ORIGINAL ARTICLE
QUALITATIVE RESEARCH

# **Supporting choice, preventing harm:** Social workers' knowledge gaps and ethical challenges with assisted dying in Aotearoa New Zealand

**Laura Ann Chubb, Harriet Nickels, Liz Beddoe, Georgina Guild** and **Eileen Joy,** School of Social Practice University of Auckland, Aotearoa New Zealand.

## ABSTRACT

**INTRODUCTION:** This study is the first of its kind to explore social workers' perspectives on assisted dying following the legislation of the End of Life Choice Act 2019 in Aotearoa New Zealand. The topic is ethically complex and legally regulated, making social workers' perspectives particularly valuable since they may increasingly engage with people facing end-of-life decisions in settings like hospitals, hospices, aged care facilities, and palliative care programmes.

**METHOD:** Data were collected through an anonymous online qualitative survey from September to December 2023, capturing a diverse range of views from 120 social workers in Aotearoa New Zealand.

**FINDINGS:** Three themes were constructed from the data using Proudfoot's (2023) hybrid thematic coding strategy: 1) "some semblance of choice": navigating client autonomy, 2) "be careful": managing ethics, coercion and risk, and 3) "just my own research": limited knowledge and training. Participants noted the tension between upholding clients' rights to choose while being mindful of personal and external pressures that may influence decisions, especially among vulnerable groups. Participants also expressed a need for more precise guidelines and more training to handle the ethical dilemmas posed by assisted dying in a manner that is thoughtful, competent, and appropriate.

**IMPLICATIONS:** These findings suggest that social workers play a crucial role in mediating between client autonomy and protection. By understanding the ethical challenges and systemic barriers in assisted dying, social workers can better advocate for transparent policies and improved training, equipping them to provide better support to clients in their end-of-life decisions.

**Keywords:** Assisted dying, medically assisted dying, social work, MAiD

In 2019, the End-of-Life Choice Act (henceforth named 'the Act') was passed, granting permanent residents and citizens of Aotearoa New Zealand the right to end their lives through medical intervention (NZ Government 2019). The Act's purpose is to "give persons who have a terminal illness and who meet certain criteria the option of

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**CORRESPONDENCE TO:**
**Laura Ann Chubb**
*l.chubb@auckland.ac.nz*

lawfully requesting medical assistance to end their lives and to establish a lawful process for assisting eligible persons who exercise that option" (NZ Government, 2019). The New Zealand law requires the person accessing a medically assisted death to be over 18 years old, have a terminal illness that will end their life in under six months, be competent to make the decision and be experiencing physical suffering and defines a competent person as one who understands, retains, and communicates their knowledge and desire for an assisted death (Casey & Macleod, 2021; NZ Government, 2019). People with an intellectual impairment, such as those with dementia, as well as people who wish to access an assisted death due to mental health conditions or who are accessing it only due to being of advanced age, are not eligible for an assisted death (NZ Government, 2019).

Several terms for assisted death exist globally. For example, *medical assistance in dying* in Canada, *voluntary assisted death* in Australia, *assisted suicide*, *physician-assisted suicide*, and *euthanasia* (Blaschke et al., 2019; Hendry et al., 2013). Whilst the process can look different depending on how it is defined, the result remains the same: an eligible and voluntary person is given the right to choose when to end their life (Blaschke et al., 2019; Frey & Balmer, 2021; Hendry et al., 2013). An important caveat to the definition, as cited in Manson (2021), is the intention to end a person's life "with the primary intent of relieving pain and/or suffering at the person's voluntary, repeated, and fully informed request" (p. 27).

In Aotearoa New Zealand, *assisted dying* is the preferred name for the process, and it encapsulates both euthanasia and assisted suicide (Frey & Balmer, 2021; Manson, 2021). Euthanasia is defined as a medical professional intentionally ending the life of a voluntary participant through medical intervention (Feigin et al., 2019; Frey & Balmer, 2021). In comparison, *assisted suicide* is when a voluntary participant is prescribed medication by a professional to self-administer to end their life (Blaschke et al., 2019; Csikai, 1999; Feigin et al., 2019). For this article, the authors subscribe to the terminology used within the Act and use the term *assisted dying* to refer to the process of legally hastening one's death through medical intervention, incorporating both physician and self-induced methods (Feigin et al., 2019; Frey & Balmer, 2021).

Discussions about palliative care, also known as end-of-life care, reflect an assumption that there is competition between palliative care and the introduction of assisted dying (Close et al., 2021; Fuscaldo et al., 2021). A study of healthcare workers ($n$ = 1624) in a regional health service in Victoria, Australia, revealed some participants' hesitancy towards the process, with one stating that palliative care should be a "priority over assisted dying" (Fuscaldo et al., 2021, p. 1639). Some palliative care practitioners have also expressed concerns that due to the legalisation of assisted dying, the public might conflate palliative care with assisted dying and would not want to be involved with them as they may "assume they will be killed off" (Blaschke et al., 2019, p. 565).

Another perspective put forth is the belief that the role of doctors is to heal and preserve life, and allowing them to assist in death could undermine the ethical principles of medicine (Casey & Macleod, 2021; Csikai, 1999; Digby et al., 2022). There is an argument that assisted dying erodes trust in the healthcare system, especially in cases where patients fear their doctors might suggest death as an option too readily. Some clinical staff share their concerns that better palliative care measures could change the mind of someone wanting to access an assisted death (Digby et al., 2022). For instance, Blaschke et al. (2019) quoted a medical professional who believed that their patients "don't have a true wish to die" (p. 565). Rather, they express this wish as a symptom of their condition (Casey & Macleod, 2021; Digby et al., 2022). This raises the question of what quality of life looks like for those with a terminal illness and whether their wish to die is valid given that their symptoms cannot be relieved, and death for some is "viewed with relief" (Feigin, 2019, p. 100).

In Aotearoa New Zealand, the debate between palliative care and assisted dying is complicated by the stance of palliative care services, such as Hospice New Zealand, which practises conscientious objection toward providing assisted dying services, including administering or being present during the administration of a life-ending dose (Hospice Rotorua, 2020; Hospice Whanganui, n.d.). However, many hospice sites reaffirm their commitment to supporting all patients, including those seeking assisted death, despite their non-involvement in the process (Hospice Rotorua, 2020; Hospice Whanganui, n.d.).

Elsewhere, advocates are calling for a more collaborative approach to care, which looks like organisations working together, and an increase in funding and education to empower individuals to choose the best option for themselves (Blaschke et al., 2019; Chowns & Richardson, 2016). Organisations like Palliative Care Australia (2025) support this shift, affirming that their services remain accessible to everyone, including those considering assisted death (Close et al., 2021). Blaschke et al. (2019) asserted the necessity of recognising end-of-life care's complexity.

Social workers are uniquely positioned to advocate for patient autonomy while navigating the ethical boundaries set by law, policy, and healthcare systems. However, there is scant literature on their role in supporting the assisted-dying process in Aotearoa New Zealand, and the evidence base is still in its infancy internationally. The authors of this article conducted an exploratory qualitative study that invited registered social workers to respond to a set of questions about their views on abortion, transgender rights and assisted dying. In all three topics, there had been significant recent legislative change, and we were interested in social workers' views and understandings of these changes. This article shares findings related specifically to social workers' perspectives on assisted dying, focusing on their experiences, knowledge, and roles within this sensitive practice area. We begin by presenting the context for assisted dying in Aotearoa New Zealand, followed by a synthesis of the evidence on the social worker's role in the practice. Then, the authors present and discuss findings from the study on how social workers perceive their role in supporting clients, the ethical challenges they face, and the training and systemic barriers that impact their capacity to engage in assisted dying cases.

## The process for assisted death in Aotearoa New Zealand

The process of accessing an assisted death takes time and involves interacting with multiple people (Fuscaldo et al., 2021). The person must formally request an assisted death from a medical professional who has a range of responsibilities, including informing the person of their prognosis in writing and the processes are outlined in government policy (NZ Government, 2019; Ministry of Health, 2021). In an attempt to safeguard potentially vulnerable people, Section 10 of the Act requires the individual to initiate a discussion about assisted death before it can be discussed by the doctor (Casey & Macleod, 2021). However, if the person is unsure of whom to make a formal request to, for instance, if they are uncomfortable asking their primary physician, Support and Consultation for End of Life New Zealand (SCENZ) can be contacted through phone or email (Ministry of Health, 2021; Te Whatu Ora, 2024). Two professionals must then sign off on the person's wish for an assisted death: the attending medical practitioner and an independent medical practitioner). They do this by assessing the person, which involves speaking to other health professionals involved in the person's care (Ministry of

Health, 2021). If either practitioner is unsure of the person's competence, a psychiatrist must perform their own assessment. Casey and Macleod (2021) discussed the importance of attributing competence, which includes assessing any potential masking of mental deficits and recognising any external social or emotional pressures. If these two or three professionals believe that the person requesting an assisted death is appropriately entitled and competent to make the decision, they will grant them eligibility .The person can then choose the date and time they wish to die, and they must also select which method they would prefer: to self-ingest or trigger an intravenous delivery or for a medical practitioner to trigger ingestion of the medication through a tube or administer an injection. At any time, the person can withdraw consent for the medication or postpone the administration by up to six months. The process will also immediately stop if the person's eligibility changes or if it is thought that they are under any external pressure (Ministry of Health, 2021; Te Whatu Ora, 2024).

## Assisted dying and Te Tiriti o Waitangi

In the context of Aotearoa New Zealand, it is notable that the legislation does not refer to te Tiriti o Waitangi (hereafter te Tiriti). In an article published in 2020, Lee (2020) argued that for Māori, there are major concerns, notably that the Act (2019) is not compliant with te Tiriti: "It contains no clause expressly providing for te Tiriti concerns, let alone any mention of te Tiriti. Secondly, the Act does not even comply with Treaty principles, which set lower standards than te Tiriti itself" (p. 147). Furthermore, Lee noted many concerns that the Act is "inconsistent with tikanga Māori and the value that Māori place on the collective" (2020, p. 147). Lee set out the argument that Te Tiriti would require consideration of such matters as health inequalities and the disproportionate burden of ill-health amongst Māori. By excluding reference to Te Tiriti, the legislation fails to ensure the responsibility of the Crown to reduce such inequalities. Lee also cited Malpas et al. (2017) regarding major concerns about the concept of assisted dying raised by those making submissions during the parliamentary process: "death and the processes surrounding death are tapu, one of the most sacred concepts in tikanga Māori" (Lee, 2020, p. 153) as death is influenced by connections to whānau, ancestors and the relationship with the whenua. In reporting a qualitative study with kaumātua, Malpas et al. sum up their core concerns:

> … the dying process is imbued with cultural significance that draws centrally on an understanding of wairua and connections with the spiritual world, the protective cloak of whānau in supporting members at the end of life and sharing in the decision-making and the importance of customs and of practice to provide security and safety for everyone involved during the dying process. (2017, p. 451)

While it is early days for the legislation, it is under review at the time of writing, and we anticipate further research that will clarify what major te Tiriti and cultural issues will be faced in future in relation to assisted dying. A recently published study protocol published by Young et al. (2024) reported a plan to undertake qualitative research to explore the experiences of stakeholders in Aotearoa New Zealand, including potential service users, families, providers and those who object to assisted dying, health service leaders, and Māori community members. This study will bring insights for future research on outcomes for Māori.

## How social workers can help with assisted dying

In the medical world, social worker's scope of practice enables them to move beyond the medical environment and centre the holistic lives of their patients (Bravo et al., 2023; Foster & Beddoe, 2012; Giles, 2016; Pockett & Beddoe, 2015; Pockett et al., 2010). Social workers bring an essential perspective to medical settings, with the ability to assess a patient's emotional and social wellbeing. Pockett and Beddoe (2015) explained how social workers use psychosocial assessments to understand the context of a patient's admission and support them and "their families as they traverse the inpatient pathway" (p. 38). Psychosocial assessments lay the groundwork for comprehensive, patient-centred care by entrusting them to provide an accurate account of their lives and establish goals of care (Antifaeff, 2019; Head et al., 2019). The unique positioning of social work in the medical environment, as addressing physical health and broader psychosocial needs, is widely depicted in literature (Bravo et al., 2023; Norton & Miller, 2012; Pockett & Beddoe, 2015). Bravo et al. (2023) shared the moral navigating that social workers facilitate with patients, giving examples of social workers assisting people in making decisions informed by medical knowledge and balanced by their values. This effort to gain an understanding of the patient's personal beliefs and values ultimately promotes a more collaborative decision-making process surrounding their medical care (Wang et al., 2017), and thus, social work can make a meaningful contribution to care in services such as assisted dying.

The role of a social worker can be challenging to define due to the breadth of the work and their use of unseen emotionally holistic care coupled with more recognisable task-based focused practice (Cootes et al., 2022; Head et al., 2019). Social workers in medicalised settings often find themselves balancing the hierarchical standing of medical practice within the context of the person's life, making space for the patient's values, social supports, and circumstances (Antifaeff, 2019; Bravo et al., 2023; Cootes et al., 2022; Head et al., 2019; Pockett et al., 2010). Beresford et al. (2008) captured this in the words of a patient they interviewed about their experiences with social work: "The thing about any medical intervention . . . is it's something [that] is done to you . . . If you are going through a process of counselling, it's done with you . . . that's the difference" (p. 1397). This distinction emphasises the collaborative nature of social work, which seeks to empower patients and engage them as active participants in their care.

The profession of social work has long been an advocate for patient-centred holistic care, as shown by social workers' ability to fluidly step in to support a person at any stage of their medical journey (Giles, 2016). Research highlights the scope of social workers' practice, showing their ability to adapt across different phases of patient care and displaying the ability to address ongoing or sudden emotional and social concerns. For example, social workers are frequently introduced near the end of a patient's admission for discharge planning, ensuring the individual can maintain their physical health in their home environment (Foster & Beddoe, 2012; Giles, 2016; Pockett et al., 2010; Wang et al., 2017). The importance of social work involvement from early on in a patient's admission can be argued, as earlier integration of social work in patient care allows practitioners to address psychosocial factors that could affect a patient's treatment and recovery, ultimately creating a more personal care plan (Giles, 2016). Social workers are often the "glue" (Cootes et al., 2022, p. 264), connecting the members of the multidisciplinary teams.

In a 3-year qualitative study conducted in England by Beresford et al. (2008) exploring people's experiences with social workers in an end-of-life situation (*n* = 111), the researchers uncovered valuable insight into the impact social workers have on end-of-life care by interviewing people who were dying (*n* = 52) and people who had lost friends and family (*n* = 61. Interviewees spoke of their social worker doing what they felt was above and beyond for them, with one person stating that "my children regard [the social worker] as being one of the family. That might not be an entirely professional way to regard her, but none the less that's the kind of impact it's had" (Beresford et al., 2008, p. 1934). Antifaeff (2019) recounted a similar connection to a patient, but from a social work perspective, when they spoke of their professional experience working with a woman and her family as she underwent an assisted death, describing how they supported Jackie and her family as they navigated Jackie's assisted death, providing a safe, nonjudgemental space to talk. Researchers stress the importance of the social worker's rapport-building skills in end-of-life care, as death is emotionally challenging for patients and families (Antifaeff, 2019; Beresford et al., 2008;Foster & Beddoe, 2012). Beresford et al. (2008) also signified that social workers can comfort their patients by breaking through the barrier of taboo or sensitive subjects while maintaining professional distance. Interviewees also valued the social worker as someone they could confide in and who could help them navigate the medical setting (Beresford et al., 2008; Head et al., 2019).

Researchers have raised concerns about the potential blurred boundaries between patients and their social workers due to the nature of their relationship (Beresford et al., 2008; Bravo et al., 2023). From an outside perspective, social workers balance on a fine line between professional and friend due to the emotional support they provide; however, literature affirms that these relationships should be carefully maintained through a professional framework of social work codes and boundaries (Antifaeff, 2019; Beresford et al., 2008; Head et al., 2019). From the patient's and their family's viewpoint, Beresford et al. (2008) quelled these concerns, stating that their interviewees knew the limits of their relationship with their social worker and understood the professional barriers.

Understanding social workers' perspectives on navigating relationships within the context of assisted death is complex, mainly due to the lack of literature that focuses on their real-life experiences in this area. In a Canadian study of social workers involved in assisted death ($n = 141$), Bravo et al. (2023) found that the majority reported experiencing medium ($n = 60$) to high ($n = 58$) emotional intensity following an assisted death. This raises the question of whether the impact of a patient's death on social workers stems from their personal feelings about death, the depth of their relationship with the patient, or the nature of the event itself. A review of the literature highlights the importance of acknowledging the emotional labour a social worker invests and the toll that their patient's medically assisted death can take as a part of the natural grieving process (Bravo et al., 2023). In a study carried out by Digby et al. (2022) of clinical staff in Australia ($n = 382$), a large majority of respondents were worried about the emotional toll that they would face if they were to be involved in an assisted-dying case. In fact, 88 respondents in Bravo et al.'s (2023) study who had experienced an assisted death agreed with the statement that they felt like they needed to take a break after the death of their patient.

Interestingly, the study found a correlation between practitioners who rated themselves as more competent and those who felt they needed time off after a patient's death. Bravo et al. (2023) hypothesised that this may be because these practitioners have greater emotional awareness or a more informed understanding of the impact of death. It is also worth considering whether having a higher level of competence allows for more genuine self-reflection, leading these practitioners to recognise the need to address their grief.

The relationships social workers build extend beyond patients to include the families and support networks of those seeking an assisted death (Antifaeff, 2019; Wang et al., 2017). According to research by Antifaeff (2019) and Head et al. (2019), a social worker's role with families can range from providing practical information to creating a space to hold emotions. Developing connections with patients' loved ones is recognised by researchers (Bravo et al., 2023; Feigin, 2019; Head et al., 2019) as a standard part of the social work role, with academics acknowledging the impact a patient's support system has on their holistic health. Furthermore, Antifaeff (2019) asserted that an essential aspect of the psychosocial assessment process is considering how the patient's family and friends will be impacted by the patient pursuing an assisted death. Social workers frequently participate in family meetings, discussing the patient's wishes and needs, allowing the family to explore how best to support the patient and themselves (Antifaeff, 2019; Bravo et al., 2023). Providing patient's families with space to navigate emotional distress due to grief is a crucial part of the social work role (Digby et al., 2022).

The scope of social work practice ensures practitioners reflect on micro and macro levels of a person's experiences, considering not only their present needs but also the impact broader societal complexities have on their situation (Csikai, 1999; Lilley & Reid, 2023; Manson, 2021). This holistic approach equips social workers to assess how systemic factors shape individual, family, and community challenges. Lilley and Reid (2023) explained how social workers often have to "consider how inequity issues, and the ability for a person, family, whānau or community to cope and adapt during adversity, is impacted by societal systems that either detrimentally affect, or positively empower, autonomy and choice" (pp. 49–50). In relation to detrimental impacts on a person's life, these can look like services neglecting cultural needs, organisational and government policies being unrepresentative of the population, and scarce resources or funding issues (Csikai, 1999; Lilley & Reid, 2023). Research points out the challenges marginalised groups face, citing it as an equity issue (Lilley & Reid, 2023; Manson, 2021). Regarding the need for services to be culturally responsive, Lilley and Reid (2023) articulated how "despite the universality of death, it does not necessarily provoke the same responses and accompanying expressions across both individuals and cultures" (p. 18), underscoring the need for services to be equitable and responsive to people's unique circumstances and the nuances of providing care.

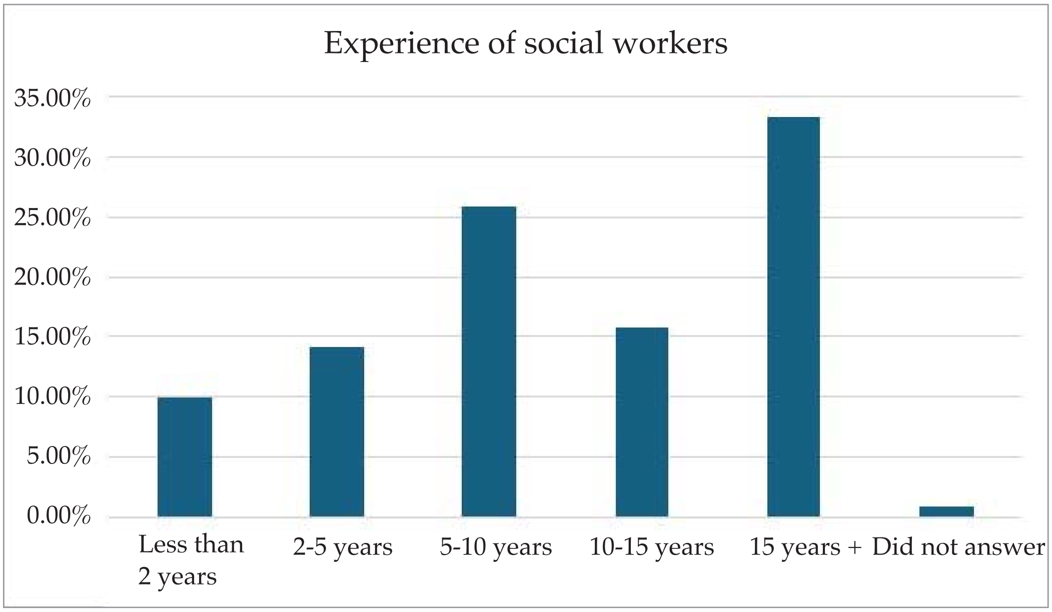

*Figure 1. Participants Years of Experience as a Social Worker*

## Method

### *Study design*

This study used an exploratory, descriptive, qualitative approach, using an online qualitative questionnaire (Braun et al., 2021) to capture the perspectives of social workers nationwide on their responses to assisted dying. Braun et al. (2021) discussed the advantages of using qualitative surveys with open-ended questions to elicit responses in the participant's own words, describing what is important to them. It is also noted that the anonymity offered by an online survey is useful in sensitive research topics where "issues of 'face' and social desirability might strongly impact face-to-face data collection" (Braun et al., 2021, p. 645). While our participants were not invited to provide personal history, some chose to do so, and others reacted to the topic in ways that they might not have in a face-to-face interview with a social work researcher.

### *Participants*

We recruited participants via a distributed online advertisement placed within a regular e-newsletter of the professional social work association Aotearoa New Zealand Association of Social Workers (ANZASW) and via private, professional social media groups. The survey was live for 3 months, from September to December 2023. The qualitative survey consisted of open-ended questions designed to capture participants' views on ethical challenges, knowledge, training, and professional roles in assisted dying.

A total of 120 social workers responded to the survey. Age and years of experience were collected via ranged buckets.

Figure 1 shows the distribution of social work experience among the respondents in years. The data suggest that a substantial portion of participants have long-term social work experience.

Gender and ethnicity demographic data were also self-described and, therefore, had to be aggregated by the researchers. The study's gender distribution is predominantly female (90.8%) compared to 85% in the workforce (Social Workers Registration Board, 2023). Male participants comprise only (8.3%) of the study compared to 15% in the workforce (0.9% did not disclose their gender). This imbalance could reflect survey participation and social media use biases.

The study has a lower percentage of Māori (11.7%) and Pasifika (1.6%) participants than their representation in the workforce (23% for Māori and 11% for Pasifika) (see Table 3). This underrepresentation may limit the study's cultural diversity and the extent to which it reflects the experiences of these ethnic groups.

### *Data collection*

The survey was created on Qualtrics gathering limited demographic information and included ten open-ended questions covering the following areas:

- Knowledge of assisted dying legislation
- Personal beliefs about assisted dying

*Table 1. Age Demographics of Survey Participants*

| Range (years) | Study (%) | New Zealand Social Work Workforce (%) |
|---|---|---|
| 20 – 29 | 12.5 | 7 |
| 30 – 39 | 30.0 | 19 |
| 40 – 49 | 20.8 | 24 |
| 50 – 59 | 21.7 | 27 |
| 60+ | 15.0 | 23 |

*Table 3. Aggregated Ethnicity Data of Survey Participants*

| Ethnicity | Study (%) | New Zealand Social Work Workforce (%) |
|---|---|---|
| Pākehā/New Zealand European | 78.1 | 67 |
| Māori | 11.7 | 23 |
| Pasifika | 1.6 | 11 |
| Asian | 3.9 | 9 |
| MELAA (Middle Eastern, Latin American, African) | 2.3 | 2 |
| Other Ethnicity | 2.3 | 2 |

- Role in supporting clients
- Ethical challenges
- Experience with training
- Need for further training
- Perception of coercion
- Navigation of personal vs. professional boundaries
- Client autonomy
- Systemic issues

### Analysis

A hybrid thematic analysis was conducted following Proudfoot’s (2023) inductive–deductive coding strategy, which emphasises researcher subjectivity, active engagement with the data, and an iterative coding process using both inductive (where researchers use participants’ words to construct themes from the data) and deductive (applying pre-existing theories and concepts reflecting a critical perspective on power dynamics and systemic issues affecting social workers’ roles in assisted dying contexts to organise and interpret the data) coding approaches. This approach involved a discussion of the researcher’s positions on assisted dying, familiarisation with the data, generating codes, constructing initial themes, reviewing and refining themes, defining themes clearly, and producing the final analysis. Before looking at the data, the reflexive discussions revealed that all researchers were aware and supportive of the existing legislation; the lead author also had a personal experience, having gone through the assisted dying process with her father in Canada. All researchers read the data—engaging in multiple rounds of coding and refinement—shared initial themes and then reached a consensus on naming final themes, choice of quotes and agreement on the overall analytic narrative. Ethics approval was obtained from the University of Auckland Human Participants Ethics Committee, ensuring adherence to ethical standards, including participant anonymity and informed consent.

### Findings and discussion

Proudfoot’s (2023) inductive–deductive coding strategy was chosen to allow predefined ethical concepts (e.g., autonomy, harm) to guide the analysis while still permitting unanticipated themes about social workers’ experiences to surface. As such, our reporting of themes is linked to relevant existing literature.

### “Some semblance of choice”: Navigating client autonomy

Autonomy was central to social workers’ accounts, reflecting a broader commitment to client-centred care. While participants primarily supported autonomy in end-of-life decisions, there was an undercurrent of frustration and being overwhelmed with systemic barriers and regulatory frameworks that still restrict genuine choice and autonomy with “lots of hoops to jump”. Such responses echo Frey and Balmer’s (2021) assertion that legal processes, while intended to ensure safe and voluntary decisions, can inadvertently complicate access. While the Act (NZ Government, 2019) aims to protect patient choice, many participants thought its procedural requirements could restrict access, especially for those with limited resources or facing complex health conditions. Several participants suggested that the process was not only complicated but also constrained by broader structural issues, such as limited healthcare resources and policy restrictions that shape who can access assisted dying. One participant commented, "I am not confident [however] that there is adequate infrastructure", demonstrating a tension between the promise of the legislation and the practical realities shaped by systemic factors, such as inequitable access to healthcare and information, which may further marginalise certain groups. This was a particular concern recognised by one participant who expressed concern that there was not enough consultation with Māori during the legislation development.

Whilst expressing support for assisted dying, some participants raised concerns about systemic constraints of the overall health system and articulated worries that people might choose assisted dying in the absence of access to appropriate physical and mental health care. One participant commented, "I see a major problem when someone wants to make this choice due to unmet health and wellbeing needs due to under-resourcing and gaps in the system." Another participant noted that they would like to ensure that "it's not our health system letting them down" by not providing "good pain relief", suggesting that access to good palliative care is currently inadequate, leading to the demand for assisted dying. These responses highlight the strains on our health system and unease about assisted dying being considered a valid option for people who are not able to access adequate healthcare.

Participants frequently described their roles as advocates for clients' choices and gatekeepers within a legally constrained environment, navigating the balance between client autonomy and control. One participant succinctly said, "We're often the link between medical teams and clients", reflecting Giles's (2016) observation of the social worker as an intermediary in medical settings. However, the same practitioner also noted that "it's hard to know where we stand legally" This ambiguity was a recurring challenge, with another social worker observing that "It's unclear what our role is under the End of Life Choice Act."

A need for clarity may be especially important when personal beliefs come into play. One respondent stated, "I want to support clients fully, but sometimes my own beliefs make it difficult." This aligns with the broader professional challenge of managing power relations, as another participant noted, "I wouldn't disclose my personal views in a professional setting," reflecting an effort to centre the client while navigating socio-legal constraints. Such social workers felt caught between navigating personal beliefs and professional duties (Norton & Miller, 2012). It is possible that clear guidelines for social workers working in this space may help to reduce uncertainty and serve to protect practitioner wellbeing and reduce personal distress (Cootes et al., 2022; Digby et al., 2022).

### *"Be careful": Managing ethics, coercion, and risk*

The ethical dilemmas faced by social workers were closely linked to concerns about coercion and negotiating risk extending beyond individual cases to reflect broader societal anxieties about who is deemed "fit" to die, implying concerns with broader discourses about vulnerable, oppressed communities. This was expressed through the notion of needing to "be careful". Worries about coercion, particularly within families or in socio-economically disadvantaged contexts, hint at the socio-political forces that influence assisted dying decisions. One participant observed: "I'm concerned about who accesses this and possible coercion from family members, especially in the case of inheritance and our ageist society". Another participant emphasised the need for robust safeguards and stated, "I wouldn't want my daughter-in-law advocating for me in this respect." These comments raise ethical concerns about individual cases and signal anxieties about structural inequalities, such as financial pressure or familial dynamics, potentially driving decisions. Such comments align with researchers who previously shared concerns for those impacted by such inequalities (Blaschke et al., 2019; Casey & Macleod, 2021). These comments potentially speak to a lack of understanding about the legislative safeguards currently in place. However, participants acknowledged that such assessments are inherently complex, often requiring a nuanced understanding of clients' cultural and familial contexts, echoing Lilley and Reid's (2023) call for culturally responsive care.

Participants worried about any move to extend eligibility to those with disabilities and mental health conditions: "It's a slippery slope . . . for the intellectually disabled and mentally ill." Such concerns reflect a broader debate about the ethical boundaries of assisted dying and are not simply about the process but speak to how power operates in healthcare settings and society more broadly, where vulnerable groups might be more susceptible to overt or subtle pressure (Mathison, 2020; Winnington & MacLeod, 2020;Winnington et al., 2018). These apprehensions centre around the ethical implications of potential vulnerabilities created for intellectually disabled and mentally ill populations. Scholars such as Pullman (2023) and Downie and Schuklenk (2021) critiqued the rapid liberalisation of Canada's Medical Assistance in Dying (MAiD) legislation, highlighting the comparative looseness of Canadian criteria relative to more conservative jurisdictions, such as California in America. They asserted that this liberalisation has led to significantly higher rates of assisted deaths in Canada, prompting concerns about inadequate safeguards for vulnerable individuals. Fear about the use of assisted dying with such groups was also highlighted by a participant in our study who stated, "I am concerned re the possibility of this being the thin end of the wedge" and another who "would be deeply concerned if people experiencing chronic mental health difficulties could access assisted dying". Such concerns are inherently linked to socio-political discussions about the differential value of some lives over others (Butler, 2020) and whose suffering is deemed worthy of intervention and whose suffering is seen as justifying death. Downie and Schuklenk (2021) underscored ethical tensions within MAiD policies, stressing the critical balance between patient autonomy and social justice. They argued that insufficient social support, inadequate healthcare access, and broader systemic inadequacies, including poverty, might indirectly pressure vulnerable populations toward MAiD as a solution to otherwise preventable social suffering. Winnington and MacLeod (2020) further stressed these ethical concerns by examining societal and healthcare power dynamics, indicating the risk that vulnerable populations may feel implicitly coerced into choosing MAiD. Their analysis complemented Pullman's (2023) observation that legislative and procedural expansions could inadvertently accelerate Canada's descent along the slippery slope.

In the context of our Aotearoa New Zealand-based findings, social workers similarly expressed cautious support for assisted dying in specific contexts, such as terminal illness or degenerative diseases. Statements such as it is "fine [about it] in circumstances of terminal illness" and "I support it [for] a person facing a degenerative disease" all reflect a need to "be careful" to avoid a slippery slope of eligibility to those with mental health challenges and disabilities. Indeed, for some, *care* contrasted with an expressed need for unbearable suffering to be expressed and experienced before assisted dying could be considered: "If a person is absolutely terminal and in severe pain, then I have no issue with them following this process." Such responses pose questions about what might be considered to be 'enough' pain and perhaps reflect an underlying ethos by some that suffering is almost always worth going through. The findings may also point toward the necessity of precise legislative safeguards and comprehensive social supports tailored to Aotearoa New Zealand's unique cultural and societal landscape to prevent unintended harms and ensure genuinely autonomous decision-making in assisted-dying cases.

### *"Just my own research": Limited knowledge and training*

Many social workers described limited formal training in assisted dying, often having to rely on self-study: their "own research". These responses suggested that social worker knowledge about assisted dying was very much down to individual interest and engagement and raised concerns about the practitioner's ability to provide support (Frey & Balmer, 2021). One participant remarked, "I've read about it but haven't received formal education," potentially indicating how social workers employ informal education methods to supplement practice. Indeed, one participant shared, "I have no formal education around this. My information is from media and online reading," while another noted, "Some brief training at uni . . . but that's it." One social worker stated this lack of structured education was a common concern: "There's no standardised training, which makes it hard to know what's best practice." While many participants indicate personal resourcefulness this also points to a broader conversation about the knowledge(s) informing social worker practice and potential for mis- and dis-information to inform practice. While less explicit in this data, incorrect assumptions about legislation and practice were something we observed in responses to questions about abortion and transgender rights in the broader research project. Such concerns speak to broader conversations about a lack of supported ongoing training and education for social workers in Aotearoa New Zealand, past their qualifying degree (Beddoe & Stanfield, 2022) and raise concerns about how practitioners remain current when legislation and policies change.

Participants wanted formal education, with one saying, "I would be interested in receiving training in this area," and another acknowledging, "I have had very little training, education, or supervision on assisted dying." One respondent admitted this gap affected their confidence, stating, "We are expected to guide clients through this, but there's little guidance for us." Another added, "It's something I know little about, so I would need to make that clear to clients." Antifaeff's (2019) observation that without comprehensive education, social workers may struggle to offer holistic care that genuinely considers the client's needs seems especially relevant to these practitioner concerns.

A few respondents had some exposure through workplace discussions, webinars, or in-service training, but many reported minimal to no training on the topic. A notable desire among respondents was more comprehensive training, specifically around the legal framework and criteria for assisted dying, ethical considerations, the social work role in supporting clients, and best practices for supporting clients and their families in assisted-dying cases. These responses point to a clear need for more targeted training, as the current lack of formal preparation limits social workers' ability to effectively support clients. Further, this education and training gap could reinforce medical hierarchies and sideline social work perspectives in end-of-life care (Bravo et al., 2023).

## Strengths and limitations

This study is the first in social work in Aotearoa to explore social work views on the recent development of an assisted dying service under the End of Life Act. It provides a useful snapshot, revealing a range of views and illuminating social work concerns with rights and wellbeing.

However, a key limitation of this study is its reliance on self-reported data, which may reflect social desirability bias, as participants could have tailored their responses to align with perceived professional norms despite the anonymity offered by the data-collection tool and the express request for personal views in some questions. Social desirability bias may have influenced participants in our study to align their responses with professional norms or values, potentially leading them to downplay personal beliefs or concerns. Despite assurances of anonymity, participants may have self-censored, especially given the ethically sensitive and professionally regulated nature of assisted dying (Althubaiti, 2016; Larson, 2019). The sample was limited to social workers who chose to participate, potentially skewing the results towards those who are more confident or experienced in discussing assisted dying. This self-selection bias could mean that the findings do not fully capture the perspectives of those less familiar or less comfortable with the topic. Additionally, the qualitative nature of this study, while providing in-depth insights, limits the generalisability of the findings to the broader social work profession in New Zealand. Further research with a larger, more diverse sample (especially including Māori and Pasifika social workers), including quantitative measures, could help verify and expand on these results.

## Conclusion

Participants' uncertainty about their legal and professional role under the Act is a critical finding. Some respondents reported feeling like intermediaries between medical teams and clients yet also expressed confusion about their legal standing. This aspect of role ambiguity aligns with previous studies about the social work role in healthcare which highlight how the role is underdefined compared to other professions (Giles, 2016; Vungkhanching & Tonsing, 2016). The ANZASW Position Statement on the EoLCA also acknowledges this ambiguity, recognising that while social workers have an important role in advocating for client rights and navigating ethical complexities, their specific responsibilities under the Act require further clarity (ANZASW, 2021). This ambiguity suggests that clearer practice guidelines and policy direction are needed to ensure that social workers feel equipped to support clients while maintaining ethical and legal integrity. A step that may be helpful in addressing this ambiguity may be for professional bodies such as the ANZASW to work alongside policymakers to develop a specific scope of practice for social workers involved in assisted death.

Additionally, the lack of formal training was a recurring concern among participants. With may social workers indicating that much of their knowledge came from personal research, the media or informal discussions, this raises important questions about how social workers remain informed in the context of a rapidly evolving legal and ethical landscape. Such findings align with international calls for standardised education on assisted dying with these studies also highlighting that without this, social workers risk being sidelined in the provision of assisted dying services. (Bravo et al., 2023) The ANZASW Position Statement affirms that ongoing education is critical to ensure social workers fulfil their responsibilities working in this field of practice and emphasises the responsibility employers have in providing access to this (ANZASW, 2021). The development of standardised training programmes which cover topics such as legal obligations, ethical considerations, and cultural factors could be achieved through partnerships between the ANZASW, universities, and healthcare providers ensuring that new graduates and experienced practitioners receive appropriate education.

Beyond formal education, there is also a need for ongoing professional development and supervision whereby social workers are able to navigate the ethical complexities of assisted dying. This is particularly pertinent when personal views and values conflict with professional and legal obligations. This echoes the call from the ANZASW (2021) which emphasised the responsibility that professional supervisors have in being familiar with the Act and how it operates, as well as the organisational policy for assisted dying for each social worker they supervise.

In practice, social workers should keep a client-centred focus, which respects the client's dignity and right to choose (Bravo et al., 2023). It is essential to create a space where clients and their families feel they can discuss end-of-life decisions without fear of judgment. Social workers hold a dual responsibility: first, to safeguard individual clients' ability to make informed, uncoerced decisions, and second, to address systemic barriers that may restrict marginalised groups' access to assisted dying. This means that, while ensuring each client's choice is fully voluntary and informed, social workers also advocate at a structural level to promote equitable access for all. Social workers' on-the-ground experience offers a valuable perspective that can inform fairer healthcare funding, improved access, and better implementation of the Act. Engaging in policy reform efforts can help ensure assisted dying is applied more equitably across different communities in Aotearoa New Zealand. However, social workers also need opportunities to actively participate in these processes, including platforms for advocacy, collaboration with policymakers, and resources to support their involvement in leading out inclusive practices.

Social workers must navigate a delicate balance between advocating for client autonomy, navigating personal beliefs, and addressing potential risks like coercion, all while working with limited formal training and ambiguous professional guidelines for assisted dying. Our analysis suggests that social workers may need better training or further exposure to the Act and clearer role definitions to provide consistent support in this ethically contentious area. Enhancing professional development and policy clarity would benefit practitioners and their clients, making end-of-life care more equitable and respectful of both rights and needs. Such professional development would also serve to protect social worker wellbeing in what is considered by many to be a sensitive area of practice. Given the te Tiriti concerns briefly outlined earlier in this article, further research is needed to illuminate outcomes for tangata whenua and related professional development will need to be ongoing.

These issues are relevant to social workers, policymakers, healthcare organisations, and professional bodies in Aotearoa New Zealand and beyond, where there is still a paucity of research on social workers' responses to the issue of assisted dying. Improving training and policy frameworks would enable social workers to offer more ethical, client-centred care and uphold the intentions of the Act more effectively. The profession and social workers can take these steps to move toward a more just and supportive approach to end-of-life care in Aotearoa New Zealand, ensuring that te Tiriti obligations and the rights and needs of vulnerable populations are adequately protected while respecting individual choice.

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