International Journal of Nursing Studies 173 (2026) 105253

Contents lists available at ScienceDirect

International Journal of Nursing Studies

journal homepage: www.elsevier.com/locate/ns

Evolving nursing roles in assisted dying services in New Zealand: A scoping review

Isaac Amankwaa [a,*], Cathy Liu [b], Jacqui Coates-Harris [b], Mellisa Chin [b], Sharon Brownie [b,c], Patricia McClunie-Trust [a]

[a] Auckland University of Technology, Auckland, New Zealand
[b] Waikato Institute of Technology, Hamilton, New Zealand
[c] Charles Sturt University, School of Rural Medicine, NSW, Australia

ARTICLE INFO

Keywords:
Assisted dying
End of life choice
New Zealand
Nursing roles
Scoping review

ABSTRACT

Background: The implementation of New Zealand's End-of-Life Choice Act 2019 provides a unique lens for examining the early-stage implementation of assisted dying policy. As legislation expands globally, nurses are emerging as central yet under-examined actors in delivering assisted dying care. This review addresses the urgent need to understand how nursing roles evolve in newly legalised contexts.

Objective: This scoping review aimed to understand the experiences, roles, and challenges faced by registered nurses and nurse practitioners in delivering assisted dying services under the End-of-Life Choice Act in Aotearoa New Zealand.

Method: The scoping review followed Joanna Briggs Institute guidelines. A systematic search was performed across ProQuest Central, Scopus, PubMed, and CINAHL to identify literature published between 2021 and 2025. Two screened the articles and extracted the data. A convergent, segregated approach was used for thematic synthesis.

Results: Nineteen studies were included, spanning anticipatory commentary and experiential data after the End-of-Life Choice Act came into force. Four themes were identified. First, evolving nursing roles revealed fragmentation: nurse practitioners administer life-ending medication but remain excluded from eligibility assessments. In contrast, registered nurses act as frontline coordinators yet are legally barred from initiating discussions. Experiential accounts added unanticipated burdens, including family management, logistical coordination, and supporting colleagues without formal preparation. Second, ethical dimensions extended beyond legal safeguards. Anticipatory sources predicted value conflicts, while experiential studies described lived moral distress, fractured team dynamics from conscientious objection, and confidentiality risks in small communities. Third, preparedness and support showed a marked gap. While early literature assumed structured training and clear guidance, experiential findings reported uneven preparation, reliance on informal peer networks, and culturally unsafe or absent emotional support. Debriefing was valued but inconsistently delivered. Finally, contextual variations shaped implementation. Hospices diverged between integration and resistance, aged residential care exposed nurses to family conflict and role ambiguity, rural practice intensified inequities and professional isolation, and community nurses often became central coordinators of home-based deaths. Māori perspectives were largely absent.

Conclusions: New Zealand's assisted dying policy creates a fragmented framework for nursing roles, confirmed by anticipatory projections and lived experience. This contrasts with integrated approaches in countries such as Canada, while also exposing gaps in preparedness, ethical support, and cultural responsiveness. Addressing these challenges requires legislative refinement, consistent support systems, and Māori-led, longitudinal research across diverse care contexts.

* Corresponding author at: Auckland University of Technology, 90 Akoranga Drive, Northcote, Auckland 0627, New Zealand.
E-mail addresses: isaac.amankwaa@aut.ac.nz (I. Amankwaa), Cathy.Liu1@health.nsw.gov.au (C. Liu), jacqui.CoatesHarris@wintec.ac.nz (J. Coates-Harris), mellisa.chin@nie.edu.sg (M. Chin), sbrownie@swin.edu.au (S. Brownie), patricia.McClunie-Trust@wintec.ac.nz (P. McClunie-Trust).
@Keepit_simpleGh (I. Amankwaa)

https://doi.org/10.1016/j.ijnurstu.2025.105253
Received 2 May 2025; Received in revised form 6 October 2025; Accepted 13 October 2025
Available online 16 October 2025

Social media abstract: New Zealand's assisted dying policy fragments nursing roles, creates ethical tensions, and leads to access inequities. Cultural safety and the integration of the nurse practitioner role are essential. #PalliativeCare #NursingPolicy.

What is already known

- Nurses deliver direct assisted dying care and coordinate services, yet their roles remain poorly defined and professionally under-recognised.
- Role ambiguity and ethical constraints challenge nurses' ability to provide holistic end-of-life care.
- Nurse practitioners in New Zealand are authorised to administer life-ending medication but are excluded from eligibility assessments.

What this paper adds

- Experiential evidence shows nurses carry unexpected burdens, including emotional support, logistical coordination, and family care, often without guidance.
- The End-of-Life Choice Act fragments nursing roles, creating persistent ambiguity for both nurse practitioners and registered nurses.
- Ethical tensions exceed legal safeguards, with nurses reporting moral distress, conscientious objection challenges, and confidentiality risks in small or rural settings.

1. Introduction

Assisted dying legislation has expanded rapidly internationally. Nurses are commonly the first point of contact for patients exploring end-of-life options and play central roles in providing information, emotional support, care coordination, and advocacy (Bellon et al., 2022; Sandham et al., 2022). Their responsibilities span the full trajectory, from receiving initial requests to providing information, administering life-ending medications, and offering post-mortem support to families (Bellens et al., 2020; Denier et al., 2009). Despite this, their roles in assisted dying discussions remain under-defined in law and policy, blurring scope of practice, ethical accountability, and professional recognition (Pesut et al., 2019a, 2019b).

These legislative shifts have directly affected the scope of nursing practice; however, international comparisons reveal striking contrasts (Mroz et al., 2021). The Netherlands formalised euthanasia and assisted suicide in 2002, followed by Belgium (2002), Luxembourg (2009), and Spain (2021) (Deliens and van der Wal, 2003; Orsini et al., 2025; Van Wesemael et al., 2009). Canada introduced Medical Assistance in Dying (MAID) in 2016, while over ten U.S. states now permit physician-assisted suicide, beginning with Oregon in 1997 (Chin et al., 1999; Colombo and Dalla-Zuanna, 2024). New Zealand's End of Life Choice Act came into effect in 2021, alongside state-by-state reforms in Australia from 2017 to 2023 (Jeanneret and Prince, 2024; Richardson, 2023). Momentum continues globally, with the Australian Capital Territory in 2024 becoming the first jurisdiction to allow nurse practitioners to assess eligibility (Orsini et al., 2025; Rosenberg, 2025). These developments illustrate expanding legal reform within which nursing roles remain fragmented and under-defined.

These legislative shifts directly affect the scope of nursing practice. Nurses are often the first point of contact for patients exploring end-of-life options and play central roles in providing information, emotional support, and care coordination (Sandham et al., 2022). However, international comparisons reveal striking contrasts. In Canada, nurse practitioners hold full authority to assess eligibility and administer medication, representing the most expansive model (Bustin et al., 2024). In Belgium, nurses are positioned as key coordinators throughout the process, whereas in the Netherlands, their role remains largely supportive, despite frequent patient contact (Bellon et al., 2022). By contrast, opposition among nurses in countries such as Greece and Turkey reflects strong ethical and cultural resistance (Cayetano-Penman et al., 2021). Across settings, recurring challenges include role ambiguity, limited training, and lack of clear legal guidance, which expose nurses to ethical and professional strain (Richardson, 2023). At the same time, studies consistently describe nurses as moral agents navigating these complexities, supported when clear policies and team-based frameworks are in place (Elmore et al., 2018).

In Aotearoa New Zealand, the End of Life Choice Act 2019 came into force in November 2021 following a national referendum (Casey, 2021; Cheung et al., 2022). The Act allows eligible citizens to request assisted dying under strict criteria (Casey, 2021). While proponents emphasised patient autonomy (Wilson et al., 2019), critics raised concerns about safeguards, the impact on palliative care, and the risks of coercion (Frey and Balmer, 2022; Gerson et al., 2019). Under the Act, medical practitioners assess eligibility and prescribe medication. Nurse practitioners may administer medication but are excluded from eligibility assessments, while registered nurses provide support, information, and ongoing care (Casey, 2021; Longmore, 2021a). Since its implementation, both groups have engaged in professional discourse to clarify their roles under the new legislative framework.

These legislative changes have introduced new and evolving responsibilities for registered nurses and nurse practitioners in New Zealand (Dehkhoda et al., 2023). Early review of these roles is necessary to identify emerging ethical tensions, practical ambiguities, and gaps in professional support, particularly around guideline clarity, training adequacy, and legal authority (Bellon et al., 2022; Egger-Rainer et al., 2023). These challenges are consistent with those reported in other jurisdictions, reinforcing the need for nursing-specific regulatory guidance. While healthcare systems and cultural contexts vary internationally (Matus, 2021), understanding how nurses navigate newly legalised assisted dying services is critical to informing safe, sustainable practice globally. New Zealand's early experiences are especially relevant for countries like the United Kingdom, where similar legislation is under active debate (Nwatu, 2024).

Besides practical challenges, the literature reveals enduring limitations in how nursing roles have been theorised and researched. Most existing articles subsume nurses' perspectives within broader interdisciplinary analyses, obscuring their distinct responsibilities, ethical burdens, and legal constraints (Fujioka et al., 2018; Vézina-Im et al., 2014). Nurse practitioners, despite their growing autonomy in many health systems, remain notably underrepresented in the evidence base (Richardson, 2023). This gap is particularly problematic in contexts like New Zealand, where NPs hold clinical independence yet face statutory restrictions in assisted dying care (Hewitt et al., 2023). Addressing these evidence gaps is essential to inform safe, coherent, and inclusive policy in jurisdictions moving toward legalisation.

This review focuses on the early implementation phase of New Zealand's End of Life Choice Act. This is a period during which nursing roles, responsibilities, and support structures are still being actively shaped. Early-stage evaluation of how the policy impacts nursing roles enables the identification of emerging role ambiguities, ethical tensions, and organisational barriers before they become embedded in routine practice (Damschroder et al., 2009; Molas-Gallart et al., 2021). Capturing nurses' real-world experiences at this formative stage provides an opportunity to refine policy, clarify the scope of practice, and inform the design of targeted education and support systems. Implementation science emphasises that examining how new policies are adopted during initial rollout is essential for preventing system-level failures and ensuring sustainable role integration (Stetler et al., 2006).

Insights from this early phase are not only timely for Aotearoa New Zealand but also transferable to other jurisdictions navigating the initial stages of legalisation (Mroz et al., 2021; Nwatu, 2024).

The review addresses interrelated policy, practical, and evidence gaps by synthesising available evidence to provide timely, context-specific insights that inform the development of supportive practices and policies. A scoping review methodology was selected due to the nascent nature of the field and the heterogeneity of evidence types. This approach enables the inclusion of empirical research, professional commentary, and grey literature (Colquhoun et al., 2014; Munn et al., 2018). With the field dominated by opinion pieces and editorials, the methodology would allow for the inclusion of both published and grey literature (Pham et al., 2014). Gaps and patterns in how registered nurses and nurse practitioners perceive their roles are identified (Munn et al., 2018). The findings would inform policymakers, healthcare organisations, and educators of the need for clear guidelines, adequate training, and robust support systems.

This scoping review aimed to understand the experiences, roles, and challenges faced by registered nurses and nurse practitioners in delivering assisted dying services under the End-of-Life Choice Act in Aotearoa New Zealand. Specific research questions included:

1. How have registered nurses and nurse practitioners' roles and responsibilities evolved under the End-of-Life Choice Act, and what are the implications for nursing practice and patient care?
2. What ethical challenges do nurses encounter when engaging with assisted dying in New Zealand?
3. How do contextual factors influence nurses' experiences and challenges with assisted dying?

2. Methods

A scoping review methodology was selected as the most appropriate design, given the emerging nature of assisted dying policy in Aotearoa New Zealand and the methodological diversity of the existing literature. This approach enables the inclusion of empirical articles, professional commentary, and grey literature, critical in a field where peer-reviewed evidence is limited and much of the discourse remains opinion-based (Pham et al., 2014). The review followed the Joanna Briggs Institute methodology for scoping reviews (Peters et al., 2015), building on the framework by Arksey and O'Malley (2005) and refinements by Levac et al. (2010). Reporting in this manuscript adhered to the PRISMA-ScR guidelines (Tricco et al., 2018).

2.1. Protocol and registration

No formal protocol was registered for this review.

2.2. Eligibility criteria

Articles were included if they focused on registered nurses and nurse practitioners in New Zealand (Population) and explored their roles and experiences related to assisted dying practices and policies (Concept). Only articles conducted within New Zealand were included (Context). Both empirical research and published literature, such as theoretical discussions, editorials, and opinion papers, were considered to capture the emerging discourse and early implementation of the assisted dying policy (Article Type). Articles were excluded if they focused on other healthcare professionals, patients, family members, policymakers, or the public. Articles concentrating on end-of-life care practices unrelated to assisted dying or those discussing legal, ethical, or philosophical issues without emphasis on nurses' roles were also excluded.

2.3. Information sources

A comprehensive search was conducted across five major academic databases: ProQuest Central, Scopus, PubMed, CINAHL, and Google Scholar. Additional information sources included the Australasian Medical Index, New Zealand Government websites, Ministry of Health publications, and documents from professional nursing organisations such as the Nursing Council of New Zealand and the New Zealand Nurses Organisation. Grey literature was also retrieved through manual searches of publicly available policy documents, organisational position statements, editorials, and other relevant publications. Citation tracking and reference list screening of included articles and key reviews were conducted to ensure thorough coverage. Only English-language sources published from 2021 onward were included. The final search was completed in July 2025.

2.4. Search strategy

Search strategies were developed using a combination of controlled vocabulary (e.g., MeSH terms) and free-text terms. Keywords included "registered nurse," "nurse practitioner," "assisted dying," "assisted suicide," "euthanasia," "New Zealand," and their variants. Boolean operators ("AND," "OR") were used to refine combinations, and syntax was adapted for each database. The PubMed search string is presented in Table 1.

2.5. Selection of sources of evidence

For screening, all the identified articles were collated and imported into the online software Covidence (Veritas Health Innovation, 2025). Titles and abstracts were independently screened by two reviewers (IA and MC) for compliance with the inclusion and exclusion criteria. Next, two reviewers assessed the full text of the selected articles in detail to establish compliance with the inclusion criteria (CL and MC). Any disagreements between reviewers during the screening or eligibility assessment process were resolved through discussion or the involvement of additional reviewers (PT and IA). A PRISMA flow chart detailing the selection process is presented in Fig. 1.

2.6. Data charting process

Four reviewers (IA, CL, JC, and MC) independently extracted data using a structured form within Covidence. The data charting tool was piloted on a subset of articles and refined iteratively before being fully extracted. The lead reviewer conducted thematic coding and analysis using NVivo 14Coding frameworks and interpretive decisions were reviewed regularly by the research team to ensure consistency and

Table 1
Search terms.

Search terms	MESH terms
Registered nurse	Nurses
Nurse practitioner	Nurse practitioners
Nursing staff	
Clinical nurse	
Advanced practice nurse	
Assisted dying	Assisted Suicide
Assisted suicide	
Euthanasia	
Aid in dying	
Medically assisted death	
New Zealand	New Zealand
Aotearoa	
PubMed search string	
((("Nurses"[Mesh] OR "Nurse Practitioners"[Mesh] OR "registered nurse*"[tiab] OR "nurse practitioner*"[tiab] OR "nursing staff"[tiab] OR "clinical nurse*"[tiab] OR "advanced practice nurse*"[tiab]) AND ("Assisted Suicide"[Mesh] OR "assisted dying"[tiab] OR "assisted suicide"[tiab] OR "aid in dying"[tiab] OR "euthanasia"[tiab] OR "medically assisted death"[tiab])) AND ("New Zealand"[Mesh] OR "New Zealand"[tiab] OR "Aotearoa"[tiab])) Filters: English, Publication date from 2021/01/01	

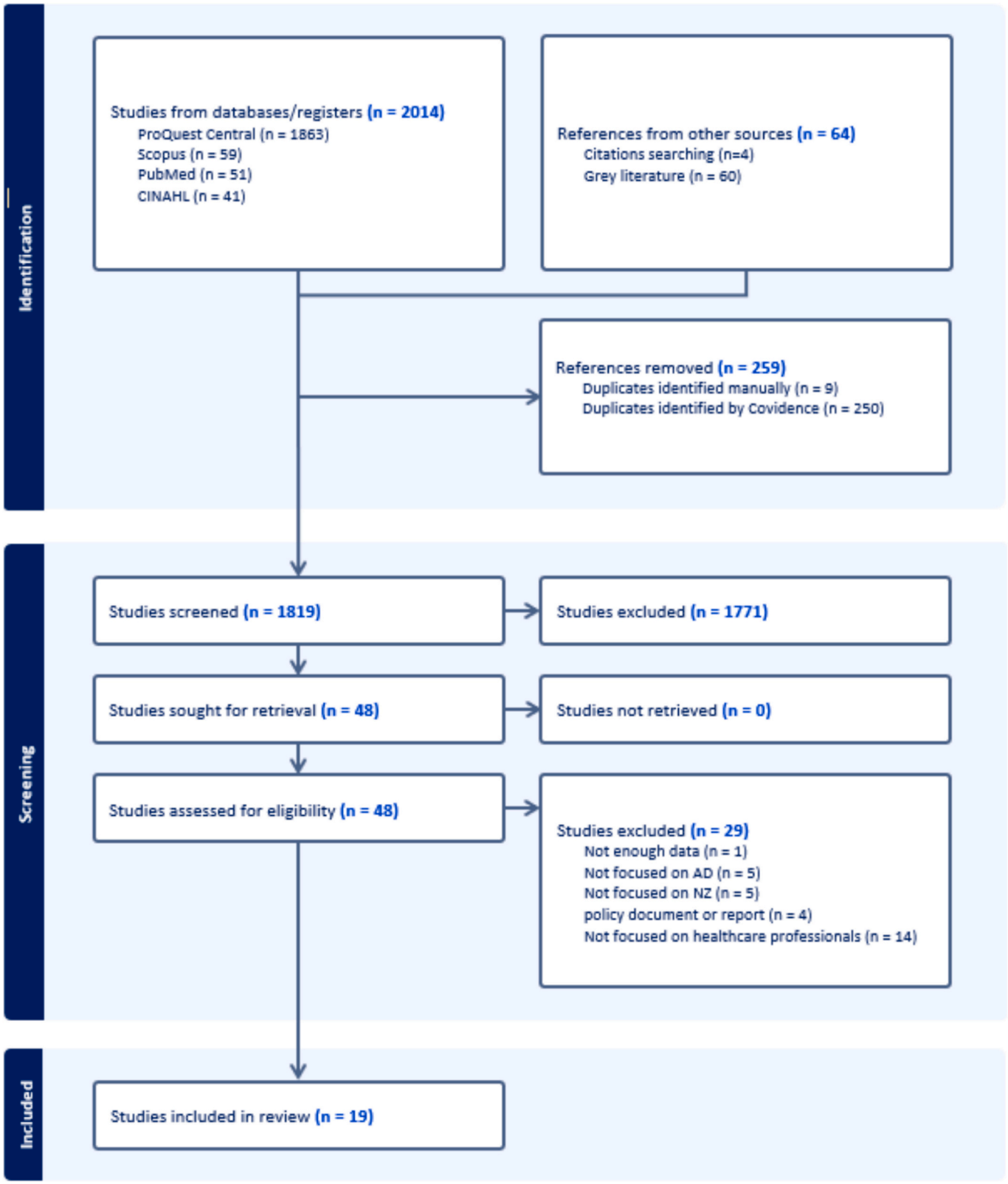

Fig. 1. Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews study flow chart.

rigour. Disagreements were settled through discussions.

2.7. Data items

The following data items were extracted from each included source: the type of publication and bibliographic details; the category of nurse discussed (registered nurse or nurse practitioner); the healthcare setting in which the discussion was situated (such as hospice, aged residential care, or rural contexts); and detailed descriptions of nursing roles and responsibilities related to assisted dying. In addition, any reported

ethical tensions or dilemmas, training needs, and organisational supports were recorded. To address potential temporal bias, each source was also classified as either anticipatory (projecting roles and challenges prior to November 2021) or experiential (reporting on post-implementation practice).

2.8. Critical appraisal of individual sources of evidence

As scoping reviews are not focused on the quality of retrieved articles, a formal quality appraisal was not undertaken (Peters et al., 2021).

2.9. Synthesis of data

Thematic synthesis was conducted using a two-phase approach. An initial round of inductive coding was undertaken to identify emerging ideas and role descriptors. These codes were then grouped into deductive themes informed by the review questions. Analysis was carried out in NVivo 14 (Lumivero, 2023), using tools such as matrix queries, node classifications, and coding visualisations. Subtheme patterns were compared across anticipatory and experiential sources to explore temporal influences. This comparative lens enabled us to assess how pre-implementation projections aligned or diverged from post-implementation realities. Subtheme patterns were examined across anticipatory and experiential sources. A visual representation of the final NVivo node hierarchy is provided in Supplementary Fig. S1.

2.10. Ethical consideration

This study did not acquire ethical approval because it was an analysis of secondary data.

3. Results

3.1. Selection of sources of evidence

Fig. 1 shows the PRISMA-ScR selection process for the inclusion of sources of evidence. A total of 2078 records were identified through database searches ($n = 2014$) and grey literature sources ($n = 64$). After removing 259 duplicates, 1819 unique records were screened. Full texts were retrieved for 48 potentially relevant articles. At full-text screening, 29 articles were excluded for the following reasons: insufficient data ($n = 1$), not focused on assisted dying ($n = 5$), not focused on the New Zealand context ($n = 5$), policy documents or reports ($n = 4$), and articles not focused on healthcare professionals ($n = 14$). This resulted in 19 articles included in the final review.

3.2. Characteristics of sources of evidence

The characteristics of the 19 included articles are summarised in Table 2 and Supplementary Table 1. The included sources comprised non-empirical scholarly articles ($n = 9$, 47.4 %), such as commentaries, discussion papers, editorials, and position statements; peer-reviewed articles reporting empirical findings ($n = 7$, 36.8 %); and academic works ($n = 3$, 15.8 %), which included book chapters and thesis chapters. Based on timing and content focus, 7 articles reflected experiential engagement, reporting on clinical practice or direct involvement with assisted dying services following the Act's enforcement. Twelve articles reflected anticipatory perspectives, typically involving theoretical or policy-oriented commentary published before or during the early phase of implementation. Most articles focused on registered nurses ($n = 14$, 73.7 %), while five (26.3 %) examined nurse practitioner roles. One study focused exclusively on Māori nurses (Manson, 2021), and another focused specifically on hospice nurses (Woods and Rook, 2022). Settings included general healthcare ($n = 8$), mixed or unspecified contexts ($n = 6$), palliative/hospice care (n = 3), and geriatric care ($n = 1$). Key topics addressed include nurse practitioner readiness, policy uncertainty, eligibility assessments, workplace needs, early implementation experiences, and ethical or cultural considerations related to assisted dying.

3.3. Results of individual sources of evidence

3.3.1. Overview of thematic analysis

Four themes emerged from the 19 articles (Fig. 2). Evolving Nursing Roles in Assisted Dying includes expanded responsibilities, legal constraints, and role differentiation between registered nurses and nurse practitioners. As shown in Table 3, anticipatory sources projected these subthemes, while experiential accounts confirmed them in practice. This temporal comparison shows how pre-implementation expectations often became nurses' lived realities, especially regarding role expansion and legal restrictions. Ethical Dimensions and Professional Identity reflects the moral tensions nurses face, including conflicted identity, conscientious objection, and moral distress. Preparedness and Support for Nurses emphasises the importance of training, guidelines, and ongoing psychological support. Contextual Variations in Assisted Dying Practice demonstrates how different care settings, from aged residential facilities to rural communities, shape distinct implementation challenges. Collectively, these findings show that nursing involvement in assisted dying extends beyond clinical tasks to include professional identity, ethical navigation, and context-sensitive practice adaptation.

3.3.2. Evolving nursing roles in assisted dying

Anticipatory and experiential sources converged on four subthemes: adaptation to new care paradigms, expanded responsibilities, legal and practical limitations, and role differentiation between registered nurses and nurse practitioners. Anticipatory accounts positioned nurses as central to patient and whānau support despite limited statutory recognition. They emphasised person-centred care, continuity of relationships, and the importance of collegial, team-based approaches (Longmore, 2021a; McGrath, 2021; NZNO, 2021). Experiential evidence confirmed this trajectory. Nurses described assisted dying as "a learning curve and a voyage of discovery" and reported learning from every case (Snelling et al., 2023). They emphasised the emotional importance of being present at the bedside and coordinating support across diverse roles (Davis, 2022; Woods, 2023).

Expanded responsibilities were identified in both anticipatory and experiential literature. Anticipatory commentary (Longmore, 2021a; NZNO, 2021) predicted that nurses would shoulder added duties in patient and family support. Experiential reports confirmed this, with nurses describing the emotional and practical demands of new tasks: "what do you say… how do you behave… what do you do with your box of medications?" (Snelling et al., 2023). Others highlighted the need to extend support to receptionists, cleaners, volunteers, and whānau, calling for consistent education and organisational backing (Davis, 2022).

Legal and practical limitations appeared in both evidence groups. Anticipatory sources flagged restrictions on registered nurses and the exclusion of nurse practitioners from eligibility assessments, as well as prescribing barriers (Meares et al., 2021; NZNO, 2021; Oster, 2021). Experiential accounts echoed these constraints. Nurse practitioners described being "brought at the end stage rather than at the assessment process," which "will require a legislation change" (Snelling et al., 2023). Registered nurses reported discomfort when unable to discuss assisted dying further after a patient raised it (Davis, 2022). Role differentiation between registered nurses and NPs persisted. Anticipatory commentaries promoted Nurse-Practitioner-General Practitioner (GP) models and RN-led rural services to reflect the realities of the workforce (Longmore, 2021b; McGrath, 2021; Oster, 2021). Experiential findings confirmed the underuse of nurse practitioner expertise in early stages and reinforced the reliance on medical practitioners for assessments, with registered nurses remaining in limited support roles (Hewitt et al., 2023; Snelling et al., 2023).

Table 2
Included articles categorised by evidence type and relationship to the End-of-Life Choice Act.

1st author/ year	Article type	Focus	Context/ perspective	Relationship to the Act
Peer-reviewed articles (n = 7, 36.8 %)				
Dehkhoda et al. (2023)	Empirical study	Registered nurse (general practice)	Attitudes toward the End-of-Life Choice Act	Anticipatory
Dehkhoda et al. (2025)	Empirical study	Nurse practitioners (general practice)	Preparedness to provide assisted dying services	Experiential
Hewitt et al. (2023)	Empirical study	Nurse practitioners (general practice)	Eligibility assessments in assisted dying	Experiential
Richardson (2023)	Discussion paper	Registered nurses (general practice)	Implications of assisted dying for nursing	Experiential
Snelling et al. (2023)	Empirical study	Registered nurses (general practice)	Early experiences of assisted dying	Experiential
Woods and Rook (2022)	Empirical study	Registered nurses, hospice	Viewpoints on assisted dying	Experiential
Young et al. (2023)	Discussion paper	Registered nurses (general practice)	Research priorities for assisted dying	Anticipatory
Academic works (n = 3, 15.8 %)				
Davis (2022)	Thesis chapter	Registered nurses (general practice)	Nursing narratives on assisted dying implementation	Experiential
Manson (2021)	Thesis chapter	Registered nurses (Māori)	Te Ao Māori perspectives on assisted dying	Anticipatory
Woods (2023)	Book chapter	Registered nurses (General practice)	Nursing responses to euthanasia	Anticipatory
Non-empirical scholarly articles (n = 9, 47.4 %)				
Boyd (2021)	Commentary	Nurse practitioners (geriatric)	End-of-life care decisions	Anticipatory
Clapham (2021)	Viewpoint	Nurse practitioners (general practice)	NPs readiness for the End-of-Life Choice Act	Anticipatory
Longmore (2021a)	Commentary	Nurse practitioners (hospice)	NP readiness for assisted dying	Anticipatory
Longmore (2021b)	Commentary	Nurse practitioners (palliative)	Uncertainty in assisted dying decisions	Anticipatory
McGrath (2021)	Commentary	Registered nurses (general practice)	Need for workplace policies	Anticipatory
Meares et al. (2021)	Editorial	Registered nurses (general practice)	Implementing the End-of-Life Choice Act	Anticipatory
NZNO (2021)	Position statement	Registered nurses (general practice)	Impact of the end-of-life law on nurses	Anticipatory
Oster (2021)	Commentary	NPs (general practice)	Exclusion from end-of-life prescribing	Anticipatory
Sandham et al. (2022)	Viewpoint	Registered nurses (general practice)	Nurses' needs in assisted dying	Experiential

Notes: Articles classified as "Anticipatory" were published around the time the End-of-Life Choice Act came into force (November 2021) and reflect preparatory discourse, role interpretation, or policy framing. "Experiential" articles report on clinical experience, role enactment, or lived responses to the Act following implementation.

3.3.3. *Ethical dimensions and professional identity*

Fourteen articles examined how ethical challenges intersect with professional identity for nurses under the End-of-Life Choice Act. Six subthemes emerged: confidentiality and privacy concerns, conflicted identity, conscientious objection, impact on nurse–patient relationships, moral distress and value conflicts, and safeguards and clarity of eligibility. Confidentiality and privacy concerns were raised in both anticipatory and experiential literature. Anticipatory sources warned of risks to patient privacy in small communities and multidisciplinary communication (Longmore, 2021a; Oster, 2021; Young et al., 2023). Experiential accounts described uncertainty about what information could be shared and how to maintain discretion in close-knit settings (Davis, 2022; Snelling et al., 2023).

Conflicted identity was a recurring theme. Anticipatory work explored how assisted dying might challenge nursing identity, particularly for nurse practitioners facing restrictive legislation despite their advanced clinical role (Boyd, 2021; McGrath, 2021; Oster, 2021). Experiential findings described emotional strain, role conflict, and reconciling assisted dying with personal ethics. One nurse described the role as both physically and emotionally demanding, emphasising the importance of "looking after themselves" (Snelling et al., 2023). Hewitt et al. (2023) noted that cultural and religious beliefs also influenced nurses' decisions to participate. Conscientious objection appeared in both evidence types. Anticipatory sources addressed the need for clear protocols, legal protections, and referral processes to ensure patient access (Boyd, 2021; Longmore, 2021a; Woods, 2023; Young et al., 2023). Experiential studies described the operational impacts of objection, such as rostering challenges, and strategies to support both objecting and participating colleagues (Davis, 2022; Sandham et al., 2022; Snelling et al., 2023).

Impact on nurse–patient relationships was found only in experiential evidence.

Nurses reported deepened emotional bonds with patients choosing assisted dying, alongside challenges in maintaining professional boundaries and managing emotional overload (Snelling et al., 2023; Woods and Rook, 2022). Moral distress and value conflicts were predicted in anticipatory literature, with concerns about ethical uncertainty and emotional toll (Boyd, 2021; Meares et al., 2021; NZNO, 2021). Experiential evidence illustrated these challenges, including sleeplessness, fatigue, and conflict between personal values and patient choices (Davis, 2022; Hewitt et al., 2023; Snelling et al., 2023). Manson (2021) highlighted systemic inequities for Māori patients, adding to the ethical burden. Safeguards and eligibility clarity were discussed in both groups. Anticipatory accounts raised concerns about the adequacy of legal safeguards and highlighted ambiguity in eligibility criteria (Oster, 2021; Woods, 2023; Young et al., 2023). Experiential reports described uncertainty in applying safeguards and responding to patient ambiguity, highlighting the need for clearer organisational guidance (Dehkhoda et al., 2023; Snelling et al., 2023).

3.3.4. *Preparedness and support for nurses*

Sixteen articles examined how nurses were prepared to deliver care under the End-of-Life Choice Act and what supports were required.

Fig. 2. Thematic framework of nursing involvement in assisted dying practice.

Subthemes included debriefing and peer reflection, emotional and psychological support, guidelines and protocols, ongoing professional development, practical and ethical support, and training needs. Training needs were consistently highlighted in anticipatory sources. Commentaries and surveys (Hewitt et al., 2023; Meares et al., 2021; Sandham et al., 2022; Young et al., 2023)emphasised that communication, cultural safety, and clarity around role boundaries were essential for safe practice. Experiential accounts confirmed uneven preparation, with some nurses describing limited awareness and sector differences in training. Davis (2022) and Snelling et al. (2023) reported that nurses sought advanced supervision and communities of practice to build confidence in this evolving area.

Guidelines and protocols were another dominant theme. Anticipatory literature (Clapham, 2021; Manson, 2021; Meares et al., 2021; NZNO, 2021) called for clear institutional policies, delineated roles, and consistent processes. Experiential studies found that the Ministry of Health resources and Support and Consultation for End of Life in New Zealand (SCENZ) systems provided functional structure but also constrained communication. Dehkhoda et al. (2025) described how strict referral requirements could leave nurses uncertain about how to respond to patients, while Davis (2022) reported instances of ambiguity when guidelines did not match practice realities. Emotional and psychological support was considered essential across all evidence types. Anticipatory commentary (Manson, 2021; Sandham et al., 2022) called for culturally safe, spiritually grounded supports. Experiential evidence showed this need was only partially met: Davis (2022) described emotional overload and a lack of structured follow-up, while Snelling et al. (2023) highlighted the importance of routine check-ins and accessible support, especially for those who objected.

Debriefing and peer reflection were described as critical mechanisms for sustaining practice. Anticipatory work (Manson, 2021; Sandham et al., 2022; Young et al., 2023) recommended structured group debriefs and mentoring systems. Experiential accounts confirmed their value: Snelling et al. (2023) reported that Ministry-facilitated peer groups were "not high pressure" and highly supportive, while Davis (2022) noted that informal team debriefs sometimes filled gaps where formal structures were absent. Practical and ethical support appeared in both anticipatory and experiential material. Richardson (2023) identified the need for systems to provide tangible and ethical backing for nurses, while Davis (2022) described how team presence and support during assisted dying cases were essential to safe and compassionate care. Finally, ongoing professional development was highlighted only in experiential studies. Dehkhoda et al. (2025) and Davis (2022) reported sector differences in understanding of the Act, with ongoing training and education identified as necessary for embedding knowledge across the workforce and sustaining competence over time.

3.3.5. *Contextual variations in assisted dying practice*

Thirteen articles highlighted how practice settings shaped nurses' roles, experiences, and ethical positioning under the End-of-Life Choice Act. Both anticipatory and experiential evidence demonstrated that context, whether in aged care, hospice, community, or rural settings, not only determined access but also the emotional and logistical burdens that nurses carried. Aged residential care (ARC) drew consistent attention. Anticipatory sources predicted that limited resources and ethical complexity would challenge implementation, particularly in terms of space constraints, access, and continuity of care (Manson, 2021; Oster, 2021; Young et al., 2023). Experiential accounts confirmed these challenges. Nurses described role ambiguity and moral strain in coordinating assisted dying when organisational systems lagged. One ARC nurse

Table 3
Temporal comparison of subthemes across anticipatory and experiential sources.

Theme	Subtheme	Anticipatory codes	Experiential codes	Interpretation	Representative articles
Evolving nursing roles in assisted dying	Expanded responsibilities	2	3	Anticipatory sources projected that nurses would assume expanded responsibilities in supporting patients and families. Experiential accounts confirmed this, with nurses describing how they became the central coordinators of care, providing emotional support and filling gaps when formal structures were absent.	**Anticipatory:** Longmore (2021a); NZNO (2021) **Experiential:** Davis (2022); Snelling et al. (2023); Woods (2023)
	Expanded responsibilities	2	3	Anticipatory pieces framed assisted dying as requiring significant cultural and professional adjustment. Experiential studies confirmed this, with nurses describing a "learning curve" and reflecting on the challenge of aligning assisted dying with established palliative values while continuing to support whānau before and after death.	**Anticipatory:** McGrath (2021); Oster (2021) **Experiential:** Snelling et al. (2023); Davis (2022); Woods (2023)
	Legal and practical limitations	2	2	Anticipatory material highlighted the restrictions nurses would face, particularly around initiating conversations. Experiential studies confirmed this tension, with nurses reporting moral unease when patients hinted at suffering but they were legally unable to respond directly.	**Anticipatory:** Longmore (2021a); Meares et al. (2021); NZNO (2021) **Experiential:** Davis (2022); Sandham et al. (2022)
	Role differentiation (NP vs RN)	3	2	Anticipatory sources debated the inequity of excluding NPs from eligibility assessments despite their advanced clinical expertise. Experiential accounts reinforced this concern, with NPs describing frustration at being brought in only at the final stage of care.	**Anticipatory:** (Longmore, 2021b); Oster (2021); McGrath (2021). **Experiential:** Snelling et al. (2023); Hewitt et al. (2023)
Ethical dimensions & professional identity	Confidentiality and privacy concerns	2	2	Anticipatory sources raised risks of privacy breaches, particularly in small communities and team communication. Experiential accounts confirmed these risks, describing uncertainty over information-sharing boundaries and tensions in multidisciplinary coordination.	**Anticipatory:** Longmore (2021a); Oster (2021) **Experiential:** Davis (2022); Snelling et al. (2023)
	Conflicted identity	5	5	Anticipatory literature debated how assisted dying might challenge nursing identity, especially for NPs balancing legislative restrictions with patient-centred values. Experiential evidence confirmed identity tensions, with nurses describing emotional strain, role conflict, and challenges reconciling assisted dying with their professional ethos.	**Anticipatory:** Longmore (2021a); McGrath (2021); NZNO (2021); Meares et al. (2021). **Experiential:** Davis (2022); Snelling et al. (2023); Woods and Rook (2022)
	Conscientious objection	7	7	Both anticipatory and experiential sources highlighted the prevalence of conscientious objection. Anticipatory texts emphasised legal rights and employer obligations; experiential accounts described navigating objections in practice, managing rostering impacts, and supporting objecting colleagues while ensuring patient access.	**Anticipatory:** Longmore (2021a); McGrath (2021); NZNO (2021); Meares et al. (2021); Oster (2021) **Experiential:** Davis (2022); Sandham et al. (2022).
	Impact on nurse–patient relationships	0	3	Absent in anticipatory literature. Experiential findings described strengthened emotional bonds with patients choosing assisted dying, but also emotional overload and the challenge of maintaining professional boundaries.	**Experiential:** Davis (2022); Snelling et al. (2023); Woods and Rook (2022)
	Moral distress and value conflicts	5	6	Anticipatory sources predicted ethical uncertainty and potential distress from participating in assisted dying. Experiential evidence illustrated these tensions, including sleeplessness, emotional fatigue, and conflict between personal values and patient choices.	**Anticipatory:** McGrath (2021); NZNO (2021); Meares et al. (2021); Oster (2021) **Experiential:** Davis (2022); Snelling et al. (2023); Woods and Rook (2022)
	Safeguards and eligibility clarity	6	4	Anticipatory literature focused on the adequacy of legal safeguards and the clarity of eligibility criteria. Experiential accounts described uncertainty in interpreting safeguards, difficulty responding to patient ambiguity, and the need for consistent guidance.	**Anticipatory:** Longmore (2021a); McGrath (2021); NZNO (2021); Meares et al. (2021); Oster (2021); Woods (2023) **Experiential:** Davis (2022); Snelling et al. (2023)
Preparedness and support for nurses	Debriefing and peer reflection	3	2	Anticipatory sources highlighted the importance of structured debriefing and peer groups to protect nurses' wellbeing. Experiential accounts confirmed this by describing Ministry of Health-facilitated peer groups and informal team debriefs as valuable, while also noting gaps where such support was unavailable.	**Anticipatory:** Manson (2021); Young et al. (2023) **Experiential:** Snelling et al. (2023); Davis (2022)
	Emotional and psychological support	2	2	Anticipatory literature stressed the need for culturally safe, spiritually grounded, and ongoing psychological support. Experiential studies echoed this, with nurses describing emotional overload, limited access to	**Anticipatory:** Manson (2021) **Experiential:** Davis (2022); Snelling et al. (2023)

(*continued on next page*)

Table 3 (*continued*)

Theme	Subtheme	Anticipatory codes	Experiential codes	Interpretation	Representative articles
				formal supports such as EAP, and the importance of routine check-ins and culturally responsive care.	
	Guidelines and protocols	7	3	Anticipatory sources consistently called for clear policies, defined roles, and structured communication boundaries. Experiential evidence confirmed that ministry of health resources and Support and Consultation for end-of-life care in New Zealand processes were useful but sometimes restrictive, leaving nurses uncertain about how to respond in ambiguous situations and feeling constrained by "straight referral" requirements.	**Anticipatory:** Boyd (2021); Clapham (2021); Meares et al. (2021); NZNO (2021). **Experiential:** Davis (2022); Dehkhoda et al. (2025); Snelling et al. (2023)
	Ongoing professional development	0	2	No anticipatory references explicitly discussed ongoing development. Experiential accounts highlighted gaps in knowledge across sectors (e.g., hospice vs ARC) and stressed the need for continuous education and training for all staff involved in assisted dying.	**Experiential:** Davis (2022); Dehkhoda et al. (2025).
	Practical and ethical support	1	1	Anticipatory sources suggested the need for practical and ethical supports to sustain safe practice. Experiential evidence confirmed this need, describing how coordinated team support and the presence of nurses were essential in managing complex care situations.	**Anticipatory:** Richardson (2023) **Experiential:** Davis (2022).
	Training needs	6	3	Anticipatory literature strongly emphasised training in communication, cultural safety, and role boundaries. Experiential accounts confirmed uneven awareness and sectoral variation, pointing to the need for advanced training, clinical supervision, and communities of practice to embed sustainable competence.	**Anticipatory:** Hewitt et al. (2023); Meares et al. (2021); Young et al. (2023) **Experiential:** Davis (2022); Dehkhoda et al. (2025); Snelling et al. (2023)
Contextual variation in assisted dying practice	Aged residential care	3	4	Anticipatory sources anticipated unique challenges in Aged Residential Care, including limited resourcing and ethical complexity. Experiential studies confirmed these concerns: nurses described role ambiguity, reliance on external prescribers, and moral strain when coordinating assisted dying in resource-limited settings.	**Anticipatory:** Manson (2021); Oster (2021); Young et al. (2023). **Experiential:** Davis (2022); Snelling et al. (2023); Woods and Rook (2022); Woods (2023).
	Community & primary care	0	1	No anticipatory literature addressed community and primary care directly. Experiential findings showed nurses often acted as coordinators, balancing confidentiality, logistical demands, and maintaining trust with whānau while facilitating assisted dying in patients' homes.	**Experiential:** Snelling et al. (2023)
	Hospice and palliative care	3	5	Anticipatory sources predicted tensions between assisted dying and hospice philosophy, raising concerns about mission drift and organisational readiness. Experiential studies reported mixed realities: some hospices integrated assisted dying through protocols and support, while others resisted or placed the burden on individual nurses. This confirmed anticipatory tensions while adding detail about institutional variability.	**Anticipatory:** Manson (2021); NZNO (2021); Woods (2023) **Experiential:** Davis (2022); Dehkhoda et al. (2025); Snelling et al. (2023); Woods and Rook (2022)
	Rural and remote care	2	1	Anticipatory literature highlighted risks of inequitable access in rural and remote areas, particularly due to limited practitioners and cultural safety issues. Experiential evidence showed these risks materialised, with patients facing delays and nurses reporting resource strain and professional isolation when coordinating care in rural contexts.	**Anticipatory:** Longmore (2021a); Longmore (2021b); Oster (2021) **Experiential:** Snelling et al. (2023)

Note: NPs – nurse practitioners, RNs – registered nurses.

recounted that responsibilities were placed on them due to their strong relationship with the whānau, noting the absence of clear guidelines (Davis, 2022). Others reported relying on external prescribers, which compounded the workload and increased uncertainty (Snelling et al., 2023; Woods, 2023).

Community and primary care were rarely addressed in anticipatory discussions, but experiential findings highlighted the distinctive pressures of supporting assisted dying in patients' homes. Snelling et al. (2023) noted that nurses often acted as central coordinators, balancing logistical demands and maintaining trust with whānau. In these settings, confidentiality was both critical and fragile: nurses described the need to safeguard patient discretion in small, close-knit communities where social familiarity was pervasive (Snelling et al., 2023). Hospice and palliative care settings generated the sharpest ethical tensions. Anticipatory commentaries warned of conflicts between assisted dying and hospice philosophy, raising fears of mission drift and questioning organisational readiness (Manson, 2021; Woods and Rook, 2022). Experiential evidence revealed mixed realities. Some hospices created protocols and Ministry-backed kits to integrate assisted dying (Snelling et al., 2023) while others resisted, leaving the burden on individual nurses. One hospice nurse described the strain of institutional objection, noting that staff were not permitted in the room during the procedure

but were expected to support the whānau before and after (Davis, 2022). These experiences confirmed anticipatory concerns while showing how responses diverged across hospices.

Rural and remote care was consistently framed in terms of inequity. Anticipatory texts (Longmore, 2021a; Oster, 2021) predicted delays and cultural safety risks due to the limited availability of practitioners. Experiential accounts affirmed these fears. Snelling et al. (2023) described how rural patients often waited longer for services and how nurses felt professionally isolated when coordinating assisted dying across large geographic areas. The emotional load was intensified by resource scarcity, with one nurse recalling travel "to the South Island because nobody else was available at the time" (Snelling et al., 2023).

3.3.6. Temporal comparative analysis: pre- and post-implementation thematic evolution

Key temporal patterns emerged (Table 3 and Supplementary Table S2). Expanded responsibilities, nurse–patient relationships, and community care contexts were absent from anticipatory literature but prominent in experiential accounts. These suggest that these dimensions only became visible through lived practice. By contrast, conscientious objection and challenges to aged residential care were anticipated in sources and later validated in practice. However, experiential accounts added depth, describing staff conflict, emotional fatigue, and relational consequences that early writings had primarily framed as procedural issues. In Evolving Nursing Roles, anticipatory literature has emphasised legal restrictions and the differentiation between the Nurse Practitioner/Registered Nurse roles. Experiential findings confirmed these but introduced new logistical demands, such as family management, coordination across staff, and end-of-life mediation without formal preparation. In "Ethical Dimensions and Professional Identity," both groups discussed conscientious objection; yet experiential accounts highlighted its interpersonal and moral toll. Impacts on nurse–patient trust and intimacy were uniquely revealed post-implementation.

Preparedness gaps were especially evident. Anticipatory sources assumed structured training, guidelines, and ongoing professional development would follow implementation. In practice, experiential reports described inconsistent access to resources, limited supervision, and the absence of systematic support. Notably, professional development and ethical mentoring, discussed in anticipatory texts, were largely missing in experiential accounts, exposing a significant implementation shortfall. Contextual Variation in Practice appeared across both groups. Anticipatory sources predicted strain in ARC, hospice, and rural settings; experiential accounts confirmed these but provided granular detail, describing institutional resistance, resource constraints, and family conflict. Hospice integration and rural delivery were especially variable, with experiential data revealing tensions and inequities not fully captured in early commentaries.

4. Discussion

4.1. Summary of evidence

This scoping review aimed to explore how the End-of-Life Choice Act in New Zealand has shaped nurses' roles, responsibilities, and experiences. The review identified evidence across four domains: evolving roles, ethical and professional identity, preparedness and support, and contextual variations in practice. A distinctive feature of the evidence was its temporal composition. A substantial proportion of sources were anticipatory, projecting challenges and responsibilities before implementation, while experiential studies reported on post-implementation practice. Comparing these two phases showed how early projections were either confirmed, contradicted, or expanded in lived experience.

A central issue highlighted by this review is the fragmented framework for nursing roles within New Zealand's End-of-Life Choice Act. Although nurse practitioners (NPs) are authorised to administer life-ending medications, they are excluded from eligibility assessments, creating a disconnect between procedural authority and relational continuity of care. Registered nurses face similar constraints, as they are legally barred from initiating discussions despite being positioned as frontline coordinators. This compartmentalisation of responsibilities has been described in other reviews as a source of ethical and legal ambiguity, generating uncertainty and emotional strain for nurses involved in assisted dying (Bustin et al., 2024; Sandham et al., 2022). International comparisons reinforce this critique: Canada's integration of nurse practitioners into both assessment and administration ensures continuity, while Belgium's task-based guidance clarifies nursing roles (Krol et al., 2022; van Bruchem-van de Scheur et al., 2008). By contrast, New Zealand's current framework risks ambiguity in roles, inconsistent practices across settings, and inequitable access to services. These limitations also reflect the exclusion of nurses from policy design, thereby removing frontline expertise in safety assessment and care for vulnerable populations. This leaves staff to work within frameworks that compromise patient safety.

Ethical tensions in assisted dying extend beyond legal safeguards and directly shape nursing identity. These tensions are relational and emotionally demanding, requiring nurses to reconcile professional responsibilities with personal values and cultural commitments. In small communities, excluding nurses heightens the risk by reducing the number of trusted professionals, weakening confidentiality, and limiting safe escalation. International literature confirms the centrality of these challenges. Meta-syntheses report that nurses experience moral distress, role conflict, and enduring emotional strain when involved in assisted dying (Elmore et al., 2018; Pesut et al., 2019b; Sandham et al., 2022). A lack of clear guidelines has been identified as a key driver of ethical uncertainty (Pesut et al., 2019a), while clearer policies are understood to provide both psychological reassurance and legal protection (Sandham et al., 2022). Other reviews highlight the dual nature of involvement, noting that nurses often feel moral conflict and powerlessness but also attribute meaning to their role in supporting what they perceive as a dignified death (Cayetano-Penman et al., 2021). Comparative research further shows that although Canada and Belgium have developed stronger safeguarding frameworks, these reduce but do not eliminate moral injury (Richardson, 2023). In contrast, New Zealand's fragmented legislative framework leaves nurses without consistent guidance or institutional support, heightening ethical ambiguity and increasing the emotional burden of participation.

Preparedness and systemic support emerged as a critical gap. Anticipated sources assumed that structured training, clear guidelines, and professional development would follow implementation. However, experiential evidence revealed uneven preparation, inconsistent access to resources, and a reliance on informal supervision in place of systematic support. Nurses described limited education, culturally unsafe emotional support, and uncertainty when guidelines did not align with practice realities. Existing reviews have reported similar findings (Bellon et al., 2022; Richardson, 2023), with surveys indicating that 71 % of nurses reported insufficient knowledge or training (Cayetano-Penman et al., 2021). The lack of robust policy guidance has been linked to role ambiguity, diminished confidence, and vulnerability to moral and legal uncertainty (Bustin et al., 2024; Suva et al., 2019). In practice, support is often sustained through peer relationships rather than institutional frameworks (Bustin et al., 2024; Elmore et al., 2018), a pattern also evident in New Zealand, where debriefing and peer reflection filled critical gaps. Even in Canada, where policies exist, implementation is inconsistent and often relies on local workarounds (Pesut et al., 2020). Across contexts, the mismatch between anticipated structured preparation and the lived reality of fragile, informal support undermines confidence, amplifies moral distress, and threatens the sustainability of assisted dying services.

Our findings revealed that nurses' experiences of assisted dying in New Zealand are highly shaped by context, with practice varying across hospices, aged residential care, rural settings, and community care. International evidence consistently reinforces this contextual complexity.

Elmore et al. (2018) emphasised that nurses' moral experiences are deeply influenced by time, resources, and institutional culture, while Cayetano-Penman et al. (2021) similarly reported that attitudes and practices are highly contextualised. Espírito Santo et al. (2014) highlighted variation across institutions, and Bellon et al. (2022) observed that protocols often centre on physicians, leaving nurses' roles undefined and amplifying contextual variation. Canadian evidence confirms this pattern: Pesut et al. (2020) documented variability in how Medically Assisted Dying is enacted, with support structures often shaped by informal leadership rather than consistent frameworks. Hospice-specific tensions are echoed elsewhere, with Sandham et al. (2022) describing conflicts between voluntary assisted dying and palliative care philosophy; while some nurses framed assisted dying as a "beautiful death," others experienced ethical strain in the absence of organisational support. Reviews also highlight inequities in aged care and rural contexts, where role ambiguity and lack of organisational backing undermine confidence (Bustin et al., 2024; Suva et al., 2019). Taken together, both New Zealand and international evidence underscore that uniform approaches cannot support assisted dying; instead, tailored, context-sensitive policies and supports are essential to ensure services are safe, equitable, and sustainable for nurses.

Direct evidence on Māori nurses' perspectives and the systematic integration of Māori cultural frameworks in assisted dying practice is limited. While some anticipatory sources raised questions of equity (Manson, 2021), experiential accounts rarely engaged with cultural analysis. This omission is not unique to New Zealand: Sandham et al. (2022) noted the absence of Indigenous voices, leaving cultural diversity largely unexamined. The authors warned that Indigenous nurses may face the most significant existential tensions, often bridging vulnerable communities and mainstream services, and called for research on how cultural differences shape the delivery of assisted dying. Broader international evidence reinforces the significance of culture in shaping nurses' roles. Elmore et al. (2018) found that nurses' moral experiences of assisted dying are contingent on contextual and cultural features, while Cayetano-Penman et al. (2021) and Vézina-Im et al. (2014) showed that attitudes and motivations are highly contextualised, shaped by factors such as religion, geography, and immediate professional environments. Pesut et al. (2020) similarly reported variability in Canadian MAID practice is linked to sociocultural and institutional contexts.

4.2. Implications for practice, research, and policy

Healthcare organisations must address the fragmented framework identified in this review by developing comprehensive guidance that clarifies nursing roles within legal constraints. This includes explicit protocols for registered nurses responding to patient inquiries, clear referral pathways, and structured support systems to mitigate moral distress. Context-specific training is essential, particularly in hospice settings where tensions between palliative care philosophy and assisted dying are most pronounced. Routine debriefing processes and ethics consultation services should be embedded into practice to support nurses navigating these complex ethical tensions.

Legislative refinement is needed to address role fragmentation within the End-of-Life Choice Act. Nurse practitioners should be authorised to participate in eligibility assessments when also responsible for medication administration, enhancing care continuity and reflecting successful international models. Regulatory bodies must develop explicit communication guidelines for registered nurses and mandate organisational support systems across all healthcare facilities. The Ministry of Health should implement context-sensitive guidelines recognising the unique challenges across different settings, with proportional resource allocation to ensure effective implementation.

Given the reliance on anticipatory literature, longitudinal studies following the evolution of nursing roles and implementation experiences are urgently needed. Priority should be given to empirical research examining real-time practice across healthcare settings and evaluating the adequacy of institutional support. Indigenous-led research using culturally appropriate methodologies is essential to examine how Māori cultural practices and family dynamics influence assisted dying practice, ensuring policy upholds treaty obligations and supports culturally safe care. Comparative studies with established international jurisdictions could identify best practices to inform the refinement of New Zealand policy.

4.3. Limitations

This review includes a large proportion of non-empirical articles, such as commentaries, editorials, and discussion papers, many of which reflect anticipatory discourse rather than lived clinical experience. While these sources were retained for relevance, their inclusion may bias the thematic emphasis toward projected roles and speculative concerns. Empirical articles often lacked clear data collection timelines, which limited the ability to confirm whether findings reflected post-implementation practice. Although articles without clear timelines were included, this weakens the strength of conclusions about the Act's operational impact. A sensitivity analysis was conducted to compare themes between anticipatory and experiential articles; however, the small number of empirical articles with verifiable timelines limits the robustness of this comparison. The generalisability of the findings is limited to the New Zealand context, and caution should be exercised when applying these results to other jurisdictions. The inclusion of grey literature was restricted to publicly accessible policy statements and professional publications; unpublished abstracts and untraceable sources were excluded. As this review focused solely on nursing roles, it did not include the perspectives of other stakeholders such as patients, whānau, or other healthcare professionals. Furthermore, the search was limited to English-language articles published from 2021 onwards, which may have excluded relevant preparatory work or sources in languages other than English.

5. Conclusion

New Zealand's End of Life Choice Act creates a fragmented framework that excludes nurse practitioners from eligibility assessment despite their central role. While these constraints were anticipated, experiential evidence suggests that they also impose additional burdens of emotional care, family management, and logistical coordination without adequate guidance. Ethical tensions are compounded by moral distress, conscientious objection, and confidentiality risks in small communities, while uneven training and reliance on informal peer support expose a significant gap in preparedness. Context amplifies these challenges, with hospice resistance, aged care ambiguity, rural inequities, and the centrality of community nurses confirming that one-size-fits-all approaches are ineffective. International models such as Canada's integrated system offer clearer alternatives, but progress in New Zealand requires legislative refinement, consistent and context-specific support systems, and longitudinal research. Critically, the absence of Māori perspectives highlights a structural gap, underscoring the need for Māori-led inquiry to ensure culturally safe and equitable practices that honour te Tiriti o Waitangi.

CRediT authorship contribution statement

Isaac Amankwaa: Writing – review & editing, Writing – original draft, Validation, Software, Methodology, Formal analysis, Data curation, Conceptualization. **Cathy Liu:** Writing – review & editing, Validation, Methodology, Formal analysis, Data curation. **Jacqui Coates-Harris:** Writing – review & editing, Resources, Methodology, Formal analysis, Data curation. **Mellisa Chin:** Writing – review & editing, Project administration, Methodology, Formal analysis, Data curation. **Sharon Brownie:** Writing – review & editing, Supervision, Methodology, Formal analysis, Conceptualization. **Patricia McClunie-Trust:**

Writing – review & editing, Supervision, Methodology, Formal analysis, Conceptualization.

Funding

This research received no specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgments

The authors gratefully acknowledge the anonymous reviewers for their comments on early versions of this article.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ijnurstu.2025.105253.

References

Arksey, H., O'Malley, L., 2005. Scoping studies: towards a methodological framework. Int. J. Soc. Res. Methodol. 8 (1), 19–32.
Bellens, M., Debien, E., Claessens, F., Gastmans, C., Dierckx de Casterlé, B., 2020. "It is still intense and not unambiguous." Nurses' experiences in the euthanasia care process 15 years after legalisation. J. Clin. Nurs. 29 (3–4), 492–502.
Bellon, F., Mateos, J.T., Pastells-Peiró, R., Espigares-Tribó, G., Gea-Sánchez, M., Rubinat-Arnaldo, E., 2022. The role of nurses in euthanasia: a scoping review. Int. J. Nurs. Stud. 134, 104286.
Boyd, M., 2021. End-of-life care: 'you can't go into this blind'. Kai Tiaki Nurs. N. Z. 27 (9), 20–21.
van Bruchem-van de Scheur, G.G., van der Arend, A.J., Huijer Abu-Saad, H., van Wijmen, F.C., Spreeuwenberg, C., Ter Meulen, R.H., 2008. Euthanasia and assisted suicide in Dutch hospitals: the role of nurses. J. Clin. Nurs. 17 (12), 1618–1626.
Bustin, H., Jamieson, I., Seay, C., Reid, K., 2024. A meta-synthesis exploring nurses' experiences of assisted dying and participation decision-making. J. Clin. Nurs. 33 (2), 710–723.
Casey, J., 2021. End of Life Choice Act 2019.
Cayetano-Penman, J., Malik, G., Whittall, D., 2021. Nurses' perceptions and attitudes about euthanasia: a scoping review. J. Holist. Nurs. 39 (1), 66–84.
Cheung, G., Frey, R., Young, J., Hoeh, N., Carey, M., Vara, A., Menkes, D.B., 2022. Voluntary assisted dying: the expanded role of psychiatrists in Australia and New Zealand. Aust. N. Z. J. Psychiatry 56 (4), 319–322.
Chin, A.E., Hedberg, K., Higginson, G.K., Fleming, D.W., 1999. Legalized physician-assisted suicide in Oregon—the first year's experience. N. Engl. J. Med. 340 (7), 577–583.
Clapham, T., 2021. Nurse practitioners ready to. Kai Tiaki Nurs. N. Z. 27 (11), 10.
Colombo, A.D., Dalla-Zuanna, G., 2024. Data and trends in assisted suicide and euthanasia, and some related demographic issues. Popul. Dev. Rev. 50 (1), 233–257.
Colquhoun, H.L., Levac, D., O'Brien, K.K., Straus, S., Tricco, A.C., Perrier, L., Kastner, M., Moher, D., 2014. Scoping reviews: time for clarity in definition, methods, and reporting. J. Clin. Epidemiol. 67 (12), 1291–1294.
Damschroder, L.J., Aron, D.C., Keith, R.E., Kirsh, S.R., Alexander, J.A., Lowery, J.C., 2009. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. Implement. Sci. 4.
Davis, R.A., 2022. Nursing Narratives of Assisted Dying Implementation in New ZealandAuckland. University of Technology.
Dehkhoda, A., Frey, R., Carey, M., Jing, X., Bull, S., Sundram, F., Hoeh, N., Menkes, D., Robinson, J., Cheung, G., 2023. Health professionals' understanding and attitude towards the End of Life Choice Act 2019: a secondary analysis of Manatū Hauora - Ministry of Health workforce surveys. N. Z. Med. J. 136 (1576), 11–31.
Dehkhoda, A., Frey, R., Carey, M., Robinson, J., Sundram, F., Hoeh, N., Bull, S., Cheung, G., 2025. Early experiences of the End of Life Choice Act 2019 amongst assisted dying practitioners in Aotearoa New Zealand. BMC Palliat. Care 24 (1), 149.
Deliens, L., van der Wal, G., 2003. The euthanasia law in Belgium and the Netherlands. Lancet 362 (9391), 1239–1240.
Denier, Y., Dierckx de Casterlé, B., De Bal, N., Gastmans, C., 2009. Involvement of nurses in the euthanasia care process in Flanders (Belgium): an exploration of two perspectives. J. Palliat. Care 25 (4), 264–274.
Egger-Rainer, A., Bublitz, S., Lorenzl, S., Weck, C., Paal, P., 2023. First-hand recommendations for nursing management to support nurses involved in the process of hastened death: a systematic review of the qualitative evidence. J. Nurs. Manag. 2023 (1), 8601814.
Elmore, J., Wright, D.K., Paradis, M., 2018. Nurses' moral experiences of assisted death: a meta-synthesis of qualitative research. Nurs. Ethics 25 (8), 955–972.
Espírito Santo, C., Lima, C., Silva, L., Costa, R., Rodrigues, B.M., Pacheco, S., 2014. The nursing's scientific production on euthanasia: integrative literature review. Rev. Pesqui. Cuidado Fundam. 6 (3), 1231–1242.
Frey, R., Balmer, D., 2022. The views of Aotearoa/New Zealand adults over 60 years regarding the End of Life Choice Act 2019. J. Relig. Health 61 (2), 1605–1620.
Fujioka, J., Mirza, R., McDonald, P., Klinger, C., 2018. Implementation of medical assistance in dying: a scoping review of health care providers' perspectives. J. Pain Symptom Manag. 55 (6), 1564–1576.e9.
Gerson, S.M., Bingley, A., Preston, N., Grinyer, A., 2019. When is hastened death considered suicide? A systematically conducted literature review about palliative care professionals' experiences where assisted dying is legal. BMC Palliat. Care 18 (1), 75.
Hewitt, J., Grealish, L., Bonner, A., 2023. Voluntary assisted dying in Australia and New Zealand: exploring the potential for nurse practitioners to assess eligibility. Collegian 30 (1), 198.
Jeanneret, R., Prince, S., 2024. Nurses and voluntary assisted dying: how the Australian Capital Territory's Law could change the Australian regulatory landscape. J. Bioeth. Inq. 21 (3), 393–399.
Krol, P., Amiri, M., Vonarx, N., 2022. De l'aide médicale à mourir au Québec: une analyse du contexte et de la pratique infirmière en soins palliatifs. Rech. Soins Infirm. 147 (4), 67–81.
Levac, D., Colquhoun, H., O'Brien, K.K., 2010. Scoping studies: advancing the methodology. Implement. Sci. 5 (1), 69.
Longmore, M., 2021a. Nurse practitioners ready to play a role in assisted dying. Kai Tiaki Nurs. N. Z. 27 (11), 10–11.
Longmore, M., 2021b. You can't know what you would decide. Kai Tiaki Nurs. N. Z. 27 (16), 102021b.
Lumivero, 2023. NVivo (Version 14). Available online: https://www.lumivero.com (Accessed, Computer software).
Manson, L.M., 2021. Te Ao Maori: Maori Nurses' Perspectives on Assisted Dying and the Te Ao Maori Cultural Considerations Required to Guide Nursing Practice. Auckland University of Technology.
Matus, J.C., 2021. A comparison of country's cultural dimensions and health outcomes. Healthcare (Basel) 9 (12).
McGrath, M., 2021. Workplace policies needed on end of life law. Kai Tiaki Nurs. N. Z. 27 (8), 19.
Meares, S., Gasquoine, S., Manson, M.L., 2021. Implementing the End of Life Choice Act: support for members. Kai Tiaki Nurs. N. Z. 26 (11), 36.
Molas-Gallart, J., Boni, A., Giachi, S., Schot, J., 2021. A formative approach to the evaluation of Transformative Innovation Policies. Res. Eval. 30 (4), 431–442.
Mroz, S., Dierickx, S., Deliens, L., Cohen, J., Chambaere, K., 2021. Assisted dying around the world: a status quaestionis. Ann. Palliat. Med. 10 (3), 3540–3553.
Munn, Z., Peters, M.D.J., Stern, C., Tufanaru, C., McArthur, A., Aromataris, E., 2018. Systematic review or scoping review? Guidance for authors when choosing between a systematic or scoping review approach. BMC Med. Res. Methodol. 18 (1), 143.
Nwatu, E.I., 2024. Legislative Activity and the Law on Assisted Dying in the United Kingdom. Available at SSRN 4702126.
NZNO, 2021. Nurses 'profoundly affected' by end-of-life law. Kai Tiaki Nurs. N. Z. 27 (4), 8.
Orsini, F., Cioffi, A., Cipolloni, L., Bosco, M.A., Fabrello, C., Cecannecchia, C., De Simone, S., 2025. Towards a European end-of-life regulation: a necessary analysis. Healthcare (MDPI) 13 (2), 130.
Oster, S., 2021. NPs excluded from end-of-life prescribing. Kai Tiaki Nurs. N. Z. 27 (7), 8.
Pesut, B., Thorne, S., Greig, M., Fulton, A., Janke, R., Vis-Dunbar, M., 2019a. Ethical, policy, and practice implications of nurses' experiences with assisted death. Adv. Nurs. Sci. 42 (3), 216–230.
Pesut, B., Thorne, S., Stager, M., Schiller, C.J., Penney, C., Hoffman, C., Greig, M., Roussel, J., 2019b. Medical assistance in dying: a review of Canadian Nursing Regulatory documents. Policy Polit. Nurs. Pract. 20 (3), 113–130.
Pesut, B., Duggleby, W., Warner, G., Kervin, E., Paxton, B., Antifeau, E., Hooper, B., 2020. Implementing volunteer-navigation for older persons with advanced chronic illness (Nav-CARE): a knowledge to action study. BMC Palliat. Care 19, 1–16.
Peters, M.D.J., Godfrey, C.M., Khalil, H., McInerney, P., Parker, D., Soares, C.B., 2015. Guidance for conducting systematic scoping reviews. JBI Evid. Implement. 13 (3).
Peters, M.D.J., Marnie, C., Colquhoun, H., Garritty, C.M., Hempel, S., Horsley, T., Langlois, E.V., Lillie, E., O'Brien, K.K., Tunçalp, Ö., Wilson, M.G., Zarin, W., Tricco, A.C., 2021. Scoping reviews: reinforcing and advancing the methodology and application. Syst. Rev. 10 (1), 263.
Pham, M.T., Rajić, A., Greig, J.D., Sargeant, J.M., Papadopoulos, A., McEwen, S.A., 2014. A scoping review of scoping reviews: advancing the approach and enhancing the consistency. Res. Synth. Methods 5 (4), 371–385.
Richardson, S., 2023. An international expansion in voluntary euthanasia/assisted dying: the implications for nursing. Int. Nurs. Rev. 70 (1), 117–126.
Rosenberg, R.M., 2025. Moral and Practical Considerations in the Debate on Physician-assisted Suicide: The Terminally Ill Adults (End of Life) Bill in England. Available at SSRN 5091810.
Sandham, M., Carey, M., Hedgecock, E., Jarden, R., 2022. Nurses' experiences of supporting patients requesting voluntary assisted dying: a qualitative meta-synthesis. J. Adv. Nurs. 78 (10), 3101–3115.
Snelling, J., Young, J., Beaumont, S., Diesfeld, K., White, B., Willmott, L., Robinson, J., Moeke-Maxwell, T., 2023. Health care providers' early experiences of assisted dying in Aotearoa New Zealand: an evolving clinical service. BMC Palliat. Care 22 (1).
Stetler, C.B., Legro, M.W., Wallace, C.M., Bowman, C., Guihan, M., Hagedorn, H., Kimmel, B., Sharp, N.D., Smith, J.L., 2006. The role of formative evaluation in

implementation research and the QUERI experience. J. Gen. Intern. Med. 21 (Suppl. 2), S1–S8.
Suva, G., Penney, T., McPherson, C.J., 2019. Medical assistance in dying: a scoping review to inform nurses' practice. J. Hosp. Palliat. Nurs. 21 (1), 46–53.
Tricco, A.C., Lillie, E., Zarin, W., O'Brien, K.K., Colquhoun, H., Levac, D., Moher, D., Peters, M.D.J., Horsley, T., Weeks, L., Hempel, S., Akl, E.A., Chang, C., McGowan, J., Stewart, L., Hartling, L., Aldcroft, A., Wilson, M.G., Garritty, C., Lewin, S., Godfrey, C.M., Macdonald, M.T., Langlois, E.V., Soares-Weiser, K., Moriarty, J., Clifford, T., Tunçalp, Ö., Straus, S.E., 2018. PRISMA Extension for Scoping Reviews (PRISMA-ScR): checklist and explanation. Ann. Intern. Med. 169 (7), 467–473.
Van Wesemael, Y., Cohen, J., Onwuteaka-Philipsen, B.D., Bilsen, J., Deliens, L., 2009. Establishing specialized health services for professional consultation in euthanasia: experiences in the Netherlands and Belgium. BMC Health Serv. Res. 9 (1), 220.
Veritas Health Innovation, 2025. Covidence systematic review software. Available online: www.covidence.org (Accessed, Melbourne, Australia).
Vézina-Im, L.A., Lavoie, M., Krol, P., Olivier-D'Avignon, M., 2014. Motivations of physicians and nurses to practice voluntary euthanasia: a systematic review. BMC Palliat. Care 13 (1), 20.
Wilson, M., Oliver, P., Malpas, P., 2019. Nurses' views on legalising assisted dying in New Zealand: a cross-sectional study. Int. J. Nurs. Stud. 89, 116–124.
Woods, M., 2023. 20 life and death Nursing responses to euthanasia Martin Woods. In: Routledge Handbook of Philosophy and Nursing.
Woods, M., Rook, H., 2022. Exploring hospice nurses' viewpoints on end-of-life practices and assisted dying: a thematic analysis. J. Hosp. Palliat. Nurs. 24 (4), E117–e125.
Young, J., Snelling, J., Beaumont, S., Diesfeld, K., White, B., Willmott, L., Robinson, J., Ahuriri-Driscoll, A., Cheung, G., Dehkhoda, A., Egan, R., Jap, J., Karaka-Clarke, T., Manson, L., McLaren, C., Winters, J., 2023. What do health care professionals want to know about assisted dying? Setting the research agenda in New Zealand. BMC Palliat. Care 22 (1).