Perioperative Period\textsuperscript{1} in 2009 to which we contributed. The correspondence\textsuperscript{2} should be read in conjunction with this reply.

The purpose of publishing the guidelines was to:

(i) Ensure patients approaching the end of their life receive high-quality treatment until they die with dignity, in accordance with General Medical Council guidance which has subsequently been published.\textsuperscript{4} The editorial does not reference this practice defining document.

(ii) Protect healthcare professionals from retrospective accusations of assault arising from resuscitative interventions for which consent had not been granted, and from assisting euthanasia by pharmacologically inducing cardiopulmonary instability and then actively withholding cardiopulmonary resuscitation (CPR).

Definitions are so essential to this subject that a separate section of the AAGBI guidelines was dedicated to them. The definition of CPR in the guidelines was taken from the Joint Statement from the British Medical Association, The Resuscitation Council (UK), and the Royal College of Nursing 2007,\textsuperscript{5} which stated: ‘CPR is undertaken in an attempt to restore breathing and spontaneous circulation in a patient in cardiac and/or respiratory arrest. CPR . . . usually includes chest compressions, attempted defibrillation with electric shocks, injection of drugs and ventilation of the lungs’. The much narrower definition of CPR given by Knipe and Hardman is not referenced.

In our opinion, the ‘improvements’ suggested by the authors make the two purposes stated above for publishing the AAGBI guidelines less likely. The authors’ plea for simplification and greater patient autonomy cannot be fulfilled by arguing that a DNAR decision implies refusal of the elements of CPR only after cardiac arrest has taken place. If that was the case, it would hypothetically be defensible to intubate and ventilate the lungs of a DNAR patient in respiratory failure at ward level before cardiorespiratory arrest, which is clearly what the patient has refused by implementation of their DNAR decision.

Autonomy is only achieved by full participation by individuals in making informed choices about their healthcare. The Lay Representative on the AAGBI working party had input to all discussions during the process and was in concordance with the final position reached by the other members including legal representatives and others with ethical expertise. The guidelines sought to offer options, using accurate definitions and explicit legal and ethical reasoning, to patients and healthcare professionals rather than simplified processes requiring subjective interpretation of concepts as suggested by Knipe and Hardman.

The final point we wish to refute is the suggestion by Knipe and Hardman that by implementing the AAGBI guidelines ‘Patients are given the choice of either altering their DNAR order or not undergoing the . . . operation’.\textsuperscript{3} The three option approach along with the DNAR management consent form in Appendix 1 of the AAGBI guidelines clearly lets the patient, proxy decision maker, or doctor in charge of the patient’s care along with relatives and carers, if indicated, decide what resuscitative measures, if any, will be embarked upon and outlines a process for conflict resolution. There is no suggestion of coercion anywhere in the document, and we are disappointed that the authors are of the opinion that the AAGBI guidelines will ‘act to encourage patients towards a course of action that they would not choose freely’. This accusation is unjustified. Those involved in producing the guidelines had motives which were patient centred at all times.

\textbf{Declaration of interest}


M. E. McBrien*

G. Heyburn

Belfast, UK

*E-mail: michael.mcibrien@btinternet.com


4 General Medical Council. Treatment and Care Towards the End of Life: Good Practice in Decision Making. London, 2010

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\textbf{Autonomy and the possibility of perioperative euthanasia}

Editor—I was interested to read Knipe and Hardman’s\textsuperscript{1} editorial on the use of do not attempt resuscitation (DNAR) orders in the perioperative period. They make several important points, not least the central role of patient autonomy in modern medical thinking.\textsuperscript{2} They conclude that current guidance on cardiopulmonary resuscitation (CPR) in the perioperative period could be distilled to a binary patient choice of continuing or suspending a DNAR order.

However, I am concerned that this over-simplifies what is in fact a highly nuanced problem and by having patient autonomy trump all other moral and legal factors limits consideration of these. To be truly autonomous, a full discussion with the patient or their representative would need to take place before their operation as to what they would or would not consent to. Despite this, the authors go on to state that ‘separate decisions will need to be made for each individual patient about what other treatment would be appropriate for them’. It is hard to reconcile these two viewpoints unless patient autonomy is held to be one factor out of many. The
acknowledgement that there is much overlap between anaesthesia and CPR is the correct one and to then contend in the conclusion that they should be recognized as entirely separate concepts is not supported by logic or clinical experience.\textsuperscript{3} It is precisely for this reason that many more options exist than simply ‘continue’ or ‘suspend’. On the sliding scale of intervention, with CPR at one end, it makes no more sense to draw an arbitrary line at that point to stop life-sustaining treatment, while making every effort up until then, than it does at any other.

The second area in which this new approach is fraught with both legal and ethical problems is with respect to euthanasia. This question raises an important issue in perioperative period. This ‘doctrine of double effect’ relies upon knowledge of the primary intention of the treating doctor.\textsuperscript{5} This presents a fine line over which it is easy to conceive of anaesthesia with the primary intention of euthanasia rather than the absence of sensation and relief of pain. Although this is likely to be exceptionally rare, it merits more consideration in any proposed guideline.

For these reasons, I would suggest that the current guideline\textsuperscript{6} represents the correct approach, with a presumption in favour of suspending a DNAR order perioperatively. This would limit the prospect of any suggestion of euthanasia and allow for a more balanced view of patient autonomy than the black and white approach proposed.

**Declaration of interest**

None declared.

T. E. Green
Dorset, UK
E-mail: tomgreen@doctors.org.uk

2 Re T (Adult: Refusal of Treatment) [1993] Fam 95
3 McBrian M, Heyburn G. Do not attempt resuscitation orders in the peri-operative period. Anaesthesia 2006; \textbf{61}: 625–7
4 Airedale NHS Trust v Bland [1993] AC 789

doi:10.1093/bja/aeu174

**Does local infiltration anaesthesia really provide longer analgesia than intrathecal morphine?**

Editor—I read the article by Kucha\’lik and colleagues\textsuperscript{1} with interest. However, their conclusion that local infiltration anaesthesia (LIA) provides better pain relief up to 24 h compared with the intrathecal morphine has to be challenged. I believe that the study methodology is flawed and has favoured the LIA group by injecting a treatment drug mixture (ropivacaine, ketorolac, and epinephrine) at 24 h after the surgical procedure while injecting a placebo in the intrathecal morphine group.

As the authors state in their discussion, intrathecal morphine has been shown to provide good pain relief up to 24 h after injection, so injecting a treatment drug in the other group (LIA group) after the morphine effect would have worn off (in the ITM group) can only serve to advantage the LIA group. I am unclear why the authors chose to do this. If no top ups of the LIA injection were given, maybe then the results would have had more significance.

**Declaration of interest**

None declared.

K. Mukhtar
St Helens and Knowsley, UK
E-mail: karim.mukhtar@sthh.nhs.uk

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**Neuraxial anaesthesia in patients with scoliosis**

Editor—Dr Bowens and colleagues\textsuperscript{1} have provided great help to those planning epidural and spinal blocks in scoliotic patients, with the publication of their recent paper. For many years, in our obstetric patients, we have followed the second of their recommendations with regard to epidural needle insertion, by using a midline approach, with the needle angled towards the convex side of the curve, with mostly satisfactory results, although increased volumes of local anaesthetic were often required. We have investigated 21 of our obstetric patients with idiopathic scoliosis, using epidural contrast injection and fluoroscopic screening \(~24\ h) post-partum,\textsuperscript{2, 3} after informed consent and ethics committee approval. A fairly consistent finding, present in 17 (81\%) of these patients, was that the first 10–12 ml of contrast flowed most