

# Cultural dimensions of palliative care: rebalancing toward psychosocial, spiritual, and community-based approaches

## Abstract

In many Indigenous communities, the final stage of life is understood not as a medical emergency but as a relational and spiritual transition in which identity, kinship, and continuity are honored. The dying process is embedded in cultural narrative, ceremony, and community presence, requiring sufficient mental clarity for individuals to participate in prayer, smudging, singing, storytelling, and reflection on the relationships and responsibilities that have shaped their lives. In contrast, palliative care in Western health care systems has become increasingly medicalized, often relying on psychotropic medications as the first response to distress, agitation, or existential suffering. These practices risk disrupting the narrative coherence of dying, weakening communal bonds, and interfering with the spiritual work that many Indigenous communities consider essential.

Although the term medicalization includes the use of medications for physical symptoms, this article focuses specifically on psychiatric drugs—particularly antipsychotics, benzodiazepines, and antidepressants—which are most likely to impair cognitive clarity and emotional presence. Drawing on Indigenous theoretical frameworks, prescribing patterns, decolonizing scholarship, and clinical experience, this article examines how routine psychotropic use can disrupt the cultural, relational, and spiritual integrity of the dying process. The analysis emphasizes a biopsychosocial–spiritual model of care, demonstrating how Indigenous frameworks already embody this holistic approach and how international spiritual care models reinforce its relevance. Lessons from Indigenous end-of-life programs show that culturally grounded communication, interdisciplinary teamwork, and community-based care reduce reliance on psychotropics and support a more coherent, culturally aligned dying experience. A model of palliative care that relies less on medical intervention and is culturally and spiritually grounded offers a more ethical and dignified way of supporting individuals, families, and communities during the final stage of life.

**Keywords:** cultural approaches to palliative care, Indigenous health practices, psychopharmacology, deprescribing, peer specialists in palliative care

Volume 10 Issue 1 - 2026

Marcello Maviglia,<sup>1</sup> Thomas Parker<sup>2</sup>

<sup>1</sup>Clinical Professor, Family and Community Medicine, Core Faculty Member, Center for Native American Health (CNAH), University of New Mexico, USA

<sup>2</sup>Peer Support Specialist, Enrolled member of the Seneca Nation of Western New York, Descendant of the Omaha Tribe of Nebraska

**Correspondence:** Marcello Maviglia, Clinical Professor, Family and Community Medicine Core Faculty Member, Center for Native American Health (CNAH), University of New Mexico, USA, Email [MMaviglia@salud.unm.edu](mailto:MMaviglia@salud.unm.edu)

**Received:** January 30, 2026 | **Published:** February 11, 2026

## Introduction

Contemporary palliative care has developed within a biomedical framework that prioritizes symptom management, risk reduction, and pharmacologic intervention. While these interventions can be beneficial, they are often employed as the first response to distress, agitation, or existential suffering, even when relational presence or spiritual support may be more appropriate.<sup>1–16</sup> Evidence from the palliative care literature shows that existential distress is frequently approached through pharmacologic means, including sedation.<sup>17,18</sup>

This approach contrasts with the values of many Indigenous communities, where end-of-life care is rooted in continuity with ancestors, communal presence, and the relational bonds that support a person through the final stage of life.<sup>2–4</sup> These frameworks embody a holistic biopsychosocial–spiritual model, emphasizing balance among physical, emotional, relational, and spiritual domains.<sup>3,4</sup> In these traditions, mental clarity is essential for participating in prayer, smudging, singing, storytelling, and reflecting on one's life story, including the relationships and responsibilities that have shaped it.<sup>3–5</sup> Sedation can disrupt these processes by impairing communication, diminishing awareness, and interrupting the culturally coherent narrative of dying.<sup>6–9</sup>

Research on American Indian and Alaska Native (AI/AN) end-of-life care has long been shaped by assumptions that Indigenous

elders avoid discussing death or resist advance care planning.<sup>10</sup> Early studies suggested that conversations about terminal illness might be viewed as dangerous or culturally inappropriate. However, subsequent work—including the Spirit of Eagles survey and programs at Ft. Defiance, Cherokee Nation, Zuni, and the University of New Mexico—demonstrates that these assumptions are incomplete and often inaccurate.<sup>11–13</sup> When communication is grounded in cultural humility, relational presence, and the absence of predetermined biomedical agendas, Indigenous elders frequently engage openly in discussions about care goals and end-of-life preferences.<sup>2,11–13</sup>

These examples highlight a central theme: the way the final stage of life unfolds is shaped more by the cultural, relational, and spiritual context in which care occurs than by medical interventions. When palliative care relies primarily on pharmacologic interventions—especially sedatives, antidepressants, and antipsychotics—it risks reproducing colonial patterns in which Indigenous voices, bodies, and spiritual practices are marginalized.<sup>2,5,20</sup> A psychosocial–spiritual approach, aligned with Indigenous frameworks, offers a more coherent and ethically grounded model for supporting individuals and families during the final stage of life.<sup>2–5,21,22</sup>

## Medicalization and its discontents

The medicalization of the final stage of life has intensified over the past two decades, shaping palliative care in ways that often

conflict with the cultural, relational, and spiritual needs of patients and families. In many settings, the first response to distress—whether physical, emotional, or existential—is medication.<sup>1</sup> This approach reflects a narrow biomedical lens that can obscure the psychosocial and spiritual dimensions of suffering.

Prescribing data show a consistent rise in the use of antipsychotics, benzodiazepines, and other sedating medications in hospice and long-term care environments.<sup>1</sup> These medications are often initiated early, sometimes before non-pharmacologic methods have been attempted, and frequently without a clear discussion of their potential to impair communication, cognition, and emotional presence. The result is not simply overuse but a structural bias toward biomedical interpretations of distress, even when the underlying causes are relational, cultural, or spiritual.

In many Indigenous communities, the final stage of life is marked by presence and connection.<sup>2-4</sup> Sedation can interrupt these processes by dulling awareness and limiting participation in prayer, storytelling, ceremony, and relational closure.<sup>3-5</sup> The iatrogenic effects of psychotropics are well documented: sedation, cognitive dulling, emotional blunting, paradoxical agitation, akathisia, and withdrawal phenomena can all occur, especially when medications are introduced rapidly or in combination.<sup>6-9</sup> These effects can mimic or exacerbate the very symptoms clinicians aim to treat, creating a cycle in which distress is interpreted as pathology rather than as part of the relational and spiritual work of dying.

When medications override cultural practices, they risk reinforcing colonial and post-colonial patterns in which Indigenous voices and values are marginalized.<sup>2,5,20</sup> This is not merely a clinical concern but an ethical one: whose knowledge system defines what counts as suffering, and whose values shape the response?

Across Indigenous palliative programs—including those at Ft. Defiance, Cherokee Nation, Zuni, and the University of New Mexico—distress at the end of life is often addressed as relational or spiritual rather than biomedical.<sup>11-13</sup> When communication is culturally grounded, families feel supported, and the need for psychotropics decreases.<sup>11-13</sup> These patterns underscore that medicalization is not inevitable; it reflects choices shaped by worldview, training, and institutional norms.

## Biopsychosocial approaches in palliative care

In theory, the biopsychosocial model offers a comprehensive framework for understanding suffering at the end of life, integrating physical, emotional, relational, and spiritual dimensions. Although widely endorsed in theory, its application in palliative care remains inconsistent, often overshadowed by biomedical priorities. In many Indigenous communities, biopsychosocial-spiritual principles are embedded in longstanding cultural frameworks such as the Medicine Wheel, which emphasizes balance among physical, emotional, mental, and spiritual domains.<sup>3</sup> These frameworks demonstrate that suffering is relational and contextual rather than solely biological.

A biopsychosocial approach in palliative care requires attention to several interconnected domains. Relational assessment involves understanding family dynamics, community roles, and cultural responsibilities that shape how individuals interpret illness and approach the final stage of life. Emotional and narrative understanding recognizes that distress often reflects processes of meaning-making rather than pathology, a view that resonates with anthropological work on explanatory models and experience.<sup>15,16</sup> This scholarship

shows how people interpret suffering through cultural, relational, and ethical frameworks, reinforcing the need for palliative approaches that honor these dimensions rather than reducing them to symptoms. Spiritual grounding acknowledges that spiritual preparation is central to the dying process in many communities, particularly those in which ceremony, prayer, and ancestral continuity guide the transition.<sup>2-4</sup> Community-based support, including the involvement of peer specialists and cultural practitioners, can help interpret distress within cultural frameworks and reduce reliance on pharmacologic interventions.<sup>14</sup>

When these dimensions are integrated, reliance on psychotropics decreases naturally—not because medications are rejected, but because the underlying sources of distress are addressed through relational, cultural, and spiritual means. This approach aligns with Indigenous models of care and with broader efforts to decolonize palliative care by restoring balance between biomedical tools and the cultural and spiritual practices that give coherence to the dying process.<sup>2,5,21,22</sup>

## International spiritual care models and challenges

International palliative care frameworks increasingly recognize spiritual care as a core component of high-quality end-of-life support. The European Association for Palliative Care (EAPC) and the World Health Organization (WHO) have emphasized that spiritual care must be integrated into routine clinical practice, supported by interdisciplinary collaboration, and grounded in cultural humility.<sup>17</sup> These models highlight that spiritual care is not an adjunct to biomedical treatment but an essential dimension of whole-person care.<sup>18</sup>

Indigenous communities worldwide have long practiced forms of palliative care that align with these principles. In Aotearoa/New Zealand, Māori frameworks emphasize wairua (spirit), whānau (family), and whakapapa (ancestral continuity) as central to the dying process.<sup>26</sup> In Australia, Aboriginal palliative care models highlight the importance of connection to land, kinship networks, and culturally grounded decision-making.<sup>27,28</sup> First Nations communities in Canada have developed participatory, community-anchored palliative programs that integrate ceremony, relational authority, and collective responsibility.<sup>29</sup> Sámi communities in northern Scandinavia similarly emphasize cultural continuity, relational presence, and spiritual preparation as essential components of end-of-life care.<sup>30</sup>

Despite international recognition of the importance of spiritual care, significant challenges remain. Many health systems lack formal recognition of spiritual care practitioners, particularly those outside Western religious traditions. Role ambiguity within interdisciplinary teams can limit the integration of spiritual care, while institutional discomfort with non-Western spiritual practices may marginalize Indigenous knowledge holders. Reimbursement structures and credentialing requirements often privilege biomedical roles, reinforcing epistemic hierarchies that devalue relational and spiritual expertise.<sup>20-22</sup>

These challenges mirror those faced by Indigenous communities in the United States, where culturally and spiritually oriented care is frequently underrecognized despite its benefits.<sup>2-5,21,22</sup> Integrating spiritual care into palliative practice requires not only structural changes but also a shift in worldview—one that acknowledges the legitimacy of Indigenous knowledge systems and the essential role of spiritual, relational, and communal dimensions in supporting a good death.

## Indigenous programs: in-depth review

The Indigenous programs described in *Moving Beyond Paradigm Paralysis* offer practical lessons that challenge many assumptions in mainstream palliative care.<sup>11–13</sup> These programs—Ft. Defiance, Cherokee Nation, Zuni, and the urban Indigenous work at the University of New Mexico demonstrate that when care is rooted in cultural frameworks, the need for psychotropic medications decreases, communication improves, and families feel more supported. These lessons emerge from decades of work in communities navigating the tensions between biomedical systems and Indigenous values, a pattern documented across multiple Indigenous health systems internationally.<sup>26–30</sup>

### A. Communication, trust, and language

The Ft. Defiance Home-Based Care Program illustrates how culturally framed communication can transform end-of-life care.<sup>11</sup> The team found that direct biomedical language about prognosis or “advance directives” often created fear or confusion. When conversations were reframed using Navajo language, imagery, and relational modalities, elders engaged openly and expressed their wishes without feeling that they were violating cultural norms. Similar findings have been reported in Māori and Aboriginal Australian palliative care programs, where communication grounded in cultural metaphors and kinship structures increases trust and reduces distress.<sup>26,27</sup> These patterns highlight that communication is not merely the transfer of information but a relational act shaped by cultural meaning. When providers approach families without assumptions, listen before speaking, and allow cultural frameworks to guide the encounter, discussions about end-of-life care become possible and meaningful.<sup>11–13</sup>

### B. Family-centered and community-anchored care

Cherokee Nation Home Health Services offers a complementary lesson.<sup>12</sup> Their approach begins with a simple question—“What do you need?”—which conveys humility and respect for family leadership. This question creates space for families to share concerns that might otherwise be interpreted as agitation, resistance, or denial. Similar patterns have been observed in First Nations palliative care programs in Canada, where family-centered approaches reduce crisis-driven care and enhance continuity of care.<sup>29</sup> Across the programs described in the report, families consistently expressed that what they needed most was support, presence, and clarity—not sedation.<sup>11–13</sup> Emotional intensity at the end of life was understood not as pathology but as part of the relational and spiritual work of dying.

### C. Interdisciplinary, Culturally Grounded Models

The Zuni Home Health Care Agency demonstrates how interdisciplinary teams can incorporate cultural values without strictly adhering to biomedical timelines.<sup>13</sup> A clear example is the program’s decision to set aside the six-month hospice eligibility rule, which presumes a linear, predictable disease trajectory. This rule does not align with Zuni cultural understandings of illness, preparation, and relational responsibility. By allowing care to unfold at a culturally appropriate pace, the team supported families more effectively and reduced the need for crisis interventions. Similar findings have been reported in Sámi palliative care initiatives in northern Scandinavia, where culturally grounded timelines and relational decision-making improved family engagement and reduced emergency care use.<sup>30</sup> These international parallels show that culturally aligned timelines are not exceptions but essential components of effective palliative care.

### D. Urban Indigenous Care

The University of New Mexico Palliative Care Program highlights the specific challenges and opportunities in supporting Indigenous patients in urban settings.<sup>13</sup> Many families arrived in crisis, often shaped by long histories of mistrust, fragmented care, or previous negative experiences with healthcare systems. The team found that open, non-directive communication—listening first, speaking later—was crucial for building trust and enabling meaningful discussions about care goals. These experiences suggest a broader insight: culturally grounded care is not limited to tribal or reservation settings. It can be practiced in any clinical environment when providers recognize the validity of Indigenous knowledge systems, approach interactions with humility, and allow cultural frameworks to guide communication and decision-making.<sup>2–5,21,22</sup>

## Synthesis of programs’ philosophies

Across Indigenous palliative programs, a consistent pattern emerges. When care is grounded in cultural frameworks, when communication is relational rather than intervention-driven, and when providers approach families with humility, reliance on psychotropic medications decreases.<sup>11–13</sup> Distress is addressed through relationships, ceremony, and community rather than through medication alone.<sup>2–5</sup> These practices reflect a biopsychosocial–spiritual model in action, in which suffering is understood as relational and contextual rather than solely biomedical. These experiences challenge the assumption that suffering at the end of life is primarily a pharmacologic issue. Instead, they suggest a model of care that is relational, culturally grounded, and spiritually coherent—an approach echoed throughout the global Indigenous palliative care literature.<sup>26–30</sup> The convergence of Indigenous programs with international spiritual care frameworks underscores that culturally grounded care is not an alternative model but a necessary corrective to the limitations of medicalized palliative care.<sup>20–22</sup>

### Toward a culturally grounded, minimally medicalized model of care

The iatrogenic effects of psychotropic medications become particularly significant in the final stage of life, when clarity, communication, and relational presence are essential for fulfilling cultural, spiritual, and family responsibilities.<sup>3–5</sup> At this stage, the distinction between side effects and functional impairment becomes blurred, and medication-induced cognitive or emotional dulling can interrupt the very processes that bring coherence and continuity to dying.

Sedation is one of the most visible iatrogenic effects of antipsychotics, benzodiazepines, and other sedating agents commonly used in hospice settings.<sup>1</sup> The European Association for Palliative Care has long warned that sedation, when used without cultural or relational grounding, risks suppressing communication and reducing the patient’s ability to participate in the final stage of life.<sup>17</sup> Systematic work on palliative sedation further shows that sedating medications can impair awareness and relational presence, raising ethical concerns when used as a routine response to existential distress.<sup>18</sup>

Paradoxical agitation—including restlessness, pacing, and emotional intensity—can occur with benzodiazepines and antipsychotics.<sup>6–9</sup> Akathisia, a form of severe internal restlessness, is particularly underrecognized in palliative care. Patients may appear distressed or “unable to settle,” leading clinicians to increase doses of the very medications causing the problem.<sup>6–9</sup> This dynamic illustrates

how a biomedical lens can misinterpret spiritual or relational distress as pathology, reinforcing medicalization.

Withdrawal symptoms from SSRIs, benzodiazepines, and antipsychotics—especially when medications are reduced abruptly or stopped without planning—can resemble terminal agitation, anxiety, or delirium.<sup>7,14</sup> Horowitz and Taylor have shown that SSRI withdrawal may cause irritability, insomnia, agitation, sensory changes, and emotional lability.<sup>7</sup> These symptoms can be misinterpreted as disease progression, prompting further medication escalation rather than relational or spiritual support.

For these reasons, thoughtful deprescribing in the final stage of life deserves careful consideration. Although challenging, a deliberate process of reducing or discontinuing psychotropic medications can help restore clarity, preserve communication, and support cultural and spiritual coherence.<sup>6–9,14</sup> Evidence from Indigenous palliative programs suggests that when medications are prescribed and monitored with attention to relational context, families often report improved presence, reduced distress, and greater alignment with cultural values.<sup>11–13</sup>

A culturally grounded model requires integrating spiritual care practitioners, peer specialists, and cultural knowledge holders into interdisciplinary teams.<sup>14,26–30</sup> This approach aligns with international models that recognize spiritual care as a professional domain requiring training, recognition, and structural support.<sup>17,18</sup> It also reflects Indigenous frameworks in which ceremony, relational presence, and community participation guide the final stage of life.<sup>2–5,21,22</sup>

Such a model does not reject biomedical tools but situates them within a broader relational and cultural context. It prioritizes clarity, presence, and connection; recognizes the importance of narrative and spiritual coherence; and supports families in ways that reduce reliance on psychotropics. By restoring balance between biomedical interventions and cultural and spiritual practices, palliative care can better honor the values, identities, and stories that shape the final stage of life.

## Conclusion

Dying is not solely a biomedical event but a relational, cultural, and spiritual passage. Indigenous frameworks remind us that clarity, presence, and connection are essential for completing the final responsibilities of life.<sup>2–5</sup> These responsibilities include reaffirming relationships, engaging in ceremonies, and preparing spiritually for the transition ahead. When psychotropic medications are used in ways that overshadow these priorities, they can disrupt these processes by impairing communication, diminishing awareness, and interrupting the cultural and spiritual practices that give coherence to the dying experience.<sup>1,3–9</sup> Evidence from Indigenous palliative programs demonstrates that when care is grounded in cultural frameworks—when communication is relational, when families are supported, and when spiritual practices are honored—the need for pharmacologic intervention decreases naturally.<sup>11–13</sup> International spiritual care models reinforce this insight, emphasizing that spiritual presence and relational clarity are essential components of high-quality palliative care.<sup>17,18</sup>

Within this context, thoughtful deprescribing and, when appropriate, the careful withdrawal of psychotropic medications deserve consideration in the final stage of life. Research on psychiatric drug withdrawal and iatrogenic effects shows that abrupt changes or continued exposure can produce symptoms—agitation, restlessness, emotional lability, sensory disturbances—that may be mistaken for

disease progression or existential distress.<sup>6–9,7,14</sup> When these reactions are misinterpreted, clinicians may escalate medications rather than support the relational, cultural, and spiritual needs that are central at this time. A deliberate, individualized approach to deprescribing can help restore clarity, preserve communication, and align care with the values and responsibilities that guide the dying process.<sup>6–9,11–14</sup>

Rebalancing palliative care requires embracing a biopsychosocial–spiritual model that honors cultural continuity, relational presence, and spiritual integrity.<sup>2–5,21,22</sup> This model does not reject biomedical tools but situates them within a broader relational and cultural context. By integrating cultural knowledge holders, spiritual care practitioners, and peer specialists into interdisciplinary teams, palliative care can better support individuals and families in navigating the final stage of life with dignity, coherence, and cultural alignment.<sup>14,26–30</sup> A minimally medicalized, culturally grounded approach offers a more ethical and community-centered way of supporting the dying process—one that respects the values, identities, and stories that shape the final chapter of life.

## Acknowledgments

None.

## Conflicts of interest

The author declares there is no conflict of interest.

## References

- Gerlach LB, Fashaw S, Strominger J, et al. Trends in antipsychotic prescribing among long-term care residents receiving hospice care. *J Am Geriatr Soc*. 2021;69(8):2152–2162.
- Anderson M, Woticky G. The end of life is an auspicious opportunity for healing: Decolonizing death and dying for urban Indigenous people. *Int J Indig Health*. 2018;13(2):48–60.
- Dapice AN. The medicine wheel. *J Transcult Nurs*. 2006;17(3):251–260.
- Ermine W. The ethical space of engagement. *Indig Law J*. 2007;6(1):193–203.
- Snyder BE. Reclaiming Our Ancestral Wisdom: Decolonizing Palliative Care. Poster presented at: Annual Assembly of Hospice & Palliative Care; Baltimore, MD. 2024.
- Breggin PR. *Psychiatric Drug Withdrawal: A Guide for Prescribers, Therapists, Patients and Their Families*. Springer Publishing Company; 2012.
- Horowitz MA, Taylor D. Tapering of SSRI treatment to mitigate withdrawal symptoms. *Lancet Psychiatry*. 2019;6(6):538–546.
- Gotzsche P. *Deadly Medicines and Organized Crime*. Radcliffe, 2013.
- Whitaker R. *Anatomy of an Epidemic*. Crown; 2010.
- Michalek AM, Mahoney MC, Gilbert A, et al. Palliative care services: A survey of tribal health directors. *IHS Prim Care Provider*. 2005;30(5):118–119.
- Domer T, Martin L. Ft. Defiance Home-Based Care Program. In: Baldrige D, editor. *Moving Beyond Paradigm Paralysis: American Indian End-of-Life Care*. National Association of Chronic Disease Directors; 2010.
- Richards R. Cherokee Nation Home Health Services. In: Baldrige D, editor. *Moving Beyond Paradigm Paralysis: American Indian End-of-Life Care*. National Association of Chronic Disease Directors; 2010.
- Bowannie T, Peterson E. Zuni Home Health Care Agency. In: Baldrige D, editor. *Moving Beyond Paradigm Paralysis: American Indian End-of-Life Care*. National Association of Chronic Disease Directors; 2010.

14. Maviglia M, Hume D, Cooney NJ. Peer support's role in helping individuals withdraw from psychiatric medications. *J Psychol Clin Psychiatry*. 2023;14(6):157–162.
15. Kleinman A. *The Illness Narratives*. Basic Books; 1988.
16. Good B. *Medicine, Rationality, and Experience*. Cambridge University Press; 1994.
17. Cherny NI, Radbruch L. The European Association for Palliative Care (EAPC) recommended framework for the use of sedation in palliative care. *Palliat Med*. 2009;23(7):581–593.
18. Morita T. Palliative sedation to relieve psycho-existential suffering of terminally ill cancer patients. *J Pain Symptom Manage*. 2004;28(5):445–450.
19. Tjia J, Rothman MR, Kiely DK, et al. Daily medication use in nursing home residents with advanced dementia. *J Am Geriatr Soc*. 2010;58(5):880–888.
20. Smith LT. *Decolonizing Methodologies: Research and Indigenous Peoples*. Zed Books; 1999.
21. Kirmayer LJ, Dandeneau S, Marshall E, et al. Rethinking resilience from Indigenous perspectives. *Can J Psychiatry*. 2011;56(2):84–91.
22. Browne AJ, Varcoe C, Victoria Smye, et al. Cultural safety and the challenges of translating critically oriented knowledge in practice. *Nurs Philos*. 2009;10(3):167–179.
23. Reeve E, Gnjidic D, Long J, et al. A systematic review of deprescribing tools and their applicability to older adults. *Drugs Aging*. 2015;32(6):389–398.
24. Tannenbaum C, Philippe Martin, Robyn Tamblyn, et al. Reduction of inappropriate benzodiazepine prescriptions among older adults through direct patient education. *JAMA Intern Med*. 2014;174(6):890–898.
25. Charon R. *Narrative Medicine: Honoring the Stories of Illness*. Oxford University Press; 2006.
26. Schill K, Caxaj S. Cultural safety strategies for rural Indigenous palliative care: a scoping review. *BMC Palliat Care*. 2019;18(1):21.
27. McGrath P. “I don’t want to be in that big city hospital”: Aboriginal palliative care in Australia. *J Pain Symptom Manage*. 2007;34(4):406–414.
28. Warburton J, Chambers B. Elder–provider relationships in Indigenous health: relational authority and narrative practice. *Aust J Rural Health*. 2007;15(4):280–285.
29. Kelley ML, Holly Prince, Shevaun Nadin, et al. Developing palliative care programs in First Nations communities: a participatory action research approach. *Rural Remote Health*. 2018;18(2):4315.
30. Nystad K. Sámi end-of-life perspectives: cultural frameworks for palliative care in northern Scandinavia. *Int J Circumpolar Health*. 2019;78(1):1601990.