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Implementing assisted dying in rural and remote Australia and comparable jurisdictions: A scoping review

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ABSTRACT

Assisted dying presents unique challenges in rural and remote communities, where geographic isolation, cultural norms, and service limitations shape access and experience. This scoping review synthesized peer-reviewed and grey literature from Australia and comparable jurisdictions (primarily Canada, one study from India) identifying key themes relating to assisted dying implementation in rural and remote contexts. Five themes emerged: legislative and policy frameworks; cultural, social, and ethical considerations; access and equity in service provision; healthcare provider roles and experiences; and family and community impact. Findings highlight how restrictive telehealth laws, provider scarcity, and administrative burden disproportionately affect rural and remote patients. Cultural and institutional dynamics influence acceptance, while families face emotional, logistical, and social pressures. Innovative models such as nurse practitioner inclusion, care navigation, and culturally safe outreach offer potential solutions. Assisted dying is not merely a clinical procedure but a socially embedded practice. Equitable access requires coordinated legal, relational, and infrastructural reforms.

Background

Globally, people living in rural and remote regions experience longstanding inequities in access to healthcare, including fewer clinicians, reduced service availability, and poorer health outcomes compared with metropolitan populations (Australian Institute of Health and Welfare, 2024; Pugh et al., 2019; Schiller, 2017; Whitehead et al., 2018). These disparities have significant implications for assisted dying, a practice that relies on timely access to trained practitioners, coordinated assessments, and supportive end-of-life services. For rural and remote patients, geographic isolation, limited resources, and workforce shortages can impede access to assisted dying and related supports, despite legislative intentions to provide equitable care (Health Canada, 2025; New South Wales Health, 2023).

Assisted dying is now lawful in a growing number of jurisdictions worldwide, including the Netherlands, Belgium, Luxembourg, Switzerland, parts of the United States, Canada, Australia, New Zealand, and Colombia, each with distinct eligibility criteria and service delivery models (Dyer et al., 2015; Emanuel et al., 2016; Government of Canada, 2025). However, despite this global expansion, very little empirical research has examined how assisted dying is implemented in rural and remote regions across these settings.

Empirical literature on rural and remote assisted dying is concentrated in Australia and Canada (Schiller, 2017; Willmott et al., 2023). As such, it is necessary to outline the key features of their respective legal frameworks: voluntary assisted dying (VAD) and medical assistance in dying (MAiD), to contextualize the issues examined in this review. VAD in Australia and MAiD in Canada provide legal frameworks for eligible adults to request medical assistance to end life in the context of advanced, progressive illness (Government of Canada, 2025; New South Wales Government, 2024). VAD generally applies to individuals expected to die within six months, or 12 months for neurodegenerative disease (New South Wales

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Health, 2023), while MAiD, introduced federally in 2016, is governed by strict eligibility criteria and safeguards to ensure decisions are informed and voluntary (Government of Canada, 2025). For clarity, this review uses the umbrella term "assisted dying" to refer to these jurisdictional practices, retaining statutory terms when discussing specific legislation or data. Both systems emphasize autonomy and person-centred care and aim to support patients to receive end-of-life care as close to home as possible (Government of Canada, 2025; New South Wales Health, 2023). Yet for rural and remote residents, this goal is often compromised by the structural realities of distance, limited services, and workforce maldistribution.

Because this review examines assisted dying access in rural and remote settings across multiple jurisdictions, it is necessary to outline how rurality is defined in different contexts. Assisted dying legislation and service delivery models operate within country-specific geographic, administrative, and health-system structures, and these differences shape how "rural" and "remote" are conceptualized in the literature. Although our search strategy was global, the empirical evidence identified came predominantly from Australia and Canada, with one study from India. Clarifying the major rurality frameworks used in these jurisdictions provides essential context for interpreting the evidence and understanding how access barriers manifest across diverse settings.

Definitions of rurality differ across jurisdictions. In Australia, the Australian Statistical Geography Standard classifies regions by service accessibility, while the Modified Monash Model (MM) further categorizes rurality from large rural towns (MM3) to remote communities (MM6) (Australian Bureau of Statistics, 2024; Department of Health, 2019). Canada commonly uses an Index of Remoteness that measures geographic proximity to population and service centers (Statistics Canada, 2023; Subedi et al., 2020). In India, the Census distinguishes urban from rural areas using statutory town status and demographic thresholds, with researchers often supplementing these definitions with travel-time, service-availability, or socioeconomic indicators to identify remote communities (Aijaz, 2017; Government of India, 2018). These frameworks highlight the diversity of rural contexts and the logistical challenges of delivering assisted dying across geographically dispersed populations.

The implementation of assisted dying legislation in NSW illustrates how access inequities manifest at a local level. The NSW Voluntary Assisted Dying Act 2022 guarantees that eligible rural and remote patients are "entitled to the same level of access" as metropolitan residents (Voluntary Assisted Dying Act 2022 (NSW) s 4(1)(i)). However, the vast geographic scale of some NSW's health districts – up to 246,676 square kilometers – creates substantial logistical barriers to equitable access (New South Wales Government, 2025). Access is further constrained by the Commonwealth Criminal Code, which makes it an offense to use a carriage service to "counsel or incite suicide" (Criminal Code Act, 1995 (Cth) ss 474.29 A–474.29B). Recent Federal Court interpretation has confirmed that these provisions can apply to lawful assisted dying communications, meaning state assisted dying laws cannot authorize telehealth for certain steps (Barry Nilsson Lawyers, 2023; Ferris, 2023). As a result, key assessments must occur in person, disproportionately affecting rural and remote patients who must travel long distances for consultations. In response, jurisdictions such as Queensland and Western Australia (WA) have implemented targeted access-equity initiatives, including travel support schemes, care navigator services, and expanded practitioner roles (Queensland Health, 2023; Willmott et al., 2023).

While individual jurisdictions have developed strategies to address rural and remote access challenges, the evidence base remains fragmented. Existing reviews focus on specific states or countries (Schiller, 2017; Willmott et al., 2023), but to our knowledge, no comprehensive scoping review has synthesized international evidence on assisted dying implementation in rural, remote, and geographically isolated settings. Establishing this evidence base is essential for informing future policy, evaluating implementation, and identifying gaps requiring further investigation. Therefore, this scoping review seeks to identify, examine, and synthesize the current evidence regarding the implementation, challenges, and outcomes of assisted dying in rural and remote areas.

Research question

What is the current evidence base regarding the implementation, challenges, and outcomes of assisted dying in rural and remote areas?

Methodology

Study design and rationale

The review was guided by Arksey and O'Malley (2005)'s scoping review framework, enhanced by Levac et al. (2010)'s methodological recommendations, and strengthened by adherence to the Preferred Reporting Items for Systematic reviews and Meta-Analysis extension for scoping reviews (PRISMA-ScR) (Tricco et al.,

2018). An initial *a priori* review protocol and eligibility criteria were devised with consideration of the research question. The protocol was registered at Open Science Framework prior to conducting the primary literature search strategy.

Eligibility criteria

Inclusion criteria

No date limits were applied. We included studies and reports addressing assisted dying in non-metropolitan settings for adult populations only. Eligible sources comprised primary empirical studies of any design, relevant systematic reviews, government and higher-education reports, theses and dissertations, non-peer-reviewed professional and industry publications, conference abstracts/presentations, and relevant opinion pieces, blogs, websites, and resource materials. Because national definitions of rurality and remoteness differ, we used each jurisdiction's official classification when extracting and reporting jurisdiction-specific findings (Australia: Australian Statistical Geography Standard/Modified Monash Model; Canada: Statistics Canada remoteness indices; India: Census/administrative definitions). Although the review was not restricted by country, included literature was limited to English-language sources; in practice the empirical evidence located was concentrated in Australia and Canada, with one study from India retained as a contextual comparator. We report this geographic concentration and its implications for transferability in the Discussion.

Exclusion criteria

We excluded studies that focused exclusively on metropolitan populations and studies that included pediatric populations. Sources not available in English were excluded because the review team did not have resources for systematic, reliable translation of legal and culturally nuanced material. Bibliographic details of non-English records identified during screening were recorded for potential targeted translation in future work.

Search strategy

A preliminary search of literature was conducted by the first author at the end of 2024 and again in June 2026 to ensure currency. Databases searched included: Medline, PubMed, Cumulated Index in Nursing and Allied Health Literature (CINAHL), and Scopus. A Google Scholar search for additional grey literature was also conducted. The reference lists of all included sources of evidence were screened for additional studies. An initial exploratory search and consultation with a university health librarian indicated that Medline, PubMed, CINAHL, and Scopus were the most appropriate databases for this topic, as they index the core clinical, nursing, health policy, and rural health literature. The selected databases provided the most comprehensive coverage for assisted dying and rural health research.

Keyword search terms and Boolean operators utilized are displayed in the Supplementary material section (Supplementary Table 1). Keywords were mapped to database subject headings where possible. The search results from all databases were imported into Covidence™, for level one (title and abstract) and level two (full text) screening and duplicates were removed before screening.

Selection of studies

Titles and abstracts were then systematically reviewed by three independent reviewers (MH, SJ, PI) against the predefined eligibility criteria.

Full texts of potentially relevant sources were retrieved and examined in detail by the same reviewers. Reasons for exclusion at the full-text stage are documented in the PRISMA flow chart. At each stage of the selection process, any discrepancies between reviewers were resolved through discussion and consensus, thereby ensuring methodological rigor.

The overall study selection process is presented in accordance with PRISMA-ScR and is depicted in Figure 1.

Data extraction and synthesis

Data was extracted from papers included in the scoping review by three independent reviewers (MH, SJ, PI) using a data extraction tool developed by the reviewers. The data extraction tool was piloted by the three reviewers, modified and revised prior to data extraction commencing.

Data extraction captured the author/s, year, country, study design, study aim, and key findings relevant to the review questions, as presented in Table 1.

Data analysis was guided by the Braun and Clarke (2006) six-stage thematic analysis process to facilitate the identification of common patterns within the data. The first step involved three authors (MH, SJ, PI) familiarizing themselves with the data collected from the extraction tool where key findings were collated and summarized. Step two involved all four authors coding the data to organize and categorize important data that captured the essence of the content relevant

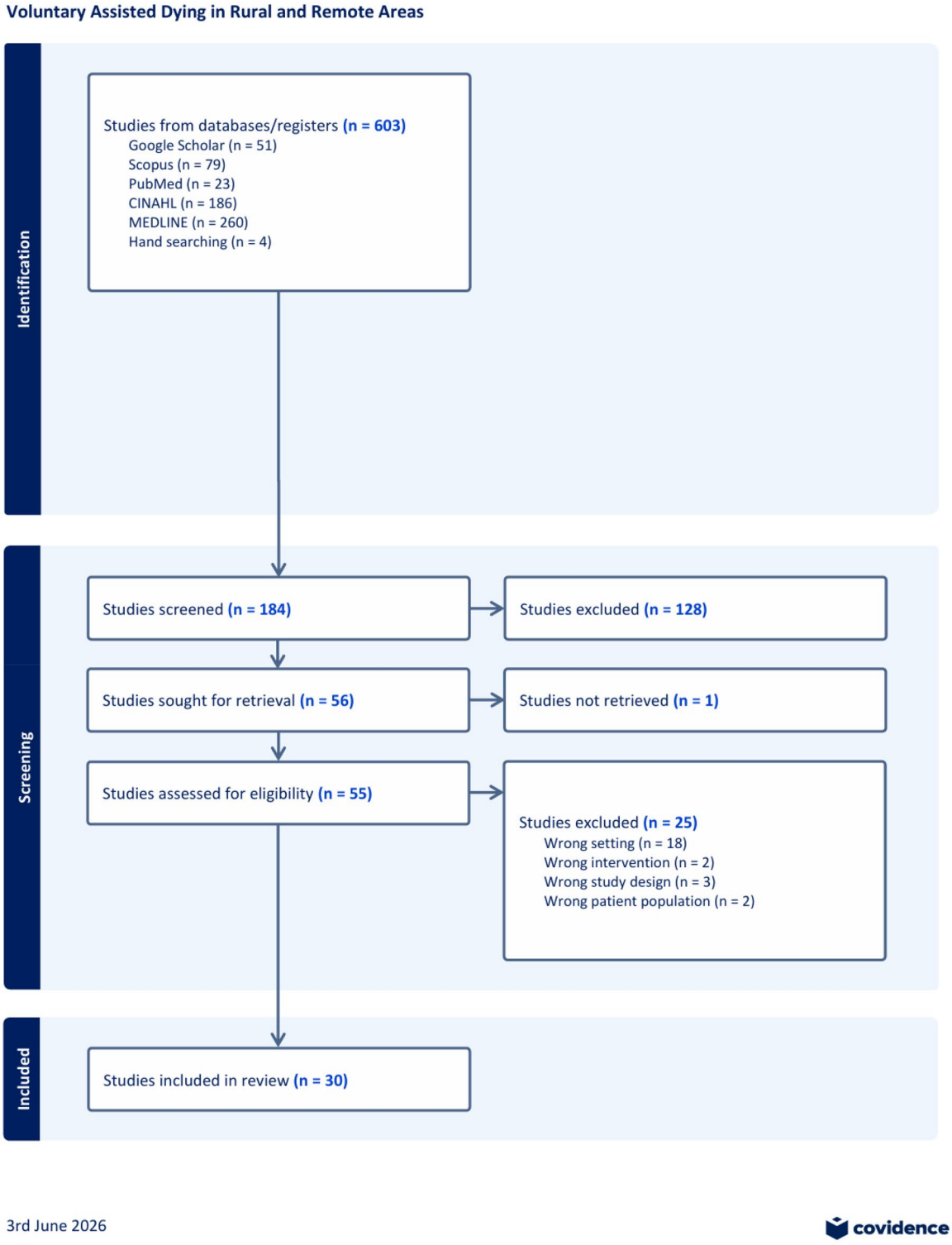

Figure 1. PRISMA diagram.

to the research question. This enabled the authors to begin generating the central organizing concepts as initial themes (step three), and then the themes were reviewed and refined by three authors (step four). Step five required the authors to define and name the themes. Consensus was achieved through an iterative process in which the authors independently reviewed the preliminary themes against the extracted data, discussed areas of convergence and divergence, and refined theme names and descriptions until agreement was reached. Once consensus was achieved, each theme was extrapolated to present a detailed picture of the analyzed data. As per scoping review methods, the quality of the included studies was not appraised.

Table 1. Characteristics of included studies.

Author(s)	Year	Country	Study design	Aim	Key findings
Auret et al., 2022b	2022	Australia	Qualitative	To explore how staff, volunteers, and community members expected a rural hospice to respond to the introduction of voluntary assisted dying (VAD).	Participants expressed diverse expectations about whether a hospice should provide VAD, balancing community trust, cultural safety, and organizational identity. Rural inequities were emphasized, with concerns that restrictive policies could further disadvantage regional patients.
Auret et al., 2022a	2022	Australia	Qualitative	To describe how a rural hospice board made organizational decisions about whether to participate in VAD.	Decision-making was shaped by personal beliefs, formative experiences, organizational risk, and community expectations. Board members ultimately aligned their decision with hospice values, highlighting the importance of time, resources, and trust in navigating VAD implementation.
Auret et al., 2025	2025	Australia	Mixed methods	To examine early experiences of staff and volunteers at a rural hospice two years after VAD became available.	Staff felt prepared and described VAD as compatible with palliative care. They reported emotional impacts, subtle shifts in workplace culture, and a need for ongoing education and debriefing. Rural context shaped workload, access, and support needs.
Close et al., 2021	2021	Australia	Commentary	To analyze how Commonwealth carriage service laws restrict telehealth discussions about VAD.	Commonwealth Criminal Code provisions prohibit telehealth discussions about suicide, creating major barriers for VAD assessments. This disproportionately affects rural and remote patients who rely on telehealth due to distance and limited specialist availability.
Cole et al., 2025	2025	Australia	Empirical study	To examine equity of access to VAD substances under a centralized pharmacy model.	Centralized pharmacy distribution created delays and logistical barriers, particularly for rural and remote patients. The model improved safety and standardization but amplified geographic inequities. Findings highlight the need for regionally responsive dispensing pathways.
Collins & Leier, 2017	2017	Canada	Discussion	To examine how medical assistance in dying (MAiD) affects rural physicians and palliative care delivery.	MAiD risks undermining palliative care in rural areas where services are already limited. Physicians face ethical tensions, resource shortages, and heavy workloads, raising concerns about equitable end-of-life care.
Del Villar et al., 2022	2022	Australia	Commentary	To highlight inconsistencies between state VAD laws and the Commonwealth Criminal Code.	Telehealth restrictions conflict with state VAD frameworks, limiting equitable access. Authors argue practitioner-administered VAD is distinct from suicide and should be exempt from federal prohibitions.
Draper et al., 2024	2024	Australia	Conference abstract	To describe how the Victorian VAD Navigator Service operated without digital technology due to legal restrictions.	Criminal Code restrictions forced navigators to avoid telehealth, phone, and email. In-person visits caused delays, especially for regional patients. Geographic location and travel limitations significantly affected timely access. Regional navigators were essential to mitigate inequity.
Durant & Kortes-Miller, 2020	2020	Canada	Qualitative	To explore physician experiences with MAiD in northwestern Ontario.	Physicians reported limited palliative care resources, unclear roles, and emotional challenges. Integration of palliative care and MAiD, along with better support systems, was identified as essential for rural equity.
Haining et al., 2023	2023	Australia	Qualitative	To explore early experiences of regional stakeholders with VAD in Western Australia.	The Regional Access Support Scheme (RASS) was vital for reducing inequities. Local providers were essential for continuity, but distance and limited telehealth capacity continued to restrict access.
Jeanneret et al., 2024	2024	Australia	Qualitative	To investigate how patients and families take "regulatory action" to overcome barriers to VAD.	Families actively shaped system behavior by navigating obstacles, advocating for access, and coordinating care. Their actions highlighted systemic gaps and the need for stronger structural support.
Kissane et al., 1998	1998	Australia	Case report	To describe clinical and psychosocial features of seven cases under the Rights of the Terminally Ill Act.	Patients experienced depression, social isolation, and complex decision-making. Rural providers faced difficult gatekeeping roles, including assessing terminal status and mental health with limited resources.
Komesaroff & Philip, 2023	2023	Australia	Editorial	To reflect on the implementation of VAD in Victoria.	VAD is widely accepted but inequities persist, especially for rural patients. Institutional barriers and legislative constraints require ongoing evaluation and reform.
Lamba et al., 2025	2025	Australia	Perspective	To explore challenges in implementing VAD in Northern Territory Aboriginal communities.	Cultural tensions, kinship-based decision-making, and limited services shape VAD acceptability. Telehealth was strongly supported as a means to improve equity in remote regions.
La Brooy et al., 2024	2024	Australia	Qualitative	To examine grief and bereavement experiences of families involved in VAD.	Anticipatory grieving was common, and families valued supporting a "good death." Rural participants faced additional burdens due to travel and limited local services.
Lewis et al., 2024	2024	Australia	Qualitative	To explore carers' emotional and practical experiences supporting someone seeking VAD.	Carers undertook significant emotional labor and navigated moral tensions. Rural carers faced additional logistical barriers that limited agency and shaped outcomes.

(*Continued*)

Table 1. Continued.

Author(s)	Year	Country	Study design	Aim	Key findings
Light et al., 2024	2024	Australia	Survey	To assess clinician support for VAD and willingness to participate.	Awareness and support were high, but willingness to take on VAD roles was lower, especially among medical specialists. Despite this, enough clinicians were willing to enable statewide implementation.
Murphy, 2022	2022	Australia	Review	To provide an overview of VAD legislation and access barriers.	Safeguards sometimes create unintended barriers, particularly in rural areas. Restrictions on initiating discussions and limited provider availability reduce equitable access.
Panchuk & Thirsk, 2021	2021	Canada	Ethical analysis	To examine conscientious objection to MAiD in rural nursing.	Rural isolation and limited staffing intensify ethical tensions. Urban-focused policies fail to address rural realities, risking reduced access for patients.
Ramalingam & Ganesan, 2019	2019	India	Qualitative	To explore sociocultural determinants of end-of-life practices in rural South India.	Traditional practices such as Thalaikoothal reflect cultural beliefs and limited access to palliative care. Economic pressures and spiritual values strongly influence decisions.
Schiller, 2017	2017	Canada	Review	To examine challenges of MAiD in rural communities.	Geography, limited resources, and provider shortages hinder access. Nurse practitioners (NPs) play a crucial role but face emotional and ethical pressures.
Sedgwick et al., 2024	2024	Canada	Qualitative	To understand rural healthcare professionals' experiences with MAiD.	Participation is fluid and context-dependent, shaped by moral beliefs, patient suffering, and evolving legislation. Clearer guidance is needed.
Sinclair et al., 2014	2014	Australia	Qualitative	To explore attitudes toward advance care planning (ACP) among Dutch and Italian migrants in rural Australia.	Cultural heritage and migration experiences shaped ACP and euthanasia attitudes. Dutch participants emphasized autonomy; Italian participants emphasized family-centred decision-making.
Summers et al., 2025	2025	Australia	Systematic review	To synthesize evidence on telehealth use in VAD.	Telehealth improves access but is constrained by legal prohibitions. Rural and remote patients are disproportionately affected by telehealth bans. Review highlights urgent need for legislative reform.
White et al., 2023a	2023	Australia	Qualitative	To examine how Commonwealth telehealth restrictions affect VAD.	Telehealth bans delay assessments and disproportionately burden rural patients. Travel requirements create inequity and distress.
White et al., 2023c	2023	Australia	Qualitative	To investigate barriers and facilitators to VAD access in Victoria.	Barriers included difficulty finding trained physicians, institutional objections, and telehealth bans. Facilitators included care navigators and coordinating practitioners.
White et al., 2024	2024	Australia	Qualitative	To examine models of care for VAD in Queensland.	Public-sector model with strong NP involvement. Rural access constrained by geography and workforce shortages.
Willmott et al., 2023	2023	Australia	Policy report	To identify initiatives addressing regional and remote access inequities in Western Australia.	Regional Access Support Scheme (RASS), care navigators, and NP roles improved access, though distance and telehealth restrictions remain challenges.
Willmott et al., 2024	2024	Australia	Research report	To review the operation and effectiveness of the Western Australia VAD system.	System functions well once patients connect, but public awareness, navigation, and workforce sustainability remain priority issues.
Waller et al., 2023	2023	Australia	Legal analysis	To compare VAD laws across Australian states.	States share a broadly consistent model, but variations in eligibility, practitioner roles, and safeguards affect equity and implementation.

For clarity, we use the following terms throughout the manuscript. "Physicians" refers to medically qualified doctors. "Nurse practitioners" (NP) refers to advanced practice registered nurses with formal endorsement that authorizes autonomous prescribing and expanded practice (Nursing & Midwifery Board of Australia, 2016). "Practitioners" is used as an umbrella term to denote either physicians or NP when studies do not distinguish between these professions. Where a study reports a specific role (for example, administering practitioner, coordinating practitioner), we report that role verbatim.

Results

The primary electronic search strategy identified 184 records from level one screening. Of these, 55 records were retrieved in full text and subjected to level two screening. Twenty-five articles were excluded from the review due to not meeting the inclusion criteria. Following the second round of level screening, a total of 30 full-text articles were included for review. Article publication dates spanned 28 years (1998–2026), and the majority were from Australia and Canada; one study originated from India and is discussed as a low-resource comparator where relevant. Overarching themes that emerged from the data, which span multiple jurisdictions, cultural contexts, and facets of end of life (EOL) care legislation and practice, are presented below (Table 2).

Legislative and policy frameworks

Several articles have highlighted the challenges for assisted dying that stem from inconsistent or developing legislation, such as the Rights of the Terminally

Table 2. Themes.

Theme	Codes	Articles
Legislative and policy frameworks	Conscientious objectors, Legislation, Telehealth	Auret et al. (2022a) Auret et al. (2025) Cole et al. (2025) Collins and Leier (2017) Close et al. (2021) Del Villar et al. (2022) Draper et al. (2024) Durant and Kortes-Miller (2020) Haining et al. (2023) Komesaroff and Philip (2023) La Brooy et al. (2024) Lamba et al. (2025) Light et al. (2024) Murphy (2022) Panchuk and Thirsk (2021) Schiller (2017) Sedgwick et al. (2024) Summers et al. (2025) Waller et al. (2023) White et al. (2023c) White et al. (2023d) Willmott et al. (2023)
Cultural, social, and ethical considerations	Rural communities	Auret et al. (2022b) Collins and Leier (2017) Durant and Kortes-Miller (2020) Haining et al. (2023) La Brooy et al. (2024) Ramalingam and Ganesan (2019) Sedgwick et al. (2024) Sinclair et al. (2014) Waller et al. (2023)
Access and equity in service provision	Access, Barriers, Delays, Eligibility, Initiatives	Cole et al. (2025) Collins and Leier (2017) Close et al. (2021) Draper et al. (2024) Durant and Kortes-Miller (2020) Haining et al. (2023) Kissane et al. (1998) Komesaroff and Philip (2023) Murphy (2022) Schiller (2017) Sinclair et al. (2014) Waller et al. (2023) White et al. (2023c) White et al. (2024) Willmott et al. (2023)
Healthcare provider roles and experiences	Local clinicians, Nurse practitioners, Palliative care, Qualified practitioners	Collins and Leier (2017) Draper et al. (2024) Durant and Kortes-Miller (2020) Haining et al. (2023) Murphy (2022) Schiller (2017) Sedgwick et al. (2024) Waller et al. (2023) Willmott et al. (2023)
Family and community impact	Advocacy, Family and carers	Haining et al. (2023) Jeanneret et al. (2024) La Brooy et al. (2024) Lewis et al. (2024) Ramalingam and Ganesan (2019) Sedgwick et al. (2024) White et al. (2023d)

Ill Act and restrictions under the Commonwealth Criminal Code (Close et al., 2021; Del Villar et al., 2022; Haining et al., 2023; Panchuk & Thirsk, 2021; White et al., 2023d; Willmott et al., 2023). Many of these articles call for legislative amendments that clarify legal uncertainties, align state and federal laws, and remove barriers, such as those relating to telehealth, that impede equitable access for patients, particularly those in rural and remote areas. One example, WA, has implemented tailored initiatives such as the RASS, telehealth guidance, and expanded roles for NPs, to specifically address the inequities in accessing assisted dying in rural and remote settings (Haining et al., 2023; Willmott et al., 2023).

> The rural solution in WA would not have worked without the RASS on the current payment schedule. [Health Practitioner 6]. (Haining et al., 2023, p. 5)

Newer evidence reinforces these concerns. Summers et al. (2025) found that telehealth plays a critical role in improving access to assisted dying, yet Australia remains constrained by federal legislation that prohibits its use for assisted dying-related discussions. Their systematic review highlights how these restrictions disproportionately disadvantage rural patients and strengthens calls for reform of the Commonwealth Criminal Code. Similarly, Draper et al. (2024) demonstrated how Victorian care navigators were required to operate "in a digital era without digital technology" (conference abstract), relying on in-person visits and postal communication to remain compliant with federal law. These adaptations resulted in significant delays for regional patients, illustrating the real-world consequences of legislative misalignment. Cole et al. (2025) also showed how policy decisions, such as implementing a centralized pharmacy model, can unintentionally exacerbate geographic inequities, with rural patients experiencing longer wait times and greater logistical burden. Together, these studies underscore the ongoing need for coordinated legislative and policy reform to ensure that assisted dying systems function equitably across diverse geographic contexts.

Further legislative challenges are present in the significant bureaucratic and administrative demands related to assisted dying processes (La Brooy et al., 2024; Murphy, 2022; Waller et al., 2023; White et al., 2023c). Assisted dying laws require substantial documentation at each stage – First Request, Assessment Reports, Written Declarations, Final Requests, Final Reviews, and Notifications of Death – each with associated verification, witnessing, and lodgment requirements (La Brooy et al., 2024; Murphy, 2022; Schiller, 2017; Waller et al., 2023). Practitioners must also complete extensive, state-specific training before participating (Light et al., 2024). This creates a significant impact on access, particularly for rural and remote patients. For already stretched rural and remote health workforces, these administrative requirements are a deterrent. Practitioners commonly cited paperwork as a reason for nonparticipation or limiting their assisted dying involvement (White et al., 2023c). Delays in paperwork processing, training access, and communication with oversight boards can prolong suffering for patients with short prognoses (Willmott et al., 2023).

> When you live regionally, everything takes at least another 24 hours… Even if it's priority post that's coming from a regional area to the city, that's not going to happen overnight. (White et al., 2023d, p. 2)

Further administrative and reporting challenges are related to mandates for the collection and publication of statistics on rural and remote access to enable evaluation of equity and guide iterative improvements in policy and practice (La Brooy et al., 2024; Murphy, 2022; Waller et al., 2023; Willmott et al., 2023). Breaches in reporting can attract penalties, and failure to strictly comply is treated seriously under professional misconduct provisions, increasing practitioner anxiety about involvement in unfamiliar processes (Willmott et al., 2023). While rigorous administration is essential to safeguard assisted dying processes, the studies uniformly report the risk that administrative complexity itself becomes a barrier to access, particularly for rural and remote patients and their local providers (La Brooy et al., 2024; Murphy, 2022; Sedgwick et al., 2024; Waller et al., 2023; White et al., 2023c).

Additional important findings related to assisted dying and its legislative requirements include telehealth restrictions, particularly in Australia, under the Commonwealth Criminal Code (Close et al., 2021; Del Villar et al., 2021; White et al., 2023d).

> The barrier around what can and can't be discussed over a carrier service … is just crazy, and in the era of telehealth. (White et al., 2023d, p. 2)

The Australian Commonwealth Criminal Code (sections 474.29A and 474.29B) makes it a criminal offense to use any means of telehealth, such as phone, video, email or other electronic media, to discuss or provide information deemed to incite or counsel suicide, which some studies interpret may include lawful assisted dying consultations (Close et al., 2021; Del Villar et al., 2022; Komesaroff & Philip, 2023; White et al., 2023d; Willmott et al., 2023). This legislative interpretation means that even where assisted dying is legal at state level, eligible patients and health professionals cannot use telehealth for assessments, information-sharing, or even prescription consultations relating to assisted dying. The risk of a substantial fine and prosecution acts as a deterrent for both practitioners and institutions (Close et al., 2021; Del Villar et al., 2022; Komesaroff & Philip, 2023; White et al., 2023d). The ban on telehealth use disproportionately impacts those in rural and remote Australia, as it requires travel for multiple consultations, which many terminally ill or severely disabled patients cannot manage (White et al., 2023c).

> I think that the difficulties facing rural and remote living people will be enormous so telehealth must be considered. (Lamba et al., 2025, p. 293)

> [My patient] was in a wheelchair coming in her jammies and her dressing gown because she was too sore and too tired to get dressed, but had to come in person to have another consultation … because you're not allowed to talk over the phone. (White et al., 2023d, p. 2)

In order to meet the needs of patients who are unable to travel, physicians are compelled to travel long distances, often at personal cost, to conduct assessments in person (White et al., 2023d). It is clear that the requirement for in-person consultation not only delays the process but can mean that some patients deteriorate and lose decision-making capacity before assisted dying can be accessed (Haining et al., 2023; Murphy, 2022; White et al., 2023d). The telehealth ban is widely recognized as an outdated legislative piece, enacted long before assisted dying was contemplated as a lawful medical practice (Close et al., 2021; Del Villar et al., 2022; Komesaroff & Philip, 2023; White et al., 2023d; Willmott et al., 2023). In today's environment where telehealth is routine for many health services, including those involving confidential, EOL decisions, it stands as a unique and distressing impediment for dying patients, especially in rural and remote communities (Close et al., 2021; Del Villar et al., 2022; Murphy, 2022; White et al., 2023d).

> People having to travel over 10 hours to get this done is cruel, and I don't think it's what was intended by this legislation. (White et al., 2023d, p. 3)

The consensus among practitioners, advocacy groups, and families is that this restriction is not a safeguard but instead a source of unnecessary suffering, burden, and risk for the most vulnerable – those for whom dignified, timely EOL choices may be out of reach without remote access technologies (Close et al., 2021; Del Villar et al., 2022; Komesaroff & Philip, 2023; White et al., 2023d; Willmott et al., 2023).

Legislative barriers further impact the provision of assisted dying through the assisted dying laws being highly regulated and complex (Del Villar et al., 2022; Komesaroff & Philip, 2023; Murphy, 2022; Waller et al., 2023). Assisted dying laws assert that eligibility is strictly limited to competent adults diagnosed with an advanced, incurable, and progressive condition likely to cause death within a specified timeframe (Del Villar et al., 2022; Murphy, 2022; Waller et al., 2023; Willmott et al., 2023). All practicing Australian states and Canada follow this model (Schiller, 2017). In most Australian states, the process mandates multiple requests and assessments by at least two independent, specially trained physicians. Some states, such as Victoria and Tasmania, additionally require that at least one practitioner have five years' experience and expertise in the patient's condition or specialty, a criterion that is difficult to satisfy in rural regions (Komesaroff & Philip, 2023). International comparisons show that Australia's rules are more restrictive than those in Canada, Belgium, or Switzerland (Waller et al., 2023). These complexities amplify existing workforce shortages in rural and remote areas, where there are fewer physicians overall and even fewer meeting the specialist or training requirements. Beyond these structural challenges, legislation has also been criticized for failing to accommodate advance directives, leaving patients vulnerable if they lose decision-making capacity at the EOL (Durant & Kortes-Miller, 2020; Komesaroff & Philip, 2023; Murphy, 2022). Physicians have expressed frustration that this gap undermines patient autonomy, and some have argued for reform to allow directives to guide care when competence is lost (Durant & Kortes-Miller, 2020). Auret et al. (2025) further highlight the moral distress that can arise when organizations adopt policies supporting assisted dying, noting that some individuals perceive such frameworks as devaluing those at the EOL. While participants reported that their views were respected within their organizations, their accounts underscore the tension between legislative requirements, institutional policy, and deeply held personal convictions (Auret et al., 2022b; 2025; Komesaroff & Philip, 2023; Sedgwick et al., 2024).

All jurisdictions allow health professionals to refuse assisted-dying participation on grounds of conscientious objection, and individual refusals take multiple forms (Collins & Leier, 2017; Panchuk & Thirsk, 2021; Sedgwick et al., 2024; Waller et al., 2023). In rural and remote areas, where practitioners are already scarce, individual conscientious objection is particularly consequential because it can directly impede referral pathways and patient access (Collins & Leier, 2017; Panchuk & Thirsk, 2021; Sedgwick et al., 2024; Waller et al., 2023). Some legislation mandates that objecting clinicians provide information or connect patients to assisted-dying navigator services, but requirements for information provision, referral, or active facilitation vary across states (Collins & Leier, 2017; Panchuk & Thirsk, 2021; Waller et al., 2023; White et al., 2023c). WA, Queensland, and NSW require immediate notification and referral of any patient who requests information and access to

assisted dying, while Victoria and South Australia allow up to seven days, potentially delaying access (Panchuk & Thirsk, 2021; Waller et al., 2023). Studies describe a spectrum of individual responses from outright refusal to selective participation and note a silent objection in which some providers step back from direct involvement while remaining in administrative or supportive roles (Sedgwick et al., 2024). Interviews with rural nurses report feelings of guilt for refusing participation alongside anxiety about being compelled to act against conscience (Panchuk & Thirsk, 2021), and surveys of NSW clinicians found that around one-third cited moral or religious grounds for non-participation, with rural respondents expressing heightened concern about stigma and lack of peer support (Light et al., 2024). Case examples in the literature illustrate how the choices of one or two local clinicians can determine whether assisted dying is available in an entire service area, forcing patients to travel long distances or forgo the option (Collins & Leier, 2017; Haining et al., 2023; Sedgwick et al., 2024).

Institutional conscientious objection can force patients to transfer to metropolitan facilities or travel long distances, which may be unfeasible for the gravely ill (Collins & Leier, 2017; Haining et al., 2023; Komesaroff & Philip, 2023; Murphy, 2022; White et al., 2023c). Some organizations adopt policies that allow individual staff to abstain from direct duties while requiring facilitation of referrals to willing providers (Auret et al., 2022a), but institutional policy shifts can still produce profound distress among staff who perceive assisted dying as inconsistent with their values (Auret et al., 2025). Because institutional and individual conscientious-objection rules and practices vary across Australian states, rural and remote patients may have no local lawful avenue for assisted dying unless they relocate or arrange metropolitan consultations – a significant ethical and practical hurdle for people who are terminally ill (Collins & Leier, 2017; Panchuk & Thirsk, 2021; Sedgwick et al., 2024; Waller et al., 2023; White et al., 2023c).

In summary, many assisted dying statutes in the jurisdictions represented in our review (Australia and Canada) are characterized by strict eligibility windows, residency mandates, specialist requirements, conscientious objection protocols, and counterintuitive telehealth bans. This establishes a complex legal framework that both enables and constrains rural access. How these rules play out in practice, however, cannot be divorced from the values, beliefs, and communal relationships that underpin rural life.

Cultural, social, and ethical considerations

Cultural norms, community values, and ethical tensions play a pivotal role in how assisted dying is perceived, accepted, and enacted in rural and remote settings (Auret et al., 2022b; Durant & Kortes-Miller, 2020; Ramalingam & Ganesan, 2019; Sedgwick et al., 2024; Sinclair et al., 2014). This theme encompasses rich and complex examples of institutional identity contrasted with community expectations, migrant community attitudes, sociocultural determinants in South India, and the unique ethical pressures of small communities (Auret et al., 2022b; Durant & Kortes-Miller, 2020; Ramalingam & Ganesan, 2019; Sinclair et al., 2014). Several studies underscore the complex ethical responsibilities placed on clinicians (Auret et al., 2022b; Durant & Kortes-Miller, 2020; Komesaroff & Philip, 2023; Sedgwick et al., 2024). Gatekeeping roles and the moral challenges faced by healthcare providers are recurrent themes. This complexity is accentuated by the evolving nature of assisted dying, which demand sensitivity to both professional ethics and individual moral convictions.

Physicians' experiences with assisted dying are shaped not only by legislation but also by the cultural and geographic realities of the communities in which they practice (Auret et al., 2022b; Durant & Kortes-Miller, 2020; Komesaroff & Philip, 2023; Panchuk & Thirsk, 2021; Sedgwick et al., 2024). In rural and remote regions, particularly Northwestern Ontario, logistical barriers such as extensive travel, reliance on locum practitioners, and limited local providers compound the ethical weight of participation (Durant & Kortes-Miller, 2020). For some clinicians, close relationships with patients and families intensified the moral complexity of providing assisted dying, as familiarity could be both a privilege and a source of distress. The expectation that rural general practitioners deliver high-quality palliative care alongside assisted dying further highlights tensions between government policy and the lived realities of practice, raising questions about equity, sustainability, and the ethical burden placed on sole providers (Durant & Kortes-Miller, 2020).

Administrative requirements for accessing assisted dying can impose significant emotional strain, particularly for families already navigating EOL care (Close et al., 2021; Jeanneret et al., 2024; La Brooy et al., 2024). La Brooy et al. (2024) highlight how bureaucratic hurdles compounded grief and bereavement, with rural and remote participants facing the added burden of traveling long distances to metropolitan centers for assessment. For some, the logistical

challenges of relocation intensified distress, underscoring how procedural frameworks may inadvertently exacerbate suffering at a profoundly vulnerable time.

Rural hospices frequently face fraught debates over whether to participate in assisted dying, balancing organizational mission, staff beliefs, and local sentiments (Auret et al., 2022b; 2025). A study by Auret et al. (2022b) of a WA community hospice board found that while some members viewed assisted dying as congruent with person-centred care, others felt it conflicted with the hospice's traditional palliative philosophy. Ultimately, the board adopted a policy allowing individual conscientious objection alongside mandated referral pathways to ensure patient access. Interviews with staff at a second rural hospice revealed deep ambivalence – long-standing community trust in hospice services led many families to expect assisted dying access, yet institutional reputation concerns drove some leaders to defer participation decisions (Auret et al., 2022b).

Migrant groups in rural Australia bring diverse cultural and familial norms that shape their views on EOL options, including assisted dying (Sinclair et al., 2014). Dutch-Australian and Italian-Australian seniors living in rural Victoria expressed strong family-centred decision-making tradition (Sinclair et al., 2014). Some regarded assisted dying as an individual right, while others felt it clashed with intergenerational obligations and religious beliefs. Differences in health-care communication styles, such as directness versus deference, also influenced willingness to discuss advance care planning and assisted dying. Those from cultures favoring collective consensus often deferred decisions to adult children or extended family (Sinclair et al., 2014).

In low-resource settings, caste, religion, and familial hierarchies profoundly influence EOL practices and any future adoption of assisted dying (Ramalingam & Ganesan, 2019). The ethnographic work by Ramalingam and Ganesan (2019) in Tamil Nadu highlights that decisions about pain relief and withdrawal of care are typically made by eldest family members, with caste status dictating who is involved. This collective decision-making framework poses significant challenges to individualized assisted dying models. Religious beliefs, particularly Hindu notions of karma and duty, led many to view suffering as spiritually meaningful, making assisted dying a culturally alien concept in these communities. Traditional practices like Thalaikoothal and the broader socio-cultural ethos deeply influence the EOL practices of the Tamil Nadu. Thalaikoothal is a covert practice of senicide observed in some rural districts of Tamil Nadu, where families perform what is described as a compassionate way to end the life of an elderly relative.

> My relatives and neighbors said that by giving water mixed with mud from my land will give my mother peaceful death as she may be thinking about our land. (Ramalingam & Ganesan, 2019, p. 226)

Early each morning, the elder is given an extensive oil bath and then forced to drink multiple glasses of tender coconut water. The combination of cold-water exposure, oil massage, and high potassium intake precipitates organ failure, usually within two to three days. In Tamil society, deep reverence for elders coexists with harsh socioeconomic realities. When families lack the financial, medical, or infrastructural resources, the moral imperative to care can warp into a perceived duty to relieve suffering or economic strain.

> "I do not have enough money and facilities to take care of her, and she developed bed sores……" Doctor said that she has to undergo treatment that will be expensive and cannot guarantee her good quality of life. (Ramalingam & Ganesan, 2019, p. 225)

This ethos is underpinned by filial piety and joint-family obligations that emphasize collective well-being over individual autonomy. This is similar to the previously mentioned migrant communities in Australia, where cultural values of individualistic versus family-based decision-making shape attitudes toward advance care planning and EOL care (Sinclair et al., 2014). The persistence of practices like Thalaikoothal highlights critical gaps in Tamil Nadu's palliative infrastructure and social support systems. When formal hospice care, pain management, and culturally sensitive counseling are unavailable or unaffordable, families may revert to clandestine rituals.

Physicians' and other practitioners' experiences with assisted dying are also shaped by the cultural and geographic realities of their communities, where close personal relationships, local reputations, and communal expectations intensify ethical complexity (Auret et al., 2022b; Durant & Kortes-Miller, 2020; Komesaroff & Philip, 2023; Panchuk & Thirsk, 2021; Sedgwick et al., 2024). In small towns, the views of a few local clinicians can substantially influence whether services are available and how patients experience care (Auret et al., 2025; Haining et al., 2023).

> Most of the practitioners are in small practices in country towns, and we've known from the outset that in those settings a lot of clinicians didn't want to be identified as Dr Death. [Health Practitioner 6]. (Haining et al., 2023, p. 6)

Small-town stigma, fear of social ostracism, and the weight of community scrutiny can heighten moral distress for clinicians and leave patients feeling

isolated when seeking assisted dying options (Collins & Leier, 2017; Sedgwick et al., 2024).

To summarize, the cultural norms, community values, and ethical stances that inform rural attitudes toward assisted dying also manifest in concrete obstacles – shaping who feels supported, who faces stigma, and how services are organized. These social and ethical dynamics intersect with logistical, regulatory, and workforce-driven factors to create uneven pathways to care. Importantly, these underlying influences can be used to explore the practical barriers of access and equity in assisted dying service provision across rural and remote regions. These structural settings create the context within which rural and remote access challenges arise, which are explored in the following theme.

Access and equity in service provision

While legislative and policy frameworks establish the structural conditions for assisted dying, this theme examines how these conditions play out in practice for rural and remote communities, shaping the availability, timeliness, and feasibility of service delivery. A significant theme present in the literature is the inequity in access to assisted dying services, for individuals in rural or remote areas (Auret et al., 2022b; Collins & Leier, 2017; Panchuk & Thirsk, 2021; Sedgwick et al., 2024; Waller et al., 2023). Challenges include limited staffing, geographic dispersion, and urban-centric policies that do not always translate effectively to the needs of remote communities (Collins & Leier, 2017; Durant & Kortes-Miller, 2020; Haining et al., 2023; Murphy, 2022; Sedgwick et al., 2024; Willmott et al., 2023). While there are facilitators, such as care navigators, coordinating practitioners, and supportive frameworks that help streamline the process, the constant struggle is to overcome barriers related to resource limitations, inconsistent service provision, and infrastructural challenges. However, recent evidence also shows that system-level design choices can unintentionally exacerbate rural inequities. Cole et al. (2025) found that the centralized pharmacy model used in Victoria created additional delays and logistical barriers for rural and remote patients, who often waited longer for substance delivery and required more complex coordination than metropolitan patients.

The significant work by Kissane et al. (1998) documents the very first period of legal euthanasia in Australia, and indeed the world. It reports on seven patients who formally sought voluntary euthanasia under the Rights of the Terminally Ill Act, which was passed in the Northern Territory in 1995 and came into effect in July 1996. The Act was in force for only nine months before being overturned by the Australian Federal Parliament in March 1997. Even in this study, the profound inequities faced by rural patients is illustrated, with some traveling thousands of kilometers to access assisted dying assessments only to encounter repeated refusals or withdrawals from specialists. In one instance, public appeals were required before a willing practitioner could be found, underscoring how geographic isolation and professional reluctance created significant barriers to timely and equitable access.

To this day, access to assisted dying remains constrained by lengthy procedural timelines, with the median interval from initial request to dispensing of substances extending to over a month: an often-prohibitive delay for patients in advanced stages of illness (Komesaroff & Philip, 2023). Although the pool of registered providers has grown in recent years, specialist availability remains uneven, particularly in disciplines such as neurology, and geographic distribution continues to disadvantage rural communities. Moreover, many referrals are now facilitated through statewide navigator services rather than patients' usual clinicians, which can alter the quality and continuity of EOL discussions (Komesaroff & Philip, 2023). These findings are consistent with more recent work showing that structural features of service delivery can compound delays. Cole et al. (2025) reported that centralized dispensing processes contributed to extended waiting periods for rural patients, further limiting timely access for those with rapidly declining health.

The literature shows that rural and remote disparities appear not just in Australia, but the two other countries represented in our included studies (Canada and India) (Auret et al., 2022b; Collins & Leier, 2017; Komesaroff & Philip, 2023; Panchuk & Thirsk, 2021; Ramalingam & Ganesan, 2019; Sedgwick et al., 2024; Sinclair et al., 2014; Waller et al., 2023). In both Australia and Canada, access to assisted dying, and more broadly, to EOL and specialist health services, is significantly better in urban than rural or remote areas (Collins & Leier, 2017; Haining et al., 2023; Schiller, 2017; Sedgwick et al., 2024). This echoes a recurring global pattern of service maldistribution, with rural communities having fewer practitioners, fewer support services, and greater travel burdens (Durant & Kortes-Miller, 2020; Murphy, 2022). Rural and remote health settings are characterized by high physician and allied health staff shortages, high turnover, reliance on fly-in-fly-out and locum staff, and lower levels of

NP and specialist presence (Haining et al., 2023; Willmott et al., 2023).

> [In] regional areas… … their doctors are very transient and often the GPs [General Practitioners] are only there for a short amount of time. They might be overseas doctors that come in and they're also not aware that this is legislation and not aware of what even to do. [There's] often … this cultural religious influence there as well … I definitely think our regional patients still … struggle with access [Participant 4]. (Willmott et al., 2024, p. 15)

In the Australian context, limitations in infrastructure, such as reliable digital connectivity, health facility capacity, access to interpreters, as well as unpredictable transport, and socioeconomic disadvantage intersect to make regular or specialized in-person assisted dying assessments and provision difficult to provide and sustain (Auret et al., 2022b; Collins & Leier, 2017; Panchuk & Thirsk, 2021; Sedgwick et al., 2024; Waller et al., 2023). Multi-factorial disparities are present, for example, only about 35% of assisted dying-eligible practitioners are based in rural and remote Australia, and these clinicians are less likely to be specialists in the relevant disease/condition (Willmott et al., 2023). Further, the increasing reliance on internationally trained physicians to service rural Australian regions has reduced cultural alignment between patients and providers, creating additional barriers to trust and communication in end-of-life care (Sinclair et al., 2014).

Unlike Australia, where eligibility is tightly constrained by terminality, prognosis timeframe, and residency, Canada allows assisted dying in cases of intolerable suffering, not just terminal disease, and does not impose residency duration requirements (Schiller, 2017; Waller et al., 2023). However, both countries require multiple assessments by trained practitioners, and administrative hurdles exist. Canada's decision to include NPs as assessors and providers of assisted dying is credited with mitigating, though not eliminating, rural access inequities (Schiller, 2017; Sedgwick et al., 2024). Canada also permits virtual assessments and consults, improving access in remote provinces, while Australia's federal law still criminalizes telehealth for assisted dying, entrenched as a major access barrier (Close et al., 2021; Schiller, 2017). In these ways, Canada's experience with broader provider eligibility and virtual care offers models for reform in Australia and other countries newly implementing legalized assisted dying.

Access to assisted dying for terminally ill patients worldwide is impacted by the significant travel burden that is present for those living in rural and remote communities (Auret et al., 2022b; Collins & Leier, 2017; Komesaroff & Philip, 2023; Panchuk & Thirsk, 2021; Ramalingam & Ganesan, 2019; Sedgwick et al., 2024; Sinclair et al., 2014; Waller et al., 2023). Terminally ill patients in rural and remote areas face significant travel requirements due to lack of local assisted dying-trained providers and the necessity for in-person consultations at each step of the process (Haining et al., 2023; Murphy, 2022; White et al., 2023c). This imposes both financial and physical hardship on patients who are often frail and in pain. The prohibition on telehealth creates a double disadvantage, particularly for those too unwell to travel or for whom travel risks their remaining health stability. Draper et al. (2024) demonstrated that Victorian care navigators were required to operate "in a digital era without digital technology," relying on in-person visits and postal communication to remain compliant with federal law. These constraints resulted in significant delays for regional patients and increased travel demands for both patients and staff. In several studies, patients missed the window for access because long-distance travel opportunities did not align with their rapidly declining health (Haining et al., 2023; Murphy, 2022; White et al., 2023c).

> By the time I managed to get a meeting with the pharmacist … [my patient] was now on a syringe driver and semi-comatose and no longer eligible. (White et al., 2023d, p. 2)

Not only patients, but also practitioners must travel, which de-incentivises participation and strains rural health service capacity (Willmott et al., 2023). The need for navigators to travel extensively in lieu of telehealth, as described by Draper et al. (2024), further illustrates how federal restrictions shift logistical and workforce burdens disproportionately onto rural services. Families also bear substantial logistical and emotional burdens in arranging and accompanying travel (Haining et al., 2023; White et al., 2023c). WA's RASS plays a key role in addressing this barrier, providing funding for both patient and provider travel (Haining et al., 2023; Willmott et al., 2023). The data suggests that, while not eliminating the burden, this support has enabled access in cases where local practitioners were unavailable. In Canada, similar travel burdens have been reported, especially in northern and Indigenous communities (Schiller, 2017). Innovative use of NPs, more localized provider models, and virtual care where permitted are seen as partial solutions (Schiller, 2017; Sedgwick et al., 2024). These examples show that travel-related burdens are a universal access challenge in rural and remote

assisted dying implementation, and while financial supports and logistical facilitation are helpful mitigations, they cannot fully address the fundamental difficulties for the terminally ill. Unless practitioners can consult and deliver care locally, either in-person or, via secure, lawful telehealth, many patients will remain effectively excluded from exercising their legal EOL rights (Auret et al., 2022b; Collins & Leier, 2017; Komesaroff & Philip, 2023; Panchuk & Thirsk, 2021; Ramalingam & Ganesan, 2019; Sedgwick et al., 2024; Sinclair et al., 2014; Waller et al., 2023).

Further to this, remote health facilities are often under-resourced, limiting the ability to meet the specific needs of diverse, often older and more chronically ill, rural populations (Haining et al., 2023; Murphy, 2022; Schiller, 2017; Sedgwick et al., 2024). It is well-known that rural communities, especially Aboriginal and First Nations populations, bear a higher disease burden and face multifaceted socioeconomic, educational, and linguistic challenges. These studies discuss how cross-cultural difficulties, especially where English is not the first language, further entrench inequity, as does a lower level of palliative care resources in some remote areas. Furthermore, concerns around confidentiality and stigma in close-knit communities can deter some local practitioners from assisted dying participation, further shrinking the pool of available providers (Haining et al., 2023; Sedgwick et al., 2024; Willmott et al., 2023).

Several governments have included explicit equity commitments in their assisted dying policies (Haining et al., 2023; White et al., 2024; Willmott et al., 2023). The WA Government explicitly built into the Voluntary Assisted Dying Act 2019 guiding principles that commit to equitable access for rural and remote residents (Haining et al., 2023; Willmott et al., 2023). To ameliorate provider shortages, WA broadened physicians' qualification requirements for assisted dying roles, unlike more restrictive jurisdictions that require specialist endorsement. NPs are also permitted to administer assisted dying – an innovation driven by the realities of rural workforce composition. Further infrastructure and process innovations include the establishment of a Statewide Care Navigator Service, which serves as a critical interface for patients, practitioners, and families, linking patients to eligible providers and supporting the procedural journey. Additionally, RASS funds facilitate travel for patients, practitioners, and interpreters, addressing both practitioner and patient travel needs in the face of geographic remoteness. Finally, the Statewide Pharmacy Service ensures timely, secure substance provision and supports rural and remote logistics, with explicit Key Performance Indicators for timely delivery even in remote areas (Willmott et al., 2023). Queensland has adopted a similar equity-focused approach, with the majority of assisted dying delivered through the public sector and rural GPs engaged within Health and Hospital Services (White et al., 2024). The Health Service Directive requires each Health and Hospital Service to establish a local model of care, ensuring at least some level of participation statewide. Central to this system is the Queensland Voluntary Assisted Dying Support and Pharmacy Service, which issues nearly all assisted dying substances and provides back-up assessment and administration capacity to meet unmet demand. Although not originally envisaged, this expanded role has been pivotal in guaranteeing statewide access, complemented by initiatives such as the QVAD Access travel scheme (White et al., 2024). WA legislation requires comprehensive collection and publication of statistics related to rural and remote assisted dying access, allowing for ongoing monitoring, evaluation, and iterative improvement. Early data from this legislated collection indicates that 21% of individuals accessing assisted dying reside in rural areas, reflecting initial progress toward proportionate access compared to state demographic distribution. Participating practitioners had practice addresses in all WA regions except the Wheatbelt, and the RASS was utilized in all but one region (Mid-West) (Haining et al., 2023). WA's suite of innovations, both legislated and operational, is viewed as a model for addressing rural access inequity and is referenced in national and international literature as a template for future reform (Haining et al., 2023; Willmott et al., 2023). The Care Navigator model is especially highlighted for its role in overcoming informational, bureaucratic, and logistical barriers for patients. Importantly, while some gaps remain, especially in WA's Wheatbelt and where telehealth remains restricted, the combination of infrastructure investment, policy attention, funding for practitioner training, and local delivery models is narrowing some of the most persistent access gaps for remote populations (Haining et al., 2023; Willmott et al., 2023). Addressing assisted dying access inequities in rural and remote Australia and comparable regions in Canada requires not only legislative reform but also ambitious strategic investments in digital and physical health infrastructure and the cultivation and funding of a larger, better-supported, multidisciplinary workforce (Auret et al., 2022b; Haining et al., 2023; Komesaroff & Philip, 2023; La Brooy et al., 2024; Murphy, 2022; Panchuk & Thirsk, 2021; Sedgwick et al., 2024; Waller et al., 2023; White et al., 2024; Willmott et al., 2023).

Healthcare provider roles and experiences

Healthcare providers across rural and remote settings consistently described the significant practical and emotional demands involved in delivering assisted dying (Haining et al., 2023; Murphy, 2022; Schiller, 2017; Sedgwick et al., 2024). Clinicians reported the complexity of navigating eligibility assessments, prognostic uncertainty, administrative requirements, and the need to balance assisted dying processes alongside already stretched workloads. Many rural practitioners described the additional burden of long-distance travel, limited local support, and the expectation that they assume multiple roles within small communities. These pressures were heightened by workforce shortages, reliance on locum staff, and the absence of specialist colleagues, which often left individual clinicians responsible for coordinating and delivering the entire assisted dying pathway (Durant & Kortes-Miller, 2020; Haining et al., 2023). Recent evidence reinforces these pressures. Draper et al. (2024) reported that Victorian care navigators were required to deliver assisted dying support without access to digital communication tools, relying instead on in-person visits and postal correspondence to remain compliant with federal restrictions. These adaptations significantly increased workload, coordination demands, and emotional strain for staff supporting patients across geographically dispersed communities. Providers also highlighted the emotional intensity of supporting patients and families in close-knit communities, where longstanding relationships could amplify both the privilege and the strain of participating in assisted dying. Close-knit rural communities create unique professional and social pressures for clinicians involved in assisted dying (Haining et al., 2023; Sedgwick et al., 2024; Willmott et al., 2023). Several studies describe how practitioners may experience reputational risk, strained relationships, or community scrutiny when participating in assisted dying, particularly in towns where personal and professional boundaries are tightly interwoven (Haining et al., 2023; Sedgwick et al., 2024; Willmott et al., 2023). Providers also reported challenges arising from organizational policies in hospitals, aged-care facilities, and health services that do not facilitate assisted dying on-site, requiring patients to transfer elsewhere for assessments or administration (Auret et al., 2022b; Collins & Leier, 2017; Haining et al., 2023; Komesaroff & Philip, 2023; Murphy, 2022; Waller et al., 2023; White et al., 2023c). For rural patients, these transfers often involve long travel distances, logistical complexity, and emotional strain, adding to the workload and coordination responsibilities of local clinicians (La Brooy et al., 2024; Panchuk & Thirsk, 2021; Schiller, 2017; White et al., 2023d). Workforce shortages, limited service availability, and the absence of alternative providers mean that even minor organizational constraints can have amplified effects in rural settings, leaving clinicians to navigate gaps in service delivery while supporting patients and families through already challenging circumstances (Haining et al., 2023; Sedgwick et al., 2024; Willmott et al., 2023).

In addition, rural physicians often extend themselves beyond the call of duty to meet patient needs, yet limited resources, inadequate training, and insufficient support in managing complex EOL symptoms can exacerbate requests for assisted dying (Auret et al., 2022b; Durant & Kortes-Miller, 2020; La Brooy et al., 2024; Light et al., 2024; Murphy, 2022; Panchuk & Thirsk, 2021; Sedgwick et al., 2024; Sinclair et al., 2014; White et al., 2023d; Willmott et al., 2023). Collins and Leier (2017) and Durant and Kortes-Miller (2020) emphasize that in rural and remote areas, where practitioners are few and sometimes the sole provider, opting out of participation raises difficult questions about referral pathways and continuity of care. The scarcity of willing providers means patients may struggle to access alternatives, and without robust, accessible palliative care, the exercise of autonomy and informed consent is compromised. This tension is further underscored by evidence that only a minority of Canadians receive palliative care, and many palliative specialists have expressed reluctance to participate in assisted dying (Durant & Kortes-Miller, 2020). These dynamics highlight the ethical imperative to strengthen palliative care capacity alongside assisted dying frameworks, ensuring that patients are not forced into one option simply due to the absence of another (Collins & Leier, 2017).

The role of NPs in assisted dying provision was mentioned in multiple resources (Haining et al., 2023; Panchuk & Thirsk, 2021; Schiller, 2017; Sedgwick et al., 2024; Waller et al., 2023; White et al., 2023; Willmott et al., 2023). In WA and NSW, NPs are approved to act as administering practitioners, in recognition of their extensive training and established role in palliative care delivery outside metropolitan areas (Haining et al., 2023; Waller et al., 2023; Willmott et al., 2023). In Victoria and some other states, only physicians may administer assisted dying, and NPs are limited to supportive roles (Willmott et al., 2023). Despite the legislative allowance, the actual number of NPs involved in assisted dying remains low, only one out of 68 administering practitioners in WA was an NP as of 2023, indicating slow adoption. This slow

uptake is attributed to lack of formal recognition in some models, inadequate remuneration, resistance from some professional medical bodies, and challenges in accessing appropriate assisted dying-specific and EOL law training, especially in remote regions (Haining et al., 2023; Willmott et al., 2023). In comparison, in Canada, NPs play an essential role in assisted dying, constituting 5% of practitioners and performing about 9% of all assisted dying procedures (Schiller, 2017; Sedgwick et al., 2024). Their involvement has demonstrably enhanced access in remote and northern communities and supports the consensus that expanding the scope of NPs in other regions could significantly improve rural and remote access by leveraging their local presence and established community relationships (Haining et al., 2023; Sedgwick et al., 2024; Waller et al., 2023; Willmott et al., 2023). Despite their advanced training and deep integration in rural palliative care, NPs remain a significantly under-engaged resource in the delivery of assisted dying, particularly in underserved regions (Haining et al., 2023; Panchuk & Thirsk, 2021; Waller et al., 2023; Willmott et al., 2023). Legislative frameworks in some jurisdictions have recognized their potential by authorizing expanded roles, yet uptake remains slow due to structural barriers, limited training access, and professional resistance.

The challenges experienced by healthcare providers are not experienced in isolation. They ripple outward, shaping the experiences of families and communities, who may struggle to access assisted dying services, face delays in care, or encounter moral tensions within their local networks. As such, provider participation and system design are not just clinical issues – they are deeply entwined with the social fabric of EOL care.

Family and community impact

Families and caregivers in rural and remote areas are not only impacted emotionally but also play a crucial role in navigating the complexities of assisted dying (Haining et al., 2023; La Brooy et al., 2024; Lewis et al., 2024; Sedgwick et al., 2024; White et al., 2023d; Willmott et al., 2024). Although emotional experiences were not the primary focus of this review, the included studies consistently showed that the emotional and relational impacts on families arose directly from the structural, logistical, and cultural challenges of implementing assisted dying in rural and remote settings (Haining et al., 2023; La Brooy et al., 2024; Sedgwick et al., 2024; White et al., 2023d). For this reason, these impacts form an essential part of understanding how implementation unfolds in practice.

Families and caregivers in rural and remote areas play a central role in navigating assisted dying pathways, and their experiences are shaped by the unique pressures of distance, limited services, and community visibility (Haining et al., 2023; La Brooy et al., 2024; Lewis et al., 2024; Sedgwick et al., 2024; White et al., 2023d; Willmott et al., 2024). While many families recognize the relief and dignity that assisted dying can offer, the process is often emotionally complex. Studies describe a distinctive form of anticipatory and orchestrated grief, in which family members simultaneously prepare for a planned death and manage the emotional aftermath of the chosen day (White et al., 2023d; Willmott et al., 2024). This dual process can be intensified in rural contexts where support networks are small and bereavement services are geographically distant.

> I was so focused on being Dad's support, and the coordinator, and working through the logistics of it all, I didn't stop for that. […] there was no space for me to be in grief. I had to be very, very present and very, very strong and calm for Dad [Participant 84]. (Lewis et al., 2024, p. 1355)

Families also take on substantial logistical and advocacy responsibilities, often coordinating travel, assessments, and administrative requirements across long distances (Jeanneret et al., 2024; La Brooy et al., 2024; Willmott et al., 2024). These practical burdens intersect with emotional labor, leaving caregivers exhausted, anxious, and stretched between supporting the patient and managing system-level obstacles.

> I can remember crying every day in February … because I'd cared for her for so long, and then jumping over all these hurdles and getting her to Melbourne (for VAD assessments) (P86). (La Brooy et al., 2024, p. 6)

In small communities, the lack of anonymity can further complicate the experience. Families may face judgment, gossip, or silence, particularly where assisted dying conflicts with local cultural or religious norms (Auret et al., 2022b; Durant & Kortes-Miller, 2020; Ramalingam & Ganesan, 2019; Sinclair et al., 2014). These dynamics can leave families feeling isolated or morally conflicted, especially when communal expectations diverge from the patient's legal choices.

Cultural traditions also shape how families interpret and respond to assisted dying. In some rural migrant or Indigenous communities, longstanding collective decision-making practices and spiritual beliefs can clash with individualized assisted dying frameworks, creating tension between respecting cultural norms and adhering to statutory processes (Auret et al.,

2022b; Ramalingam & Ganesan, 2019; Sinclair et al., 2014).

Given these intersecting pressures, several studies recommend outreach-based bereavement support, culturally safe counseling, and community-embedded peer networks to address the gaps faced by rural families (La Brooy et al., 2024; White et al., 2023d). Telehealth-enabled grief support, training local facilitators, and partnering with community leaders are identified as strategies to mitigate the emotional and logistical burdens that arise from rural implementation constraints.

Across the literature, it is clear that assisted dying in rural and remote contexts reverberates beyond the clinical encounter, shaping family roles, community relationships, and cultural practices (Auret et al., 2022b; Collins & Leier, 2017; Durant & Kortes-Miller, 2020; La Brooy et al., 2024; Ramalingam & Ganesan, 2019; Sinclair et al., 2014; White et al., 2023c). These findings demonstrate that implementation challenges are not only operational but relational, and that equitable assisted dying access requires support systems that recognize the intertwined emotional, cultural, and logistical realities faced by rural families.

Discussion

This scoping review reveals that assisted dying in rural and remote settings is shaped by a complex interplay of legal, ethical, cultural, and relational factors. While legislation has enabled lawful access, the lived experience of assisted dying is deeply embedded in community dynamics, provider roles, and family relationships. Across Australian and international literature, the underlying message is clear: legal, structural, and practical access to assisted dying in rural and remote communities is marked by persistent inequity. This gap is driven by a confluence of legislative complexity, workforce shortages, telehealth restrictions, logistical and administrative burdens, and insufficiently tailored models of care. Each of the aforementioned themes were seen to converge to influence equity, participation, and emotional outcomes.

Legal frameworks governing assisted dying are both enabling and constraining. Inconsistencies between state and federal laws, particularly the telehealth ban under the Commonwealth Criminal Code, have entrenched inequities for rural and remote patients (Close et al., 2021; Del Villar et al., 2022). The requirement for in-person consultations, extensive documentation, and specialist assessments disproportionately burdens remote communities, where workforce shortages and geographic isolation are already acute (Murphy, 2022; Willmott et al., 2023c). WA's RASS and Statewide Care Navigator Service offer promising models for mitigating these barriers, yet the persistence of outdated federal laws and administrative complexity continues to delay or deny access for many. While these targeted initiatives offer promising templates, the single greatest barrier – telehealth prohibition under the Commonwealth Criminal Code – remains unresolved as of June 2026, perpetuating suffering and limiting choice for those most marginalized.

Although only one of the 30 peer-reviewed articles explicitly reported cases where patients died before the assisted dying substance could be prescribed due to mandated waiting periods and travel burdens (White et al., 2023c), other grey literature provides further illustration of this issue. Go Gentle Australia (2023) recounts the case of Alan Clark, an 82-year-old man from rural Victoria with progressive supranuclear palsy, who was approved for assisted dying but died just one day before he was scheduled to receive the substance. His experience highlights how procedural delays can critically undermine timely access, particularly for those in geographically isolated settings. Since 2023, calls for amending the Commonwealth Criminal Code to expressly permit telehealth for assisted dying have gained momentum, supported by a joint statement from 17 leading health agencies, every state Attorney-General, advocacy organizations, and practitioners (Australian Nursing & Midwifery Journal, 2024). Recent evidence reinforces this direction. Summers et al. (2025) found that telehealth is a critical enabler of timely and equitable assisted dying access internationally, and that Australia's continued prohibition places rural and remote patients at a distinct disadvantage. Their review strengthens the argument that legislative reform is essential to align practice with contemporary models of care and to reduce avoidable delays for geographically isolated patients. Independent Member of Parliament Kate Chaney's Voluntary Assisted Dying Telehealth Bill (Chaney, 2024) proposes a simple clarification: assisted dying, when provided lawfully under a state regime, is not suicide for the purposes of the Code. Assisted dying, when provided lawfully under a state or territory regime, is a regulated medical practice in which an eligible person chooses to end their life through a legislated process involving clinical assessment, multiple safeguards, and practitioner oversight; it is therefore treated in law and policy as distinct from suicide for the purposes of the Commonwealth Criminal Code (Close et al., 2021; Del Villar et al., 2022; Government of Canada, 2025; Willmott et al., 2023).

As of June 2026, the bill has not yet passed, although debate and stakeholder support remain strong (Go Gentle Australia, 2023). The future direction of reform is clear among researchers and practitioners: legalizing telehealth for assisted dying is seen as a critical, compassionate, and evidence-based strategy to redress the most egregious access barriers for rural and remote populations. Implementation requires not just legal change, but the resourcing, support, and monitoring needed to ensure reforms truly deliver for the most underserved communities. Del Villar et al. (2022) argue that the Commonwealth Criminal Code must clearly distinguish counseling suicide from advising or providing information about assisted dying, emphasizing that assisted dying is not suicide. They also highlight the need for clear provisions around conscientious objection to ensure practitioner rights are respected. They argue that this is required to ensure that refusal to participate in assisted dying is respected without criminalizing referral or providing information. There are also recommendations for remuneration reform, streamlined administrative processes, increased specialist and NP training outreach to remote areas, expanded culturally safe resources for Aboriginal, Torres Strait Islander, and culturally and linguistically diverse populations, and improved infrastructure investment in digital health connectivity (Go Gentle Australia, 2023; Voluntary Assisted Dying Australia & New Zealand, 2023).

Clinician participation is a critical determinant of rural assisted dying access. While all jurisdictions uphold the right to conscientious objection, the impact is magnified in remote areas where provider options are limited. The selected articles have shown that rural practitioners experience moral distress, reputational risk, and professional isolation whether they choose to participate or abstain (Panchuk & Thirsk, 2021; Sedgwick et al., 2024; White et al., 2023b). Institutional objection, particularly by faith-based or aged care providers, can force patients to relocate or forgo assisted dying altogether (Haining et al., 2023; Komesaroff & Philip, 2023). Innovative policies, such as WA's mandated referral protocols and hospice board-shaped models (Auret et al., 2022b), demonstrate that balancing conscience rights with patient access is possible, but requires deliberate design and community engagement.

Clinicians in rural and remote areas face significant emotional, ethical, and logistical challenges when engaging with assisted dying. These pressures are compounded by operational constraints. Draper et al. (2024) showed that Victorian care navigators were required to provide assisted dying support without access to digital communication tools, relying instead on in-person travel and manual processes to remain compliant with federal law. This significantly increased workload, coordination demands, and emotional strain for staff supporting patients across dispersed regional communities. The dual burden of assessing eligibility and navigating personal beliefs is compounded by community stigma and reputational risk (Haining et al., 2023; Sedgwick et al., 2024). Higher objection rates among internationally trained physicians, particularly in rural settings, further limit provider availability (Willmott et al., 2023). NPs, despite their advanced training and deep integration in rural palliative care, remain underutilized. Some states in Australia have authorized expanded NP roles, yet uptake remains slow due to structural barriers, limited training access, and professional resistance. In contrast, Canada's inclusion of NPs has demonstrably improved access in remote communities (Schiller, 2017; Sedgwick et al., 2024). Their clinical autonomy, broad scope, and local assimilation position them well to bridge the workforce shortfalls in remote communities, but broader regulatory or funding reforms are necessary to fully realize this potential. Many of the studies highlight the potential for expanded NP roles to improve access for underserved communities, and advocate not only for NP role expansion but also for improved formal recognition, better access to assisted dying-specific training, and Medicare reforms to ensure NPs and other rural practitioners are fairly compensated for their contributions to EOL care.

Rural communities are not identical, therefore cultural diversity adds further complexity to assisted dying implementation. Migrant populations in rural and remote Australia were found to often hold collective decision-making traditions, religious convictions, and communication styles that influence attitudes toward assisted dying (Sinclair et al., 2014). Ethical tensions were also shown to potentially arise in small towns where visibility, stigma, and moral scrutiny regarding assisted dying can suppress open dialogue and deter both patients and providers (Collins & Leier, 2017; Sedgwick et al., 2024). In South India, practices like Thalaikoothal reflect how socioeconomic pressures and filial duty can shape EOL choices in ways that diverge from Western legal models (Ramalingam & Ganesan, 2019). These findings underscore the need for culturally sensitive assisted dying frameworks that respect communal values while safeguarding individual autonomy.

Further to this, it was found that families in rural and remote areas are deeply affected by the emotional, logistical, and cultural dimensions of assisted dying.

The literature highlights a unique form of anticipatory and orchestrated grief, where family members navigate both the psychological lead-up to assisted death and the emotional aftermath (La Brooy et al., 2024; White et al., 2023d). While some describe healing rituals and legacy-building, others report isolation, guilt, and stigma, especially in small towns where assisted dying remains socially contested (Ramalingam & Ganesan, 2019). Caregivers often bear the burden of advocacy, coordination, and emotional labor, particularly when institutional barriers or policy restrictions place the onus on families to facilitate access (Jeanneret et al., 2024; Willmott et al., 2024). The lack of tailored bereavement support and geographic distance from counseling services further compounds this impact. Outreach models that deliver peer support, spiritual care, and telehealth counseling into remote communities are urgently needed to validate and support families through this complex journey.

By addressing these identified gaps, challenges and interconnected domains, through improved legislative frameworks, enhanced training, or better resource allocation, policymakers and practitioners can move toward an assisted dying system that is not only lawful and safe, but also compassionate, inclusive, and just, especially for those in Australia's most underserved communities. The intersection of legal, ethical, cultural, and relational factors reveals that assisted dying is not merely a clinical procedure but a socially embedded practice. In rural and remote contexts, access is shaped as much by community relationships and institutional identity as by policy design. Equity requires more than legislative reform: it demands strategic investment in infrastructure, culturally responsive care models, and sustained support for clinicians and families navigating moral complexity. Future reforms should prioritize telehealth legalization for assisted dying consultations; expanded provider eligibility, including NPs; culturally tailored communication tools and decision aids; community-led engagement strategies to build trust and understanding; robust data collection to monitor rural and remote access and guide iterative improvements; bereavement and caregiver support tailored to the emotional and logistical realities of rural and remote families. Furthermore, systemic administrative, funding, and digital infrastructure reforms need to focus on parity of access across the rural–urban continuum. There also needs to be ongoing evaluation, transparency, and community engagement, especially with Indigenous and other historically marginalized rural populations. Until these measures are enacted nationally and supported locally, the promise of equal and dignified EOL choice will remain, for many in rural and remote communities, an unrealized aspiration rather than a lived reality.

Future research

Future research is needed to address several gaps identified in this review. Empirical studies examining assisted dying in rural and remote settings remain limited, particularly outside Australia and Canada, and there is a need for comparative international research to understand how different legal, cultural, and service contexts shape access. Further work should explore the long-term impacts of assisted dying on rural clinicians, including moral distress, professional identity, and workforce sustainability. Research is also needed to evaluate the effectiveness of emerging models such as care navigation, expanded nurse practitioner roles, and telehealth-enabled pathways once legal barriers are resolved. Little is known about the experiences of Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse communities, and migrant populations in rural areas, representing a critical gap in culturally safe implementation. Finally, future studies should examine the bereavement and psychosocial needs of rural families over time, and assess how community attitudes, stigma, and institutional policies influence access and emotional outcomes. Addressing these gaps will support the development of evidence-informed, equitable, and culturally responsive assisted dying systems across diverse rural and remote contexts.

Limitations

Despite the use of a comprehensive search strategy across multiple databases and grey literature sources, it is possible that some unpublished studies or locally disseminated reports were not identified. Such omissions may have led to gaps in the evidence base, particularly in contexts where research is not routinely indexed or widely circulated.

The review was restricted to English-language publications, which may have excluded relevant studies from non-Anglophone jurisdictions and introduces the potential for language bias. Future reviews should allocate resources for bilingual screening or targeted translation to improve global coverage and capture perspectives from jurisdictions where assisted dying is debated or practised in other languages.

In addition, the evidence base for rural and remote assisted dying implementation is geographically concentrated in Australia and Canada. While the Indian study offers important insights into socio-cultural and

resource-driven differences, readers should be cautious about generalizing findings to other global contexts with different legal, cultural, and health-system structures. Because national definitions differ, cross-jurisdictional comparisons should be interpreted cautiously. The conclusions drawn should therefore be interpreted with caution when considering applicability to other international contexts.

Finally, as with all scoping reviews, the emphasis was on breadth rather than depth of analysis. This approach provides a useful mapping of the available evidence but does not allow for detailed appraisal of study quality or causal inference.

Conclusion

Assisted dying in rural and remote communities is shaped by more than just law – it is shaped by people, place, and the profound emotional labor of EOL care. This review reveals that access is not simply a matter of eligibility, but of equity: shaped by geography, culture, infrastructure, and the relational dynamics that define small communities. Families and clinicians alike carry disproportionate burdens, navigating grief, stigma, and systemic barriers in pursuit of compassionate choice. While this review identifies several areas where further empirical work is urgently needed, the implications for practice and policy are already clear. To honor the intent of assisted dying legislation, reforms must go beyond legal clarification. They must invest in culturally safe care, telehealth access, expanded provider roles, and adapted bereavement support. Only through coordinated, inclusive, and community-informed action can Australia and indeed the world move toward an assisted dying system that is not only lawful, but truly just – where dignity at the EOL is a lived reality for all, regardless of location or geographic setting.

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Author's contributions

MH was involved in all aspects of the review, including conceptualization, design, search strategy, data collection, analysis and synthesis, drafting the manuscript, and overall supervision. SJ and PI contributed to the search strategy and data collection, assisted with analysis and synthesis, and were involved in manuscript review, editing, and supervision. PG assisted with analysis and synthesis, manuscript review and editing, and provided supervisory input. All authors read and approved the final manuscript.

Availability of data and materials

No datasets were generated or analyzed during the current study.

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