
Assisted Suicide and Suicide Prevention: Ethical Perspectives, Attitudes and Challenges for Nurses in Long-Term Care – A Qualitative Focus Group Study

[Karen Klotz](#)*, Pia Madeleine Haug, Thomas Heidenreich, [Eva-Maria Stratmann](#), [Erik Jacob](#), [Annette Riedel](#)

Posted Date: 10 November 2025

doi: 10.20944/preprints202511.0686.v1

Keywords: assisted suicide; voluntary assisted dying (VAD); medical assistance in dying (MAiD); desire to die; suicide prevention; ethics; ethical challenges; moral values; long-term care; nurses



Preprints.org is a free multidisciplinary platform providing preprint service that is dedicated to making early versions of research outputs permanently available and citable. Preprints posted at Preprints.org appear in Web of Science, Crossref, Google Scholar, Scilit, Europe PMC.

Copyright: This open access article is published under a Creative Commons CC BY 4.0 license, which permit the free download, distribution, and reuse, provided that the author and preprint are cited in any reuse.

Disclaimer/Publisher's Note: The statements, opinions, and data contained in all publications are solely those of the individual author(s) and contributor(s) and not of MDPI and/or the editor(s). MDPI and/or the editor(s) disclaim responsibility for any injury to people or property resulting from any ideas, methods, instructions, or products referred to in the content.

Article

Assisted Suicide and Suicide Prevention: Ethical Perspectives, Attitudes and Challenges for Nurses in Long-Term Care – A Qualitative Focus Group Study

Karen Klotz *, Pia Madeleine Haug, Thomas Heidenreich, Eva-Maria Stratmann, Erik Jacob and Annette Riedel

Esslingen University of Applied Sciences, Faculty Social Work, Education and Nursing Sciences, Flandernstraße 101, 73732 Esslingen, Germany

* Correspondence: Karen.Klotz@hs-esslingen.de

Abstract

Background/Objectives: Assisted suicide and suicide prevention remain subjects of intense societal, political, and professional-ethical debate in Germany. Nurses working in residential and home-based long-term care (LTC) play a pivotal role in responding to requests for assisted suicide and in supporting suicide prevention. While international research has explored diverse ethical perspectives and challenges related to these issues, little is known about how LTC nurses in Germany experience and navigate them. This study examines German LTC nurses' ethical perspectives on assisted suicide and suicide prevention and explores the associated ethical challenges. **Methods:** A qualitative design employing both in-person and online focus groups was used. Data were analyzed following Mayring's qualitative content analysis. **Results:** Twelve focus groups with a total of 96 nurses working in residential and home-based LTC were conducted between February and September 2025. Findings show that nurses perceive assisted suicide and suicide prevention as ethically complex and emotionally demanding. Three overarching themes emerged: (1) Intuitive and Emotional Reactions, (2) Ethical Perception and Ethical Reflection, and (3) Ethical Challenges. **Conclusions:** LTC nurses expressed varying ethical perspectives on and attitudes towards assisted suicide and suicide prevention. The ethical challenges identified may contribute to the development of moral distress. To help nurses navigate these ethically demanding situations, strategies at multiple levels are required. These include continuous ethics education, an open ethical culture, role definitions and clear professional guidance, alongside societal support for equitable access to general healthcare and suicide prevention services.

Keywords: assisted suicide; voluntary assisted dying (VAD); medical assistance in dying (MAiD); desire to die; suicide prevention; ethics; ethical challenges; moral values; long-term care; nurses

1. Introduction

Research has shown that end-of-life care poses significant ethical challenges for healthcare professionals, including nurses [1–3]. These challenges become particularly pronounced in the context of care recipients expressing a desire to die [1,2,4]. Such a desire is understood as a subjective, dynamic, multidimensional, and complex phenomenon, encompassing a spectrum of meanings – from the mere acceptance of one's own death (without any intention of hastening death) to acute suicidality [4–9]. The underlying motives are equally diverse, ranging from physical, psychological and social to spiritual and existential dimensions [5,6,8,9]. While a desire to die in its broader sense does not necessarily imply a desire to *hasten* death, it may evolve into such a wish [4,5,8,9]. Requests for assisted suicide and euthanasia may constitute a manifestation of such a wish to hasten death [5]. Both practices involve the intentional ending of a person's life "at that person's voluntary and competent request" [10] (p. 108), with the involvement of another individual, often a healthcare

professional. The key distinction lies in who administers the life-ending medication: In assisted suicide, the individual self-administers the lethal dose, whereas in euthanasia, the medication is directly administered by the healthcare professional [10].

Globally, an increasing number of countries are moving toward the legalization of assisted suicide and euthanasia. Each country is governed by distinct legal frameworks and regulations [11], fueling ongoing debate given the ethical controversy surrounding the issue [11–13]. To account for this variation, which complicates cross-country comparisons, the term *Medical Assistance in Dying* (MAiD) will hereafter be used as an umbrella term encompassing both practices, unless a specific distinction is required. In Germany, a landmark ruling of the Federal Constitutional Court on 26 February 2020 declared §217 of the German Criminal Code, which was introduced in 2015 and prohibited assisted suicide services, null and void [14]. As a result, assisted suicide was recognized as a legally permissible option, whereas euthanasia continues to remain prohibited. Since the ruling, the German Federal Parliament rejected two legislative proposals on assisted suicide in July 2023 [15]. Consequently, assisted suicide in Germany is legally regulated solely by the ruling of the Federal Constitutional Court, which emphasized the importance of the concept of *Freiverantwortlichkeit*. This concept requires that the decision be based on a genuinely autonomous and well-considered choice, where the individual carefully weighs the pros and cons in light of their own values. The decision must be made free from acute mental illness, coercion, or manipulation, and it should demonstrate lasting inner firmness and stability [14]. Compared with other countries, Germany currently maintains one of the most liberal legal frameworks for assisted suicide worldwide [16,17].

Parallel to discussions on assisted suicide, suicide prevention has gained increasing political, societal and professional significance in Germany: In 2024, the Federal Ministry of Health published a national suicide prevention strategy [18] and the Federal Cabinet approved a draft law on suicide prevention [19]. The concept of suicide prevention is generally understood as a collective societal responsibility, encompassing universal measures targeting the general population, selective measures aimed at high-risk groups, and indicated measures directed at individuals at acute risk of suicide [20–22]. In Germany, this concept is also discussed in the context of assisted suicide, as requests for assisted suicide may indicate an underlying suicide risk, which can potentially be mitigated through targeted interventions [20,23,24]. In light of the legal and political developments outlined above, the nursing and medical community continues to grapple with balancing the legal option of assisted suicide against the responsibility for suicide prevention – a tension that is particularly relevant for healthcare professionals [25–30].

Nurses, in particular, often serve as the first point of contact when care recipients express a desire to die, including requests for MAiD [25,31–33]. This applies particularly to residential and home-based long-term care (LTC) of older adults [26,34–37], as suicide, suicidal ideation [38–41], and the desire to die – including requests for MAiD – are relatively common in this population [42,43]. Moreover, international [44–46] and German [47] data indicate that it is predominantly older adults in need of care who pursue MAiD (internationally) and assisted suicide (in Germany). Within LTC, nurses carry particular responsibilities: They spend substantial time with care recipients and frequently build long-standing, caring and trust-based relationships [26,30,37]. When confronted with requests for MAiD, nurses are expected to respond professionally. This entails respecting and taking such requests seriously, while at the same time upholding their professional and ethical responsibility for suicide prevention [26,29,30,37]. In navigating these ethically complex and contentious situations, nurses are guided by professional values and core responsibilities of nursing, including “to alleviate suffering and promote a dignified death” [48] (p. 2). However, nurses’ experiences with MAiD are influenced not only by professional values and professional ethical standards, but also by personal convictions, organizational frameworks, institutional and societal attitudes [31,49,50]. A systematic review found that nurses’ support for MAiD is generally lower than that of the general public [11]. Consequently, international research shows that nurses encounter a wide range of ethical challenges related to MAiD, which can vary depending on the legal framework [25,49,51], and may also face ethical dilemmas in the context of suicide prevention [52,53]. Thus,

nurses may require moral self-efficacy, understood as the confidence that one's own decision-making and action competencies are sufficient to actively and successfully manage ethically challenging situations [54–57].

To date, little is known about the ethical perspectives, attitudes and challenges nurses face regarding assisted suicide and suicide prevention in LTC in Germany [25]. Existing research has primarily examined nurses' experiences with assisted suicide and suicide prevention in palliative and hospice care [58–60] or their general experiences across various settings [61]. Only a few studies have focused specifically on LTC; those that exist primarily address encounters with desire to die in residential LTC within faith-based organizations [62] or residential LTC nurses' general attitudes toward assisted suicide [63]. Against this background, it is particularly important to investigate the *ethical* dimensions of assisted suicide and suicide prevention in both *residential and home-based* LTC in Germany, taking into account the perspectives of nurses working across organizations of different types (i.e., faith-based vs. non-faith-based). This approach enables a more comprehensive understanding of the diverse ethical viewpoints and challenges, thereby contributing to the advancement of current knowledge.

The aim of this study is to address this gap by examining German nurses' ethical perspectives and attitudes on assisted suicide and suicide prevention in residential and home-based LTC, and by identifying the related ethical challenges. It intends to answer the following research question: What are the ethical perspectives, attitudes and ethical challenges of nurses in residential and home-based LTC care of older adults regarding assisted suicide and suicide prevention?

2. Materials and Methods

2.1 Study Design

The study was preregistered on the German Clinical Trials Register [64]. An explorative qualitative design was employed, using in-person and online single focus groups [65]. This approach was deemed particularly appropriate for exploring the ethical perspectives and related challenges, as it enables the capture of a wide range of participant opinions, perceptions, ideas, and feelings [66] and fosters discussion and debate on research topics that require insight into the meanings, experiences, and beliefs underlying participant views [65]. To ensure transparency in reporting, the Consolidated Criteria for Reporting Qualitative Studies (COREQ) [67] were applied (Supplementary File 1).

2.2. Ethical Considerations

Ethical approval for the focus groups was obtained from the Ethics Committee of the German Society of Nursing Science prior to their commencement (ethics proposal number: 24-035). Informed consent was obtained from each participant. Participation was entirely voluntary, and participants could withdraw at any time without providing a reason. All data were anonymized and stored securely for transcription purposes, accessible only to the research team.

2.3. Participants and Setting

To be eligible, participants had to have completed a minimum of a three-year nursing education program and to be currently employed in either residential or home-based LTC of older adults in one of six cooperating organizations. Furthermore, participants were required to have sufficient proficiency in German to actively engage in discussions and to provide informed written consent.

By LTC, we refer specifically to formal LTC, meaning care provided by trained professionals such as nurses. According to the World Health Organization, this "includes a package of services aimed at preventing, mitigating, and rehabilitating functional decline, delivered in a variety of settings" [68] (p. 5). In this study, we focus on residential and home-based formal LTC services, which are most commonly required by older adults [68].

As recommended for focus groups, we used a non-probability purposive sampling strategy [65,69]. Participants were recruited from both residential and home-based LTC of older adults and included both direct care providers and staff with broader responsibilities (e.g., quality management, leadership, practice education). Moreover, participants were drawn from six organizations of varying sizes and ownership structures (faith-based, non-faith-based, non-statutory welfare, municipal, and private organizations), in both urban and rural areas and across different federal states in Germany.

Recruitment was facilitated through designated contact persons in cooperating organizations who were informed that a diverse sample – in terms of age, professional experience, gender, religious beliefs, and cultural background – was desirable in order to capture a wide range of perspectives on the research topic.

Prior to the focus groups, participants received an information package containing:

1. An overview of the research project;
2. Details on the topic and objectives of the focus groups;
3. Formal information about session duration and structure;
4. A description of participants' rights;
5. Contact details of the research team and the designated organizational contact person.

2.4. Data Collection

In-person and online single focus groups (no repeats) [65], were conducted in residential or home-based LTC between February and September 2025 (Table 1). Each group consisted of five to twelve nurses, allowing participants sufficient space to share their experiences while also enabling the exploration of diverse perspectives [66]. The in-person focus groups were conducted in quiet, confidential rooms provided by the cooperating organizations. For these, six participants withdrew prior to commencement: two due to illness, one for unknown reasons, one because they forgot the session, and two owing to short-notice shift coverage. To accommodate participants, two focus groups were held online via Webex, with nurses joining from a location of their choice, typically their home or workplace. In the online format, four participants withdrew – three for unknown reasons and one due to technical difficulties. Overall, focus groups ranged in duration from 110 to 190 minutes, with an average length of 153 minutes.

All focus groups were conducted using a pilot-tested interview guide developed by the research team, drawing on a comprehensive literature review and subject-matter expertise (Supplementary File 2). The interview guide aimed to address both, nurses ethical and professional experiences with assisted suicide and suicide prevention – however, results on professional experiences will be reported elsewhere. Following the pilot phase, minor adjustments were introduced, and further minor adaptations were made during the sessions to respond to group dynamics while ensuring that the planned timeframe was respected. The guide comprised eight phases aimed at exploring nurses' ethical and professional experiences with assisted suicide and suicide prevention in LTC. Each session began with a brief welcome and introduction (phase 1), followed by definitions of assisted suicide and suicide prevention to set the focus of discussion (phase 2). Participants were then asked to recall a situation in which they had received a request for assisted suicide – or, if not, a situation in which they encountered a desire to die (phase 3). Although the broader phenomenon of desire to die was not the main focus of the study, this step was designed to encourage participants to share personal experiences and to promote early engagement in the discussion [66]. Next, participants completed a short online survey on moral self-efficacy which guided self-reflection during the focus groups (phase 4, results will be reported elsewhere) and then noted their initial thoughts and feelings related to assisted suicide and suicide prevention (phase 5). The following phases invited discussion of professional and ethical challenges (phase 6), moral values and value conflicts (phase 7), and finally expectations and wishes for the future (phase 8).

Four female (K.K., P.M.H., A.R., E.M.S.) and one male (E.J.) author were involved in data collection and supported by three female research assistants. Each focus group was facilitated by 2-3 researchers, with a minimum of one moderating and one observing. Moderators guided the

discussion using the interview guide, while observers took field notes on content and group dynamics [65]. Apart from the researchers and participants, no one else was present.

Due to the sensitive nature of the topic, no audio or video recordings were made. Instead, facilitation cards, flip charts, and posters were used to capture content. The material from facilitation tools was transcribed together with the field notes. To make efficient use of participants' time, transcripts were not returned for comment, nor did participants provide feedback on the findings. Data collection continued until theoretical saturation was reached, when no new insights emerged [65,66].

Table 1. Focus Groups by Setting, Format, and Participant Numbers.

	Residential LTC		Home-Based LTC	
	Number of Focus Groups	Number of Participants	Number of Focus Groups	Number of Participants
In-Person Focus Group	n=7	n=62	n=3	n=17
Online Focus Group	n=1	n=11	n=1	n=6
Total	n=8	n=73	n=4	n=23

2.5. Data Analysis

Data analysis was conducted using MAXQDA (VERBI Software 2024) [70]. Mayring's structuring content analysis was applied [71]. This strictly rule-based approach aims to systematically extract and summarize specific aspects from the data material. Following this method, categories, corresponding definitions, anchor examples, and coding rules were initially developed deductively based on the research question and theoretical considerations, and subsequently expanded inductively through analysis of the data [71]. Three of the authors (K.K., A.R., P.M.H.) immersed themselves in the data and pilot-coded three focus groups using the deductive coding system, adding inductive categories where necessary. The resulting codes were then discussed with a fourth researcher (T.H.). Based on these discussions and refinements, one researcher (K.K.) proceeded to code all focus groups using the updated coding scheme. All codes and findings were subsequently reviewed, discussed, and interpreted by four team members (K.K., P.M.H., A.R., T.H.). Additionally, the coding scheme and interpretations were presented to two independent researchers (E.M.S., E.J.), who had not been involved in the focus groups at this stage, to assess the appropriateness of both coding and analytical conclusions. An overview of the final coding scheme, detailing themes, categories, definitions, anchor examples and coding rules is provided in Table 2.

2.6. Research Team and Reflexivity

The research team comprised two project leaders – one professor of nursing science and ethics (A.R.) and one professor of psychology with a focus on nursing and social work (T.H.) –, both experienced in qualitative research. Four additional researchers (K.K., P.M.H., E.M.S., E.J.) were employed as research associates at the time of the study, held M.A. degrees in nursing science and brought experience in group moderation as well as initial training in qualitative research methods acquired during their studies. Acknowledging the crucial role of moderator skills in the success of focus groups, the less experienced team members received targeted briefings from the project leaders, consistent with recommendations [65]. With the exception of T.H., who holds professional experience

as a clinical psychologist, all researchers had professional backgrounds in nursing across various care settings. At the beginning of each focus group, participants were informed about the researchers' professional backgrounds, the overarching project, and the researchers' specific areas of interest. No prior relationships existed between the research team and the participants.

2.7. Trustworthiness

Several strategies were applied to strengthen the trustworthiness of the study, addressing key aspects such as credibility, transferability, dependability, and confirmability [72].

Credibility was strengthened through ongoing researcher reflexivity and prolonged engagement with participants during focus groups, which helped establish a good rapport [72]. Reflexivity was considered particularly important due to the sensitive and potentially controversial nature of the research topic. To support this, postscripts were written after each focus group, allowing for the ongoing acknowledgment of researchers' perspectives and potential biases. These postscripts documented information on the researchers (e.g., professional backgrounds, research experience) as well as reflections on: (1) group interactions, (2) moderation, (3) key content points, (4) researchers' own feelings, values, and attitudes, (5) other observations, and (6) remarks related to the original objectives of the focus group and the methodology.

We aimed to increase *transferability* by providing a detailed description of our research context (i.e. description of German legal framework, participants/sampling procedure, setting/cooperating organizations, data collection and research team). This allows readers to judge the applicability of our findings to other settings and contexts [72].

To improve *dependability*, we kept an audit trail supplemented by research documents (e.g. different versions of participant handouts, postscripts, logbook on MAXQDA) to document methodological decisions, modifications and adaptations made throughout the research process [72].

Although member checking was not conducted in order to respect participants' time, *confirmability* was ensured through systematic reflective journaling (postscripts), and complemented by continuous peer debriefing and team discussions [71].

3. Results

3.1. Description of Study Sample

A total of n=12 focus groups was conducted. n=8 focus groups were conducted with nurses working in residential LTC facilities and n=4 focus groups were conducted with nurses working in home-based LTC in the South (Baden-Württemberg) and Mid-West (North Rhine-Westphalia) of Germany (Table 1). n=96 nurses participated in the focus groups, with n=73 employed in residential LTC and n=23 employed in home-based LTC. In light of the ethically sensitive nature of the research topic and to safeguard participants' anonymity, no formal sociodemographic data were collected. Nonetheless, at the beginning of each focus group, participants were invited to provide a brief self-introduction, including information on their professional background, current role, and work experience. This contextual information provided the researchers with insight into the sample's composition. Based on these introductions, the sample included both male and female nurses from diverse cultural backgrounds, with varying levels of professional experience in general nursing as well as LTC for older adults. Participants spanned a wide age range and included both direct care providers and staff with broader responsibilities (e.g., quality management, leadership, practice education).

3.2. Overview of Themes

This article reports on the findings concerning nurses' ethical experiences – their ethical perspectives, attitudes and associated challenges in relation to assisted suicide and suicide

prevention. Our analysis identified three major themes: (1) Intuitive and Emotional Reactions, (2) Ethical Perception and Ethical Reflection, and (3) Ethical Challenges (Table 2).

Table 2. Coding Scheme, detailing the Coding Tree.

Theme 1. Intuitive and Emotional Reactions			
This theme encompasses participants' initial moral intuitions and moral emotions related to assisted suicide and suicide prevention in care recipients who request assisted suicide.			
Category	Definition	Anchor Example	Coding Rule
1.1. Moral Intuition	Moral intuitions refer to immediate moral judgments, or instinctive reactions that arise spontaneously in a given situation, before conscious moral reasoning occurs [73–75].	<i>“Under no circumstances!”</i> (F6)	Code text segments in this category when participants express spontaneous emotions, or thoughts that reveal an immediate moral evaluation of a situation in the context of assisted suicide or suicide prevention.
1.2. Moral Emotions	Moral emotions are emotions that serve as a motivational force, providing the energy and drive necessary to act ethically and to refrain from wrongdoing [73,76].	<i>“I feel sad about challenges in the healthcare system in getting timely help during mental health crises”</i> (F3)	Code text segments in this category when the expressed emotion (e.g., guilt, shame) is described as motivating or discouraging ethical behavior, or when participants indicate that the emotion arose in response to a moral or ethical issue. General emotional expressions without moral relevance are not included.
Theme 2. Ethical Perception and Ethical Reflection			
This theme illustrates how participants demonstrated ethical sensitivity, identified the moral values at stake in relation to assisted suicide and suicide prevention in care recipients who request assisted suicide, and engaged in ethical reasoning by reflecting on their own moral stances toward these issues.			
Category	Definition	Anchor Example	Coding Rule
2.1. Ethical Sensitivity	Ethical sensitivity refers to the ability to recognize the moral significance of a situation. It is a source of ethical reflection and ethical decision-making [75,77].	<i>“Morality – how do I feel afterwards?”</i> (F7)	Code text segments in this category when participants show awareness of the moral relevance or ethical implications of a situation.

2.2. Guiding Moral Values	"Values in nursing are those ends sought by both the profession and in nurse – patient relationships. These include, for example, health, dignity, respect, compassion, equity, inclusivity." [48] (p. 27)	<i>"respect" (F1)</i> <i>"self-determination" (F9)</i>	Code text segments in this category when participants refer to values that guide nursing practice or shape nurse – care recipient relationships and related care situations.
2.3. Ethical Reasoning	Ethical reasoning is the process by which individuals make decisions about what is right and wrong, based on ethical principles, values, social norms or theories that inform their arguments [78].	<i>"We deal with older people every day. For example, we have a 105-year-old here. She says she didn't want to live that long; that wasn't what she wished for. At some point, they are ready to go, and you have to accept that" (F11)</i>	Code text segments in this category when participants explain or justify decisions, actions, or judgments by referring to ethical principles, values, social norms, or moral theories.
<p>Theme 3. Ethical Challenges</p> <p>This theme captures the range of ethical challenges participants discussed in relation to assisted suicide and suicide prevention in care recipients who request assisted suicide, encompassing the moral controversy with its diverse ethical perspectives and value-based conflicts, as well as participants' experiences of moral uncertainty and perceived moral constraints that at times impeded what they regarded as the morally right course of action.</p>			
Category	Definition	Anchor Example	Coding Rule
<p>3.1. Moral Controversy</p> <p>This subtheme highlights the moral complexity and contentious nature of assisted suicide and suicide prevention in care recipients who request assisted suicide, arising from the diverse ethical perspectives held by different individuals and value-based conflicts.</p>			
3.1.1. Varying Ethical Perspectives	Varying ethical perspectives capture "the variation and complexity of [...] perspectives" [79] (p. 2) on assisted suicide and, in our understanding, also on suicide prevention.	<i>"Recognition of the resident's desire to die versus my own position as a nurse, not wanting to take an active or facilitating role in the dying process" (F6)</i>	Code text segments in this category when participants describe, compare, or reflect on different moral or ethical viewpoints regarding a situation, decision, or practice (e.g., assisted suicide, suicide prevention), highlighting the variation or complexity of ethical reasoning.

3.1.2. Value-Based Conflicts	Value-based conflicts arise when two or more equally important moral values come into conflict and cannot be fulfilled simultaneously [80]	<i>“Confidentiality (resident) vs. truth (nurse)” (F10)</i>	Code text segments in this category when participants describe situations in which two or more moral values are in conflict, making it impossible to fulfill all of them simultaneously.
3.2. Moral Uncertainty	Moral uncertainty occurs, when a moral agent feels uncertain about the ethically right course of action to take in a situation [81,82].	<i>“Shortening a person’s life – is it killing? Or helping? How do I deal with it myself?!!!” (F6)</i>	Code text segments in this category when participants express uncertainty or doubt about the ethically correct course of action in a given situation (e.g., statements indicating hesitation, doubt, or indecision about what is morally right).
3.3. Moral Constraints	Moral constraints arise when a moral agent is prevented/constrained from acting in the way they believe to be the most ethically justified [81,82].	<i>“One reaches one’s limits because, from a medical perspective, there is often little real support available – neurologists are overbooked and provide only medication-based treatment, whereas psychotherapy and similar interventions would in fact be more helpful” (F9)</i>	Code text segments in this category when participants describe situations in which they are prevented or restricted from taking the action they believe to be ethically justified (e.g., situations where external factors block ethically preferred actions or expressions of being hindered from doing what is perceived as morally right).

Theme 1. Intuitive and Emotional Reactions

Theme 1.1. Moral Intuition

When reflecting on their initial reactions to requests for assisted suicide, nurses reported a range of intuitive responses. Some reactions included strong categorical refusal, with participants stating *“Under no circumstances!”* (F6) or *“I’m not willing to do that”* (F6). Nurses also expressed *“disapproval”* (F6) and reporting feelings of powerlessness, nervousness, shock, caution, and astonishment, illustrated by comments such as feeling *“powerless”* (F12), *“uneasy”* (F12), *“shocked”* (F5), *“cautious”* (F4) and *“aghast”* (F6) when thinking about a request for assisted suicide. Additional responses included stress and uneasiness, as reflected in statements like *“I feel stressed”* (F3) and experiencing *“the expected uneasiness”* (F10).

When considering suicide prevention, nurses described similar reactions, including powerlessness, astonishment, irritation, nervousness, and caution. For example, participants noted feeling *“powerless”* (F4), *“astonished”* (F8), *“irritated”* (F8), *“nervous”* (F2) and *“cautious”* (F6). However,

although these responses were qualitatively similar to reactions to assisted suicide, they were discussed less frequently.

Theme 1.2. Moral Emotions

In response to requests for assisted suicide, nurses reported a range of moral emotions. Some described feeling *“anxious”* (F7), because assisted suicide conflicted with their religious or cultural beliefs that life should end naturally. Others expressed worry, saying, *“When I think about requests for assisted suicide, I feel worried because the person might act on their wishes”* (F7). Feelings of *“helplessness”* (F7), *“powerlessness”* (F7) and *“sadness”* (F4) were common, particularly when nurses felt unable to relieve suffering. One participant noted, *“A request for assisted suicide would make me very sad, because I would ask myself what had happened. What reason does the person have for no longer wanting to live?”* (F11). Others described feeling *“unhappy”* (F4) because they could not intervene, or even described feeling *“guilty”* (F6) if a care recipient under their care might request assisted suicide.

When reflecting on suicide prevention, similar emotions emerged. Nurses spoke of a recurring *“feeling of powerlessness”* (F8) and of feeling *“helpless because one often becomes aware of the problems too late”* (F3). They reported being *“sad”* (F6), feeling *“down”* (F12) or *“angry”* (F6) when insufficient time was available for care recipients and emphasized systemic barriers, stating, *“I feel sad about challenges in the healthcare system in getting timely help during mental health crises”* (F3).

Theme 2. Ethical Perception and Ethical Reflection

Theme 2.1. Ethical Sensitivity

Nurses described requests for assisted suicide in general terms as an *“ethical challenge”* (F6). They reflected on the moral dimension of these requests, questioning the *“Ethics?”* (F2) behind such statements and considering how they may be impacted by the practice: *“Morality – how do I feel afterwards?”* (F7). This reflection prompted them to assess their own emotional readiness, asking, *“Do I feel emotionally stable enough to fulfill this person’s final wish?”* (F9) or *“Can I live with that?”* (F1) and emphasizing the importance of protecting their own well-being. At the same time, nurses acknowledged their moral responsibility, reflecting statements such as, *“I am responsible for whether the resident lives or dies”* (F7), and having to *“Ask about reasons for the desire to die”* (F4). They also sensitively highlighted the moral importance of dialogue and involving relatives, stating, *“Was this discussed with the family?”* (F2).

In the context of suicide prevention, nurses emphasized the importance of safeguarding patient rights. One nurse stated: *“I keep in mind that the person’s wish takes priority”* (F12), while another stressed the need to *“preserve the resident’s/patient’s self-determination”* (F9). They recognized the moral weight of their actions, acknowledging that *“incorrect actions can lead to a deterioration of the resident’s situation”* (F9) or *“I can intervene to help, but I could also make things worse”* (F7). Nurses also reflected on the personal impact of suicide prevention, asking, *“How does it affect me?”* (F9). They underscored the importance of conveying value to the care recipient, expressing, *“You are important to me”* (F6), while remaining attentive to their own emotional responses. They further highlighted the benefit of collaborative approaches, asserting, *“Seek collaborative solutions, including family”* (F4) and emphasized the value of structured discussions.

Theme 2.2. Guiding Moral Values

Nurses described a wide range of moral values they regarded as important in relation to assisted suicide and suicide prevention in care recipients who request assisted suicide, often adopting the perspectives of various actors involved.

For nurses themselves, commonly discussed examples of these values include *“respect”* (F1; F11), *“empathy”* (F2; F4), *“responsibility”* (F8; F5), *“dignity”* (F10; F4), *“collaboration”* (F7; F4) and *“compassion”* (F6; F5), while *“care”* (F9; F12), *“safety”* (F3; F4), *“trust”* (F1; F4), and *“confidentiality”* (F10; F5) were

discussed in some focus groups, and “acceptance” (F6) was mentioned by a few nurses in one focus group.

Regarding care recipients, nurses considered “self-determination” (F9; F4) and “dignity” (F9; F11) commonly as the most crucial moral values. Additional, though somewhat less prominent, values discussed included “respect” (F2; F5), “freedom” (F6; F11), “privacy” (F10; F4), “quality of life” (F7; F12), “confidentiality” (F3; F10), “trust” (F8; F4), or the principle of “autonomy” (F2; F11).

For relatives, the values deemed most important were “compassion” (F2; F11), “care” (F3; F12), “respect” (F1; F4) and “trust” (F6; F5), whereas “empathy” (F9; F5), “responsibility” (F3; F4), “collaboration” (F7), “truth” (F10; F5), “dignity” (F6; F4), “fairness” (F8; F10) and “safety” (F8; F4) were mentioned less frequently.

Finally, for other professional groups involved (e.g., physicians or those not further specified), “collaboration” (F7; F5) was discussed commonly, as well as “responsibility” (F3; F8), “respect” (F8; F5), “dignity” (F3; F4) and “trust” (F3; F8).

Theme 2.3. Ethical Reasoning

Nurses demonstrated that they engaged in ethical reasoning when reflecting on their own attitudes towards assisted suicide. A variety of viewpoints emerged. For some, assisted suicide was morally unacceptable because it was considered equivalent to killing: “I don’t want to end a life” (F6). For others, the acceptability of assisted suicide was highly situation-dependent and influenced by whether they could understand the care recipients wish: “It depends on the situation and the person. For example, someone who is seriously ill, alone, and 85 years old. I wouldn’t try to convince a person like that to keep living. Over time, you develop an understanding for it. So, I wouldn’t encourage it or insist on it, but I would understand” (F11). One participant stated, that “There is a difference between old and young” (F6), demonstrating that the age of the individual requesting assisted suicide seemed to play an important role in the process of ethical reasoning. Those nurses who ethically supported assisted suicide often did so with a focus in their reasoning on reducing suffering and ensuring a peaceful death: “Keep the resident’s well-being in mind, ensuring they can pass away without pain” (F8). Finally, for some nurses, acceptance formed the core ethical argument for supporting assisted suicide: “We deal with older people every day [...] At some point, they are ready to go, and you have to accept that” (F11).

In the context of suicide prevention, nurses also engaged in ethical reasoning, although much less frequently compared to assisted suicide. Some viewed suicide prevention as their primary ethical responsibility, stating, for example: “The topic of suicide prevention is at the forefront for me” (F2) and “I feel responsible” (F5). Others emphasized that the ethical appropriateness of suicide prevention was highly situation-dependent. Still others questioned whether suicide prevention was always ethically justified: “What if the resident’s wishes differ? There are limits” (F7).

Theme 3. Ethical Challenges

3.3.1. Moral Controversy

3.3.1.1. Varying Ethical Perspectives

One ethical challenge that emerged was the complex task of navigating the diverse ethical perspectives of those involved in assisted suicide. From nurses’ perspectives, this challenge was shaped by various relational dynamics. First, nurses noted the tension between care recipients’ wishes for assisted suicide and socially accepted moral norms. One group collectively described this as: “Self-determination vs. societal value norms, which may not align with individual beliefs” (F5). Several nurses emphasized the personal dilemma of reconciling their own moral convictions with their professional responsibilities: “Recognition of the resident’s desire to die versus my own position as a nurse, not wanting to take an active or facilitating role in the dying process” (F6). At times, these differing perspectives also strained the nurse-care recipient relationship. One participant recounted how a resident reacted negatively to the staff’s refusal to assist: “She reacted with offense when the staff explained

they could not assist her and expressed doubt about this as well" (F6). Additionally, nurses pointed to the challenges of navigating family conflicts: "Dealing with relatives when they disagree" (F7). Finally, intra- and interprofessional collaboration – particularly between nurses and physicians – was also affected by differing ethical positions.

These varying ethical perspectives were far less pronounced when nurses discussed suicide prevention. For some, challenges arose when they did not personally regard suicide prevention as ethically appropriate but nevertheless felt it was expected of them. As one nurse noted in relation to suicide prevention for a person who requested assisted suicide: "I am not convinced" (F8). Other challenges were described in situations where nurses and relatives held conflicting views, summarized by one participant as: "Conflict between the nurse and family members" (F2). Finally, differing perspectives on suicide prevention occasionally strained team dynamics. One nurse described "Divergent views within the nursing team (strain)" (F6), while another highlighted: "Colleagues showing a lack of seriousness and unwillingness to engage with the topic" (F3) as a challenge.

3.3.1.2. Value-Based Conflicts

The participants reported a broad range of value-based conflicts in the context of requests for assisted suicide and suicide prevention in care recipients who request assisted suicide, which could involve any of the persons involved.

When asked to identify one conflict that was particularly significant for the entire group, the most frequently mentioned was the tension between values central to the care recipient and those central to the nurse. Examples included "self-determination vs. care vs. quality of life" (F4), "confidentiality (resident) vs. truth (nurse)" (F10) and "dignity vs. self-determination" (F2). Among these, however, "care vs. self-determination" (F3) was mentioned most frequently. Some participants further elaborated on this conflict, noting that the self-determination of care recipients may not only clash with nurses' understanding of care, but also with that of relatives: "self-determination of residents vs. care of nurses vs. care of relatives" (F8). On a broader level, participants emphasized that self-determination can also come into conflict with societal or religious value systems, for example: "self-determination vs. societal value systems (which may differ from individual values)" (F5) or "self-determination vs. morality/wishes/religiosity/one's own value system" (F7).

3.2. Moral Uncertainty

When discussing the practice of assisted suicide, it became apparent that nurses often experienced moral uncertainty about the ethically appropriate course of action. Many nurses described feeling "uncertain" (F9) about how to respond ethically to requests for assisted suicide, and some even questioned, in general terms, whether assisted suicide could ever be ethically justified. One nurse reflected, "Shortening a person's life – is it killing? Or helping? How do I deal with it myself?!!!" (F6). Some expressed uncertainty about context-specific ethics, asking, "When is assisted suicide acceptable, and when is it 'reprehensible'?" (F8). For others, moral uncertainty centered on their own professional role and rights to object, with questions such as, "What am I allowed to refuse?" (F6). In certain cases, doubts were raised regarding the individual circumstances of a request, as illustrated by the question, "Has the affected person truly exhausted all medical options?" (F1). Overall, nurses reported feeling ill-prepared to navigate assisted suicide requests from an ethical perspective, asking, "How do I deal with that?" (F7). They also voiced a need for additional support in the form of further education, training, and clear guidelines to reduce moral uncertainty, emphasizing the importance of "more training" (F8) and "guidelines" (F3).

Nurses also described experiencing moral uncertainty in the context of suicide prevention, although this was reported less frequently. One nurse simply stated, "I feel uncertain" (F8) while another asked, "Who can I involve for support?" (F5). They were not always sure which changes to the care plan were ethically appropriate, as one participant asked, "What am I allowed to change?" (F4). This uncertainty could be even greater when they wished to respect the care recipient's wishes but found advance directives to be unclear. Some nurses expressed a desire for more guidance on the

topic – emphasizing the “*need for clear guidelines*” (F8) – to clarify the ethically right course of action. For others, uncertainty arose from the uniqueness of each patient case: “*There is no one-size-fits-all approach*” (F8).

3.3. Moral Constraints

When discussing assisted suicide, nurses reported facing several ethical challenges linked to external constraints. One nurse felt restricted by what she perceived to be the legal context, noting, “*Assistance to die is illegal in Germany*” (F4), although this perception does not fully reflect the current legal status. Others described feeling pressured to participate in assisted suicide despite their personal reluctance, expressing, “*I feel compelled*” (F6) and, “*I feel instrumentalized*” (F6). Time constraints were another key limitation, preventing nurses from engaging in dialogue to the extent they felt was ethically required: “*There is often insufficient time for these discussions*” (F1).

Insufficient time was also perceived as a moral constraint in the context of suicide prevention. One nurse emphasized the need for “*more time*” (F6), while another described the limitations of “*time as a framework*” (F5) in providing adequate preventive care. Beyond the lack of time, nurses pointed to broader societal constraints. One criticized “*our healthcare system*” (F9) as a barrier to suicide prevention, while another reflected, “*One reaches one’s limits because, from a medical perspective, there is often little real support available – neurologists are overbooked and provide only medication-based treatment, whereas psychotherapy and similar interventions would in fact be more helpful*” (F9).

4. Discussion

4.1. Ethically Complex and Emotionally Demanding

Our findings suggest that requests for assisted suicide constitute an ethically complex issue for nurses working in German residential and home-based LTC across various organizations, particularly given their simultaneous responsibility for suicide prevention, which has been at the center of political, professional and societal attention in recent years. Based on Monteverde’s definition [80], we understand ethical complexity as present in situations that are morally uncertain, carry a high risk of causing harm, involve interdependencies, or encompass multiple interconnected actors or interfaces.

It is noteworthy that nurses in our study exhibited both moral, intuitive, and emotional responses regarding assisted suicide and suicide prevention (*Theme 1. Intuitive and Emotional Reactions*). While international research on MAiD has documented intuitive and predominantly negative emotional responses, such as guilt or anger [25,34,83], some studies also report neutral or positive emotions, such as feeling honored, fulfilled or relieved, since suffering can be reduced [25,83,84]. In contrast, our analysis revealed only negative emotions, which may be attributed to our specific focus on *moral* emotions as defined in the coding scheme (Table 2), whereas other studies may have considered emotions in a broader sense. Moreover, nurses’ psychological well-being in relation to MAiD may be influenced by factors beyond solely moral reasons, such as legal uncertainty, fears of professional repercussions or stigma [84], their roles and level of involvement in MAiD, and the availability of support systems [32]. Furthermore, our findings indicate that intuitive and emotional responses were more pronounced for assisted suicide than for suicide prevention, although international studies also highlight nurses’ emotional labor in suicide prevention [52]. This suggests that emotional responses to suicide prevention may carry a different significance and may be less rooted in moral considerations than those elicited by assisted suicide requests. Considering that moral perspectives are shaped by cultural and societal contexts, and that societal values influence attitudes toward assisted suicide [13], one possible explanation for this pattern is the prominence of suicide prevention in contemporary political, societal, and professional debates in Germany, where it is more widely accepted and less controversial than assisted suicide [27–29].

Nurses in our study demonstrated ethical sensitivity, identified relevant moral values, and engaged in nuanced ethical reasoning regarding both assisted suicide and suicide prevention (*Theme*

2. *Ethical Perception and Ethical Reflection*). This aligns with international research on MAiD, which shows that nurses are acutely aware of the ethical complexity of MAiD requests [2,25,51], and, though less extensively documented, also acknowledges their recognition of the ethical dimensions involved in suicide prevention [52,53]. Nurses in our study reflected deeply on the moral values at stake for all parties involved in both assisted suicide and suicide prevention. Consistent with prior research [85,86], respect for autonomy and self-determination was frequently identified as a central guiding value for nurses. Our findings further suggest that nurses' ethical reasoning regarding assisted suicide is highly situation-dependent and closely tied to efforts to understand care recipients' individual wishes, a pattern also reported in previous studies [25,31,32,61]. Notably, the age of care recipients seemed to shape nurses' moral reasoning, with some showing greater acceptance of assisted suicide for older individuals. While this may reflect implicit ageism – which can undermine the quality of care and holistic approaches to suicide prevention, potentially contributing to higher suicide rates among older adults in need of care [87] – many nurses, through deliberate moral reasoning, developed a strong sense of responsibility for preventive care. Thus, in line with Eriksson et al. [88], who describe how nurses in LTC settings address suicide prevention on multiple levels, as well as with Schwartz et al. [60] and Turiaux et al. [59], who report active involvement of German palliative care professionals in suicide prevention, our findings indicate that many nurses perceive suicide prevention as an integral aspect of their professional role.

Our findings underscore the ethical challenges nurses face when navigating requests for assisted suicide alongside responsibilities in suicide prevention. These challenges include reconciling diverse ethical perspectives, negotiating value-based conflicts, coping with moral uncertainty, and managing (perceived) moral constraints (*Theme 3. Ethical Challenges*). Consistent with prior research [25,31,32,34,58,83], we observed a broad spectrum of ethical viewpoints on assisted suicide in our sample. In contrast, ethical perspectives on suicide prevention were less divergent, likely reflecting its lower ethical controversy and greater societal acceptance. Divergent perspectives on MAiD, however, can create barriers to care – for example, when healthcare professionals or entire institutions object to MAiD provision [50,79] – and may generate moral conflicts and tensions within teams, while also negatively impacting nurse–care recipient relationships [25,58]. Thus, one challenge lies in team communication, which previous studies have identified as a crucial resource for ethically managing MAiD [25,32,34]. Furthermore, good nurse-care recipient communication is particularly important, as relationship-building is central to suicide prevention [52], and meaningful conversations between nurses and care recipients may help alleviate suffering and potentially dissuade patients from pursuing MAiD [31]. We also identified value-based conflicts, particularly the moral dilemma of responding professionally to assisted suicide requests while simultaneously upholding responsibilities for suicide prevention. Similar dilemmas – balancing patient safety, understood as protection from risk and harm, against other ethical principles such as respect for autonomy or confidentiality – have been reported in prior research [52,53]. Nurses also reported experiences of moral uncertainty, especially regarding assisted suicide, and to a lesser extent suicide prevention. This aligns with international findings and may be partly attributed to the lack of clear legal and professional guidance and unclear nursing roles and responsibilities in relation to MAiD [25,31,32,34,58]. Consistent with other research [25,31,32,52,61], participants expressed a need for further education to reduce uncertainty in both assisted suicide and suicide prevention. In addition, our findings highlight several external moral constraints. Some nurses perceived assisted suicide as legally impermissible in Germany, reflecting legal knowledge gaps also identified in other German [60] and international [32] studies underscoring the need for education. Particularly concerning, some nurses reported feeling obliged to participate in MAiD against their will, emphasizing the importance of conscientious objection, defined as “a healthcare professional’s refusal to participate in a legally authorized procedure due to deeply held personal beliefs” [89] (p. 8). Although conscientious objection remains a topic of ethical debate [89], this right is affirmed both legally and professionally as both the German Federal Constitutional Court [14] and the International Council of Nurses [48] explicitly point to this right. Regarding suicide prevention, participants also reported external

barriers constraining morally appropriate practice, particularly insufficient time and limited access to specialized care. Resource constraints – especially time pressures [88] – have been identified as major challenges in suicide prevention. Time constraints are especially pressing given rising administrative demands and staffing shortages in LTC settings, which are currently recognized as critical challenges in Germany [90]. Limited access to healthcare services and resources – such as mental health care or palliative support – was identified by some nurses in our own and other studies as a concern in the context of MAiD [32,83,84,91]. Participants emphasized that better and more equitable access to these services could, in certain situations, help prevent MAiD. This highlights the need for societal changes to promote equal access to essential healthcare resources.

Overall, our findings – in the context of previous research and current political, societal and professional developments – suggest that nurses may experience moral distress when navigating the ethical challenges posed by assisted suicide requests and suicide prevention in care recipients who consider this option. Moral distress arises when nurses face psychological strain due to moral conflicts, dilemmas, uncertainty, or constraints [81,82]. Since all of these potential triggers as well as psychological stress were evident in our study, and given that moral distress related to MAiD has been documented internationally among nurses, it is likely that nurses in Germany and other countries encounter similar challenges [25]. This issue is particularly concerning because moral distress can have serious consequences for nurses – including physical and mental health impairments, job dissatisfaction, and staff turnover – as well as for care recipients, such as a reduction in the quality of care [92,93]. Accordingly, targeted measures are needed to support nurses in their moral role – both in responding professionally to MAiD requests and in suicide prevention. One approach to reducing moral distress is to strengthen nurses' moral resilience, including their moral self-efficacy [54,57,94]. Importantly, strategies and interventions – such as educational programs – should be implemented across multiple levels: societal, professional, institutional, and team-based, rather than placing the responsibility solely on individual nurses [25,57,94]. Furthermore, since ethical perspectives on and attitudes towards assisted suicide and suicide prevention vary among nurses, interventions must also be tailored to individual needs [58]. Such measures could help safeguard both nurses and care recipients from the negative consequences of moral distress [25,54,57,94], promoting nurses' well-being and enhancing the quality of care in the professional management of MAiD requests and suicide prevention.

4.2. Implications for Nursing Practice, Institutions, and Society

Based on our study findings and previous research, several practice implications emerge that should inform healthcare in Germany and are equally relevant for any country where MAiD is legal or under consideration.

At the individual level, nurses need to actively engage in strategies that foster the development of moral self-efficacy when addressing MAiD requests and suicide prevention. They should act with moral courage, remaining sensitive to their personal moral boundaries and communicating any conscientious objection to safeguard their moral integrity. To do so effectively, nurses require support at the professional, institutional, and societal levels:

Firstly, at the professional and institutional level, there is a need for enhanced education and training. Educational programs should cover ethics training to foster moral resilience and moral self-efficacy, the right to conscientious objection, legal and professional aspects of MAiD and suicide prevention care, and strategies to reduce ageism in healthcare [25,31,32,52,58,83,87].

Secondly, institutions should cultivate an ethical culture that supports personal and team reflection on ethically challenging situations. Creating an environment that encourages open discussion of differing perspectives within healthcare teams could help reduce moral conflict and tension related to MAiD and suicide prevention [25,30,79].

Thirdly, at both professional and institutional levels, nurses' roles and responsibilities in MAiD and suicide prevention need clarification. Developing ethical guidelines that address these areas,

including conscientious objection, could provide a moral framework to guide nursing practice [25,31,52,58,83].

Fourthly, at the societal level, barriers to accessing health services that support suicide prevention should be addressed as a pressing public health issue [91], alongside efforts to strengthen the nursing workforce and mitigate reported time constraints [90].

4.3. Strengths and Limitations

A major strength of this study lies in its inclusion of a wide range of perspectives from nurses working in organizations of varying size and structure, representing both residential and home-based LTC. Furthermore, the use of a structured and theoretically underpinned coding framework supported the rigorous analysis of the data.

Yet, several limitations should be taken into account when interpreting our findings. Although we captured a broad spectrum of ethical perspectives from nurses across different LTC organizations, the transferability of our results to other countries, legal frameworks and settings is limited. Furthermore, while our aim was to explore a wide range of perspectives and challenges related to assisted suicide and suicide prevention, previous research has shown that participants may be hesitant to openly address such sensitive topics in group discussions [65]. As such, in focus groups that included both frontline nurses, and nurses with additional leadership roles, hierarchical positions may have influenced participants' responses. Additionally, technical challenges arose in the online focus groups as some participants experienced connectivity issues. As a result, certain potentially valuable insights may have been missed. Finally, not all participants had direct experience with assisted suicide requests. Many instead drew on encounters with "desire to die" situations in reflecting on their practice, meaning that some responses regarding assisted suicide were necessarily hypothetical and should be interpreted accordingly.

4.4. Research Implications

Future research could adopt alternative research methods, such as individual interviews, to triangulate our results and to gain deeper insights into nurses' ethical experience in the context of assisted suicide and suicide prevention in Germany. While our study primarily focused on nurses' ethical perspectives and challenges, future research should explore strategies and practical approaches that nurses use to navigate ethically challenging situations in the context of MAiD and suicide prevention across countries. Additionally, intervention studies are needed to examine the effects of measures such as educational programs designed to enhance nurses' moral resilience and moral self-efficacy. Furthermore, it would be valuable to examine the underlying meanings and triggers of nurses' emotional responses in relation to MAiD and suicide prevention in more detail. Finally, our findings suggest that suicide prevention can pose ethical challenges, particularly when considered alongside MAiD, yet research in this area remains limited. Thus, there is a need to investigate nurses' ethical perspectives on suicide prevention in greater depth, using qualitative approaches.

5. Conclusions

Requests for assisted suicide and suicide prevention present ethically complex situations for nurses in residential and home-based LTC in Germany. Nurses must navigate intuitive and emotional responses, analyze ethical perceptions, engage in ethical reflection, and confront numerous ethical challenges in these contexts. Consequently, such situations may contribute to the development of moral distress, negatively impacting nurses' well-being and potentially compromising the quality of patient care.

Educational interventions, the cultivation of an open ethical climate, clear role definitions, guidelines and the removal of barriers to suicide prevention may help reduce nurses' moral distress, both in Germany and internationally. Taken together, these measures can safeguard moral integrity,

strengthen moral resilience, including moral self-efficacy, and provide a more stable ethical framework. This, in turn, enables nurses to respond professionally to MAiD requests while effectively supporting suicide prevention, ultimately benefiting both nurse well-being and the quality of patient care.

Supplementary Materials: The following supporting information can be downloaded at the website of this paper posted on Preprints.org, Supplementary S1: COnsolidated criteria for REporting Qualitative studies (COREQ): 32-item Checklist; Supplementary S2: Focus Group Interview Guide.

Author Contributions: Conceptualization, K.K., A.R. and T.H.; methodology, K.K., A.R., T.H.; software, K.K.; validation, E.M.S. and E.J.; formal analysis, K.K., A.R., P.M.H. and T.H.; investigation, K.K., P.M.H., A.R., E.M.S. and E.J.; resources, A.R. and T.H.; data curation, K.K.; writing—original draft preparation, K.K.; writing—review and editing, A.R., T.H., P.M.H., E.M.S. and E.J.; visualization, K.K.; supervision, A.R. and T.H.; project administration, A.R., T.H. and K.K.; funding acquisition, A.R. and T.H. All authors have read and agreed to the published version of the manuscript.

Funding: This research was funded by the German Federal Ministry of Health, grant number 2524FSB220. The APC was funded by Esslingen University of Applied Sciences.

Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki, and approved by the Ethics Committee of the German Society of Nursing Sciences (ethics proposal number: 24-035 / 4 December 2024).

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: The data presented in this study are available from the corresponding author upon reasonable request, as they form part of an ongoing research project.

Acknowledgments: The authors gratefully acknowledge the valuable support of Stephanie Feinauer, Maren Köpke, and Dorothea Ruzek in facilitating the focus groups.

Conflicts of Interest: The authors declare no conflicts of interest.

Abbreviations

The following abbreviations are used in this manuscript:

LTC Long-Term Care
MAiD Medical Assistance in Dying

References

1. Refolo, P.; Raimondi, C.; Masilla, S. S.; Argo, A.; Capulli, E.; Ceruti, S.; Gonella, S.; Ingravallo, F.; Miccinesi, G.; Picozzi, M.; Redaelli, P.; Spagnolo, A. G. Attitudes of Physicians, Nurses, and the General Public toward End-of-Life (EoL) Decisions in European Countries: An Umbrella Review. *BMC Med. Ethics* **2025**, *26* (1), 60.
2. Ali, V.; Preston, N.; Machin, L.; Malone, J. The Experience of Nurses When Providing Care across Acts That May Be Perceived as Death Hastening: A Qualitative Evidence Synthesis. *Palliat. Med.* **2025**, *39* (6), 644–664.
3. De Brasi, E. L.; Giannetta, N.; Ercolani, S.; Gandini, E. L. M.; Moranda, D.; Villa, G.; Manara, D. F. Nurses' Moral Distress in End-of-Life Care: A Qualitative Study. *Nurs. Ethics* **2021**, *28* (5), 614–627.
4. Boström, K.; Dojan, T.; Rosendahl, C.; Gehrke, L.; Voltz, R.; Kremeike, K. How Do Trained Palliative Care Providers Experience Open Desire to Die-Conversations? An Explorative Thematic Analysis. *Palliat. Support. Care* **2024**, *22* (4), 681–689.
5. Rodríguez-Prat, A.; Pergolizzi, D.; Crespo, I.; Julià-Torras, J.; Balaguer, A.; Kremeike, K.; Voltz, R.; Monforte-Royo, C. The Wish to Hasten Death in Patients With Life-Limiting Conditions. A Systematic Overview. *J. Pain Symptom Manage.* **2024**, *68* (2), e91–e115.

6. German Ethics Council. Suicide – Responsibility, Prevention and Autonomy. Executive Summary, **2022**. Available online: <https://www.ethikrat.org/en/publications/opinions/suicide/> (accessed on 04 November 2025).
7. Leitlinienprogramm Onkologie. Erweiterte S3-Leitlinie Palliativmedizin für Patienten mit einer nicht heilbaren Krebserkrankung, Langversion 2.2 – September 2020. AWMF-Register Nr. 128/001 OL. Berlin: Leitlinienprogramm Onkologie, **2020**. Available online: <https://www.leitlinienprogramm-onkologie.de/leitlinien/palliativmedizin/> (accessed on 04 November 2025).
8. Balaguer, A.; Monforte-Royo, C.; Porta-Sales, J.; Alonso-Babarro, A.; Altisent, R.; Aradilla-Herrero, A.; Bellido-Pérez, M.; Breitbart, W.; Centeno, C.; Cuervo, M. A.; Deliens, L.; Frerich, G.; Gastmans, C.; Lichtenfeld, S.; Limonero, J. T.; Maier, M. A.; Materstvedt, L. J.; Nabal, M.; Rodin, G.; Rosenfeld, B.; Schroepfer, T.; Tomás-Sábado, J.; Trelis, J.; Villavicencio-Chávez, C.; Voltz, R. An International Consensus Definition of the Wish to Hasten Death and Its Related Factors. *PLOS ONE* **2016**, *11* (1), e0146184.
9. Ohnsorge, K.; Rehmann-Sutter, C.; Streeck, N.; Gudat, H. Wishes to Die at the End of Life and Subjective Experience of Four Different Typical Dying Trajectories. A Qualitative Interview Study. *PLOS ONE* **2019**, *14* (1), e0210784.
10. Radbruch, L.; Leget, C.; Bahr, P.; Müller-Busch, C.; Ellershaw, J.; de Conno, F.; Vanden Berghe, P.; on behalf of the board members of the EAPC. Euthanasia and Physician-Assisted Suicide: A White Paper from the European Association for Palliative Care. *Palliat. Med.* **2016**, *30* (2), 104–116.
11. Grove, G. L.; Lovell, M. R.; Hughes, I.; Maehler, E.; Best, M. Voluntary-Assisted Dying, Euthanasia and Physician-Assisted Suicide: Global Perspectives—Systematic Review. *BMJ Support. Palliat. Care* **2025**, *15* (4), 423–435.
12. Baée, J.; Draper, B.; Wijeratne, C. A Systematic Review of Reasons for and against Euthanasia and Physician-Assisted Suicide in Older People with a Non-Terminal Condition. *Australas. Psychiatry* **2025**, *33* (3), 366–375.
13. Bloomer, M. J.; Saffer, L.; Hewitt, J.; Johns, L.; McAuliffe, D.; Bonner, A. Maybe for Unbearable Suffering: Diverse Racial, Ethnic and Cultural Perspectives of Assisted Dying. A Scoping Review. *Palliat. Med.* **2024**, *38* (9), 968–980.
14. Federal Constitutional Court (Bundesverfassungsgericht). Judgment of 26 February 2020. *Federal Constitutional Court* **2020**. Available online: https://www.bundesverfassungsgericht.de/SharedDocs/Entscheidungen/EN/2020/02/rs20200226_2bvr234715en.html (accessed on 16 September 2025).
15. German Federal Parliament (Deutscher Bundestag). Bundestag Lehnt Gesetzentwürfe Zur Reform der Sterbehilfe ab. German Federal Parliament **2023**. Available online: <https://www.bundestag.de/dokumente/textarchiv/2023/kw27-de-suiziddebatte-954918> (accessed on 16 September 2025).
16. Henking, T. Assistierter Suizid – die juristische Perspektive. *Z. Für Gerontol. Geriatr.* **2025**, *58* (1), 28–32.
17. Hilgendorf, E. Zur rechtlichen Regulierung der Suizidassistenz nach dem Urteil des Bundesverfassungsgerichts. In *Assistierter Suizid. Rechtliche Debatte und klinische Praxis aus interdisziplinärer Sicht*; Thöns, M., ed.; Kohlhammer: Stuttgart, Germany, **2025**; pp 41–54.
18. Federal Ministry of Health (Bundesministerium für Gesundheit). *Nationale Suizidpräventionsstrategie*; Federal Ministry of Health, **2024**. Available online: https://www.bundesgesundheitsministerium.de/fileadmin/Dateien/5_Publikationen/Praevention/abschlussbericht/240430_Nationale_Suizidpraeventionsstrategie.pdf (accessed on 04 November 2025).
19. Federal Ministry of Health (Bundesministerium für Gesundheit). *Gesetz Zur Stärkung Der Nationalen Suizidprävention*; Federal Ministry of Health, **2024**. Available online: <https://www.bundesgesundheitsministerium.de/service/gesetze-und-verordnungen/detail/gesetz-zur-staerkung-der-nationalen-suizidpraevention.html> (accessed 04 November 2025).
20. World Health Organization. *Live Life: An Implementation Guide for Suicide Prevention in Countries*, 1st ed.; World Health Organization: Geneva, Switzerland, **2021**. Available online: <https://www.who.int/publications/i/item/9789240026629> (accessed on 04 November 2025).

21. World Health Organization. *National Suicide Prevention Strategies. Progress, Examples and Indicators*; World Health Organization: Geneva, Switzerland, 2018. Available online: <https://www.who.int/publications/i/item/national-suicide-prevention-strategies-progress-examples-and-indicators> (accessed on 04 November 2025).
22. World Health Organization. *Preventing Suicide: A Global Imperative*; World Health Organization: Geneva, Switzerland, 2014. Available online: <https://www.who.int/publications/i/item/9789241564779> (accessed 04 November 2025).
23. Azizi, H.; Esmaili, E. D.; Khodamoradi, F.; Sarbazi, E. Effective Suicide Prevention Strategies in Primary Healthcare Settings: A Systematic Review. *Middle East Curr. Psychiatry* **2022**, *29* (1), 101.
24. Stallman, H. M.; Allen, A. Acute Suicide Prevention: A Systematic Review of the Evidence and Implications for Clinical Practice. *J. Affect. Disord. Rep.* **2021**, *5*, 100148.
25. Klotz, K.; Heidenreich, T.; Haug, P. M.; Feinauer, S.; Riedel, A. Nurses' Experience of Moral Distress in the Context of Medical Assistance in Dying (MAiD): A Systematic Review. *Ethik Med.* **2025**.
26. Klotz, K.; Seidlein, A.-H.; Riedel, A. *Todes- und Suizidwünsche: Ethische Herausforderungen in der Pflege*; essentials; Springer: Berlin, Heidelberg, 2025.
27. Lindner, R. Suizidprävention und assistierter Suizid – unvereinbar? *Z. Für Gerontol. Geriatr.* **2025**, *58* (1), 23–27.
28. D-A-CH Forum. *Ittinger Erklärung des D-A-CH Forums „Suizidprävention und assistierter Suizid“*; D-A-CH Forum: Ittingen, Switzerland, 2025. Available online: <https://www.d-a-ch-forum.org/> (accessed 04 November 2025).
29. Deutscher Pflegerat. *Positionspapier „Die Pflegerische Begleitung von Personen Mit Todeswunsch“*; Deutscher Pflegerat. Berlin, Germany, 2024. Available online: <https://deutscher-pflegerat.de/professionstaerken/positionspapiere/positionspapier-des-deutschen-pflegeratsdie-pflegerische-begleitung-von-personen-mit-todeswunsch> (accessed 04 November 2025).
30. Riedel, A.; Klotz, K.; Heidenreich, T. Ethische Aspekte von Todes- und Suizidwünschen älterer Menschen in der Pflege und für Pflegefachpersonen. *Ethik Med.* **2024**, *36* (3), 263–281.
31. Unseld, M.; Meyer, A. L.; Vielgrader, T.-L.; Wagner, T.; König, D.; Popinger, C.; Sturtzel, B.; Kreye, G.; Zeilinger, E. L. Assisted Suicide in Austria: Nurses' Understanding of Patients' Requests and the Role of Patient Symptoms. *Int. J. Environ. Res. Public Health* **2025**, *22* (2), 218.
32. Zeilinger, E. L.; Vielgrader, T.-L.; Petersen, A.; Meyer, A. L.; Brunevskaya, N.; Unseld, M. Nurses' Perspectives on Assisted Suicide: Challenges and Support Needs. *Soc. Sci. Med.* **2025**, *366*, 117663.
33. Bellon, F.; Mateos, J. T.; Pastells-Peiró, R.; Espigares-Tribó, G.; Gea-Sánchez, M.; Rubinat-Arnaldo, E. The Role of Nurses in Euthanasia: A Scoping Review. *Int. J. Nurs. Stud.* **2022**, *134*, 104286.
34. Werner, M.; Pleschberger, S.; Heimerl, K. Sterbewünsche im hohen Alter: Eine qualitative Studie zur Perspektive von Pflegenden vor dem Hintergrund des assistierten Suizids. *Pflege* **2025**, *38* (5), 258–265.
35. Salvatore, T. Dying by Suicide in Nursing Homes: A Preventable End of Life Outcome for Older Residents. *OMEGA - J. Death Dying* **2023**, *88* (1), 20–37.
36. Bareeqa, S. B.; Samar, S. S.; Masood, Y.; Husain, M. M. Prevalence of Suicidal Behaviors in Residents of Long-Term Care Facilities: A Systematic Review and Meta-Analysis. *OMEGA - J. Death Dying* **2025**, *92* (1), 83–102.
37. Seidlein, A.-H.; Riedel, A.; Heidenreich, T.; Klotz, K. Nursing Ethical Dimensions of Euthanasia and Medically Assisted Suicide for Older People in Need of Long-Term Care. *Front. Psychiatry* **2025**, *16*, 1589487.
38. Mezuk, B.; Lohman, M.; Leslie, M.; Powell, V. Suicide Risk in Nursing Homes and Assisted Living Facilities: 2003–2011. *Am. J. Public Health* **2015**, *105* (7), 1495–1502.
39. Mezuk, B.; Rock, A.; Lohman, M. C.; Choi, M. Suicide Risk in Long-term Care Facilities: A Systematic Review. *Int. J. Geriatr. Psychiatry* **2014**, *29* (12), 1198–1211.
40. Mezuk, B.; Ko, T. M.; Kalesnikava, V. A.; Jurgens, D. Suicide Among Older Adults Living in or Transitioning to Residential Long-Term Care, 2003 to 2015. *JAMA Netw. Open* **2019**, *2* (6), e195627.
41. Murphy, B. J.; Bugeja, L.; Pilgrim, J.; Ibrahim, J. E. Completed Suicide among Nursing Home Residents: A Systematic Review. *Int. J. Geriatr. Psychiatry* **2015**, *30* (8), 802–814.

42. Eggert, S.; Haeger, M.; Teubner, C.; Sperling, U.; Drinkmann, A.; Lindner, R.; Kessler, E.-M.; Schneider, B. Lebensendlichkeit, Lebensmüdigkeit Und Suizidprävention Im Kontext von Pflegebedürftigkeit – Eine Befragung Pflegenden Angehöriger. Projektbericht; Zentrum für Qualität in der Pflege: Berlin. Available online: https://www.zqp.de/wp-content/uploads/Abschlussbericht_ZQP_NaSPro_Lebensmuedigkeit.pdf (accessed 04 November 2025).
43. Rubli Truchard, E.; Monod, S.; Bula, C. J.; Dürst, A.-V.; Levorato, A.; Mazzocato, C.; Münzer, T.; Pasquier, J.; Quadri, P.; Rochat, E.; Spencer, B.; von Gunten, A.; Jox R. J. Wish to Die Among Residents of Swiss Long-Term Care Facilities: A Multisite Cross-Sectional Study. *J. Am. Med. Dir. Assoc.* **2022**, *23* (12), 1935–1941.
44. SWI swissinfo.ch. Assisted suicide numbers rose in Switzerland last year. Available online: <https://www.swissinfo.ch/eng/society/assisted-suicide-numbers-up-last-year-says-organisation/48256854> (accessed 13 October 2025).
45. Dierickx, S.; Onwuteaka-Philipsen, B.; Penders, Y.; Cohen, J.; Van Der Heide, A.; Puhan, M. A.; Ziegler, S.; Bosshard, G.; Deliens, L.; Chambaere, K. Commonalities and Differences in Legal Euthanasia and Physician-Assisted Suicide in Three Countries: A Population-Level Comparison. *Int. J. Public Health* **2020**, *65* (1), 65–73.
46. Statista. Number of Medically Assisted Deaths in Canada in 2022, by Age. Available online: <https://www.statista.com/statistics/792308/number-of-medically-assisted-deaths-canada-by-age/> (accessed 13 October 2025).
47. Gleich, S.; Peschel, O.; Graw, M.; Schäffer, B. Assistierte Suizide in München – eine erste kritische Analyse. *Rechtsmedizin* **2024**, *34* (1), 24–30.
48. International Council of Nurses. *The ICN Code of Ethics for Nurses*; International Council of Nurses: Geneva, Switzerland, **2021**. Available online: <https://www.icn.ch/resources/publications-and-reports/icn-code-ethics-nurses> (accessed 04 November 2025).
49. Byrnes, E.; Ross, A. I.; Murphy, M. A Systematic Review of Barriers and Facilitators to Implementing Assisted Dying: A Qualitative Evidence Synthesis of Professionals’ Perspectives. *OMEGA - J. Death Dying* **2025**, *90* (3), 1137–
50. White, B. P.; Jeanneret, R.; Close, E.; Willmott, L. Access to Voluntary Assisted Dying in Victoria: A Qualitative Study of Family Caregivers’ Perceptions of Barriers and Facilitators. *Med. J. Aust.* **2023**, *219* (5), 211–217.
51. Elmore, J.; Wright, D. K.; Paradis, M. Nurses’ Moral Experiences of Assisted Death: A Meta-Synthesis of Qualitative Research. *Nurs. Ethics* **2018**, *25* (8), 955–972.
52. Riedel, A.; Feinauer, S.; Jacob, E.; Haug, P. M.; Klotz, K.; Heidenreich, T. Nurses’ Roles and Responsibilities in Suicide Prevention: A Scoping Review. *BMC Nurs.* **2025**, *24* (1308).
53. Wong, V.; Hassan, N.; Wong, Y. P.; Chua, S. Y. N.; Abdul Rahman, S.; Mohamad, M. L.; Lim, S. Nurses’ Adherence to Ethical Principles – A Qualitative Study. *Nurs. Ethics* **2025**, *32* (4), 1162–1176.
54. Rathert, C.; May, D. R.; Chung, H. S. Nurse Moral Distress: A Survey Identifying Predictors and Potential Interventions. *Int. J. Nurs. Stud.* **2016**, *53*, 39–49.
55. Rullo, M.; Lalot, F.; Heering, M. S. Moral Identity, Moral Self-Efficacy, and Moral Elevation: A Sequential Mediation Model Predicting Moral Intentions and Behaviour. *J. Posit. Psychol.* **2022**, *17* (4), 545–560.
56. Hannah, S. T.; Avolio, B. J.; May, D. R. Moral Maturation and Moral Conation: A Capacity Approach to Explaining Moral Thought and Action. *Acad. Manage. Rev.* **2011**, *36* (4), 663–685.
57. Ishihara, I.; Inagaki, S.; Osawa, A.; Umeda, S.; Hanafusa, Y.; Morita, S.; Maruyama, H. Effects of an Ethics Education Program on Nurses’ Moral Efficacy in an Acute Health Care Facility. *J. Nurs. Manag.* **2022**, *30* (7), 2207–2215.
58. Surzykiewicz, J.; Toussaint, L. L.; Riedl, E.; Harder, J.-P.; Loichen, T.; Büssing, A.; Maier, K.; Skalski-Bednarz, S. B. Perspectives on Physician-Assisted Suicide Among German Hospice Professionals: Findings from a Diagnostic Survey. *Healthcare* **2025**, *13* (7), 763.
59. Turiaux, J.; Burner-Fritsch, I. S.; Fegg, M.; Marckmann, G.; Bausewein, C. Anfragen zu und Praxis von Suizidassistenten – Ergebnisse einer Befragung unter Mitgliedern der Deutschen Gesellschaft für Palliativmedizin (DGP). *Bundesgesundheitsblatt - Gesundheitsforschung - Gesundheitsschutz* **2025**.

60. Schwartz, J.; Batzler, Y.-N.; Schallenburger, M.; Scherg, A.; Jansen, J.; Meier, S.; Küppers, R.; Melching, H.; Grabenhorst, U.; Nehls, W.; Bausewein, C.; Neukirchen, M. Umgang mit assistiertem Suizid – Kenntnisse, Einstellungen und Erfahrungen von Mitgliedern der Deutschen Gesellschaft für Palliativmedizin. *Bundesgesundheitsblatt - Gesundheitsforschung - Gesundheitsschutz* **2025**, *68* (2), 141–149.
61. Dörmann, L.; Nauck, F.; Wolf-Ostermann, K.; Stanze, H. "I Should at Least Have the Feeling That It [...] Really Comes from Within": Professional Nursing Views on Assisted Suicide. *Palliat. Med. Rep.* **2023**, *4* (1), 175–184.
62. Jentschke, E.; Rabe, A.; Armbrrecht, H.; Lang, F. R.; Heckel, M. Sterbewünsche im Kontext stationärer Altenpflegeeinrichtungen – Belastungen und Bedürfnisse von Pflegenden sowie Aspekte für eine einrichtungsinterne Diskussion und Positionsfindung. *Z. Für Palliativmedizin* **2024**, *25* (06), 295–305.
63. Flügge, K.; Kirchner, C.; Seeger, Y.; Meyer, G. Einstellungen von Pflegenden zum assistierten Suizid in der stationären Langzeitpflege: Eine qualitative Interview-Studie. *Z. Für Palliativmedizin* **2024**, *25* (02), 85–93.
64. German Clinical Trials Register. Requests of Assisted Suicide from Older People in Inpatient and Outpatient Long-Term Care - Professional Care Handling and Suicide Prevention. Available online: <https://drks.de/search/en/trial/DRKS00035822> (accessed 04 November 2025).
65. O.Nyumba, T.; Wilson, K.; Derrick, C. J.; Mukherjee, N. The Use of Focus Group Discussion Methodology: Insights from Two Decades of Application in Conservation. *Methods Ecol. Evol.* **2018**, *9* (1), 20–32.
66. Krueger, R. A.; Casey, M. A. *Focus Groups: A Practical Guide for Applied Research*, 5th ed.; SAGE: Los Angeles, London, New Delhi, Singapore, Washington DC, **2015**.
67. Tong, A.; Sainsbury, P.; Craig, J. Consolidated Criteria for Reporting Qualitative Research (COREQ): A 32-Item Checklist for Interviews and Focus Groups. *Int. J. Qual. Health Care* **2007**, *19* (6), 349–357.
68. World Health Organization. Rebuilding for Sustainability and Resilience: Strengthening the Integrated Delivery of Long-Term Care in the European Region, 2022. WHO Regional Office for Europe: Copenhagen, **2022**. Available online: <https://www.who.int/europe/publications/i/item/WHO-EURO-2022-5330-45095-64318> (accessed 04 November 2025).
69. Lander, J.; Wallraf, S.; Pieper, D.; Klawunn, R.; Altawil, H.; Dierks, M.-L.; John, C. Recruiting Participants for Focus Groups in Health Research: A Meta-Research Study. *BMC Med. Res. Methodol.* **2025**, *25* (1), 9.
70. VERBI Software. MAXQDA 2024, Release 24.0; VERBI Software: Berlin, Germany, **2024**. Available online: <https://www.maxqda.com/> (accessed 04 November 2025).
71. Mayring, P. *Qualitative Content Analysis: A Step-by-Step Guide*; SAGE: London Thousand Oaks, California New, Delhi, Singapore, **2022**.
72. Ahmed, S. K. The Pillars of Trustworthiness in Qualitative Research. *J. Med. Surg. Public Health* **2024**, *2*, 100051.
73. Birnbacher, D. Moralische Empfindungen und Intuitionen. In *Handbuch Angewandte Ethik*; Neuhäuser, C., Raters, M.-L., Stoecker, R., Eds.; J.B. Metzler: Stuttgart, **2023**; pp 209–214.
74. Haidt, J. The Emotional Dog and Its Rational Tail: A Social Intuitionist Approach to Moral Judgment. *Psychol. Rev.* **2001**, *108* (4), 814–834.
75. Goldbach, M.; Riedel, A.; Lehmeier, S. Entstehung und Wirkung moralischen Belastungserlebens bei Pflegefachpersonen: Ein deskriptives Modell der Zusammenhänge eines komplexen Phänomens. In *Moralische Belastung von Pflegefachpersonen*; Riedel, A., Lehmeier, S., Goldbach, M., Eds.; Springer: Berlin, Heidelberg, **2023**; pp 35–68.
76. Tangney, J. P.; Stuewig, J.; Mashek, D. J. Moral Emotions and Moral Behavior. *Annu. Rev. Psychol.* **2007**, *58* (1), 345–372.
77. Lechasseur, K.; Caux, C.; Dollé, S.; Legault, A. Ethical Competence: An Integrative Review. *Nurs. Ethics* **2018**, *25* (6), 694–706.
78. Großmaß, R. Ethik als Professionsethik. Eine Konzeption für das berufliche Handeln in sozialen Arbeitsfeldern, in der öffentlichen Verwaltung und in der Polizei. In *Ethik in der beruflichen Bildung. Grundfragen, Aufgaben, Konzeptionen*; Verlag Barbara Budrich: Opladen, Berlin, Toronto, **2024**; pp 83–102.
79. Peisah, C.; Sheppard, A.; Leung, K. C. Objections to Assisted Dying within Institutions: Systemic Solutions for Rapprochement. *BMC Med. Ethics* **2023**, *24* (1), 100.

80. Monteverde, S. Grundlagen der Pflegeethik. In *Handbuch Pflegeethik: Ethisch denken und handeln in den Praxisfeldern der Pflege*; Monteverde, S., Ed.; Kohlhammer: Stuttgart, 2020; pp 21–44.
81. Morley, G.; Field, R. B. The Moral Distress Model Revisited: Integrating Nurses' Experiences in the United States and United Kingdom. *J. Clin. Ethics* 2025, 36 (2), 132–151.
82. Morley, G.; Bena, J. F.; Morrison, S. L.; Albert, N. M. Sub-Categories of Moral Distress among Nurses: A Descriptive Longitudinal Study. *Nurs. Ethics* 2023, 30 (6), 885–903.
83. Bustin, H.; Jamieson, I.; Seay, C.; Reid, K. A Meta-synthesis Exploring Nurses' Experiences of Assisted Dying and Participation Decision-making. *J. Clin. Nurs.* 2024, 33 (2), 710–723.
84. Wibisono, S.; Minto, K.; Lizzio-Wilson, M.; Thomas, E. F.; Crane, M.; Molenberghs, P.; Kho, M.; Amiot, C. E.; Decety, J.; Breen, L. J.; Noonan, K.; Forbat, L.; Louis, W. Attitudes Toward and Experience With Assisted-Death Services and Psychological Implications for Health Practitioners: A Narrative Systematic Review. *OMEGA - J. Death Dying* 2025, 91 (2), 590–612.
85. Parra Jounou, I.; Triviño-Caballero, R.; Cruz-Piqueras, M. Correction: For, against, and beyond: Healthcare Professionals' Positions on Medical Assistance in Dying in Spain. *BMC Med. Ethics* 2024, 25 (1), 99.
86. Sedgwick, M.; Brassolotto, J.; Manduca-Barone, A. Rural Healthcare Professionals' Participation in Medical Assistance in Dying (MAiD): Beyond a Binary Decision. *BMC Palliat. Care* 2024, 23 (1), 107.
87. De Leo, D. Suicide and Ageism. *Eur. Psychiatry* 2022, 65 (S1), S32–S32.
88. Eriksson, E.; Säfströmer, K.; Hultsjö, S.; Persdotter, A.; Wärdig, R. The Importance of Time: Nurses' Experiences of Working With Suicide Prevention and Suicide Risk Assessment in the Care of Older People. *Int. J. Older People Nurs.* 2024, 19 (5), e12650.
89. Gomez-Virseda, C.; Gastmans, C. Conscientious Objection in Euthanasia and Assisted Suicide: A Systematic Review. *PLOS One* 2025, 20 (6), e0326142.
90. Petersen, J.; Rösler, U.; Meyer, G.; Luderer, C. Interventionen, um Moral Distress in der ambulanten Pflege zu reduzieren: eine Interviewstudie mit Pflegenden und Pflegeethiker*innen. *Z. Für Evidenz Fortbild. Qual. Im Gesundheitswesen* 2025, 196, 15–21.
91. Pirkis, J.; Dandona, R.; Silverman, M.; Khan, M.; Hawton, K. Preventing Suicide: A Public Health Approach to a Global Problem. *Lancet Public Health* 2024, 9 (10), e787–e795.
92. Ahokas, F.; Silén, M.; Höglund, A. T.; Hemberg, J. Care Leaders' Moral Distress in Older Adult Care: A Scoping Review. *Nurs. Ethics* 2025, 32 (5), 1545–1563.
93. Lamoureux, S.; Mitchell, A. E.; Forster, E. M. Moral Distress among Acute Mental Health Nurses: A Systematic Review. *Nurs. Ethics* 2024, 31 (7), 1178–1195.
94. Galanis, P.; Iliopoulou, K.; Katsiroumpa, A.; Moisoglou, I.; Igoumenidis, M. Moral Resilience Protects Nurses from Moral Distress and Moral Injury. *Nurs. Ethics* 2025, 32 (5), 1617–1628.

Disclaimer/Publisher's Note: The statements, opinions and data contained in all publications are solely those of the individual author(s) and contributor(s) and not of MDPI and/or the editor(s). MDPI and/or the editor(s) disclaim responsibility for any injury to people or property resulting from any ideas, methods, instructions or products referred to in the content.