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Grieving Assisted Dying: A Synthesised Grief Framework

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ABSTRACT

The recent legalization of assisted dying (AD) in New Zealand has reshaped experiences of dying and grief, yet AD-related grief remains under-theorised. Guided by the questions of whether particular forms of grief are more prominent at different stages of the AD process, and how these manifestations can inform a grief framework tailored to AD, this qualitative study explores and explains how grief theories apply to AD. Using appreciative inquiry, we interviewed 46 individuals eligible or ineligible for AD and family members. Inductive-deductive thematic analysis identified a distinct AD grief trajectory shaped by anticipatory and preparatory processes. Advocacy work and legacy work emerged as central practices supporting readiness, meaning-making, and continuing bonds, while stigma at times complicated coping and social expression of grief. The resulting framework also explains how loss- and restoration-oriented processes unfold within the intentional and socially embedded context of AD, offering guidance for clinicians, researchers, and policymakers.

Introduction

The End of Life Choice Act 2019 (New Zealand Legislation, 2019) came into force in 2021, legalizing assisted dying (AD) and reshaping end-of-life care in New Zealand (NZ). As of 30 September 2025, 1434 people had died using AD, impacting the grief experience of many families and patients. AD is inherently relational, with families and healthcare providers playing integral roles throughout the AD journey. The experience is shaped by the sociopolitical environment, family dynamics, social norms, and professional responsibilities of care; it necessarily involves communication, trust, and the creation of shared meaning among multiple people (Snijdewind et al., 2014; Variath et al., 2020). Its newness, planned nature, and shared decision-making between patients and their family, friends, health professionals, and other carers (Young et al., 2026) make some aspects of AD-related grief unique. Despite families often playing an active role in caregiving and planning (Gamondi et al., 2019; Variath et al., 2020), and despite grief coping responses also unfolding within interpersonal and family contexts where grief is shaped through relational interactions (Stroebe & Schut, 2015), their grief remains relatively underexplored (La Brooy et al., 2024; Variath et al., 2020), particularly in NZ, where this study is based.

Further, literature on patients' grief in anticipation of death through AD is scarce. While not specific to AD, some research on preparatory grief in terminal illnesses shows that this emotional response helps patients begin to accept impending loss (Cheng et al., 2010; Milic et al., 2025). With the news of the illness being incurable, families may also experience a similar emotional response known as anticipatory grief, as they face life without their relative (Coelho & Barbosa, 2017).

Studies show that families' cognitive, emotional, and behavioral preparedness for a relative's death from terminal illness can facilitate bereavement adjustment (Beuthin et al., 2022; Hebert et al., 2006; Wen et al., 2022). Prognosis awareness aids cognitive readiness, while the opportunity to adjust to the stress of end-of-life care, anticipating loss and planning for death and life afterwards can contribute to emotional and behavioral preparedness (Breen et al., 2018; Hebert et al., 2006;

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Wen et al., 2022). These factors are inherent in AD, suggesting that AD processes may foster similar adaptive bereavement outcomes. Some AD grief studies identify these factors as grief 'facilitators' that ease grieving, concluding that AD-related grief can be no more complex than other deaths (Andriessen et al., 2020; Hashemi et al., 2021), or perhaps even easier (Swarte et al., 2003).

Conversely, some research highlights unique features of the AD process that may complicate grief. These factors include navigating the AD process (Laperle et al., 2024; Yan et al., 2023), social stigma and fear of judgment (Andriessen et al., 2020; Gamondi et al., 2015, 2019; Singer et al., 2023; Srinivasan, 2019; Yan et al., 2023), lack of social support or recognition for caregivers (Andriessen et al., 2020; Laperle et al., 2024; Serota et al., 2023), secrecy around disclosing the manner of death (Frolic et al., 2020; Gamondi et al., 2019; Serota et al., 2024; Yan et al., 2023), value conflicts (Gamondi et al., 2019; Serota et al., 2024; Srinivasan, 2019; Yan et al., 2023), and health system challenges (Serota et al., 2024). Notably, these risks stem not from the choice to die via AD per se, but from societal perceptions and structural/system barriers. One unique legislative feature of AD in NZ that is shown to have a significant emotional impact on patients and families and their grief experience is the legal requirement, as part of the approval process, to select a date when AD will be provided, often adding emotional strain and intensifying the anticipatory grief (Snelling et al., 2023; Young et al., 2026) (Box 1 provides information on NZ AD law and safeguards).

Complicated grief involves pre-loss, loss-related, and peri-loss risk variables (Simon, 2013). In the AD context, these risks may be heightened for those ethically opposed to AD, families experiencing guilt, or individuals in environments where AD is morally contested, like some rural, ethnic, or religious communities. Limited understanding of AD, common in countries where AD is still new, such as NZ, can also contribute to complicated AD-related grief. Inability to follow cultural mourning practices may lead to disenfranchized grief, where grief is not openly acknowledged, socially validated, or publicly mourned (Doka, 1999). International literature shows that some AD-bereaved families face secrecy, stigma, social isolation, and anxiety, complicating their grief (Gamondi et al., 2019; Russell, 2024; Serota et al., 2023; Srinivasan, 2019).

AD providers in NZ have voiced concerns about complicated grief among AD bereaved families who struggle to openly discuss their relative's AD choice, especially when bereavement support is lacking (Dehkhoda et al., 2025). Societal norms and expectations that do not widely accept AD may further limit support. For example, Singer et al. found that some laypeople believed that bereaved individuals 'should be fine' due to the chosen and planned nature of AD, an attitude that may reduce support (Singer et al., 2023).

These positive and negative aspects reflect what Frolic et al. describe as 'double-edged' experiences, highlighting the complexity and ambivalence of AD (Frolic et al., 2020), which can evoke emotions ranging from pain to comfort (Laperle et al., 2024). Such experiences could make the bereavement outcome dependent on various personal, systemic, and social environments such as

Box 1. Description of assisted dying law under the End of Life Choice Act (New Zealand Legislation, 2019).

Eligibility criteria:
- Aged 18 years or over
- A citizen or permanent resident of New Zealand
- Suffering from a terminal illness that is likely to end their life within six months
- In an advanced state of irreversible decline in physical capability
- Experiencing unbearable suffering that cannot be relieved in a manner that the person considers tolerable
- Competent to make an informed decision about assisted dying.

Safeguards:
- There are two independent assessments of the eligibility criteria by Attending and independent Medical Practitioners.
- Statutory prohibition: A health practitioner is not permitted to raise the AD option with patients unprompted by them.
- There is the exclusion of advanced age/mental illness/disability.
- Advance directive for AD is not legal.
- Waiver of the final consent for people already approved is not legal.
- A health practitioner is not required to assist a person seeking AD if they have a conscientious objection.
- The Act does not explicitly address whether institutions may decline to provide AD. However, a High Court ruling indicates they can, although public hospitals are legally obliged to be the place of last resort. Many hospices and institutions, such as aged residential care, have publicly stated they will not offer AD services.

Additional relevant information:
- If the patient is deemed eligible after the second assessment, the patient must agree on the date and time. The application will then be sent to the Registrar for a final compliance check and final approval.
- The set date can be changed afterwards, but any change of date and time would require at least 48 hours for the Registrar's re-verification.

supportive resources and networks, relationship and caregiving roles, coping strategies and resilience, and the quality of end-of-life care. This level of complexity calls for a nuanced analytical approach to better understand this emerging form of grief.

A recent study by La Brooy et al. explored how existing ways of understanding grief may apply to AD settings. They identified links to anticipatory grief, meaning-making, and continuing bonds among AD-bereaved families (La Brooy et al., 2024); each concept is rooted in well-established theories of grief (Box 2). These theories address different dimensions of grief: Anticipatory and Preparatory grief focus on the timing and phenomenology of the grief experience in the context of an anticipated death; Meaning-Making highlights the psychological and existential needs that arise in response to loss; and Continuing Bonds focus on the ongoing relational dimensions of grieving. In addition, the Dual Process Model offers a functional lens, conceptualizing grief as an adaptive coping process involving oscillation between loss-oriented and restoration-oriented coping (Stroebe & Schut, 2010). Grief therapists have been incorporating these grief theories into practice, including with AD-bereaved individuals (Russell, 2024). For mental health providers working with dying individuals and their families, a deep understanding of AD and its unique grief response is essential to provide specialized and informed grief support (Walker & Wong, 2018). A grief framework informed by these theories could amplify the effectiveness of these interventions, offering more meaningful support for those affected.

This study does not seek to compare AD-related grief to other types of bereavement. Instead, its primary aim is to deepen understanding and contextualize grief within the AD context. To achieve this goal, we examined AD grief through established grief theories, including anticipatory/preparatory grief, meaning-making, continuing bonds, and the dual process model. Building on La Brooy et al.'s study (La Brooy et al., 2024), which marked an important starting point, this research extends the scope by exploring the entire trajectory, from anticipation to post-death reflection and including the grief experience of patients using AD. We explored and explained how these theories manifest in the lived experiences of patients and bereaved families using the following research questions: (1) Is a specific type of grief more prominent at one or various stages of the AD process? (2) How do different forms of grief co-occur and interact across the AD trajectory? These patterns were subsequently integrated to inform a grief framework tailored to AD.

Method

This study is part of a larger research project developed in collaboration with stakeholders and guided by input from clinical, disability, Māori (the Indigenous people of NZ), legal, social science and diverse academic advisors (Young et al., 2024). The project design, methods, and care criteria have been previously reported (Young et al., 2024). In brief, the larger research project used an appreciative inquiry approach, focusing on what works well, what could be improved, the ideal AD service, and how to sustain the ideal practices (Trajkovski et al., 2013). Appreciative inquiry informed the development of the interview guides but not the interpretation of the data. While appreciative inquiry focuses on positive aspects, we also sought and were told of negative experiences. As researchers, we used any negative experiences to learn from them, aiming to turn them into an opportunity to learn from and improve care for others to come after. Ethics approval was granted by the National Health and Disability Ethics Committee [2023 EXP 18493].

Setting and recruitment

The study relied on the concept of information power, prioritizing the richness and relevance of the data over sample size (Malterud et al., 2016). Due to the

Box 2. Description of grief theories used in this research.

Preparatory Grief Theory: Refers to the emotional response of individuals who are dying, as they begin to mourn anticipated losses, such as relationships, roles, and future experiences, before death occurs (Mystakidou et al., 2008).
Anticipatory Grief Theory: Describes grief experienced by non-patients before an actual loss, often in response to a terminal diagnosis. It involves emotional, cognitive, and social reactions to expected separation (Coelho & Barbosa, 2017).
Meaning-Making Theory: Focuses on actively reconstructing meaning after loss, including understanding the death, finding benefits, and reshaping identity (Neimeyer, 2011).
Continuing Bonds Theory: Suggests that bereaved individuals maintain a relationship with the deceased by adapting the bonds in new ways, rather than detaching (Klass et al., 2014).
Dual Process Model of Coping with Grief: Describes grief as an oscillation between two coping models: Loss-Oriented (focusing on emotional pain of the loss) and Restoration-Oriented (adjusting to life changes) (Stroebe & Schut, 1999).

limited pool of potential participants, purposive and snowball sampling techniques were used. Recruitment took place from October 2023 to July 2024 via media releases, stakeholder networks, advocacy groups, and social media platforms, including the AD service, the End of Life Choice Society, Grief Center, and AD providers. Participants' eligibility was confirmed through an online survey (Box 3). Participants who identified as Māori were offered referral to a separate Indigenous sister study if they wished, resulting in a lower Māori participation.

Data collection

Data were collected using semi-structured interviews conducted by the first and second authors, who are both experienced AD researchers: a lead and a supporting team member who asked supplementary questions. The interview guides were adapted from previous AD studies and informed by literature reviews and existing guides (Dehkhoda et al., 2025; White et al., 2023; Willmott et al., 2021; Young et al., 2026). Each participant group in Box 3 received a tailored guide based on their involvement in AD, though all guides covered consistent core topics, including background, awareness, motivations, access and equity, the AD process, care and support, safety, and views on the ideal service. [Interview guides included as supplementary materials.]

Participants received an information sheet and provided online consent and demographic details before participating. Verbal consent was reconfirmed on the day of participation. In cases of joint interviews, consent was obtained from all participating individuals, and confidentiality considerations were discussed in advance. Interviews were conducted via Microsoft Teams, phone, or in person, averaging 90 minutes (ranging from 19 to 136 minutes). Some participants chose to be interviewed alongside a family member. Each participant received a $50 voucher and was followed up with a wellbeing check the next day. Suicide risk protocols and response strategies were applied when concerns arose. Interviews were transcribed using Microsoft Teams or Sonix, reviewed by a research assistant, and offered to participants for review.

Data analysis

The research team adopted a reflexive approach throughout data collection and analysis. Team members brought diverse disciplinary backgrounds and perspectives on AD, which were acknowledged and discussed during analysis to reflect on how these positions might shape interpretation. The first author is a trained grief counselor, has extensive prior experience researching AD, and conducted the interviews. Reflexive notes were recorded after each interview to document assumptions, emotional responses, and contextual factors.

All interviews were deidentified with names replaced by pseudonyms. A coding framework was developed collaboratively through an iterative process. Initially, each researcher independently coded two interview transcripts from the larger dataset. All preliminary codes were discussed within the team to compare interpretations and refine code definitions, while remaining open to alternative interpretations of data. Discrepancies in coding were resolved through discussion and consensus, with attention to how differing interpretations reflected alternative readings of the data. This process resulted in a shared coding framework consisting of 92 codes across 10 topic areas. The framework was then applied to the full dataset by the first and second authors using NVivo 15. Throughout coding, minor refinements were discussed within the team to ensure consistency and conceptual clarity. Regular analytic discussions between the first and second authors enabled ongoing comparison of coding decisions and promoted consistency in how codes were interpreted and applied across the dataset, rather than seeking statistical inter-rater reliability.

The first author then conducted an inductive-deductive thematic analysis (Braun & Clarke, 2021; Fereday et al., 2006; Morse & Mitcham, 2002) using all relevant codes related to the expression of grief, informed by the grief theories outlined in Box 2.

Box 3. Inclusion criteria for each of the participant cohorts.

Patients were eligible to participate if they:
- applied for and were assessed as eligible for AD, whether they planned to use it or not; or
- applied for and were assessed as ineligible for AD.

Families were eligible to participate if they had supported a family member or a close friend who:
- applied for AD, whether or not they died by assisted death service; or
- were assessed as ineligible and died a natural death.

For example, data were included if participants expressed emotions (negative, positive, or mixed) in general or related to grief and bereavement, or to their experiences of sharing or withholding AD, stigma and secrecy, insofar as these impacted coping and grief. Analysis began inductively, with open coding used to identify grief-related themes emerging from the data to reflect participants' experiences (e.g. guilt, stigma, anticipatory grief, and short- and long-term grief responses). These themes were subsequently re-analysed deductively using established grief theories to support analytic refinement. At this stage, all inductively derived themes mapped coherently with the theoretical framework, with no grief-related codes falling outside these domains. Themes shifted from descriptive categories to analytic constructs during this theory-informed phase of analysis, allowing deeper conceptual interpretation of participants' experiences. Emergent themes were iteratively discussed with ADe and JY and refined through team feedback. Coding and themes development continued until no new grief-related themes emerged, and reflexive team discussions were used throughout to reflect on assumptions and analytic decisions.

While the analysis began inductively with exploratory reasoning to remain grounded in participants' accounts, the overall purpose of this study was explanatory. Rather than generating new theories of grief, we aimed to deepen our understanding of how established grief theories manifest across the AD trajectory. By linking inductively identified grief experiences with existing theories, this study explored how grief unfolds within the AD context.

Findings

The study sample includes 46 participants across three cohorts, representing 42 AD applications (four joint interviews): AD service users who were assessed as both eligible (participant code E) and ineligible (participant code I); and families of both eligible and ineligible AD service users (participant code FE for families of eligible patients or FI for families of ineligible patients). Among these participants were service users who identified as having a disability, impairment, or being Deaf (participant code ED or ID) and their families (participant code FED or FID). Participants' demographic details are provided in Table 1.

Our analysis indicated that, despite variation in participants' experiences of AD, they reported shared forms of grief unique to the AD context. For many families whose relative died by AD, it enabled a peaceful death and eased their grief. However, others experienced conflicting emotions, complicating their grief. Some would have preferred a natural yet peaceful death, despite appreciating the AD option. Some patients and families who had hoped to access AD were deemed ineligible. Those who experienced a painful or distressing non-AD death reported more complicated grief, feeling denied the opportunity for a peaceful end. Being found ineligible negatively affected their ability to cope with an uncontrolled and difficult dying experience. Established grief theories helped interpret these unique experiences along five key themes. These themes are described separately, but some overlap exists.

The first two themes focus on the patients' and families' grief experiences before the death. Subsequent themes primarily focus on the families' grief experiences. However, data from AD patients have also been used for these themes to support and contextualize the families' grief experience.

AD grief starts before the death—anticipatory and preparatory grief

For many patients and families, the grieving process began long before the person's death, usually after receiving a terminal diagnosis. However, choosing a date for AD intensified this feeling of impending loss, making it impossible to ignore the imminent death.

> *It's one of those things that knowing that, you know, she had a limited amount of time with motor neurone disease. It's very, you know, it's quite quick. So I think that a lot of the grieving was done beforehand in a way. […] I do say it's such a weird experience [emphasised], kind of knowing that it's gonna be the day, and then the day coming and then that's it.* (FE16)

This anticipatory grief has unique AD-related features, with mixed feelings at its core. The majority of patients and families noted that knowing the time and circumstances of an AD death, as well as being involved in its planning, created some ambivalence, with feelings that could be positive, confronting and 'surreal'. Some families expressed that the anticipation was the 'hardest' part of the process.

> *Like the process itself is not hard, but getting your mind around the fact that you have a date that you know you are gonna pass away that's really hard. And setting the date. Counting down to the date. That's when you can start counting the days. And yeah, just kind of wrapping your whole mind around a final end date. That's probably the hardest.* (FE14)

Table 1. Demographic information of family members ($N = 46$) who participated in this study.

Demographic information	Eligible AD service users ($N = 8$)	Ineligible AD service users ($N = 8$)	Family members of AD service users ($N = 30$)	Total	%
All participants (n = *46)*					
Age					
30–39		1	1	2	4.3
40–49			7	7	15.2
50–59	2		8	10	21.7
60–69	2	4	8	14	30.4
70–79	3		5	8	17.4
80–89	1			1	2.2
>90		3		3	6.5
Missing			1	1	2.2
Gender					
Male	4	4	10	18	39.1
Female	4	3	20	27	58.7
Diverse Gender		1		1	2.2
Ethnicity—total ethnicity (some participants reported multiple ethnicities)					
NZ European/Pākehā	5	6	23	34	73.9
Māori	1	1	1	3	6.5
Other European	3	1	5	9	19.6
Pasifika			2	2	4.3
Other		2	2	4	8.7
Missing			1	1	2.2
Location					
North Island	6	4	22	32	69.6
South Island	2	4	7	13	28.3
Missing			1	1	2.2
Education					
Post-graduate Qualifications and Specializations	2		2	4	8.7
Undergraduate Degrees and Diplomas	3	4	21	28	60.9
High School	3	3	5	11	23.9
Missing		1	2	3	6.5
AD Status					
Approved					
Approved, yet to take medication	8		3	11	23.9
Approved, died with assisted dying			15	15	32.6
Approved, died natural death			7	7	15.2
Declined					
Declined, alive		8	1	9	19.6
Declined, died natural death			3	3	6.5
Application not initiated by Health NZ			1	1	2.2
Disability, impairment or Deafness					
Service user identified as / family of service user who identified as		4	6	10	21.7
Family member participants (n = *30)*					
Relative's relationship to the AD service user					
Spouse			12	12	40.0
Daughter/Son			15	15	50.0
Sibling			2	2	6.7
Parent			1	1	3.3

*AD: Assisted Dying.

Another participant expressed difficulty balancing life and death when "beating yourself up and thinking about trivia" during this grief phase:

> *The emotions, you're just slamming back and forth between, you know, like death, he's gonna be gone. And who's gonna feed my cats?* (FI21)

Simultaneously, most participants acknowledged the benefits of being able to prepare and use their remaining time mindfully. This allowed space for deepening relationships, quality time, and saying goodbyes for both dying people and families.

> *Yeah, it's been difficult. But, I think there's been actually a bonus in that because I've had an opportunity to do things and say things to people and, do stuff that I actually, had I died quickly I wouldn't have, I wouldn't have had that chance.* (E08)

> *It took away the trauma element. It's usually the shock and the 'I wish I had' […] I personally think it was Dad's last gift to me[…] We all got to say what we wanted to say. We all got to have our moment with him.* (FE10)

The realization of imminent death sparked conversations around death and post-death wishes. It allowed people to prepare and undertake initiatives such as writing their own obituaries, throwing goodbye parties, donating personal belongings, and performing other rituals. Described as 'legacy work' (Allen et al., 2008), these activities allow

individuals to reflect on their lives, document their experiences, express their values, and foster a sense of meaning and connection during a challenging time.

One family member, whose wife died by AD, shared their experience of asking people to write their obituaries while his wife was alive:

> *There might be another way of looking at yourself and actually fully appreciating that you are loved. You expose like, you know, you give so much love to others. And um, and I think that's what this process gave us was the actual ability to move through that.* (FE01)

This family chose to share the AD with others.

A feature of AD anticipatory grief was regarding the AD decision itself, the 'who, what, where, when, and how' the decision was expressed to others. Keeping AD private made it a "very lonely" (FE20) period for some participants (discussed further in theme five).

For ineligible patients, preparatory grief was more often oriented toward the loss of the option of AD, including loss of anticipated control over the timing and manner of death, and concerns about increased suffering and diminished quality of life at the end of life.

> *It is particularly disheartening when the AMP suggests that you appear fine and have many years ahead which feels dismissive and signifies a lack of understanding or acknowledgment of the severity of my condition. This disregard towards these illnesses adds to the difficulty of fighting these symptoms daily just to stay alive.* (ID07)

> *I think it's much worse I don't really figure I'm going to have much of a life. […] just sitting here on oxygen and taking medication, and it's not. I'm not gonna get better. […] It's not an illness that you're gonna get over.* (I01)

Before the AD death, anticipatory grief played a significant role in prompting patients and families to prepare for the impending loss. This engagement also facilitated the process of sense-making.

AD grief involves a sense-making process—meaning-making theory

Meaning-making occurs while patients are still alive. Patients engage in a cognitive-emotional-relational-existential process to understand what their life and death mean, and especially, what it means to die by AD or not, while families focus on making sense of their relative's death and the AD decision itself.

An eligible patient attended counseling sessions to help come to terms with his death and find ways to help prepare his family:

> *That's the nature of counselling […] reflection or, you know, just a different way to kind of look at it. So that was helpful. […] So if these guys [his children], you know, I need to talk to them about how they're going because you know, because I can say I've got, I'm pretty accepting of where this is, but they're the ones who are going to be dealing with the fact their Dad's dead.* (E01)

Family members sought to understand and find meaning in the AD decision through various means. One key avenue was advocacy by facilitating their relatives' access to AD. Their advocacy work provided a sense of purpose and meaning, alleviated suffering, enhanced autonomy for all involved, fostered a sense of control, and contributed to a more peaceful death.

> *I think the biggest thing is that Ellen [Participant's wife] achieved something that she wanted. And it relieved Ellen of potentially a very hard [emphasised] three to four months ahead. So the grief, I think losing somebody is always grief. And I think if Ellen had to survive another six years and died, then, then it would have been grief as well. The difference to the grief now is that she got to do it on her terms. And I think that softens the blow to a large degree.* (FE01)

The fear of a worse alternative or 'bad death', a prolonged and painful death without AD, also helped many to reconcile and affirm the decision to pursue AD.

> *I think it was a privilege to have the option available. Because the alternative would have been horrific. Yeah. And I think the alternative of just watching and waiting for her to deteriorate to a natural end would have been almost more damaging to the rest of us as a family.* (FE09)

Another source of sense-making was reflective alignment with the relative's values and personality. The decision to pursue AD was perceived as meaningful by others when how the person had lived and how they wished to die were congruous.

> *Mum always liked calling the shots, and she got to call the shots right up to the last minute.* (FE09)

The above quotes also illustrate that these families stood in solidarity with the person who chose AD, offering support and respecting their decision. This brought a sense of comfort, knowing that their relative died in the way they wished.

AD grief involves continuing the relationship with the deceased—continuing bonds theory

The early engagement with anticipatory grief, advocacy, and legacy work created meaningful last memories. These experiences also helped families to continue bonds with their relatives after their death. The AD process activated a desire among bereaved

family members to share their experience and continue supporting the cause.

Expressions of continuing bonds occurred during interviews through participants' ongoing support of the AD decision after their relative's death. Some continued their bonds by sharing their relative's dying experience.

> *I think it was good to tell people that. Yeah, I think that was in a way a bit of getting rid of grief by telling people the story of how she went. And just what a nice way it is, yeah.* (FE22)

Importantly, the meaning that was constructed pre-death became integrated into many participants' lives following the death. Many transformed their relationship with both the deceased and the AD experience into something larger; engaging in community talks, advocacy, and awareness-raising activities. This ongoing involvement honored their relative's life and death. They wanted to improve the AD service for others, reinforcing their continuing bonds and sense of purpose. For some participants, advocacy and storytelling functioned as ways of sustaining an ongoing relational bond with the deceased. For some participants, this advocacy and storytelling functioned as ways of sustaining an ongoing relational bond with the deceased. For example, participation in our study was one way of doing that:

> *I always like to try and turn shitty things into good things, so like try and find things to leverage that, add some goodness to shit things, and like doing this is part of that. Like trying to inform views on this and you know, provide some research that I'm hopeful will show that this is a good thing.* (FE06)

AD grief oscillates between focusing on the AD death and restoration—dual process model

Families engaged in loss-oriented coping by appraising and reflecting on aspects of the AD experience, such as the AD day and the manner of the death. This strong recollection shows the emotional significance of the day of death and its potential impact on coping with AD grief.

Some loss-oriented coping reflected on unexpected grief-related feelings and reactions.

> *So I've been waiting for this anger and all this frustration to burrow, to sort of mound up and then for me to explode, which I typically may do and have done in the past, but I'm OK. And I think being OK and being in where I am today is largely to thanks, to the way my wife went through that process, and allowed me to be, allowed me to 'do me' in that process as well, which is just love to the last day.* (FE01)

> *The irony is… I've actually been 100% OK since he died. I mean I shed tears at the funeral, but I actually haven't had breakdown yet, to the point I went and had some counselling cause I was actually worried that maybe I was in denial or something because I was handling it so well.* (FE10)

Participation in the interviews also facilitated participants' reflection, which sometimes brought up conflicting emotions, even though their experiences were mostly positive. A few participants shared intrusive thoughts about the method (e.g., one participant compared AD to suicide) and feelings of guilt about their involvement. Simultaneously, these same participants expressed relief that their relative had access to a peaceful death. These negative and at times mixed emotions complicated the coping process.

> *I was just really shocked by how, how shocking the whole thing was. But I guess, grief and death is shocking. So I mean, I had a lot of death in my life but mostly being … or been sudden death. So it was just, in that respect very different […] Just all those visuals [from the administration] and things that, you know, that's definitely… Lots of scope for PTSD with going through something, something like that.* (FE13)

> *A woman at work mentioned that she had a friend whose mother asked her to facilitate assisted dying and was talking about how she could understand why her friend would refuse to do it, because how could you assist in the death of your mother? And I was just kind of sitting there going, oh shit. I hadn't said but so it left me feeling really bad and oh, does that say something about my? How much I love my father? Does it say something really bad about our relationship or? So I think it does. […] I'm cross as well that it fell to me to do it. But then what else is he supposed to do. It's only really hit me in the last month. If I'm just being honest with myself about how I feel and why I feel that way. Because, just because I'm cross about it at the moment doesn't mean that I regret doing it because I don't. I'd do it again. And I support it and I can understand it. And if I was in that position, I would want someone who knew me intimately to do that for me. And in a way it's a privilege.* (FE18)

As participants appraised their loss, which was more dominant in the early days post-death, they were also working to re-orient themselves in a world without their relatives. We observed some variation, with some participants more focused on the painful experience of the loss itself (loss-oriented focus), while some were more concerned with the secondary consequences and moving forward with life (restoration-oriented focus). Participants' restoration-oriented coping included dealing with loss-related secondary stressors, for example, rebuilding their lives through new relationships, roles, and AD activities, such as advocacy and navigating stigma.

One family member whose wife started her application, but lost competence during the process and was therefore ineligible, described a gradual transition back to life and responsibilities in the midst of grief. His grief was complicated by the dominant and painful memory of his wife's death. This oscillation is illustrated in the quote.

> *It [AD death] […] would have drawn us together even closer as a family […] I always had a vision of lying on the bed beside Lucy. […]. I would have thought we'd have had a lot of laughs about some of the dumb things that I had done, about some of the dumb things that she had done. And that would have been a positive memory rather than the way she died being just a horrible memory. It's taken me a long [becomes upset]. Yeah, it was not nice. And it was never gonna be nice, but it could have been with some dignity. It could have been with some family positivity, you know, could have been an experience we would have talked. […]*

> *hedges and gardens and everything around it which I used to do. And Lucy used to do the inside stuff […]. I got way behind it in the last two years, but I'd go outside after she died. And I'd look at broken hose reels and hedges that have gone crazy, and honestly, I just didn't know what to do. I'd just go back inside. It took, you know, a good month.* (FI04)

Sharing AD choices publicly—social environment influences AD grief

This section considers how different theories of grief relate to the way people share their AD experience with others.

During the anticipatory grief phase, many participants experienced a range of concerns that influenced their decision-making about being public with their decision. These included fear of real or anticipated stigma surrounding AD, anxiety about being judged or disapproved of, the burden of having to explain or justify their choice, the views of religious family members, colleagues or health practitioners, and potential reactions. Accordingly, many chose to disclose their AD decision only to trusted people. They found preparation "awkward" and "hard to process" (FE09) when others did not have a full and accurate understanding of the process, the person's reasons for the AD decision (e.g., profound suffering), or opposed the decision on principle.

> *I think the hardest one was, uh, the backlash publicly, if you like. Which just initially telling people and what they might think of Dad, I didn't actually care for myself. Because once again we, I'd never met anyone or knew of anyone who had gone through the process. So we were really in uncharted territory in that regard.* (FE10)

This secrecy was difficult, obscuring the processing of the AD death openly.

> *I don't think any of our friends would have really thought about it, but my mum just didn't want to deal with the judgement or the questions. So we were only able talk about it as a family, we weren't able to talk to our friends about it. […] people are quick to judge.* (FE14)

Anticipatory grief was perceived to be easier among those who had shared and received support and/or positive feedback from others around them.

> *I always think just being open about it and having open conversations about it actually helps. […] I've got probably friends and people around me that are quite open-minded, and compassionate in that way. So, you know, they would be supportive of that. I don't feel like there was anyone I know who would think that that was the wrong thing to do or, you know. […] it is affirming, too.* (FE16)

In terms of meaning-making, those who had made sense of the AD decision as a deeply personal choice that aligned with individuals' values and personality expressed indifference toward others' opinions, noting that external judgment would not have influenced their relative's choice.

> *I don't think he really cared too much about other people thought, but it's just annoying having to listen to other people's points of view when it doesn't align with yours […]. He was quite strong and his own belief stance and his sense of what was right for him. Yeah. So I don't think it would have impacted on him, it just would have been an annoyance more than anything.* (FE08)

However, the fear of stigma and inability to share the decision openly created a barrier to this meaning-making process, post-death.

> *For me to get my head around something like, you know, I quite like to talk to different people and share with different people and get their perspectives and things. And I very rapidly got the feeling that this wasn't something I should be discussing with other people and Umm. Yeah. And that I think made it a bit harder to sort of process it.* (FI21)

This lack of openness hindered the collective meaning-making process, making it more difficult for some families to engage and discuss the decision.

In terms of continuing bonds, in families' efforts to continue bonds with their relatives' AD death by sharing their experience, many participants found that receiving validation from others affirmed their experiences. This external support helped them accept their relative's death, meaning that they could continue supporting the AD decision.

> *And I must admit, yeah, people being able to tell people and their being receptive to it did help a lot because you're not feeling like it's you're hiding in a closet somewhere.* (FE10)

On the other hand, stigma, or the fear of it, disrupted continuing bonds by preventing individuals from openly sharing their AD experience or invalidating that experience when disclosed.

In the restoration phase of grief of the dual process model, the success of this adjustment for many families was closely tied to how AD was received and validated by their social circle and the wider community. For others, negative feedback contributed to feelings of guilt and disconnection. One participant illustrates how reconnecting with the community and reorienting oneself can be tempered by others' responses:

> *I think it [grief] hit me more later on. I think at that stage was sort of like. A bit unreal. […]. Went out with some girlfriends and had a lunch. And it just, telling everyone and then actually saying what Mum had, had, had done, it was… some people were oh, OK. Yes. How did it go? So you tell the story. But no, not really. It just sort of all went quite smoothly telling people.* (FE22)

Synthesizing framework

Grief theories have helped illuminate the unique and complex nature of AD grief. Figure 1 depicts the AD grief synthesized framework, followed by its description.

During the AD process, patients and their family members experience preparatory and anticipatory grief, which manifests through two distinct but interconnected sets of activities. The first involves advocacy work mostly by families, including practical support with the application process, arranging and attending appointments, sharing information with family, friends, and the healthcare team, and organizing the actual day of AD and funeral arrangements. The second set of activities focuses on legacy work, where patients and families engage in meaningful end-of-life rituals such as saying goodbyes, reflecting on life stories, sharing memories, resolving unfinished business, reconnecting with important people, creating final memories, and participating in enjoyable activities. These advocacy and legacy efforts facilitate cognitive, emotional, mental, and behavioral preparation for death, while also contributing to the meaning-making process. Through reflection on the patient's life and death, both patients and families begin constructing narratives that help them make sense of the AD decision. This meaning-making continues into bereavement, where families reflect on values, beliefs, and the role AD played in shaping the dying experience. Post-death, advocacy and legacy work support continuing bonds, allowing families to express love and support beyond death.

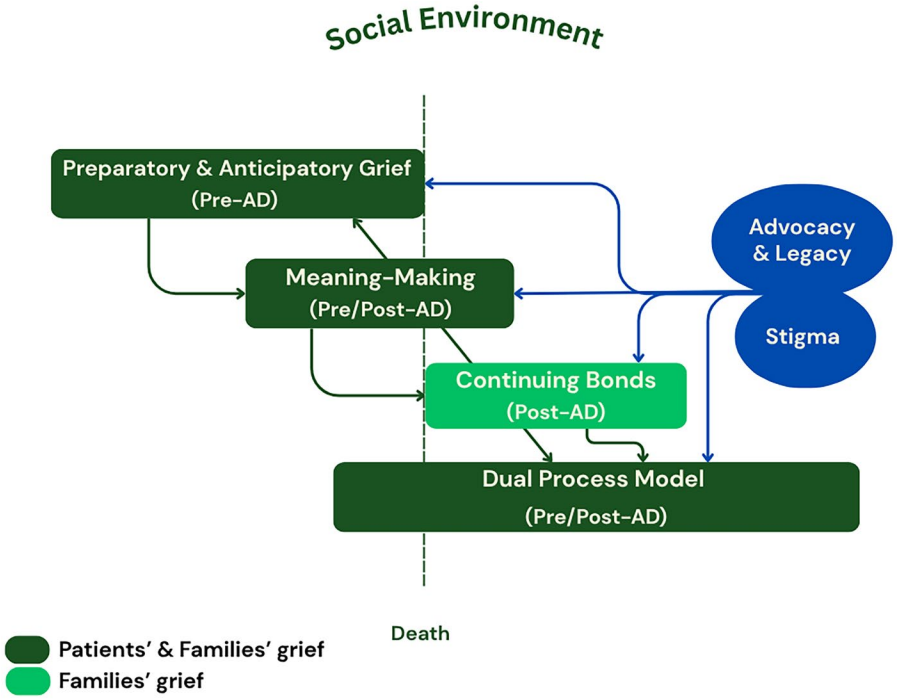

Figure 1. Synthesized framework for grief associated with assisted dying.

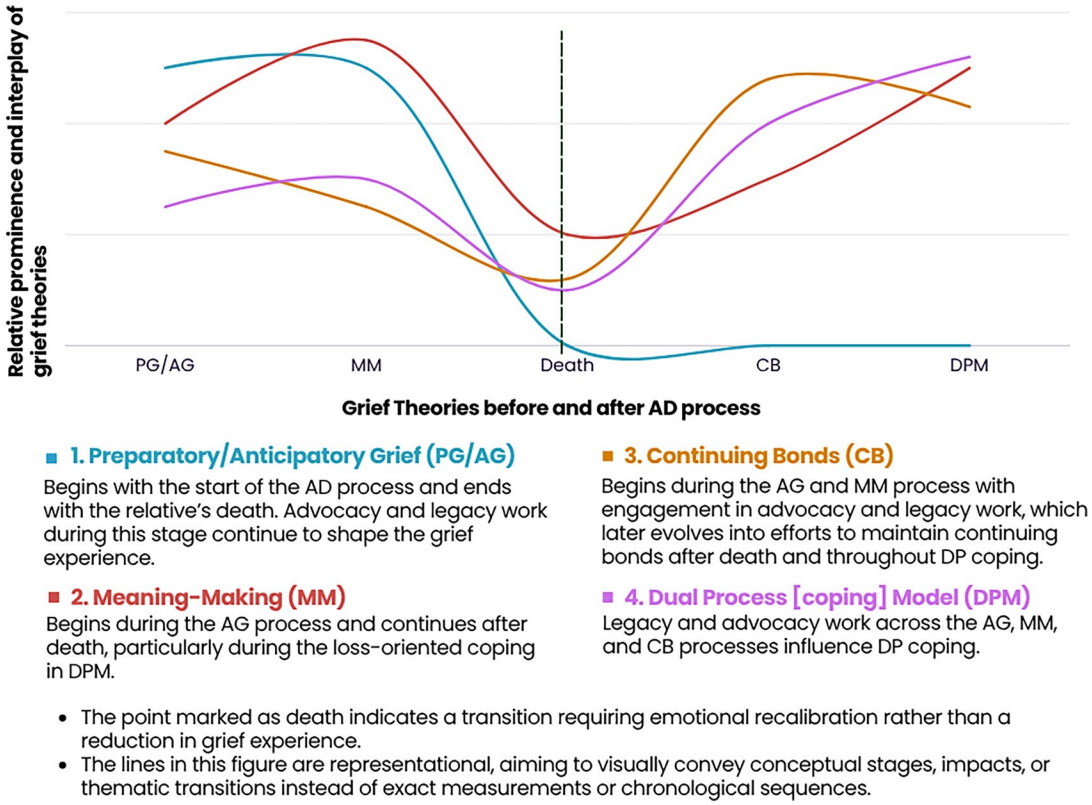

Figure 2. The interplay of AD grief across the AD process based on the grief theories.

Across these anticipatory to post-death phases, coping responses are activated from the onset of preparatory and anticipatory grief. From a functional perspective, these responses align with the Dual Process Model, whereby advocacy activities may be understood as restoration-oriented coping, while experiences of sadness, guilt, fear, or stigma reflect loss-oriented coping. It appears that loss-oriented and restoration coping and meaning-making are correlated. As individuals process the death, they simultaneously seek meaning and adjust to life without their relatives. The Dual Process Model appears to function as a pre- post-death coping framework operating throughout anticipatory, preparatory, and post-death phases of AD-related grief. This interplay highlights the unique nature of AD-related grief, shaped by its intentionality and the social environment, which influences grief across the AD journey. Figure 2 further shows the interplay of these theories across the AD process.

Discussion

This study explores AD-related grief. While grief is commonly associated with a post-death emotional response (Rogalla, 2020), our findings suggest that AD-related grief is not confined to the post-death period nor solely characterized by emotions such as sadness, anxiety, or denial. Rather, it is a multifaceted and evolving process that begins before death and continues through reflective and restorative practices afterwards. Death can bring a sense of relief, with love and compassion amidst the sadness. It involves advocacy, legacy work, meaning-making, and social navigation, serving both preparation and coping mechanisms.

Synthesizing the five themes, we find a patterned trajectory: (1) preparatory/anticipatory grief begins pre-AD and is supported by advocacy and legacy work; (2) meaning-making spans pre- and post-AD, shaping how patients and families construct narratives around the AD experience; (3) continuing bonds are sustained post-AD through legacy and advocacy extension and purposeful remembrance; (4) dual process oscillation between loss- and restoration-oriented coping characterizes post-AD adaptation; and (5) the social environment (support vs stigma/secrecy) impact each phase, either enabling or constraining grief responses. Taken together, these intertwined themes articulate a coherent framework (Figures 1 and 2) of AD-related grief across time.

These elements are common in bereavement generally (La Brooy et al., 2024; Neimeyer, 2011; Stroebe & Schut, 2010; Yan et al., 2023). However, as we and other studies have found, what distinguishes AD-related

grief is the active involvement of patients and families in shaping the dying process (Gamondi et al., 2019; Goldberg et al., 2021). What our findings add is that what distinguishes AD-related grief is not the presence of reflection, planning, or meaning-making per se, which may also occur in other forms of anticipated death, but the degree to which these processes are chosen, foregrounded, and unavoidable. The certainty of timing of death in AD requires patients and families to engage actively and deliberately in emotional, cognitive, and relational work before, during (for patients and families), and after death (for families). Grief in AD, therefore, involves an intensified and extended engagement with meaning-making, from the initial decision-making to post-death remembrance.

Our framework makes this distinctiveness explicit by locating these grief tasks along the AD timeline and showing how advocacy/legacy works and social environment feed into and shape meaning-making, continuing bonds, and dual-process coping. In this sense, AD's planned intentionality is not only contextual; it is structurally constitutive of how grief unfolds.

Gratitude for AD and grief

This research resonates with previous work that has considered the concept of gratitude in the context of AD and similarly found that people were grateful for the opportunity to seek a 'good death', avoid a 'bad death', and for being able to exercise control or choice at their death (La Brooy et al., 2024; White et al., 2025). The ability to choose AD as a means of control in the face of an inevitable death is recognized as a key condition for a good death (Martin et al., 2023). Any care that supports autonomy is also linked to improved emotional wellbeing for dying people preparing for death (preparatory grief) (Milic et al., 2025). These positive aspects can also support some families in their grief.

For both patients and families, having meaningful time together and being able to actively use that time and say goodbyes, and for families, standing in solidarity with the person's choice and knowing that their relative died in the way they wished, brought a sense of gratitude and comfort. This range of feelings has also been acknowledged by other scholars (La Brooy et al., 2024; Russell, 2024; Srinivasan, 2019).

In our research, for some, gratitude is a consequence of advocacy and legacy work that enhances meaning-making and coping. It does not necessarily diminish the sorrow of loss but rather co-exists with it and helps families to integrate autonomy, compassion, and relief into their post-AD narratives.

Advocacy, legacy, meaning-making, and grief

Findings regarding advocacy and legacy work highlight how patients and families process grief and the resulting meaning-making activities. Advocacy as grief work has also been reported elsewhere, with activities such as seeking law and policy reform, raising community awareness and engagement, and developing AD resources to support others (Jeanneret et al., 2024; 2024; La Brooy et al., 2024; Russell, 2024). Legacy work and engaging in meaningful activities and rituals both before and after death also play a key role in grief. For some patients and families, it helps to honor their life, maintain bonds, and find comfort through intentional reflection and shared memories (Beuthin et al., 2022; Boven et al., 2023; La Brooy et al., 2024). Advocacy and legacy work become especially important when low preparedness and anticipatory grief contribute to complicated grief (Nielsen et al., 2016). Recognizing continuing bonds and supporting oscillation between loss- and restoration-oriented coping, rather than becoming fixated in either mode, can facilitate better psychological adjustment by allowing individuals to process loss while adapting to ongoing life changes (Klass et al., 2014; Nielsen et al., 2016; Stroebe & Schut, 1999).

In this study, continuing bonds were expressed not evidently through direct interaction with the deceased, e.g., through conversation with the deceased or physical presence at the graveside, etc., but through extending their legacy and remembering them in meaningful ways. Rooted in upholding the deceased's values, this form of connection offers a purposeful and constructive response to loss and supports the grieving process. This interplay between continuing bonds and psychological adjustment involves how individuals make sense of the death, how they envisage their life after loss, and how they reconstruct their social identity through memories and ongoing living (Klass, 2006).

These linkages are shown in the framework: advocacy/legacy work undertaken in pre- and post-AD generate narrative resources that sustain continuing bonds and fuel meaning-making. This, in turn, facilitates the oscillation between loss and restoration. Practically, this suggests that clinicians can intentionally encourage advocacy/legacy opportunities to strengthen families' coping capacity and promote adaptive oscillation after the death.

In the AD context, the question *why AD* often feels answerable, unlike violent deaths, where meaning-making is more difficult (Currier et al., 2006; Neimeyer, 2006). Our participants answered the *why* and created new

narratives by identifying 'silver lining' benefits of AD: honoring integrity and autonomy and facilitating a more peaceful and controlled death. Participants also gained experiential wisdom and developed empathy toward others in similar situations by engaging in advocacy to improve AD services, raise public awareness, and reduce stigma, thereby continuing their relative's legacy. In this way, the death by AD held meaning (Currier et al., 2006), which supported their grieving process.

Better-informed families tend to cope more effectively with grief (Hebert et al., 2009). Combined with the knowledge of the date for AD (Young et al., 2026), AD facilitates communication with healthcare professionals, enabling preparedness across cognitive, emotional, and practical dimensions. These include resolving family conflict, clarifying spiritual or religious preferences, emotional and mental readiness, and completing tasks like wills, finances, and funeral planning (Hebert et al., 2009). These activities correspond to the preparatory/anticipatory grief phase of the framework. They provide the foundation for meaning-making and restoration after the death. A further anticipatory aspect unique to NZ relates to the early setting of the AD date (Young et al., 2026). Although date selection is necessary in all jurisdictions, in NZ it occurs soon after eligibility is confirmed, but before final approval (New Zealand Legislation, 2019). This sequencing may shape the emotional experience of patients and families, potentially intensifying anticipatory grief or creating a sense of finality earlier in the process. For some, planning around a chosen date deepened gratitude and supported emotional preparation; for others, it intensified the weight of anticipation, highlighting the complexity of grieving a chosen death.

Secrecy, stigma, and grief

The theme, 'Sharing AD Choice Publicly', revealed interpersonal and social dimensions of grief in ways not fully accounted for by the grief theories. It highlights the need to communicate grief and build social support around the AD loss. This emphasis on relational and social processes aligns with more recent extensions of the Dual Process Model, which conceptualize coping not only as an intrapersonal process but as unfolding within interpersonal and family contexts, where individuals' grief is shaped by and, in turn, shapes the responses of others (Stroebe & Schut, 2015).

AD could be categorized as a stigmatized death where it "leads others to attribute a level of responsibility to the deceased, causes a degree of peril to be perceived by the community, or has a sudden and/or unexpected nature" (Cohen & Samp, 2018). Our findings indicate that fear of stigma and judgment, and the resulting secrecy (Gamondi et al., 2019), can undermine positive cognitive appraisal of grief related to AD. This fear often discourages open conversations, which are known to help resolve AD-associated moral dilemmas, facilitate AD acceptance, and support bereavement (Snijdewind et al., 2014; Srinivasan, 2019). For example, families who keep the AD decision private may withdraw from meaningful support or experience disengaged interactions. Poor social integration and low societal appreciation of the individual's experience complicate grief (Wagner et al., 2012), while social connectedness is linked to a 'good death' (Buchbinder et al., 2018).

Our findings showed that some participants experienced heightened grief due to how AD was perceived by their family, social circles, and community. We note that this impact on grief is not related to the nature of AD itself, i.e., this additional grief burden from seeking AD does not come from a choice to seek AD but rather others' reactions to or judgments about it. We anticipate that the stigma and secrecy attached to AD, at least for some, will diminish over time as it becomes a more accepted end-of-life choice, and so too will this impact.

From a dual process model standpoint, difficulty managing loss- and restoration-oriented stressors is associated with poor bereavement outcomes (Stroebe & Schut, 2010). Consistent with our findings, families often view their relative's death as a positive and compassionate experience (Buchbinder et al., 2018; Gamondi et al., 2019; Smith et al., 2011). Conflicting emotions are also common (Yan et al., 2023) and can be processed through emotional and cognitive work (Gamondi et al., 2019). However, this work, central to both loss and restoration-oriented coping, can be disrupted when a personally meaningful and positive experience, such as a peaceful or empowering death, is not socially legitimized (Doka, 1999; Serota et al., 2023). This disconnect, although rare, may lead to self-doubt about their own feelings and internalized stigma (Hoggart, 2017). Others' disapproval of AD may increase feelings of having done something wrong (Wagner et al., 2012), reinforcing moral self-judgment and undermining restoration. A relatively positive AD experience may be overshadowed when societal norms expect grief to be marked by sorrow or distress.

An assisted death is often perceived as empowering or relieving (Goldberg et al., 2021). The tension between personal meaning and interpersonal or social perception can complicate emotional and cognitive processing, key components of the dual process model.

A disconnect between inner experience and social reality can also disrupt the continuing bond, which is often shaped and sustained through shared cultural and communal narratives. This tension can also affect those who, after the death, find the experience more emotionally challenging than they initially expected, which can intensify feelings of isolation or confusion and internal conflict. Some family members anticipated intense sadness or anger about AD and were surprised when their emotions differed. Their responses underscored the pressure of normative expectations around how one 'should' feel. It is essential that conversations about AD are inclusive and allow space for the full spectrum of emotional responses, whether positive, ambivalent, or difficult. Acknowledging all feelings without judgment supports authentic grief processing and reduces the risk of internalizing societal discomfort or stigma.

In sum, stigma and secrecy can disrupt meaning-making and oscillation, and they can also constrain the formation of continuing bonds. These findings expand on the framework's social environment component. While social stigma and lack of societal legitimization emerged as particularly prominent influences in participants' accounts, ambivalent and negative emotions were not limited to stigma alone and could also reflect moral complexity, existential dilemmas, relational dynamics, among other sources, which could be further explored in any future research.

Strengths and limitations

Including patients with lived experiences in our study on grief is a strength, as this is uncommon in other studies. This study draws on a predominantly NZ European sample, reflecting AD service users, but may limit transferability to other ethnicities. Our sister study on AD, led by Indigenous researchers, may provide unique AD-related grief related to Māori. Cultural differences in continuing bonds and social membership (Klass, 2014) may also shape how AD is perceived and how grief is expressed, underscoring the need to explore AD-related grief across diverse populations and jurisdictions. However, grief theories are derived from Western contexts, so there is salience for our participants. This research does not draw on every existing grief theory. The overall positive experience expressed by our participants may reflect self-selection, as individuals who experienced trauma related to AD may have been less likely to volunteer to participate. The few participants who were recruited through AD-supportive organizations may also have been more likely to present their experiences in ways more aligned with socially accepted and positive narratives of AD, potentially emphasizing positive aspects while glossing over more negative experiences.

There is merit in future researchers engaging with alternative models, such as Tonkin's 'Growing Around Grief' (Tonkin, 1996), to extend these findings, particularly through longitudinal studies that can capture the evolving nature of grief over time.

Further, NZ's unique legal requirement to set a date for AD may shape grief responses, limiting generalizability. In jurisdictions where AD law differs, such as those with no specific life expectancy, patients and families may have varying opportunities for emotional preparation, potentially altering anticipatory and preparatory grief and, consequently, the post-death grief. Where AD is available for conditions beyond terminal illness, such as psychiatric conditions, grief responses may be more complex, especially if families view the condition as treatable and struggle to understand the decision to pursue AD.

Conclusion

This study offers a nuanced understanding of grief in the context of AD, showing how patients and families navigate emotional, cognitive, and social dimensions of loss. Framed by grief theories, our findings show that AD activates both loss- and restoration-oriented processes, facilitating emotional preparation, legacy-building, and meaning-making. These processes, however, may be challenged when personal experiences conflict with societal norms, potentially leading to emotional confusion and challenged coping.

The findings suggest that AD can function as a protective psychological intervention, counteracting the emotional burden often associated with anticipatory and preparatory grief. AD enables patients and families to engage in end-of-life planning, resolve unfinished business, and preserve existential well-being, factors known to improve quality of life and bereavement outcomes. Advocacy and legacy work emerged as powerful tools for families to honor their loved ones, often providing comfort and pride. Longitudinal studies are, however, required to further validate this finding.

While this study draws attention to the often-positive features of AD-related grief, it is essential to acknowledge the emotional distress and moral complexity involved for some. Families are losing a relative through an unfamiliar process, which can evoke ethical dilemmas and emotional strain. Our aim is not to portray these experiences as uniformly positive or negative, but to highlight their distinctive features and how individuals navigate them. By clarifying how grief

unfolds in this unique context, through emotional processing, cognitive adaptation, and social expression, we contribute to a broader conceptualization of grief. Despite these contributions, grief theories have historically prioritized intrapersonal and psychological processes, often overlooking the interpersonal and social contexts in which grief occurs; a gap repeatedly noted by scholars calling for more socially embedded bereavement models (Stroebe & Schut, 1999). Additionally, grief and the AD experience are deeply shaped by personal beliefs, cultural norms, individual circumstances, and legal frameworks.

Future research could also explore whether individuals who pursue AD engage with preparatory grief and end-of-life planning (e.g., will-making) in distinct ways, particularly in relation to awareness of mortality, desire for control, and the impact of eligibility processes on these experiences.

This framework may be especially valuable for clinicians, researchers, and policymakers working in AD care. Importantly, while many participants did not seek formal grief counseling, the absence of AD-specific bereavement support, or bereavement support that is sensitive to the AD experience, remains a gap. Grief therapists and end-of-life practitioners may benefit from using the thematic frameworks presented (Figures 1 and 2) to guide tailored therapeutic approaches. This framework offers them a map for preparation and post-death adaptation. At a policy and practice level, these findings suggest the need for AD services to incorporate specialized, theory-informed bereavement support for patients and families, and to support knowledge transfer of AD-related grief across the wider health-care system. Based on this research, we have developed a grief resource to support assisted dying service users and their families throughout the period leading up to and following an assisted death (Dehkhoda & Young, 2026).

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Ethical approval

The ethical aspects of this study have been approved by the Northern A Health and Disability Ethics Committee through the full review pathway [ref 2023 EXP 18493].

Author's contributions

AD: Conceptualization; Data curation; Formal analysis; Investigation; Methodology; Resources; Validation; Visualization; Writing—original draft; Writing—review & editing.

JY: Conceptualization; Supervision; Project administration; Funding Acquisition; Data curation; Investigation; Methodology; Validation; Writing—review & editing.

BW, GC, KD, JS, KR, TMM, and AAD: Conceptualization; Methodology; Validation; Writing—review & editing.

Informed consent

All participants freely provided written informed consent to participate in this study.

Disclosure statement

We were invited to submit to the End of Life Choice Act Review, so some of the qualitative data presented in this article may also be represented in the findings of the review. Jessica Young and Gary Cheung were members of Support and Consultation for End of Life in New Zealand (SCENZ) from 2021 to 2023. Ben P White has received funding to conduct research on AD from the Australian Research Council, state governments, and philanthropic organizations. He was also engaged (with colleagues) by three Australian state governments (Victoria, Western Australia, and Queensland) to develop the legislatively mandated training for health practitioners providing AD in those states. Additionally, he was engaged as part of the team to provide a research report to support the Western Australian review of the AD laws. Ben was also appointed as an Expert Legal Advisor to the Legal and Constitutional Affairs Committee of the Legislative Assembly of the Northern Territory for its report on AD and (with colleagues) developed the accompanying drafting instructions. In addition, he has developed a model bill for AD for parliaments to consider. Ben's research is supported by an Australian Research Council Future Fellowship (project number FT190100410: Enhancing End-of-Life Decision-Making: Optimal Regulation of Voluntary Assisted Dying) funded by the Australian government. No potential conflict of interest was reported by the other authors.

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Data availability statement

We do not have ethical approval to share data publicly due to privacy and ethical restrictions. Interview guides are available as supplementary material.

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