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 CPR, and while the authors acknowledge that inducing anaesthesia with no intention to treat an ensuing cardiac arrest could be seen as euthanasia, it is dismissed as requiring ‘no more thought’. While in palliative care, it is a well-established principle of law that the administration of analgesics and sedative drugs which may incidentally shorten life is lawful,\textsuperscript{4} this may not be the case in the 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.

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\textsuperscript{1} Knipe M, Hardman G. Past, present, and future of ‘Do not attempt resuscitation’ orders in the perioperative period. \textit{Br J Anaesth} 2013; \textbf{111}: 861–3

\textsuperscript{2} Re T (Adult: Refusal of Treatment) [1993] Fam 95

\textsuperscript{3} McBrien M, Heyburn G. Do not attempt resuscitation orders in the peri-operative period. Anesthesia 2006; \textbf{61}: 625–7

\textsuperscript{4} Airedale NHS Trust v Bland [1993] AC 789


**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 after 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.

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\textsuperscript{1} Kucha\’lik J, Granath B, Ljunggren A, Magnuson A, Lundin A Gupta A. Postoperative pain relief after total hip arthroplasty: a randomized, double-blind comparison between intrathecal morphine and local infiltration analgesia. \textit{Br J Anaesth} 2013; \textbf{111}: 793–9