Guidelines

Implementing advance care plans in the peri-operative period, including plans for cardiopulmonary resuscitation: Association of Anaesthetists clinical practice guideline

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Summary

Contemporary guidance takes a patient-centred approach and recommends discussing and planning treatments that should be considered, not just those that should be withheld. Although some organisations and communities still use specific DNACPR (do not attempt cardiopulmonary resuscitation) forms to recommend that cardiopulmonary resuscitation is not attempted, this approach has been shown to have disadvantages and is no longer regarded as best practice. The following guidelines have been produced in response to this change. They are designed to help anaesthetists, as part of the wider healthcare team, to implement and respond to advance care planning documents before and during procedures. The guidelines apply to all procedures, however minor and low risk they are considered to be, and the same ethical and legal principles apply to procedures carried out under local or regional anaesthesia and/or conscious sedation, as well as to those under general anaesthesia.

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This is a consensus document produced by expert members of a Working Party established by the Association of Anaesthetists. It has been seen and approved by the Board of Directors of the Association of Anaesthetists. This document is endorsed by Resuscitation Council UK and by Compassion In Dying, a UK charity which helps people plan for and record their wishes regarding the end of life. Latest review date: 2026.
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Recommendations

1. Organisations should provide mandatory training relating to their advance care planning and resuscitation policies and documents.
2. Organisations should put in place processes to ensure that healthcare teams are aware of the existence and content of any advance decision to refuse treatment made by a patient.
3. Clinicians should have an early discussion with a patient pre-operatively to ensure a shared understanding about which peri-operative treatments – including cardiopulmonary resuscitation (CPR) – would be appropriate and desired.
4. It is usually appropriate to suspend a DNACPR recommendation during the peri-operative period.
5. If an anaesthetist believes they cannot facilitate a successful patient-centred outcome which satisfies the patient's wishes, further senior opinions should be sought.
6. All clinicians should consider making themselves familiar with newer processes and documents which are increasingly replacing stand-alone DNACPR forms.

What other guidelines are available on this topic?

National and regional sources of guidance are available, including:

- *Decisions relating to cardiopulmonary resuscitation* [1] (previously known as the "*Joint Statement*"), published in serial editions over many years by the British Medical Association, Resuscitation Council UK and Royal College of Nursing. It contains in-depth advice on this topic and the relevant ethical principles involved.
- The ReSPECT (recommended summary plan for emergency care and treatment) process [2], supported and led by the Resuscitation Council UK, which "*creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices*."
- *Decision-making and consent: Guidance on professional standards and ethics for doctors,* published by the General Medical Council 2020 [3].
- *Deciding Right,* created by The Northern Cancer Alliance, a resource to help clinicians and patients make individual plans in advance to guide their future treatment, including CPR [4].
- *Do not attempt cardiopulmonary resuscitation (DNACPR) decisions*, published in 2021 by NHS England to offer information to members of the public [5].

Why were these guidelines developed?

Anaesthesia and the procedures for which it is used present specific challenges when a patient has in place a plan to withhold or limit emergency treatments such as CPR. The Association's original 2009 guidance *Do Not Attempt Resuscitation (DNAR) Decisions in the Peri-operative Period* [6] was outdated and withdrawn in 2020. This created a need for up-to-date guidance for anaesthetists about emergency care and treatment plans, treatment escalation plans and DNACPR documents likely to be encountered and to require careful consideration in the peri-operative period.

Research in the last decade [7–11] has shown that considering and documenting resuscitation recommendations in isolation can have negative impacts on patient experience and outcomes. In particular, the term 'DNACPR' is sometimes misunderstood to mean that other, potentially beneficial, treatments should not be given.

Alternative approaches, which contextualise CPR within overall treatment goals, are preferred by patients and clinicians and have been shown to be associated with better patient care. In explicitly documenting what the treatment goals are, and which treatments may not or would not help to achieve them, misunderstandings are reduced. It is increasingly common to see new approaches and documents such as the ReSPECT process; in many areas, this is replacing the use of DNACPR forms and the Association's new guidance recognises this shift in practice.

The courts have confirmed the obligations on clinicians in relation to the making of DNACPR recommendations, recognising that, while they are not legally binding, they are likely to carry very great weight in decision-making in the event that the person goes into cardiac arrest.

Anaesthetists frequently encounter patients with documents relating to CPR and/or treatment escalation plans. Continuing developments mean that clinicians may be presented with unfamiliar documents and may be unclear about their provenance and scope. Clinicians who move between or work in multiple organisations may encounter different systems and different documents. Even when clinicians are clear about the intent expressed in such documents, they may be unclear whether, or to what extent, any recommendations and/or expressed wishes should be followed during and around the time of anaesthesia and surgery and how they ought to be explained and communicated to the patient.

How does this statement differ from existing guidelines?

This guidance is aimed specifically at anaesthetists, their departments and their employers, attempting to bring relevant resources together, make them accessible to anaesthetists and support best practice, specifically in a peri-operative setting.

What is the law?

The precise legal framework within which anaesthetists will need to consider advance or anticipatory care planning documents, including DNACPR notices, is different in England and Wales, Scotland, Northern Ireland and the Republic of Ireland. In Appendix S1 of the Association's guidance on consent [12], there is a table setting out the relevant laws governing capacity and consent.

In all jurisdictions, there is a clear distinction between:

- on the one hand, a decision made in advance by a person themselves as to what they want or do not want in terms of medical treatment (whether this is recorded in an advance decision to refuse treatment or – where relevant – appointing someone to make the decision on their behalf)
- on the other hand, a decision made by clinicians as to what is likely to be the right course of action for the person at a point where a particular procedure might, in principle, be required (for instance, CPR).

Only decisions made by the person themselves can be legally binding, assuming they have complied with the relevant statutory or common law criteria that apply, and assuming that these apply to the current circumstances. Any other advance or anticipatory decisions made by clinicians are, in legal terms, only recommendations as to what should happen. This does not mean that clinicians can simply make those recommendations on the basis of their assessment of relevant clinical considerations. Due to the great weight that a recommendation such as a DNACPR notice is likely to carry in decision-making, should a person (for instance) go into cardiac arrest, the courts in England and Wales have stated that clinicians must, as a general rule, consult with the person themselves or (if they lack capacity to participate) with those interested in their welfare, before placing a DNACPR notice in the person's records [13, 14]. It is very likely that this legal approach would also apply in Scotland, Northern Ireland and the Republic of Ireland. This approach would also apply in relation to documents such as ReSPECT forms, which also encapsulate clinical recommendations about CPR and other emergency treatments.

The only exception to the rule that clinicians should consult with the person themselves (if the person has capacity to participate) is where they consider that the patient will be so distressed by being consulted that the distress would be likely to cause the patient harm (see paragraph 93 in [13]).

A final point is that a person cannot demand a treatment that clinicians do not consider appropriate. The UK Supreme Court has confirmed this in relation to the four nations within the UK in *Aintree University Hospitals NHS Foundation Trust v James* [15], and there is no reason to doubt the same approach would not also apply in the Republic of Ireland. However, if any part of its consideration as to appropriateness is based on an assessment of the quality of the patient's life, the Supreme Court also made clear that clinicians must be careful to proceed by reference to the patient's own assessment of their quality of life. If the patient does not currently have capacity to participate in the discussions, their voice in this regard will have to be heard via those concerned with their welfare such as any legal proxy, family members or friends. This consideration is particularly important where recommendations regarding CPR or treatment escalation are being considered for those with long-term disabilities, to ensure they are not subject to conscious or unconscious discrimination based on judgements by others about their perceived quality of life.

While the majority of emergency care plans and DNACPR forms in place relate to adults, some documents relate to children and young people. In looking at such plans and forms, anaesthetists should make sure that they capture appropriately the voice of the child and (where relevant) the views of those with parental responsibility. It is important to note that one major difference between the law in Scotland and that in the other nations covered by this guidance is that, for most medical treatment purposes, adulthood starts at age 16 as opposed to 18 in the other nations.

What documents (relating to emergency treatment, including CPR) may be used or encountered by anaesthetists?

A range of different documents exists in health and care organisations and communities across the UK and Ireland. Some of these forms – and the policies that underpin them – are specific to individual organisations and may not be accepted by other health and care providers. Others are used and recognised across organisational and geographical boundaries, for example within a whole

county or in multiple or larger regions. Some are available as digital documents within a healthcare record, some as paper documents, some in both formats and some are intended to be held by the patient, with a copy or details of content available in their health record. Others may be filed and retained in the health record, and a copy may or may not be given to the patient.

Due to this huge variation, every clinician has a responsibility to be familiar with the policies and documents on advance care planning and resuscitation that exist in any locality where they work and how they can be accessed. If they work in more than one setting, they should familiarise themselves with the different policies and documents used in different settings. Organisations have a responsibility in this as well and should provide education and updates in staff mandatory training and staff induction sessions.

Do not attempt cardiopulmonary resuscitation forms

Some organisations and localities continue to use stand-alone DNACPR forms as their only standardised record of a plan for a future emergency such as death or sudden cardiac arrest. These forms record a recommendation that, in the event of cardiac arrest, CPR should not be provided. They used to be referred to as 'DNACPR orders' but – as emphasised above – this is not an 'order' or legally binding instruction; it is a recommendation to guide immediate decision-making by those present at the time of a cardiac arrest. These forms come in many different colours and designs and the wording may vary substantially, even though the intention is that each should convey the same single recommendation.

Treatment escalation plans

Treatment escalation plans (TEP) have mostly been developed in hospitals. When a person has the potential for rapid deterioration of serious illness, or is approaching the end of life, recommendations on a TEP can give healthcare professionals immediately accessible guidance on how to respond to the person in a crisis. A TEP may record that certain interventions or referral for intensive care are contrary to a person's wishes, or would be futile or unacceptably burdensome, but some can also record specific treatments that should be considered for the individual in appropriate circumstances. Treatment escalation plans vary in design and wording. Many include a recommendation about CPR, although some organisations or communities use a stand-alone DNACPR form in combination with a separate TEP. This may lead to some patients having a DNACPR form in place without a TEP that provides more detailed recommendations.

Emergency care and treatment plans

An emergency care and treatment plan (ECTP) aims to set out recommendations for a future emergency in a person who may or may not be at imminent risk of such an emergency. The person may, for example, have complex health needs, be at risk of cardiac arrest, be nearing the end of life or wish to record a plan for any other reason.

An ECTP should be for use in the community as well as in a hospital or other care setting (e.g. nursing home or hospice) and should be transferrable between all healthcare settings. In this context, there is some overlap between TEPs and ECTPs; some TEPs have been modified or developed for use in settings outside hospitals, effectively making them ECTPs despite retaining the label 'TEP'.

An ECTP should be completed by a clinician in discussion with the person and should record recommendations about treatments that should be considered in an emergency, as well as those not wanted or not recommended. The plan should include a recommendation regarding whether to attempt CPR in the event of death or sudden cardiac arrest, so it is unnecessary and inappropriate to have a separate DNACPR form. However, an ECTP should be completed fully and should not be used only as a means of recording a DNACPR recommendation.

Recommended summary plan for emergency care and treatment

The ReSPECT form is a specific ECTP that was developed by a national team in the UK during 2015–2016 and has continued to be iterated in response to patient and clinician feedback. The ReSPECT process aims to ensure that the recorded plan is person-centred, based on one or more conversations between patient and clinician(s) and is a clear summary of agreed priorities and recommendations.

The ReSPECT form is designed to guide clinicians and their patient through the correct sequence of discussion and decision-making. ReSPECT forms are intended to be used and recognised across all organisational and geographical boundaries within the UK. Since the process was made available for general use in early 2017, it has been adopted by increasing numbers of heath and care communities, initially across substantial parts of England and Scotland. Some people with ReSPECT forms will travel to areas of the UK and Ireland that have not adopted the ReSPECT process. All clinicians should consider making

themselves familiar with ReSPECT to help them respond optimally to an emergency in a person with a ReSPECT form.

Patient-generated documents

In addition to the above documents, clinicians should be aware that they may encounter documents which have been generated by patients. These could include advance decisions to refuse treatment (sometimes called a living will), advance statements or powers of attorney. Organisations should provide clinicians with information about which patient-generated documents are likely to be encountered in their jurisdiction.

What is the role of the anaesthetist in the peri-operative period?

Pre-operatively

A key principle is an early discussion with the patient pre-operatively to ensure a shared understanding about which peri-operative treatments – including chest compressions and/or defibrillation – would be appropriate and desired. Central to this is understanding and documenting the patient's values, preferences, wishes and ideas about their care, including any fears the patient might have. Anaesthetists and surgeons need to work together to ensure the balance of risks and benefits of surgery, anaesthesia and treatments including intensive care have been explained fully and understood by the patient. Should the patient's decision seem to be out of character or inconsistent with their values, this should be a trigger to consider carefully whether the patient has capacity to consent to the treatment in question.

Some patients will have pre-existing DNACPR forms or other documents recommending that CPR is not attempted. Intra-operative cardiac arrest is generally rare and when it does occur, survival rates are generally high. This can be attributed to two things. First, common causes of peri-operative arrest (cardiovascular response to the induction of anaesthesia; vagal response to interventions; hypoxia; hypovolaemia; haemorrhage) are treatable and potentially reversible. Second, the continuous monitoring of anaesthetised patients and presence of an anaesthetist allow immediate detection and treatment. It is, therefore, usually appropriate to suspend a DNACPR recommendation during the peri-operative period. Since DNACPR recommendations are not legally binding but are a recommendation of what the clinician should do in an emergency, they do not require explicit cancellation. However, the anaesthetist should ensure any temporary suspension of the recommendation has been discussed and agreed with the patient, and explained to the healthcare team.

The Working Party does not consider that giving chest compressions to expedite circulation of a drug in the face of low cardiac output (as distinct from cardiac arrest) is qualitatively the same as CPR. Therefore, it does not consider that an advance decision to refuse CPR would normally cover such a situation. Similarly, the Working Party does not consider that such an advance decision normally excludes the use of drugs that are part of the cardiac arrest algorithm where they are used to treat – for example – bradycardia, hypotension or cardiac arrhythmia, during the course of anaesthesia. Finally, the Working Party does not consider that such an advance decision would prevent the use of defibrillation (or synchronised direct current cardioversion) for suddenly occurring arrhythmia. Where a patient has made an advance decision to refuse CPR, the position set out above should be explained to the patient.

Organisations should put processes in place to ensure the healthcare team is aware that a patient has made an advance decision to refuse any of the treatments that might be used in an emergency, what precisely that decision covers and the legal status of that decision. If the team considers that refusing one of the treatments will alter the risks and benefits of the procedure, they will need to take appropriate steps to address the position. If the patient has capacity to participate in the discussion, the healthcare team should ask them whether they wish the advance decision to be observed during their anaesthetic or whether it should be suspended. If it is to be suspended, a clear record of this should be made, and also of the circumstances under which the patient would then want it to be brought back into force. If a patient who has made an advance decision does not have capacity to participate in the discussion, the healthcare team must consider whether the circumstances of the emergency event are those which the person envisaged when they made the advance decision.

Organisations should also have in place processes to ensure the healthcare team knows whether a patient has appointed a proxy (e.g. with power of attorney). If they have, the team should discuss treatment options with the proxy when determining how to proceed in the way that the patient would have wished.

Having discussions early offers the maximum time possible to undertake sensitive and considered discussions and planning, without delaying surgery unnecessarily. All discussions and decisions should be clearly documented, dated and signed by the healthcare professional in the patient's health record and shared at the team brief. Decisions can be reviewed and updated as necessary at any stage of peri-operative care. Review and update is

particularly important when the patient changes their mind or asks for review, when their clinical condition has changed, when significant time has passed since previous discussions or when those discussions were held by others.

After assessment (and, where relevant, discussion with any proxy), an anaesthetist may conclude that they cannot facilitate a successful patient-centred outcome which satisfies the patient's wishes. In this event, further senior opinions should be sought as to whether the operation can proceed or what alternative arrangements can be made. The consequences should be considered carefully and discussed with the patient or their proxy. It may, on rare occasions, be necessary to seek a legal opinion.

Intra-operatively

Even where the planning set out above has been followed carefully and completely, as an operation progresses, the surgical findings and condition of the patient may change considerably and/or unexpectedly. The pre-operative understanding of the patient's priorities and goals of care should influence clinical decision-making by the anaesthetist and surgical team.

Some patients will have been taken to the operating theatre rapidly, perhaps unconscious or without capacity to take decisions, and with only limited information or information conveyed by others of what their wishes would have been in the present context. The principle in this setting is to try to gather as much information as possible and, unless this indicates otherwise, to pursue full and active treatment as far as is clinically appropriate.

A surgical procedure itself carries risks of immediate adverse outcomes that may be rapidly correctable but may result in worsening of short-, mid- or long-term prognosis. For example, prompt treatment of blood loss or adverse reactions to drugs may restore a good prognosis, whereas the prognosis of intra-operative stroke or myocardial infarction will vary from person to person and require individual assessment and treatment. At the time of an intra-operative complication or cardiac arrest, clinical decisions must be made quickly. Taking time pre-operatively to understand and document the patient's wishes will mean that clinicians can act confidently and ethically and ensure the best outcomes for the individual patient.

Postoperatively

This document does not address the ongoing decision-making in critical care. However, many of the intra-operative principles apply also to postoperative management on the ICU.

Deterioration in the post-anaesthesia care unit, in ICU or on a ward may be wholly or partly due to reversible elements of anaesthesia, such as residual effects of drugs or effects of continuing analgesia. These effects may be reversible and should be treated, with reference to the recorded plan and as agreed during appropriate discussion.

At the end of a surgery in an unconscious patient, it is not uncommon to find that the prognosis has changed and is now agreed to be poor. Information that has been gathered using the processes above will be invaluable in guiding decision-making thereafter and should be shared with the ICU team and postoperative team.

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