‘A different type of death’. Māori bereavement experiences following an assisted death

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Background
The End of Life Choices Act (2019) provides a new end-of-life option for New Zealanders. Without appropriate information and navigational support to guide and prepare whānau (Māori families, including extended family), the Act can create further inequities for Māori. Indeed, the voices of bereaved whānau need to be heard to ensure they are adequately supported in their loss and grief.

Objectives
The Waerea study explored Māori whānau experiences of accessing and engaging with Assisted Dying services and how they used and adapted their tikanga (customs) to navigate this new end-of-life option. We also wanted to understand their bereavement experiences.

Design
Qualitative Kaupapa Māori Research methods were used to investigate Māori whānau experiences of using Assisted Dying services and bereavement.

Methods
Thirty six interviews were undertaken with over fifty whānau participants who were recruited from across New Zealand using Māori research and community networks. Over twenty support workers (assisted dying clinicians, rongoā (natural healing) practitioners, spiritual leaders, health professionals and funeral directors), were interviewed about their experiences of caring for people who had an Assisted Death. An inductive thematic analysis was used to analyse the data.

Findings
Assisted dying is a different type of death, and new to Māori families. Although the number of whānau using Assisted Dying services is comparatively lower than non-Maori, the impact of loss and grief on whānau is significant. Whānau were proud of their deceased family member’s decision to have an Assisted Death however, the shock, trauma, guilt, and distress they experienced was overwhelming. They identified a lack of bereavement support.

Conclusion
Whānau require access to culturally appropriate information and resources about Assisted Dying's criteria, safeguards, assessment processes and the procedure to help them plan and prepare for an Assisted death as this will also support bereavement. New healing approaches are urgently needed.

10 Lessons learned: 9 years of MAID, palliative care and the intersection of dying

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Medical Aid in Dying became legal in Canada in 2016. Palliative care clinicans across the country were concerned for the profession and their patients. In the almost ten years since legalization, there have been significant changes to palliative care services. The province of Newfoundland, with it's huge size and limited population, is somewhat of a reflection of the larger country. In reviewing how our palliative care service adapted to patient's requesting MAID, how we navigated working with clinicians and patients who did not want MAID, we learned valuable lessons, that could be of benefit for places who are considering this legal end of life option.

Ten key lessons were learned in reviewing the implimentation and growth of MAID.

1. New laws require new funding
2. Palliative care did change: just not the way we anticipated
3. Medical College policies should be written by an active MAID practitioner
4. Patients like to be creative: do what you can to fascilitate this
5. The fewer providers, the greater the strain
6. Non-terminal cases can be fraught with concerns: teamwork is key
7. Keep thorough statsitics and data
8. Develop protocols and guidance for staff dealing with mental health patients
9. All palliative care clinicians can work colleagially together, regardless of their involvement with MAID
10. Patients and staff drive change. (Where you start isn't necessarily where you end up)

Assisted Dying in Detention in the Netherlands: Legal Framework, Practice, and Ethical Dilemmas

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In the Netherlands, euthanasia in detention is rare but not inconceivable. As with individuals living in freedom, prisoners may also qualify for euthanasia. Yet such cases raise distinctive issues that do not emerge in free society.

This session examines the legal framework, practical considerations, and ethical dilemmas surrounding euthanasia in detention. Central questions include: To what extent do such requests arise from the fact of imprisonment, sometimes with no realistic prospect of release? Can a detainee’s request genuinely be regarded as voluntary? Who determines whether such a request may be granted, and how are assessment and potential implementation organized?

Particular attention will be paid to relevant case law of the Regional Euthanasia Review Committees and to the Euthanasia Work Instruction of the Dutch Custodial Institutions Agency.

Assisted dying: supporting moral uncertainties and challenges for nurses in clinical practice

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Assisted dying (AD) is a legal medical service in 13 countries and ten U.S. states. Scotland is now considering the Assisted Dying for Terminally Ill Adults (ADTIA) Bill (2024), with a parliamentary vote anticipated in Autumn 2025. Despite nurses being the largest healthcare workforce and central to end-of-life care, their role remains largely absent from the Bill, referenced only in defining healthcare professionals and in disposal of unused medication. This omission risks overlooking the ethical and professional implications for nurses, who provide 24/7 care for those with life-limiting illness.

International evidence highlights nurses' critical contributions to AD, including receiving initial requests, supporting families, educating staff and patients, administering pre-emptive medication, and delivering bereavement support (Pesut et al., 2019; Sandham et al., 2022). However, no research to date has explored these issues from a Scottish perspective, leaving a significant gap in understanding how nurses anticipate and navigate the moral and ethical challenges of AD service provision.

This study uses qualitative narrative inquiry (Riessman, 2008) to explore nurses' perspectives on the ADTIA Bill. NMC-registered nurses across Scotland, offering insight into anticipated challenges and supports required for practice.

Aim: To explore Scottish nurses' moral and ethical uncertainties regarding AD.
Objectives: (1) Identify key uncertainties and challenges; (2) Explore supports needed for implementation and delivery; (3) Examine concerns about nurses' roles in AD provision.

Findings will provide timely evidence to inform Scottish Government policy, professional guidance, and support structures at a pivotal point in Scotland's legislative history.

Between Law and Loss: Understanding Relatives' Involvement in Austria's Assisted Suicide Process

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On January 1st, 2022, Austria legalised assisted suicide through the introduction of the Dying Decree Law. The law established a structured procedure requiring the person wishing to die to undergo two separate consultations with physicians. Only 12 weeks later can they establish a dying decree with a notary or a patient lawyer. When establishing a dying decree, the person who wishes to die can name an assisting person, who is legally allowed to aid with tasks, such as picking up the lethal supplement from the pharmacy. As of now, there is only limited research on assisted suicide in Austria, none of which centers on those most involved- the relatives who are present until the very end and often named as assisting persons.

To discern what roles relatives play throughout the process of arranging an assisted suicide, we have conducted semi-structured interviews with relatives of individuals who wish to, are currently or have already established a dying decree. The study explores the barriers they faced, the function they assume, and the emotional complexity they experienced in the pre- and postmortem phases.

We will present our findings at the conference. Early analysis reveals key themes including situational altruism, anticipatory grief and patterns in bereavement reaction.

By focusing on a group that is essential in social care at the end of life, as seen in theory and practice, this study offers an important insight into how relatives of people who turn to assisted suicide in Austria navigate legally coordinated death. This study aims to inform future policy developments, give a clearer understanding of what legal immunity is in providing aid in the lead-up to assisted suicide, and highlight the invisible labour of relatives at the end of their loved ones' lives.

Challenges of Legalizing Voluntary Assisted Dying in East Asia: A Comparative Analysis

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This paper examines the current status and challenges of Voluntary Assisted Dying (VAD) legislation in East Asian countries, with comparative reference to European, Australian, and New Zealand systems. While VAD has been legalized and operationalized in jurisdictions such as the Netherlands, Belgium, Canada, and several Australian states, East Asian nations—including Japan, South Korea, Taiwan, Hong Kong, Singapore, and Thailand—continue to classify assisted suicide as a serious criminal offense. Although frameworks for withholding or withdrawing life-sustaining treatment and palliative care exist, active VAD implementation faces multilayered barriers rooted not only in constitutional and statutory frameworks but also in social, cultural, and ethical norms. Confucian family ethics, Buddhist non-harm principles, and collective social values contribute to societal resistance, emphasizing preservation of life and the implications for families and communities. In Japan, legislative and policy deliberations on medical ethics exemplify a distinctive approach, shaped by multi-party consensus, expert advisory committees, and broad societal consultation. This cautious, risk-averse framework emphasizes gradual development over rapid legal reform, allowing the establishment of end-of-life care guidelines that recognize patients' rights to refuse treatment while stopping to discuss active VAD. Similarly, in the legal context, cases are often addressed through mitigation measures rather than definitive judicial rulings, reflecting a broader preference for incremental, consensus-driven solutions that balance ethical and social considerations. Comparative analysis underscores that differences between East Asian and Euro-Australian systems manifest in challenges such as cross-border medical practice, international normative divergence, and "suicide tourism." These gaps highlight the need for context-sensitive policy design that simultaneously respects patient autonomy, prevents abuse, safeguards vulnerable populations, and aligns with prevailing social and ethical norms. By situating VAD within East Asia's distinctive cultural, ethical, and legislative contexts, this study provides a comprehensive perspective for scholars and policymakers navigating the intersections of law, medicine, and ethics in end-of-life decision-making.

Chronic Obstructive Pulmonary Disease Prognostication in Voluntary Assisted Dying: A Case Series and Practitioner Perspectives

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Chronic Obstructive Pulmonary Disease Prognostication in Voluntary Assisted Dying: A Case Series and Practitioner Perspectives

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Background:
Voluntary Assisted Dying (VAD) legislation in Queensland, effective since January 2023, has introduced new complexities in clinical decision-making, particularly for patients with Chronic Obstructive Pulmonary Disease (COPD). COPD presents a variable and often unpredictable disease trajectory, making prognostication challenging—especially when determining eligibility for VAD, which requires an expected death within 12 months.

Aim:
To explore the variability and challenges in COPD prognostication within the VAD framework and to understand the perspectives and practices of VAD practitioners across Queensland.

Methods:
This prospective study includes a case series of three patients with end-stage COPD who accessed VAD, alongside a statewide survey of VAD practitioners. Data sources include IEMR chart reviews, REDCap entries, and practitioner surveys. The study investigates clinical criteria used, respiratory physician input, and practitioner attitudes toward prognostication.

Results (anticipated):
Preliminary findings suggest significant variability in prognostic approaches and uncertainty among practitioners regarding COPD eligibility for VAD. The study aims to identify barriers to consistent prognostication and highlight the need for standardised tools and guidelines.

Conclusion:
This research addresses a critical gap in Australian literature regarding COPD and VAD. By examining real-world cases and practitioner insights, the study seeks to inform clinical practice, improve patient communication, and support policy development for clearer prognostic pathways in VAD eligibility assessments.

End of life decisions in mental health care: perspectives of relatives and health care professionals

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Background – Medical Assistance in Dying (MAID) has a profound emotional impact on patients and their relatives. Although not formally involved, guidelines recommend including relatives. This workshop explores relatives' and health care professionals' experiences with MAID and advance care planning (ACP) in persons with a psychiatric condition in the Netherlands.

Design – An online survey in the general population (n=2392) compared relatives' emotional responses to MAID, based on somatic versus psychiatric grounds. Linear regression assessed whether the underlying condition influenced relatives' emotions after and involvement in the MAID process. Next, a Group Concept Mapping (CGM) study (mixed-methods participatory design) engaged 163 mental health professionals and relatives to identify views on good ACP/MAID in mental health care. Finally, a qualitative case study examined relatives' and key actors' perspectives during the end of life phase of a patient with psychiatric illness.

Results- The survey included 616 relatives who had experienced MAID (n=110; 17.8% due to a psychiatric condition). Relatives' emotional experiences were largely similar regardless of the underlying condition, suggesting that the generally neutral to positive attitudes towards euthanasia seen in somatic cases also apply to psychiatric cases. However, stronger feelings of powerlessness and guilt in relatives involved in psychiatric MAID may require targeted attention. This was underscored by the CGM study, which emphasized the importance of self-care for health care professionals involved in end of life decisions, and by the case study, which highlighted feelings of powerlessness among relatives and health care professionals during en-of-life care.

Conclusions – Together, these three studies show that feelings of powerlessness and guilt among relatives and health care professionals require targeted support and guidance throughout both palliative care and MAID in psychiatric patients.

Grieving the Chosen Death: A Synthesised Grief Framework for Assisted Dying

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The implementation of New Zealand's End of Life Choice Act in 2021 introduced assisted dying (AD) as a legal end-of-life option, fundamentally reshaping experiences of death and grief. By March 2025, 1,210 individuals had died using AD, affecting the grief experiences of both patients and families due to the planned and collaborative nature of the process. Despite families' active involvement in caregiving and AD planning, their grief remains underexplored, particularly in the New Zealand context.

This study explores how grief theories help explain the unique experiences of AD-related grief. Using an appreciative inquiry approach, we interviewed 46 participants (eligible and ineligible for AD) and their families, representing 42 deaths. A whole-team coding approach informed our inductive-deductive analysis of grief expressions through the lens of established grief theories.

Findings reveal that anticipatory grief during AD unfolds through two interconnected sets of activities: advocacy work (e.g., navigating the AD process, sharing information, and planning logistics) and legacy work (e.g., engaging in rituals, memory-sharing, and creating final experiences). These activities support emotional, cognitive, and behavioural preparation for death and contribute to meaning-making. Post-death, families continue this process through public advocacy and remembrance, forming continuing bonds. This grief experience aligns with the dual process model, where individuals oscillate between loss-oriented (focused on confronting and processing the emotional impact of the death) and restoration-oriented (focused on adapting to life changes and rebuilding after the loss) coping. The intentional and often stigmatised nature of AD shapes a distinctive grief trajectory, offering new insights into AD bereavement.

Hospice and Palliative Care Social Workers' Perspectives on Minimal Comfort Feeding in Advanced Dementia

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Hope Wechkin and colleagues published the first paper on Minimal Comfort Feeding (MCF) in February of 2025. The MCF approach is designed as an option for people in the advanced stages of dementia who have previously expressed the desire to not have their dying prolonged in the end stages of disease. Comfort Feeding Only (CFO) is the standard palliative practice towards nutrition and hydration in advanced dementia; it provides scheduled handfeeding as long as the person with dementia is receptive to eating. MCF is being proposed as a compromise between VSED and CFO; patients receiving an MCF approach do not have scheduled mealtimes but continue to receive limited food and hydration to avoid discomfort if they appear distressed. An MCF approach to end-of-life care shortens dying from months or years to weeks. The purpose of this study was to find out from practicing social workers their thoughts and perspectives related to this new end-of-life option. Online (RedCap) survey data were collected after a presentation about MCF at the 2025 conference of the Social Work Hospice and Palliative Care Network (SWHPN) in Minneapolis, Minnesota (USA). Respondents include 76 licensed Masters prepared social workers (MSW), over half of whom reported being credentialed in palliative care. Survey items included demographic information, work setting, social work experience with people with dementia and people who had requested the withholding of food and drink, perspectives on comfort levels discussing MCF with patients and families, opinions about family openness to MCF as well as whether the respondent would elect MCF for themselves, if diagnosed with dementia. Results indicate openness to the concept of MCF, concerns about implementation feasibility and family acceptability, although the majority indicated they would elect MCF for themselves, should they find themselves in the situation.

Relatives' needs in terms of bereavement care throughout euthanasia processes: A qualitative study

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Background: A death-related loss is a profound experience that typically affects five to nine relatives and may have lasting implications for their health and well-being. While most individuals are able to cope with bereavement, a small minority experience persistent and debilitating grief that significantly impairs daily functioning. Tailored bereavement care can reduce the risk of such complications. However, in the context of assisted dying, it remains unclear how best to provide care that is responsive to the specific needs of bereaved relatives.

Aim: This study aims to explore the bereavement care needs of relatives involved in euthanasia processes, examine how healthcare providers respond to these needs, and assess the degree of alignment between relatives’ and providers’ perspectives.

Methods: A phenomenological approach was used, employing reflexive thematic analysis of interviews with relatives (N = 19) and healthcare providers (N = 47).

Results: Five main themes and several subthemes emerged, reflecting relatives’ needs throughout the euthanasia process. Both groups (relatives and healthcare providers) reported similar patterns. Although relatives infrequently communicated their needs explicitly to healthcare providers, they appreciated it when staff proactively met their needs. Healthcare providers aimed to assist with the relatives' grief process by tending to their specific needs. However, aftercare was not consistently offered, but relatives did not have high expectations for professional follow-up care.

Conclusions: This study highlights key strategies for healthcare professionals to provide needs-based bereavement care during euthanasia processes. It also emphasises the importance of recognising the unique needs of relatives and proactively addressing them in the period before the loss to positively contribute to relatives' grief process.

Voluntary Assisted Dying and General Practice: preferences for education and perceptions in Queensland

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Background and Aim
Voluntary assisted dying (VAD) was enacted in Queensland in 2023 and provides an additional end-of-life option for eligible individuals. General practitioners (GPs) play an important role in the planning and provision of end-of-life care, yet they report a lack of confidence when responding to patients seeking VAD. GPs need to be well educated about VAD legislation and related professional obligations to ensure patients are well-informed about end-of-life options. This study considered GPs' preferred learning methods about end-of-life care and explored GPs' perceptions of VAD.

Methods
GPs chose one of three educational modalities (in-clinic academic detailing, lunch and learn sessions with their peers or an educational dinner) and then completed a voluntary survey. Survey data was analysed using both descriptive statistics and the Consolidated Framework for Implementation Research (CFIR). CFIR allowed for assessment and categorisation of barriers and facilitators for GPs discussing VAD in their clinical practice.

Findings/Results
197 of 789 invited GPs attended educational sessions, 183 completed the survey. Lunch and learn sessions were the preferred modality (n=116, 59%), however all modalities increased knowledge and confidence about VAD. Only academic detailing changed GPs' consideration of becoming VAD practitioners (n=23, 61%). Most barriers and facilitators for VAD conversations related to individual factors including personal beliefs, motivation, knowledge, and clinician-patient relationships.

Conclusion
All three education modalities improved GPs' knowledge of VAD in the end-of-life care context, although small-group interactive lunchtime session was a preferred modality. For clinicians, increasing knowledge and confidence about VAD can help them inform patients about their end-of-life options and to make informed decisions about their future care. GP educators could consider offering multiple modalities incorporating elements of convenience and peer interaction, to suit individual preferences. VAD discussion barriers and facilitators could facilitate future implementation strategies for education and behaviour change interventions.