EUROPEAN PSYCHIATRIC ASSOCIATION

Ethical Principles and Dilemmas in Psychiatry: EPA Code of Ethics – ethical guide for European psychiatrists

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Overview

- Committee on Ethics of the EPA
- Code of Ethics
  - Fundamental values
  - Ethical principles
  - Specific situations
- Euthanasia in Europe
- Stance from different organizations

Committee on Ethics Members 2024

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Ethics

- The term „ethics" captures a variety of moral standards and values being held by a person within himself (Jain, Kuppili et al. 2017).
- The necessity to develop specific ethical standards for psychiatry was formally noted by the American Psychiatric Association (APA) as the consequence of malpractice observed in the 1960s. APA developed the first code of ethics for its members in 1970.
- There is a complex relationship between medical ethics and legal standards which is not unproblematic
- In biomedical ethics a widely used general concept is the one Beauchamp and Childress who formulated four basic principals

Principles of ethical guidelines

- Respect for persons - Autonomy
- Beneficence (doing good)
- Non maleficence (not doing harm), and
- justice (treating people fairly)

These are cornerstones of modern ethical codes for the health professions

Based on Beauchamp and Childress, 1983; Hoop et al. 2008; Ethics and Culture

Important Areas for ethical considerations

(selected)

- Doctor patient relationship
- Informed consent procedures
- Supported decision making
- Substituted decisions
- Detention, Coercion, involuntary treatment
- Resource allocation
- Data protection
- Duty on Confidentiality
- **End of life decisions (e.g. assisted suicide)**

- Interprofessional relationship
- Psychiatry and society
- Psychiatric research

EPA Code of Ethics

Compiled by the EPA Committee on ethical issues 2019/21
(Chair: Danuta Wasserman)
Approved by the EPA General Assembly on 11 April 2021

https://www.europsy.net/app/uploads/2021/06/EPA-Code-of-Ethics_March-2021-GA-approved.pdf

Revised 2025
https://www.europsy.net/app/uploads/2025/01/EPA-Code-of-Ethics_2025.pdf

Fundamental values

- Psychiatrists must uphold the responsibilities and ethical demands of the medical profession and specific to psychiatry and working with mental health.
- Psychiatrists should consider the ethical principles of respect for autonomy, beneficence, non-maleficence and justice.
- Practicing ethical psychiatry requires awareness, sensitivity, and empathy for the patient as an individual, including their cultural values and beliefs.
- Psychiatrists hold the obligation to advocate for universal health care for everyone, and fair and appropriate prevention, care, treatment, and rehabilitation for persons with mental disorders within available resources in their respective country.
- Psychiatrists shall not discriminate on the basis of age, race, ethnicity, nationality, religion, sex, gender, sexual orientation, social standing, criminal background, disability, disease, or political affiliations.
- Psychiatrists must ensure that they do not engage in any form of abuse or exploitation of the patient's trust or vulnerability.
- Instead, psychiatrists should promote the human rights of patients.

Psychiatrists have a responsibility to

- Ensure their knowledge and practices are up-to-date through continuing education;
- Be aware of the best available treatments for their patients in their respective country;
- Maintain therapeutic boundaries;
- Guard their health and mental wellbeing and seek help when necessary.

Specific aspects of detention and compulsion

- Avoidance of all involuntary measures whenever possible ("last resort" paradigm)
- Avoid substituted decisions whenever possible
- Promote supported decisions
- Promote and support advance care planning
- Use, when not avoidable, the least restrictive alternative for time shortest duration possible
- Consider problems of acting in the interest of third parties
- Avoid any misuse of psychiatric institutions

Understanding Ethical Principles

- Each principle plays a crucial role in guiding practitioners through challenging decisions, ensuring that patient rights and welfare remain a priority.
- Conflict is inevitable. Ethical principles provide the framework/ tools which may facilitate individuals and society to resolve conflict in a fair, just and moral manner.
- In wartime, crises etc. these principles can be challenged, requiring psychiatrists to navigate complex moral dilemmas while prioritizing patient welfare.

Ethical dilemmas

- Value conflicts, no clear consensus as to the “right” thing to do.
- A conflict between moral obligations that are difficult to reconcile and require moral reasoning.
- Situations necessitating a choice between two equal (usually undesirable) alternatives.

The Role of Crisis Situations

Crisis situations can complicate ethical decision-making. Factors such as limited

- resources,
- heightened emotions, and
- urgent needs

can pressure psychiatrists, making it essential to remain grounded in ethical principles while addressing immediate concerns.

Patient Autonomy vs. Safety

- Balancing patient autonomy with safety is a significant challenge.
- Psychiatrists must weigh the right of patients to make their own choices against the need to protect them from potential harm, especially in acute settings.

Informed Consent Challenges

- Obtaining informed consent during crises can be complex.
- Patients may be unable to fully comprehend their situation, necessitating a careful approach to ensure they are adequately informed while respecting their rights.

Resource Allocation Issues

- During crises, the allocation of limited resources poses ethical dilemmas.
- Psychiatrists must navigate decisions regarding prioritization, ensuring fair access while considering the urgency of individual patient needs.

"Ethical challenges in contemporary psychiatry: an overview and an appraisal of possible strategies and research needs"

Identify topics that pose difficult ethical challenges in contemporary psychiatry:

- the relationships between human rights and mental health care, research and training
- human rights and mental health legislation
- digital psychiatry
- early intervention in psychiatry
- **end-of-life decisions by people with mental health conditions;**
- conflicts of interests in clinical practice, training and research
- and the role of people with lived experience and family/informal supporters in shaping the agenda of mental health care, policy, research and training

Galderisi S, Appelbaum PS, Gill N, Gooding P, Herrman H, Melillo A, Myrick K, Pathare S, Savage M, Szmukler G, Torous J. Ethical challenges in contemporary psychiatry: an overview and an appraisal of possible strategies and research needs. World Psychiatry. 2024 Oct;23(3):364-386.

- Confrontation with radical and rapid social transformations;
- innovations whose consequences are difficult to predict;
- increased awareness of and, at the same time, obvious violations of human rights;
- increased focus on individual needs and autonomy that are likely to clash with decreasing societal resources;
- and increased demand for full participation in all aspects of mental health care, education, research and policy by PWLE and their family/informal supporters.

- Need of rethinking of policies, services, training, attitudes, research methods and codes of ethics in psychiatry.
- Need of engagement with major stakeholders and open-minded discussions, commitment to implementation and monitoring of locally agreed solutions across health and social policy, clinical care, training and research.

Galderisi S, Appelbaum PS, Gill N, Gooding P, Herrman H, Melillo A, Myrick K, Pathare S, Savage M, Szmukler G, Torous J. Ethical challenges in contemporary psychiatry: an overview and an appraisal of possible strategies and research needs. World Psychiatry. 2024 Oct;23(3):364-386.

Role of the Committee on Ethical Issues

- Dissemination of the Code of Ethics
- Knowledge and Experience exchange with colleagues and NPAs
- Share knowledge and skills of alternatives to coercion
- Ethical exchange, counselling, case-discussions
- explicit use of formal clinical ethics support
- more active and systematic use of implicit ways of working with moral concerns and ethical challenges in practice, such as team meetings, spontaneous discussions, and teaching
- Critical discussion and advice on the legal regulation of coercive measures
- Exchange of information on good clinical practice
- Initiation of pilot projects for the reduction of coercive measures
- Advice on the harmonization of Code of Ethics with the Code of Ethics of the EPA and the NPAs
- Cooperation with service users and care givers
- Reduction of coercion

The EPA Committee on Ethical Issues

- is responsible for giving its contribution to the EPA position statements on ethical subjects,
- collaborating with the National Psychiatric Associations to promote ethical standards in psychiatric research, teaching and care,
- organizing events during the EPA congresses as well as during independent meetings relevant to ethical issues for psychiatry in Europe and
- actively gathering information through surveys on how ethics in psychiatry is being managed in Europe and elsewhere

Specific Situation

Selection of Sex

Psychiatrist should not participate in decisions to terminate pregnancy for the purpose of sex selection.

Health guiding principles for decision-making about life-sustaining measures

- **Principle 1:** All decision-making must reflect respect for life and the patient's right to know and choose.
- **Principle 2:** All decision-making must meet the standards of good medical practice.
- **Principle 3:** All efforts must be made to obtain the appropriate consent through a collaborative approach.
- **Principle 4:** There must be transparency in and accountability for all decision-making

https://www.england.nhs.uk/wp-content/uploads/2022/03/universal-principles-for-advance-care-planning.pdf_access 03032025

Definitions

Euthanasia

Act regulated by law, by which **a third party** (a physician or qualified healthcare practitioner) **intentionally terminates a patient's life** by the patient's request

- The healthcare practitioner is administering the lethal prescription

Physician assisted suicide (PAS)

Healthcare practitioner helps **provide the means** to a patient under the patient's request, which will **intentionally terminate the patient's life**

- The patient **will self-administer** the prescription

Medical assistance in dying (MAID)

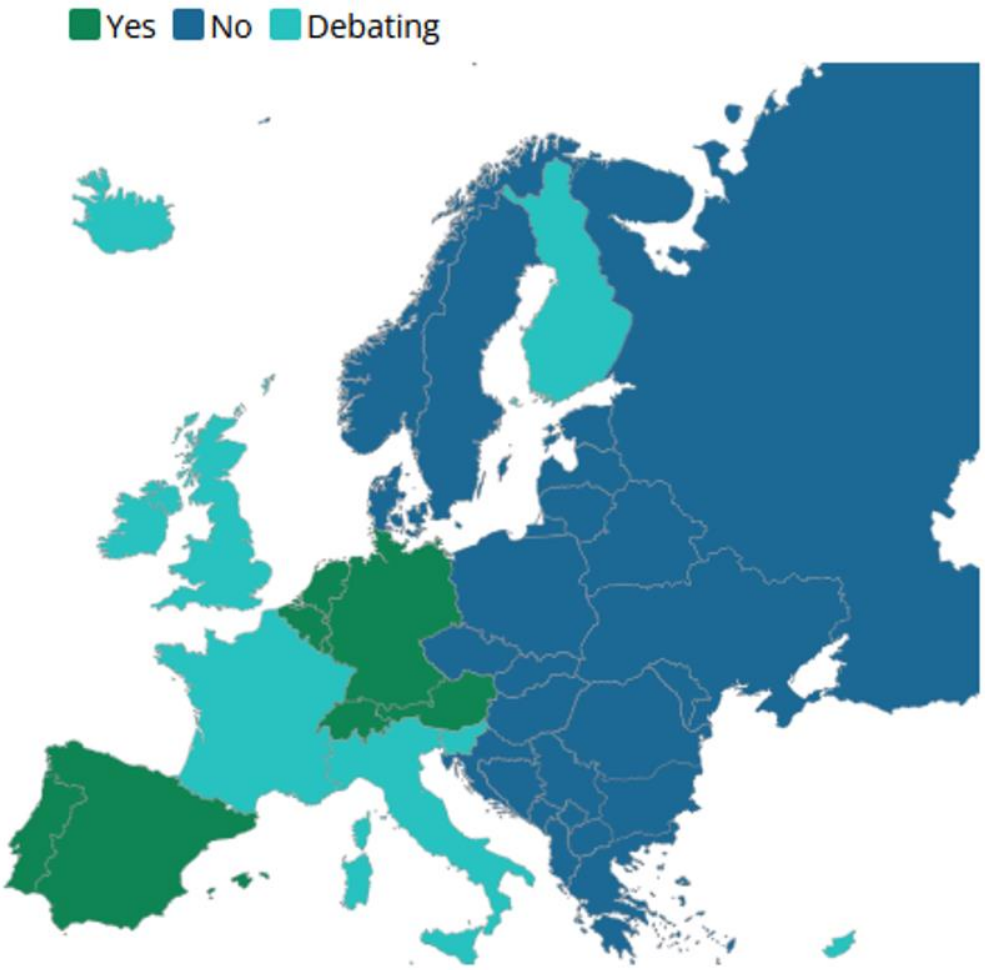
The term used in the Canada, combines legal voluntary form of euthanasia and physician assisted suicide

Assisted suicide

A physician or **healthcare practitioner would not be directly involved** (such as doing an assessment or directly providing the means) and usually another third member or organization would assist in providing the patient with the means for self-administered suicide

Emanuel, E. et al. 2016 JAMA

Europe



Euthanasia or Assisted Suicide

- **Belgium:** Assisted dying legalised in 2002 by the Belgian Act on Euthanasia.
- **The Netherlands:** Voluntary euthanasia or assisted dying have been legal in since 2001.
- **Luxembourg:** Assisted dying was legalised in 2008 when the Parliament approved a Law on the Right to Die with Dignity.
- **Spain:** passed a law to legalise euthanasia and assisted suicide in 2021.
- **Portugal:** legalised euthanasia for terminally ill people in great suffering in 2023.
- **Germany:** Constitutional Court found that there is a constitutional right to a self-determined death in 2020.
- **Italy:** Constitutional Court ruled in 2019 that assisting a suicide is not always a crime.
- **Austria:** Assisted dying was legalised by the Parliament in 2022.
- **Switzerland:** has allowed assisted suicide since 1942.

https://www.dignityindying.org.uk/assisted-dying/assisted-dying-around-the-world/europe/
https://www.euronews.com/health/2024/11/29/which-countries-in-europe-allow-assisted-suicide-and-euthanasia

Germany

Assisted suicide was decriminalized in 2020 but regulations remain undefined.

For Mental Illness: Currently unclear

Assisted Suicide, 2020, the Federal Constitutional Court declared Section 217 of the German Criminal Code unconstitutional. This section had criminalized commercial promotion of suicide assistance.
2023, two proposed bills aimed at regulating assisted suicide were presented but did not achieve a majority vote. As a result, there remains a legal vacuum, and the practice operates without specific statutory guidelines.

Euthanasia remains illegal in Germany under Section 216 of the Criminal Code.
This provision criminalizes killing at the request of the victim, regardless of the circumstances.

Germany

Passive or indirect euthanasia is not illegal, such as when doctors administer pain-relieving medication, for example in the final stages of cancer with the patient's consent. Even if the treatment shortens the patient's life. Doctors are also permitted to withhold, limit or terminate medical treatment, such as artificial nutrition or artificial respiration, if this is in accordance with the patient's actual wishes.

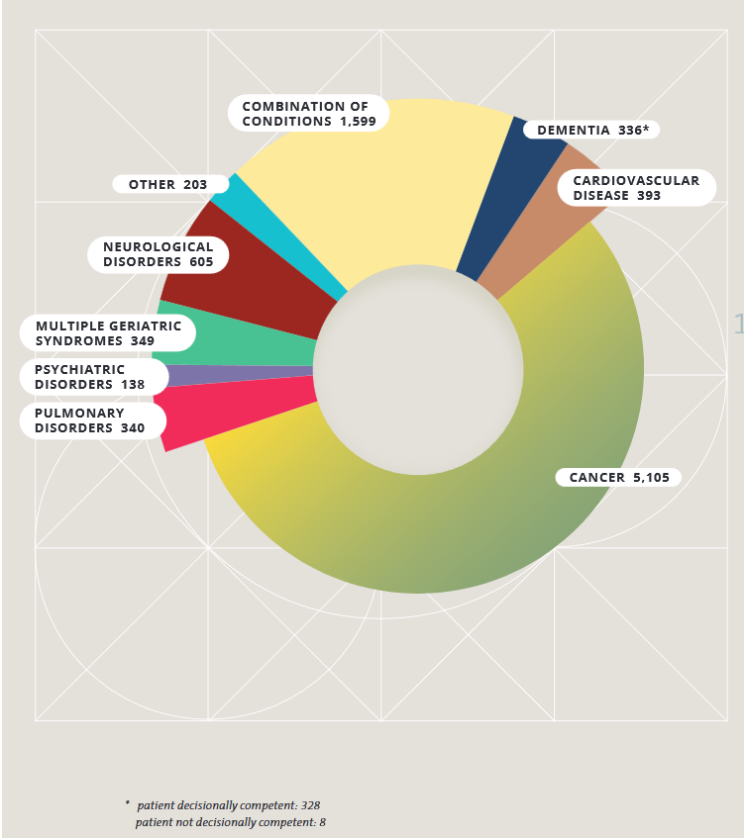
Mental Illness:

The 2020 Federal Constitutional Court ruling did not specifically address the issue of assisted suicide in the context of mental illness.

Given the absence of explicit legislation, the application of assisted suicide for individuals with mental health conditions remains a complex and ethically sensitive matter.

In practice, such cases would require meticulous assessment to ensure that the individual's decision is autonomous, well-considered, and free from external pressures.

Nature of Conditions - Regional Euthanasia Review Committees (RTEs)



file:///C:/Users/meryam1503/Downloads/RTE+-Annual-report-2023.pdf_access 01032025

Psychiatric Disorder - Regional Euthanasia Review Committees (RTEs)

- In 2023, 138 euthanasia notifications concerned patients whose suffering was (largely) caused by one or more psychiatric disorders.
- In 56 cases the physician performing euthanasia was a psychiatrist,
- in 35 cases a general practitioner and
- in 10 instances a consultant (including elderly-care specialists).
- In the other 37 cases the physician fell into the category 'other physician'.
- In 70 cases the physician performing euthanasia was affiliated with the Euthanasia Expertise Centre (EE).

- If a patient requests euthanasia because they are suffering from one or more psychiatric disorders, the physician must exercise particular caution.

file:///C:/Users/meryam1503/Downloads/RTE+-Annual-report-2023.pdf_access 01032025

Requests for Medical Assistance in Dying by Young Dutch People With Psychiatric Disorders

Key Points

Question:
What are outcomes in young people requesting medical assistance in dying based on psychiatric suffering (MAID-PS)?

Findings:
In this cohort study of 397 applications for MAID-PS by 353 Dutch people younger than 24 years between 2012 and 2021, 47% of applications were retracted and 45% were rejected.
For 3% of applications, patients died by MAID, and for 4%, the patient died by suicide during the application process.

Meaning:
The findings suggest that there is an urgent need for more knowledge about persistent death wishes and effective suicide prevention strategies for this group.

Schweren et al., 2025, JAMA Psychiatry.

The similarities among policies for euthanasia and AS

- **Disease status**:
  - Unbearable pain with no expected improvement
  - Require the disease to be terminal or that death is in the foreseeable future
    - Exception: law in the Benelux countries allows patients with unbearable mental or physical suffering, and without having a terminal illness
    - Exception: this is no longer the case with the new Canadian MAID law which does not require the disease to be terminal nor the death in the foreseeable future, and considering allowing patients with mental illnesses, discussion is ongoing
- Usually **at least 2 independent physicians** confirm eligibility
  - 1 would be patients attending physician
  - 1 physician would be an independent consultant
- **Only in some cases, a psychiatrists or psychologist might be required** to evaluate the patient, ensuring the patient's decision-making capacity is not influenced by any psychological conditions

The similarities among policies

- **Age**: often needs to be an adult of **18 years or older**
  - Exception: Belgium (no age requirement), the Netherlands (12 years), Colombia (6 years)
- Ensure completely **voluntary request**
  - **Written requests or application**, often **multiple requests** required, including oral confirmation before prescribing or administering lethal prescription
  - May have **1 to 2 witnesses** to the request
- **Waiting ("cooling off") period** vary from no period to 1 month
- To be **resident** in the country
- Policies vary in whether there needs to be a witness present during the administration of the prescription

Difficulties in diagnostics

- **Since ordinary physicians are not specialized in psychiatry, the underlying mood disorders can be missed**
- There is no gold standard for establishing of decision-making capacity and physicians should routinely include psychiatrists in these evaluations, which seldom takes place
- Patients may be evaluated by a new psychiatrist who does not know the patient which can impact the correctness of the evaluation and can limit the detectability of a treatable psychiatric disorder
- Judgement of decision-making capacity is very difficult

Primary motivations for seeking euthanasia or AS

Patients most often report fear:

- Loss of dignity
- Loss of autonomy
- Inability to enjoy life and regular activities
- Burden to family
- Current pain
- **Mental distress**

Hedberg, K. *Ann Intern Med.* 2017;167(8):579-583.
Hedberg, K., & Tolle, S. (2009). *Journal of Clinical Ethics*, *20*(2), 133-135.

Psychiatric diagnoses in euthanasia or PAS

- **Depression and other mood disorders**
- **Personality disorders: borderline personality disorder**
- **Patients who are susceptible to suicidal behaviour are also the ones most frequently seeking euthanasia and physician assisted suicide**
- In a Dutch Study (2016) conducted over a 4-year period of psychiatric patients that underwent euthanasia or physician assisted suicide:
  - **Half of the patients had a history of suicide attempts** (52%)
  - **Most patients were socially isolated or lonely** (56%)

Kim, S.Y. et al. 2016 JAMA Psychiatry;
Chochinov, H.M. et al. 1998 Psychosomatics.
Dierickx, S. et al. 2017 BMC Psychiatry;
Thienpont, L. et al. 2015 BMJ Open

Treatment refusal in psychiatric patients with euthanasia and PAS

The study in the Netherlands showed that **over half of the psychiatric patients** (56%) who underwent physician assisted suicide **refused effective treatment**

- Reasons for refusal:
  - **Lack of motivation**
  - **Concern** about adverse effects
  - **Concern** about efficacy

The same reasons for refusing treatment are core symptoms of depression

Kim, S.Y. et al. 2016 JAMA Psychiatry.

Public attitudes towards euthanasia and PAS

Public opinion differs depending on the wording and framing of the questions asked but general perceptions in some countries appear to be moving from a **'quantity of life'** to a **'quality of life'** mindset

Professionals have concerns that if legalized, the potential exists for:

- Pressure on vulnerable persons
- Pressure on minorities
- Pressure on indigenous populations
- Pressure on disabled and special need persons
- Pressure from the family who have no emotional or other capacity to take of sick and impaired persons
- Underdevelopment or devaluation of palliative care due to economical reasons

Euthanasia is a sensitive topic and support for it or against depends on many different factors such as the amount of suffering being endured, type of illness, religious denomination, country's health care system and socioeconomic status of patients

Emanuel, E. et al. 2016 JAMA; Jain, G. & Sahni, SP. 2018 Criminology and Law Review

Physician attitudes towards euthanasia and PAS

- Physician's support for euthanasia and physician assisted suicide is consistently **lower** than support from the general public
- Support for euthanasia and physician assisted suicide is highest among physicians in **the Netherlands** (86%) and **Belgium** (81%), compared to:
    - **The Netherlands** (86%)
    - **Belgium** (81%)
    - **Ireland** (67%)
    - **United States** (54%)
    - **Germany** (47%)
    - **United Kingdom** (47%)
    - **Italy** (42%)
    - **Spain** (36%)
    - **France** (30%)

Emanuel, E. et al. 2016 JAMA;
Crowley, P., Doran, K. and O'Caoimh, R. (2021) 'Euthanasia and physician-assisted suicide: Attitudes of Irish consultant physicians', Irish Medical Journal, 114(4), P328 (7pp). Available at: http://imj.ie/euthanasia-and-physician-assisted-suicide-attitudes-of-irish-consultant-physicians

Conflict for physicians and psychiatrists

- The **essence of medicine** is to **relieve the suffering of others and save lives**
- Euthanasia and physician assisted suicide is fundamentally inconsistent with this principle
- Throughout history **'do not kill'** has been an ethical absolute for medical professionals and still remains so even in regions where euthanasia and physician assisted suicide legally takes place
- It has been suggested that medical professionals should be able to conscientiously object to partake in the process of ending the lives of their patients

Boudreau, JD. & Somerville, MA. 2013 British Medical Bulletin; Sprung, CL. et al. 2018 Journal of Palliative Care

Potential implications of legalization

Emotional distress for physicians

- 86% of Dutch physicians dread the emotional burden of performing euthanasia
- Emotional impact can have personal and professional consequences

Identity

- Influence on identity as a psychiatrist

Routinization

- May no longer be reserved for extreme cases but become a routine practice for dying patients

Possible complications with the medical procedure

- Prolonged death, regaining consciousness after ingestion of lethal dose, seizures, vomiting, regurgitation of medication

Emanuel, E. et al. 2016 JAMA; Kelly, B. et al. 2019 Palliative and Supportive Care

Slippery slope argument

Slippery slope refers to the expansion of intentionally ending the life of patients who do not explicitly request for their life to be ended

Concern about performing euthanasia or physician assisted suicide on patients with:

- Mental illnesses
  - Anorexia Nervosa
- Dementia
- Minors
- Other vulnerable groups
  - Minorities; indigenous groups; disabled and special need persons; lonely elderly persons (90% who are sick but intellectually competent)

Emanuel, E. et al. 2016 JAMA

Psychiatric Patients
Children
Advanced Directives

EUTHANASIA

Adapted from Komrad, M. 2019; Komrad, M. "*You Need Help: A Step-by-Step Plan to Convince a Loved One to Get Counseling*"

Slippery slope in action

- Such expansion is inevitable; whoever is not eligible asks “why not us?” because of fairness, parity, and justice, and eventually, the same questions are asked by those who are not suffering from any illnesses
- **Once the door is open, strong advocates push to open it wider and wider**

“If thought can corrupt language, then language can corrupt thought”

George Orwell (https://journals.biologists.com/jcs/article/115/4/675/26934/If-thought-can-corrupt-language-then-language-can)

Slippery slope trajectory

Terminal

Non-terminal

Mental suffering

Children

Advanced directive

Mandated referral by consciences objections

Major mental illness

Minor mental illness

Uncomfortable lifestyle

Prisoners with life sentences

Proxy consent

Doctor-only consent (“mercy killing”)

Completed life/ tired of living

Over the counter suicide pill

Rational suicide

Euthanasia tourism

Adapted from Komrad, M. 2019

Komrad, M. "*You Need Help: A Step-by-Step Plan to Convince a Loved One to Get Counseling*"

Slippery slope steps in the philosophical aspects of life

- Belgium and the Netherlands are moving towards non-medical criteria for euthanasia eligibility called “completed life” or “tired of living”
- The same concept is also now being pushed in the United States by the ‘Completed Life Initiative’ organisation who are trying to promote PAS and related procedures

https://completedlife.org/mission/_access 01032025

Stance from different organizations

Revised declaration by the

World Medical Association (WMA)

Reiterates its strong commitment to the principles of medical ethics and that utmost respect has to be maintained for human life. Therefore, the WMA is firmly opposed to euthanasia and physician assisted suicide

It adds: “No physician should be forced to participate in euthanasia or assisted suicide, nor should any physician be obliged to make referral decisions to this end” - 2019

227th WMA Council, Helsinki, Finland, October 2024

Recommendations e. g.

All physicians should receive, during medical school and postgraduate training, education in child psychiatry and adolescent bio-psycho-social development, including education in the risk factors for suicide.

https://www.wma.net/policies-post/wma-statement-on-adolescent-suicide/_access 03032025

Stance from different organizations

American Medical Association (AMA)

Physician assisted suicide and euthanasia "is fundamentally **incompatible** with the physician's **role as healer**, would be difficult or impossible to control, and would pose **serious societal risks**"

- 2022

Stance from different organizations

American Psychiatric Association (APA)

"The American Psychiatric Associations, in concert with the American Medical Association's position on medical euthanasia, holds that a psychiatrist **should not prescribe or administer** any intervention to a **non-terminally ill person** for the purpose of **causing death**."

- 2017

Stance from different organizations

World Health Organization (WHO)

WHO recommends that governments do not consider assisted suicide and euthanasia until they have demonstrated the availability and practice of palliative care for their citizens

- 1990

World Health Organization. (1990). Cancer pain relief and palliative care: Report of a WHO Expert Committee [Technical Report Series 804]. Geneva, Switzerland

Code of Ethics - Specific Situations

Assisted suicide

A physician's duty, first and foremost, is the promotion of health, the reduction of suffering, and the protection of life.
The psychiatrist, among whose patients are some who are severely incapacitated and incompetent to reach an informed decision, should be particularly careful of actions that could lead to the death of those who cannot protect themselves because of their disability.
The psychiatrist should be aware that the views of a patient may be distorted by mental illness.
The psychiatrist's role is to treat the illness.

It is not a psychiatrist's duty to take part in assisted suicide.

Hippocrates 460 – 370 BC

"I will not give a fatal drug to anyone if I am asked… neither will I counsel any man to do so."

- The Hippocratic Oath