaths, observed that rural areas appeared to be over-represented in euthanasia applications. Her request for more data was denied by the Assisted Dying Secretariat, so the extent of the unequal distribution and the reasons for it remain unexplored.[30]

Funding challenges for hospices

New Zealand's hospices offer free palliative care as well as training for people to provide the kind of physical and emotional support patients and their families need—both before and after death. They coordinate interdisciplinary teams of health and social service professionals who work within and alongside the public health system.

In 2023-24, $174 million went into hospice care across New Zealand. The government provided $114 million of that, with the $60 million balance from community fundraising. However hospices had to raise an additional $40 million to pay for those fundraising efforts—an inefficient yet unavoidable side effect of relying on donations.[31] Hospice New Zealand's website regularly highlights fundraising efforts by local corporations such as Dilmah, Harcourts Foundation, and Farmers. The balance of donations comes from Hospice op-shops, supporters, and reserves.

Hospices reduce the burden on the public health system to the tune of $110 million a year, in no small part by making it more manageable for patients to remain in their own house or care home. Most patients die in their own home (40%), in aged residential care (24%), or in a hospice inpatient unit (19%). Only 16% die in hospital.[32] Conservative estimates of the government's return on investment in hospice care is $1.59 for every $1 spent.[33]

Unfortunately, hospices do not have the capacity or the geographic spread to serve all New Zealanders, particularly those in rural areas.[34] The services that hospices are able to provide vary, too. For adults, all facilities provided face-to-face care, symptom management, family and carer support, bereavement care, and care at home. All but one also provides direct hands-on care. Beyond those services, care for patients in aged residential care facilities and psychological care are available from 94% of hospices; spiritual care, 91%; telehealth, 53%; respite care, 53%; and rehabilitation, 25%. Fewer than half have inpatients units, and most of those have between six and ten beds.[35]

The shortfall in funding for hospice clinical services was $9.4 million a year in 2024, and at current levels this is predicted to balloon to $196 million by 2043. Without a greater effort to increase funding and training levels, a recent Martin Jenkins report predicts, hospices will face reduced services and closures.[36]

Lack of support influences choices

Reports from Canada, where euthanasia eligibility has widened, reinforce concerns that "people who are in lower socioeconomic situations and have a lack of support may choose to end their lives if they're not given alternatives." Those alternatives—which involve addressing causes of suffering as diverse as inadequate housing, symptom relief, and day-to-day support—require more resources and time than euthanasia. As the author of one report said, "The same government that is failing to offer social systems is the same government that is offering quick and easy MAiD [Medical Assistance in Dying]. There's a perverse disincentive to improve care."[37]

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[28] van Dalen, *Ending Well*, 17-18.

[29] Wayne Naylor, "Dying to be heard: National palliative care roles axed," Opinion, *The Post*, 16 February 2025.

[30] Isaac Davison, "Assisted dying in NZ: Reviewers say oversight is so limited that wrongful deaths could go undetected," *The New Zealand Herald*, 9 October 2024.

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

[32] Hospice New Zealand, *Annual Report 2024*, 12.

[33] Martin Jenkins, *Executive Summary Martin Jenkins Report: Sustainable Funding for Hospice Services* (2025), 1, https://ehospice.com/wp-content/uploads/2025/03/Executive_Summary_MartinJenkinsReport.pdf.

[34] Hospice New Zealand, *Annual Report 2024*, 15.

[35] Iupati et al., "Community specialist palliative care services in New Zealand," 37, 39.

[36] Martin Jenkins, *Martin Jenkins Report*, 2.

[37] Kate Dubinski, "New report shows who is getting medical help with dying despite not being close to natural death," *CBC News*, 28 October 2024, https://www.cbc.ca/news/canada/london/new-report-shows-who-is-getting-medical-help-with-dying-despite-not-being-close-to-natural-death-1.7363801.

When euthanasia was legalised in Canada, palliative care access was "positioned as a 'safeguard' for euthanasia," according to a 2020 report in *World Medical Journal*. "However, in reality, less than 30% of Canadians have access to any form of palliative care and less than 15% have access to specialized palliative care. Many … have questioned if euthanasia can truly be an informed choice if there is no meaningful access to palliative care."[38]

Dr Henk Jochemsen, former professor of medical ethics at the Free University of Amsterdam, wrote an open letter to Canadians when their parliament first considered legalising euthanasia in 2010, observing that "the practice of euthanasia in the Netherlands is changing the doctor-patient relationship and the attitudes of society toward the severely disabled, elderly, and terminally ill."[39] Doctors in Canada are reporting similar changes since legalisation changed there, and those who need long-term care or disability support are particularly vulnerable: "A significant number of reports have documented cases in which individuals have been told by health care professionals and others to consider euthanasia as an 'answer' to a perceived poor quality of life or a lack of health care resources to meet their needs."[40]

In 2020 Canada broadened eligibility for euthanasia to those who do not have terminal diseases, and from 2027 mental illness is expected to be allowed as a sole underlying condition. The United Nations Committee on the Rights of Persons with Disabilities has strongly opposed this approach, saying that it compounds inequality for those who are already vulnerable:

> *The concept of 'choice' creates a false dichotomy by setting up the premise that if persons with disabilities are suffering, it is valid for the State Party to enable their death, with safeguards not guaranteeing the provision of support … and the systemic failures of the State Party to address the social determinants of health and well-being, such as poverty alleviation, access to healthcare, accessible housing, prevention of homelessness, prevention of gender-based violence, the provision of community-based mental health supports and employment supports.*[41]

The committee pointed to evidence that those with additional, unaddressed support needs are more likely to opt for euthanasia. "Track 2" of Canada's Medical Assistance in Dying, representing those who are not suffering from a terminal illness, "is disproportionately accessed by women with disabilities and persons with disabilities in marginalised situations," with an "upward trajectory of persons with disabilities killed" due to the expansion of access.[42] On this basis, the UN report recommends Canada repeal euthanasia access for *all* non-terminal conditions.[43]

In the United States, where medical insurers rather than the national health system make health care determinations, the bias towards easier, cheaper solutions is more overt. The National Council on Disability reported that people with disabilities have been offered assisted suicide while being denied treatments that cost more.[44] According to the NCD, "Direct coercion is not necessary. If insurers deny, or even simply delay, approval of expensive life-sustaining treatment, patients can be steered toward hastening their deaths—and sometimes insurers help them to do so."[45]

Individual choices are influenced by the system's limitations. People who are vulnerable because of inadequate health and social support are more likely to choose euthanasia. How free, then, are those choices?

Which patients are competent to choose?

The question of how to decide which patients who want to end their lives are competent to do so and which are not will always involve arbitrary lines. Where that line is drawn to exclude those with depression or dementia, the judgment is often subjective and the patient's state can change from one day to the next.

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[38] Leonie Herx, Margaret Cottle, and John Scott, "The 'Normalization' of Euthanasia in Canada: the Cautionary Tale Continues," *World Medical Journal* 66, no. 2 (2020): 31.

[39] Herx, Cottle, and Scott, "The 'Normalization' of Euthanasia in Canada," 39.

[40] Herx, Cottle, and Scott, "The 'Normalization' of Euthanasia in Canada," 30.

[41] 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), 7, https://drive.google.com/file/d/15PKYk-aHYTv2tLMuFWvyZcJuZB7BOtLu/view.

[42] United Nations Convention on the Rights of Persons with Disabilities, *Concluding observations*, 7.

[43] United Nations Convention on the Rights of Persons with Disabilities, *Concluding observations*, 7–8.

[44] National Council on Disability, "Federal study finds nation's assisted suicide laws rife with dangers to people with disabilities," 2019, https://www.ncd.gov/2019/10/09/federal-study-finds-nations-assisted-suicide-laws-rife-with-dangers-to-people-with-disabilities/.

[45] National Council on Disability, *The Danger of Assisted Suicide Laws* (19 October 2019), 20.

The Ministry's review acknowledged the large grey area that the End of Life Choice Act allows: "Beyond the eligibility assessment, the Act is not explicit about whether and how a person's competence is to be determined throughout the rest of the process."[46]

Only 2% of successful applicants currently receive a referral for a third assessment with a psychiatrist—a stipulation for any applicant when there are questions of mental competence.[47] They could require a psychiatric evaluation for all patients, as some jurisdictions do. Instead, the Ministry recommends widening the criteria for that third assessment to include any health practitioners with "specialist vocational registration."[48] This would decrease the rigour with which competence is assessed.

A study of psychiatrists in Oregon found that 94% did not feel confident diagnosing depression after a single visit—the minimum required in Oregon to be approved for assisted suicide.[49] In New Zealand, only 1 in 50 people approved for euthanasia receive a psychiatric assessment. The rest are likely to see practitioners who are not specialists in mental competence and have limited knowledge of the psychological support that someone dealing with a terminal diagnosis might need.

Obstacles to free choice

Coercion

Coercion, in its many forms, negates free choice. Coercion can be blatant or subtle, explicit or implicit. It can originate with people whose motives are compassionate as well as those who are motivated by self-interest. The societal pressure that flows from assumptions about what it means to have dignity or a reasonable "quality of life" can be as persuasive as a personal appeal. The effect is what matters: having one's will shaped by others' opinions.

The intention for laws governing euthanasia is that they protect people from being killed without their consent. Proponents say, for example, that "In every jurisdiction with assisted-dying laws, a patient must explicitly request assisted dying: doctors cannot bring it up as an option and if they do they risk being reviewed for professional misconduct."[50]

However, medical staff routinely offer euthanasia in the Netherlands and elsewhere, and in Belgium, surveys of euthanasia practice found that people are regularly euthanised without explicit consent.[51] Saying patients must actively choose euthanasia is not the same as ensuring they always do.

New Zealand's euthanasia legislation requires those who evaluate applicants to "do their best to ensure that the person expresses their wish free from pressure from any other person." Specifically, it suggests speaking to "other health practitioners who are in regular contact with the person" and "members of the person's family approved by the person." These interactions should be noted.[52]

"Doing one's best" is not a measurable, objective standard to which attending medical practitioners can be held accountable. Moreover, to detect coercion would involve more than these conversations and would be at odds with the Ministry's desire to speed up the process.[53] While the reporting from Health NZ does not list any applicants who were found ineligible due to pressure from others, this does not guarantee that no applicants made their decision under duress.[54]

Has coercion gone undetected? Former End of Life Review Committee members were "extremely concerned" about missing and conflicting information in patients' death reports and raised this repeatedly with the Ministry of Health and successive Health Ministers. This included "a patient suspected of having frontal dementia, who did not speak English, [who] was approved for assisted dying despite not having an interpreter present for their assessment."[55]

When the Review Committee lodged concerns about blank sections in the assisted death reports, the Ministry of Health

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[46] Ministry of Health, *Review of the End of Life Choice Act 2019*, 7.

[47] Ministry of Health, *Ngā Ratonga Mate Whakaahuru—Assisted Dying Service: Registrar (assisted dying) Annual Report to the Minister of Health—June 2024* (2024), 11.

[48] Ministry of Health, *Review of the End of Life Choice Act 2019*, 111.

[49] National Council on Disability, *The Danger of Assisted Suicide Laws*, 25.

[50] Matt Vickers, *Lecretia's Choice: A Story of Love, Death and the Law* (Text Publishing Company, 14 November 2017), 233.

[51] Maxim Institute, *Submission to the Health Select Committee Investigation into Ending One's Life in New Zealand*, 1 February 2016, 21.

[52] Ministry of Health, "End of Life Choice Act 2019," 8-9.

[53] 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.

[54] Ministry of Health, Assisted Dying Service, 12.

[55] Davison, "Assisted dying in NZ."

told them "to assume nothing was wrong." They were instructed to do this despite sometimes lacking information about patients' "diagnosis, prognosis, assessment of capacity, or information which could help detect any hint of coercion." One former committee member said that they "would not be able to detect wrongdoing if it was occurring."

Even the Netherlands, which has broader eligibility criteria than New Zealand, takes better care to ensure that those who end their lives have done so willingly. Its review committees "consist of three persons: a lawyer, a physician, and an ethicist. When a case meets the criteria, the doctor is notified and the dossier will be closed; when a case does not meet the criteria, it is sent to the public prosecutor and to the Health inspector general. This happens about 6 times a year on a total of 4,000, mostly for procedural mistakes or omissions."[56]

Despite the legal requirements, New Zealand's Ministry of Health has done nothing to discourage breaches to its own protocols. Its own review noted that the legislation lacks legal recourse even if wrongdoing was suspected. Predictions of what might occur if safeguards are relaxed appear to have been present from the start:[57]

> *There will be an inevitable and uncontrollable tendency for it to be performed in cases where the request is neither clear, informed or considered; where the patient is not competent; where the patient is not terminally ill or where the suffering is not unbearable, and where alternatives are available but overlooked, or are not made available. ... Even if precise guidelines could be drafted, how could they be enforced?*

> *"Given that many disabled people live their lives every day depending on others for support and having an irreversible condition or a disability that is considered to be terminal, such legislative descriptions of their everyday reality as worthy of death would not inspire a calm and confident approach to life."*[58]

Soft coercion

The Ministry of Health's recommendation that doctors be allowed and even *encouraged* to broach euthanasia with patients—something currently prohibited—would open the door for a dangerous type of coercion.[59] The Australia and New Zealand Society of Palliative Medicine disagrees with this recommendation. It identifies the relationship between patients and health professionals as the main reason for retaining the prohibition. Ensuring that the patient must initiate the request "helps to address the potential power imbalance between a health care professional and patient. It reduces any perception of medical led coercion to consider and pursue Assisted Dying."[60]

No doubt, a health professional who raises the topic of euthanasia would do so with the best of intentions. Despite this, many patients will interpret the message as, "You may be better off dead." Inevitably, the suggestion to consider assisted dying will diminish many patients' will to live.

"They didn't mean to frighten me. I think they thought it was a comfort," a patient told Dr Kathryn Mannix.[61] Ujjal had left the hospital where he was being treated for terminal cancer in the Netherlands, where euthanasia is legal, and "ran away to the UK" with his wife and young child. He wanted to live out his days in peace. He said that "it was every day, every ward round, they told me that if I want to, I can choose to die." He came to dread ward rounds. The offer of euthanasia made him believe that his disease progression would be "worse than death." He also

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[56] Theo Boer, "Dutch Experiences on Regulating Assisted Dying," *Catholic Medical Quarterly*, 65, no. 4 (November 2015), http://www.cmq.org.uk/CMQ/2015/Nov/dutch_experiences_on_regulating.html.

[57] John Keown, "The Slippery Slope Arguments," in *The Reality of Assisted Dying: Understanding the Issues* (Maidenhead, UK: McGraw Hill, 2025), 71.

[58] Wicks, "The Consequences of Euthanasia Legislation for Disabled People," 39.

[59] Ministry of Health, *Review of the End of Life Choice Act 2019*, 55.

[60] Ministry of Health, *Review of the End of Life Choice Act 2019*, 48.

[61] Mannix, *With the End in Mind*, 187-94.

felt like a coward for not choosing euthanasia, and feared he had "brought sadness and an inescapable burden on the people he loved."

Once in the UK, Ujjal spent two more months with his wife and daughter with his symptoms being managed through palliative care, reassured that the choice to end his life was off the table. He slipped into a coma near the end and died quietly while his daughter played outside.

Offering a patient euthanasia changes the way that they view the remainder of their life, the treatment options they choose, and what they anticipate having to face. Being offered that one choice influences the way they approach all other choices—and may even persuade them that they have no real choice other than to accept an assisted death. For patients like Ujjal, who want help to live well until their natural death, the offer of euthanasia makes choosing what they consider best more difficult.

Systemic coercion

Coercion need not be the direct, intentional influence of another person. Even health systems and the legislation guiding them can have, in the words of disability rights spokesperson Diane Coleman, a "coercive effect":

> *For individuals who internalise social oppression that declares disability to be undignified, the legalisation of assisted suicide may convey the message that suicide is the best way to reclaim their dignity. It may even convey the message that suicide is the most honourable way to make one last contribution ... a mentality that tells the disenfranchised and despised to get out of the way, without ever seriously considering the decisions and motives of the policy makers who shape the culture we live in.*[62]

This type of subtle, systemic coercion is an unavoidable risk whenever euthanasia is made legal. People who come to believe that their worth is attached to their usefulness will feel a duty to die when, and because, they are no longer useful. Those who accept that being dependent is undignified will be more likely to choose death over dependency.

Calculating what constitutes "unbearable suffering" is particularly problematic because it is entirely subjective. One GP described how he interpreted it with a patient who was nearing the end of his life and considering euthanasia:

> *I think it's really important that doctors remove themselves a little bit on that and actually make sure patients understand the definition of what unbearable suffering is and allow them to make that decision ... his definition was more kind of a spiritual thing. In that he's, you know, he loves the outdoors ... He found it really upsetting to have to be inside looking out and not be able to go out. That was his, that was his quality of life. So we, that's what we defined as being unbearable suffering. Because at the time he didn't have a lot of the other things that you'd traditionally associate with unbearable suffering.*[63]

The question arises: How free is a choice to die for someone who has come to believe messages that devalue their life or extinguish their desire to find new meaning for it?

Redefining dignity

Conversations about end-of-life matters often conflate dependency with a "lack of dignity." This phrase becomes short-hand for declining independence and having to rely on family and care professionals for mobility and hygiene needs. Such emotive framing, referred to as "ableism," has earned push-back from disability rights spokespersons who object to the idea that a person with physical or mental limitations has less dignity than one who is more independent.[64]

Similarly, language that markets euthanasia as a "death with dignity" implies that death following a natural decline or illness is in some way undignified. As our discussion of palliative care highlighted, good end-of-life care honours each patient's dignity in a personal way right up to the point of death. Good care bestows dignity. People's choices can be unduly influenced by language that reinforces the idea that physical dependence makes us less dignified. Each of us, having once been a toddler who had to be dressed and toilet trained, knows this is untrue. The belief that we lose dignity as we lose autonomy requires adopting a privileged lens through which we no longer recognise the experiences of childhood, devalue the lives of the disabled, and foster an unhealthy focus on maintaining personal autonomy.

Psychological mechanisms

Psychological biases also impact the decisions of those who, following a terminal diagnosis, are presented with

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[62] Wendi Wicks, "The Consequences of Euthanasia Legislation for Disabled People," *Policy Quarterly* 11, no. 3 (August 2015).

[63] Jeanne Snelling et al., "Health care providers' early experiences of assisted dying in Aotearoa New Zealand: an evolving clinical service," *BMC Palliative Care* 22, no. 101 (2023), https://doi.org/10.1186/s12904-023-01222-4.

[64] 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), 17.

a choice between natural death and euthanasia. Natural coping mechanisms—particularly for those for whom loss of control causes anxiety—have the power to predispose people to see taking their own life as the "safer" option.

The internal pressure to act

During that split second when a soccer player aims a penalty kick, the goalkeeper usually dives to one side of the goal in an attempt to anticipate the ball's trajectory. Statistically, however, goalies are more likely to save the goal if they defend from the middle. Reacting after the ball has begun its flight delays their response, but it increases its accuracy. So why do goalies rarely take the better option? More than nine times out of ten, they prefer to do something rather than do nothing for another millisecond and improve their chances of success.

A 2007 study, *Action bias among elite soccer goalkeepers: The case of penalty kicks,* addresses humanity's "action bias."[65] In situations where acting is the norm, we are far more likely to choose options that involve doing something now than we are to simply wait. Acting or making a decision creates a false sense of influence over an unpredictable situation, reducing feelings of anxiety or helplessness.[66] The act of deciding one's date of death can reduce anxiety without addressing the main cause of anxiety.

Perceived control is expressed poignantly in *Lecretia's Choice*: "This freedom to choose would itself be palliative: she would no longer be anxious, the victim of her illness, worried about what might happen to her, but the architect and arbiter of her life, and her death."[67] The choice, of course, does not change the outcome. In addition, it is invariably influenced by the care available and constrained by legislative boundaries.

Action can also minimise the negative emotions attached to regret: "a goal scored yields worse feelings for the goalkeeper following inaction (staying in the center) than following action (jumping), leading to a bias for action."[68] A similar bias called "accountability pressure" influences the decisions of health care workers. Those in decision-making positions fear being judged for inaction, creating an incentive to take action even when the most reasonable course is to wait.

How can we mitigate action bias in what may be our final choice? Whatever one's prognosis, fears about future emotional distress should be addressed and solutions sought prior to making irreversible decisions.

Forecasting errors

Another bias is our tendency to project current emotions onto our imagined, future state. The more extreme our current emotions, the more likely we are to make incorrect predictions—also known as forecasting errors. Overestimating the severity of future emotional distress is common for those who are experiencing intense negative emotions. Research that involved people with elevated suicide risk found that this lack of ability to predict how they will feel in the future is influenced by cognitive biases that project current emotional pain into the future and assume that the causes of such pain will not only persist but worsen.[69]

Those facing a terminal diagnosis have legitimate reasons to assume their physical challenges will persist and worsen. However, their *emotional* suffering need not. Both the provision of psychological support and their own capacity to adapt may reduce mental suffering.[70]

We make decisions for our future selves all the time, but most are not significant enough to require absolute certainty and many decisions are reversible. Death, on the other hand, is permanent and consequential. We are unlikely to make the best decisions for ourselves during periods of distress—such as the days following a terminal diagnosis. New Zealand's euthanasia applicants are referred for psychiatric guidance and assessment at extremely low rates, and then only to verify that they are mentally competent. This is despite a proven relationship between hopelessness and a range of psychiatric symptoms.[71]

Therapeutic interventions such as cognitive-behavioural strategies can address these "forecasting errors" and

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[65] Michael Bar-Eli et al., "Action bias among elite soccer goalkeepers: The case of penalty kicks," *Journal of Economic Psychology* 28, no. 5 (2007).

[66] Ellen J. Langer, "The illusion of control," *Journal of Personality and Social Psychology* 32, no. 2 (1975), https://doi.org/10.1037/0022-3514.32.2.311.

[67] Vickers, *Lecretia's Choice*, 224.

[68] Bar-Eli et al., "Action bias."

[69] Brian W. Bauer et al., "Does Hopelessness Accurately Predict How Bad You Will Feel in the Future? Initial Evidence of Affective Forecasting Errors in Individuals with Elevated Suicide Risk," *Cognitive Therapy and Research*, no. 46 (17 January 2022), https://doi.org/10.1007/s10608-021-10285-7.

[70] Bauer et al., "Does Hopelessness Accurately Predict How Bad You Will Feel in the Future?"

[71] Ministry of Health, *Assisted Dying Service*, 11.

equip patients with the hope they lack.[72] Bioethicist Wesley J. Smith identifies compassion as a key component in this approach. The word's literal meaning is "to suffer with"—compassion ensures that people are accompanied and do not feel alone. He said that euthanasia, by contrast, "is abandonment. If you decide that eliminating suffering is the primary purpose of society—and that's where a lot of us have gone—that very quickly mutates into eliminating the sufferer."[73]

> *"The strength of the human spirit is astonishing. People all think that they have a limit, beyond which they cannot endure. Their capacity to adapt and to reset their limits has been a constant wonder to me over my decades in working with people living with some of the most challenging illnesses imaginable."* [74]

The final answer

The stories Dr Kathryn Mannix shares of people who learn how to "die well"—thanks in large part to good support—illustrate that it is possible to help people overcome the fear of losing agency by giving them meaningful choices; overcome the fear of pain by explaining their treatment and care options; mitigate the distress of leaving or burdening loved ones by preparing the whole whānau for what is to come; and ease the fear of being alone by ensuring they never are.

"I'm glad I didn't kill myself earlier," one patient told Mannix. He had become suicidal each time progressive stages of motor neuron disease presented new challenges. At every stage, she shared tools that helped him adjust. When he had just days to live, he said, "It would have been too soon, I would have missed so much. I had no idea that I would be able to tolerate living such a changed life."[75]

Mannix writes, "Enabling people to be architects of their own solution is key to respecting their dignity. They are only in a new phase of life; they have not abdicated personhood."[76]

The Ministry of Health advocates for eligible patients who choose euthanasia to be able to access it quickly, but its review never acknowledges that our choices are dependent on internal and external influences and liable to change. As the National Council on Disability points out, adapting to news that impacts our quality of life takes far longer than the 15-day "cool-down period" that, in Oregon, patients are required to wait before accessing assisted suicide.[77]

New Zealand is an outlier among countries that have legalised euthanasia. We have no cool-down period; the shortest time recorded between formal application and death is only two days. The Ministry has reported a mean period of 21 days to being declared eligible and 43 days to death, but the publicly available numbers have been skewed by outliers.[78] Information received under the Official Information Act shows that the most common wait time between application and death—the mode—is only 14 days.[79]

The Ministry of Health's recommendations in its 2024 review reject the possibility of a mandatory cool-down period because it would present a "barrier to access."[80] It is true that with, say, a two-week cool-down period, those who have less than two weeks to live would die naturally. The Ministry's review treats natural death in such circumstances as a failure of the health system, which is a strange attitude given the goal of euthanasia.

The "failure," then, is only that a patient would not die at a time and in a way they have chosen. If we applied this standard to childbirth, imagine how often the health system would fail to provide a satisfactory level of choice. In childbirth—another physical process that we can hasten but not control—some women want a natural birth but must

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[72] Bauer et al., "Does Hopelessness Accurately Predict How Bad You Will Feel in the Future?" 691.

[73] Wesley J. Smith, "Wesley J. Smith on human exceptionalism," interview by Simon O'Connor, Family Matters, 4 March 2025, https://www.youtube.com/watch?v=RYdzMo7HMDo.

[74] Mannix, *With the End in Mind*, 61.

[75] Mannix, *With the End in Mind*, 67.

[76] Mannix, *With the End in Mind*, 67.

[77] National Council on Disability, *The Danger of Assisted Suicide Laws*, 22.

[78] Ministry of Health, *Assisted Dying Service*.

[79] Michael Nestmann, "Your request for official information, reference: HNZ00075034," (Health New Zealand, 31 January 2025).

[80] Ministry of Health, *Review of the End of Life Choice Act 2019*, 62.

have a C-section, while others prefer the surgical option but give birth naturally first. This doesn't reflect failings in the health system. We already have the right to choose between reasonable options; we will never have control over natural processes.

The one, irreversible choice of euthanasia precludes all other choices. People who desire suicide urgently may not get their wish if there is a waiting period; with no waiting period, people whose suffering could have been eased will instead have a premature death. Thanks to the legalisation of euthanasia, we must answer this question: which is worse?

Waikato physician Dr Lara Hoskins had a patient repeatedly beg her to help her die, "only to thank her weeks later for keeping her alive—for giving her more time with family." After more than a decade treating dying patients, Hoskins has witnessed more than one patient abandon a wish for euthanasia. One had plans to commit suicide once he needed hospice care. Instead, Hoskins said, "he established close relationships in the hospice and was able to enjoy the end of his life, including gardening there."[81]

Numerous stories from palliative care specialists illustrate that when patients who wish to die receive care that eases their anxiety about death, they are likely to change their minds. The Ministry's 2024 review never addresses this possibility. It says, in passing, that introducing a cool-down period—during which such needs could be addressed—would only "marginally" improve safety.[82]

How do we measure that margin, and are we failing the people who fall into it?

Say when

The Ministry's 2024 review of the euthanasia legislation also identified issues with the requirement that applicants choose the date of their death. Some found the task confronting. Others wanted to change the date as time went on—which they are free to do. However, submitters reported that having a fixed date created unwelcome pressure to follow through, particularly when loved ones were planning to take part in end-of-life events.[83]

The review suggested removing the need to set a date at the time of approval, but that is no solution; the same challenges will appear whenever patients choose the date. The review never addresses the actual problem: we do not know how we will feel physically or emotionally at any point in the future.

The choice afforded a patient to set the date of their death at one point in time necessarily constrains their choices at a future date—eliminating choice altogether after the chosen hour.

Perverse incentives to die sooner

The End of Life Choice Act (2019) requires mental competence both at the time of application and the time of death. This is necessary to reduce the possibility of those with dementia or other mental disabilities being coerced into an early death by someone who would find that more convenient or profitable. So, those who anticipate mental decline from dementia or conditions like a brain tumour take a gamble when they choose their date of death. If they set it too late, they may not be competent to consent on the day and will die naturally. If they set it too early, they may not feel ready to die but will have all the pressure of expectations.

THE CHOICE FOR VOTERS

The End of Life Choice Act (2019) came into force the year after a public referendum in 2020, where 65% of voters approved it. The architects of the bill were open about the fact that they allowed more restrictions to euthanasia access than they preferred in order to gain the necessary support from the public and MPs.[84] However, the Government's public summary of the bill omitted a detail that made the legislation appear to have tighter eligibility criteria than it does. A post-election survey found that this may have materially affected the outcome.

Of the respondents to an October 2020 Curia poll, 66% had voted "yes." Most believed, per the government's information flyer and referendums website, that one of the criteria for eligibility was "unbearable suffering that cannot be relieved." The legislation in full, however, stipulates that the suffering "cannot be relieved *in a manner that the person considers tolerable*." Had respondents known that they were making assisted dying available to terminally ill people "for whom treatment exists that could relieve their suffering," 38% of those who voted "yes" would have voted

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[81] Ellen O'Dwyer, "Waikato doctors speak out about euthanasia," *Waikato Times*, 10 September 2020.

[82] Ministry of Health, *Review of the End of Life Choice Act 2019*, 62, 149.

[83] Ministry of Health, *Review of the End of Life Choice Act 2019*, 68.

[84] Jo Moir, "End of Life Choice Act: Changes needed in review, say advocates," RNZ, 23 April 2024, https://www.rnz.co.nz/news/political/514951/end-of-life-choice-act-changes-needed-in-review-say-advocates.

"no." This, in the election, would have reduced support to 40% and ended the bill's life.[85]

This is just one example of how the quality of information impacts the quality of our decisions. "End of life choice" is not a clinical, legal or scientific phrase; it is an emotive one. And the discussion around legalising euthanasia was also an emotive one, appealing to the desire to ease suffering without addressing the reasons for that suffering or the new challenges euthanasia introduces.

THE CHOICE FOR MEDICAL PROFESSIONALS

Palliative care physicians, who spend most of their professional careers with those at the end of their lives, are overwhelmingly opposed to offering it as an option. Canadian doctors writing in the *World Medical Journal* explain the way it compromises patient care:

> *In our clinical work with other suffering or "hopeless" patients we will inevitably be weighing in our minds the question of whether killing the patient would be in their best interest. It is very difficult to be continually moving between the vision of classical medical care (to cure sometimes, relieve often, and console always) and the idea of killing this person. It's like continually shifting our car's gears back and forth, between forward and reverse. This severely grinds the gears. It creates too much stress in us to cope with, so we have to reduce the gear-shifting. We can do this either by suppressing the "reverse" to euthanasia, thus failing our society in its desire for euthanasia, or else by restraining the "forward", namely our professional calling to give of ourselves to the maximum care for patients in dire circumstances. Society will therefore suffer in the quality of care it gets from its physicians.*[86]

In the UK, where there have been repeated attempts to legalise euthanasia, the Royal College of Physicians reported that only 24.6% of its fellows and members would be prepared to participate in assisted dying if the law were to change.[87] In a 2015 statement, it said that "with improvements in palliative care, good clinical care can be provided within existing legislation, and that patients can die with dignity."[88]

In New Zealand, only a "small group of practitioners" have opted in to receive referrals through the Assisted Dying Service to provide euthanasia.[89] Unlike prescribing morphine to keep someone comfortable, actively ending someone's life is not a task that medical professionals train for. In fact some, including a number of Kiwi professionals, do not define it as "health care."[90] The Ministry of Health acknowledged this in its review of the euthanasia legislation: "The right to conscientiously object is upheld under section 13 of the New Zealand Bill of Rights Act 1990, which provides that 'everyone has the right to freedom of thought, conscience, religion, and belief, including the right to adopt and to hold opinions without interference.'" It states that this allows practitioners to decline to "provide or interact with the service on the basis of personal, moral, religious or ethical beliefs"—including the "ethical commitment to 'do no harm.'"[91]

Yet the Ministry argues that conscientious objection comes into conflict with "consumer rights"—specifically, the right to services of an appropriate standard and the right to be fully informed. The Ministry's position is that the patient's right to access euthanasia trumps the physician's right to decline to assist with access to euthanasia. It also advocates for removing the requirement that practitioners tell a patient if they have a conscientious objection, lest it make the patient feel that "a judgement has been passed on them."[92] This approach is designed to normalise euthanasia, not simply guarantee access to it. It treats low levels of buy-in from medical professionals as a hurdle, not a sign.

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

86 Herx, Cottle, and Scott, "The 'Normalization' of Euthanasia in Canada."

87 "2019 assisted dying survey results," 2019, https://www.rcp.ac.uk/news-and-media/news-and-opinion/2019-assisted-dying-survey-results-no-majority-view-moves-rcp-position-to-neutral/.

88 Keown, "The Slippery Slope Arguments," 73.

89 Ministry of Health, *Review of the End of Life Choice Act 2019*, 85.

90 "An open letter from doctors around the world to medical ethicists and lawmakers," 2023, https://doctorssayno.net/.

91 Ministry of Health, *Review of the End of Life Choice Act 2019*, 83.

92 Ministry of Health, *Review of the End of Life Choice Act 2019*, 84-85.

The Ministry of Health also recommends removing the restriction on broaching the topic of euthanasia with patients in discussion of end-of-life care. And it goes even further—advocating for it to be included alongside health services.[93] Canadian doctors already face this scenario. Writing in opposition to the undermining of conscientious objection, doctors have pointed out that this "is the very first time in Canada that the burden of ensuring access to other parts of the health care system has rested on the individual physician. ... in no other clinical situations are physicians required to discuss all potential options and procedures if they determine that those options are not medically indicated."[94]

In Ontario, as in New Zealand, the justification for this pressure is "ensuring access" despite no evidence that anyone lacks access. New Zealand's own review observed widespread awareness of euthanasia's legalisation.[95] This matter has gone before courts in Ontario, which have ruled that requiring physicians to refer patients "violates the conscience/religious rights of physicians (which are protected under the Canadian Charter of Rights and Freedoms)."[96]

The Ministry of Health does not acknowledge that there are valid reasons to opt out of participating in euthanasia. It identifies that "Some communities' tikanga (customary values) are not aligned with or supportive of assisted dying," and that "some held the view that the wairua (spirit) belongs to God, and the body should be allowed to perish naturally."[97] This belief—shared not just by many Māori, but also by many faith communities—is one that the Ministry considers misguided. Regarding Māori whānau who consider euthanasia to be the same as suicide, they write "that this points to a lack of awareness and acceptability of assisted dying within Māori communities and an urgent need for assisted dying to become familiar, understood, and accepted."

Is it the Ministry of Health's job to normalise a practice that a significant, diverse cross-section of New Zealanders objects to? In a democratic society, government agencies should honour people's traditions—particularly those that honour life—rather than take a paternalistic stance. The "urgent need" that the Ministry sees for segments of society that would not choose euthanasia to learn to accept it seems antithetical to "choice." Members of cultural, spiritual and professional communities that do not choose to access euthanasia are not preventing anyone else from doing so.

Contrast the Ministry of Health's statements with the principles expressed in Western Australia's Voluntary Assisted Dying Act 2019: "all persons, including health practitioners, have the right to be shown respect for their culture, religion, beliefs, values and personal characteristics."[98]

Mandating the participation of physicians will not increase the options available to patients; rather, it would undermine networks that already provide end-of-life care. This is the experience of Canadian care providers:

> *Palliative care clinicians have a high level of burnout, and the perceived lack of control over the scope of practice and forced participation in something that goes against their convictions about the very core of their vocation may be contributing to increasing moral distress and moral injury. This is reflected in colleagues who come to us on a daily basis to share experiences of repeated distress from euthanasia cases. Even colleagues who support euthanasia in some circumstances have reported experiencing this serious distress at times. Moral distress and moral injury manifest as early retirements, leaves of absence, and career changes by physicians who will no longer provide palliative care due to the expectation that euthanasia is included in the scope of practice. Additional moral distress is experienced by some palliative care leaders when health region administrators arbitrarily put euthanasia administration and oversight into the "end of life care" portfolio. The probable loss of palliative care physicians from the workforce at a time when even more clinicians are needed is in part a direct consequence of such stressful situations and heavy-handed measures.*[99]

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[93] Ministry of Health, *Review of the End of Life Choice Act 2019*, 82.

[94] Herx, Cottle, and Scott, "The 'Normalization' of Euthanasia in Canada," 33.

[95] Ministry of Health, *Review of the End of Life Choice Act 2019*, 130.

[96] Herx, Cottle, and Scott, "The 'Normalization' of Euthanasia in Canada," 33.

[97] Ministry of Health, *Review of the End of Life Choice Act 2019*, 141, 44.

[98] Ministry of Health, *Review of the End of Life Choice Act 2019*, 125-26.

[99] Herx, Cottle, and Scott, "The 'Normalization' of Euthanasia in Canada," 34.

> *"Hospice Whanganui deeply respects the choice of all New Zealanders to choose how they want to die, and we want our service to be a safe place for everyone. We are careful to ensure, however, that our patients and whānau know that palliative care (provided by Hospice) is separate from assisted dying services (provided by independent Government-approved clinicians). These services can, and do, work closely with each other, but they are not the same thing and we will continue to strongly advocate for these two services to remain independent of each other."*[100]

THE CHOICE FOR CARE PROVIDERS

In 2020, ruling on a declaration sought by Hospice NZ (Hospice New Zealand v Attorney-General), the High Court of New Zealand said that the Ministry of Health could not compel service providers, such as hospices, to provide assisted dying services.[101] The Ministry's own review lists reasons why most care facilities and all but one hospice provider don't want euthanasia on site: "a belief that assisted dying and palliative care are distinct or incompatible, noting the ethos of palliative care ... 'neither to hasten nor postpone death' ... preserving a reputation for providing end-of-life care, or wanting to avoid a reputation as a location for assisted deaths ... to avoid discomfort for other residents living in the same facility ... to avoid tension with staff who may hold a range of perspectives on assisted dying."[102]

Euthanasia is at odds with the way many facilities provide end-of-life care. The Ministry, however, has proposed that all of them should now allow access so that residents who want euthanasia will not be inconvenienced. It does this without addressing real concerns of palliative care professionals, other residents, and care home employees—ignoring protections to freedom of conscience that are guaranteed by law.[103] The Ministry considered, but then rejected, obvious compromises, such as requiring that facilities inform potential residents if euthanasia may not be performed on site. And it goes so far as to recommend that care facilities forfeit their certification if they will not provide access to euthanasia.[104]

Ironically, one of the Ministry's reasons for wanting to require all care facilities to provide access is that unequal access would "entrench inequity of access for those living in care facilities, and particularly for those living in rural areas who may have fewer options for facilities available to them." However, the Review Committee has already observed a higher uptake of euthanasia in rural communities.[105] Everyone can access euthanasia there, though they may need to go to a private residence; few have the option of palliative care.

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[100] "Our Position on Assisted Dying," accessed 16 April 2025, https://hospicewhanganui.org.nz/about-us/end-of-life-choice-act/.

[101] "Hospice New Zealand v Attorney-General [2020] NZHC 1356," (16 June 2020).

[102] Ministry of Health, *Review of the End of Life Choice Act 2019*, 88, 95.

[103] Ministry of Health, *Review of the End of Life Choice Act 2019*, 16.

[104] Alex Penk, "Euthanasia review reveals a flawed law and proposals to erode conscience rights," 12 December 2024, https://www.ethosalliance.nz/articles/euthanasia-review-reveals-a-flawed-law-and-proposals-to-erode-conscience-rights.

[105] Ministry of Health, *Review of the End of Life Choice Act 2019*, 96.

CONCLUSION

In order to guarantee people the best death, we need to discipline our health system—prioritising training, and resourcing the people and places that provide end-of-life care. The short-term costs will be a wise investment; a well-resourced, self-sustaining network of hospices and palliative care specialists will reduce more expensive hospital stays, improving both the affordability and the quality of end-of-life care. While no one disputes this in theory, it has yet to be put into practice. The 2017 Palliative Care Action Plan, despite its name, has not translated into action.

The End of Life Choice Act (2019) was introduced in New Zealand under the banner of expanding personal freedom. But choice, to be meaningful, must be more than the removal of barriers to one option. It needs to present real alternatives to an informed public. Systemic inequities, limited provision of palliative care, diagnostic uncertainty, psychological vulnerability, and the realities of coercion—overt or subtle—all distort the choices available to us at the end of our lives.

The Ministry of Health's 2024 review of the Act focuses heavily on improving ease of access to euthanasia while downplaying structural shortcomings. It treats the speed and simplicity of ending life as hallmarks of a compassionate system, without recognising that the best death is not always the "easiest" death. A system that presents the fastest, cheapest, and most final solution as the most rational one is unlikely, of its own accord, to begin offering patients better care and information.

Freedom to choose is the moral foundation of New Zealand's euthanasia legislation, so we have a duty to safeguard the quality of those choices. It cannot end with minor adjustments to who can access lethal drugs. The health system must also offer hope, uphold dignity, and provide compassionate alternatives to each person—ending the postcode lottery that denies many people the "good death" they prefer.

The following recommendations are offered to better align both policy and practice with the goal of universal choice. They draw on Maxim's 2021 recommendations in *Ending Well: The urgent case for accessible palliative care*—all of which remain applicable.

RECOMMENDATIONS

1. **Improve public awareness of essential end-of-life information**
    a. Health NZ should increase public awareness of end-of-life care options, particularly in spaces where people access primary care.
    b. Increase "death literacy" in much the same way, reducing fear and pointing people toward places where support is available.
    c. Create partnerships with organisations already involved in raising awareness, such as Hospice NZ, to expand capacity and reach.
2. **Provide universal access to palliative care**
    a. Health NZ should collect and consistently report data on the provision and availability of palliative care services in New Zealand.
    b. The Ministry of Health should evaluate and address specific barriers to accessing palliative care, from regional and cultural factors to financial ones.
    c. Along the lines of amendments to the UK's Health and Care Bill in 2022, legislation in New Zealand should guarantee equal access to palliative care and resource Health NZ to address all barriers.
    d. The Government should increase hospice funding to levels that support community need. This would be roughly double the current capacity both for in-hospice care and for specialist staff who support and advise primary palliative care providers.
3. **Prioritise training in palliative care**
    a. Improve end-of-life training for physicians at every level. Ensure all primary carers and residential care staff are continually improving their understanding of care options and their ability to communicate compassionately with dying patients and their whānau.
    b. Ensure undergraduate palliative care training is part of medical and nursing degrees.
    c. Increase the number of specialty palliative care physicians.
4. **Fortify protections around euthanasia**
    a. Give the Review Committee for assisted dying the authority to commission Health New Zealand to investigate any safety signals or trends they find concerning—particularly if a region or demographic is disproportionately represented in euthanasia cases.
    b. Reject the Ministry of Health's recommendations that undermine conscience rights for doctors and operating principles for care facilities.
    c. Reject proposals to widen eligibility to patients who do not have a terminal diagnosis of six months.
    d. Amend the End of Life Choice Act (2019) so that the Registrar is required to pause any application that does not have all the required information.
    e. Amend the End of Life Choice Act (2019) to require a cooling-off period following an application for euthanasia, in line with other jurisdictions.
    f. Amend the End of Life Choice Act (2019) to specify that at least one of the two physicians approving an application specialise in an area relevant to the terminal diagnosis, and one specialise in psychiatric care. This is in the interest of minimising inevitable prognostic and diagnostic errors and increasing the opportunities to identify coercion and unexplored treatment options.

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