Ethics Guidelines

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Published 27 October 2025
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References

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Planning for emergency and future care and treatment

The conversation

- Discussions and recommendations about CPR are best made in the context of broader discussions and recommendations about emergency and future care planning.

- Emergency and future care planning conversations must be person-centred, realistic and individualised.
- Clinicians should integrate the following to achieve shared understanding:
    - Talk about the person's diagnosis and prognosis in a clear and honest manner; ensure their understanding and expectations are aligned with clinical understanding and expectations.
    - Seek and document information about the person's goals, values, and treatment preferences.
- Emergency and future care planning conversations can take place over multiple meetings and should be started early.
- All healthcare professionals can have a role in facilitating emergency care and treatment planning conversations. Where it is within their scope of practice, they should be willing to discuss emergency and future planning options with all people they care for, particularly those nearing the end of their lives, those with chronic health care conditions and those at risk of sudden deterioration or cardiac arrest.
- Supplemental materials and resources can help people better prepare and participate in emergency and future care planning conversations and should be provided wherever possible.
- It should be respected that a person has the right to refuse treatment.
- When a shared agreement about emergency treatment recommendations cannot be reached by those involved in a planning conversation, steps should be taken to rectify this, including seeking a second opinion, advice from a clinical ethical advisory group and/or legal advice.
- If the person who the planning relates to is unable to take part in a conversation, other appropriate representatives must be invited to contribute on their behalf.
- Emergency treatment plans and clinical recommendations should be reviewed regularly to ensure they remain relevant to the needs of the person they relate to and support their care goals.

The documentation

- Emergency care and treatment plans should reflect the contents and outcomes of a planning conversation.
- The written contents of an emergency care and treatment plan should be clear, concise and written in a way that is easily understood by all who read it.

- Use of a standardised emergency care and treatment plan, such as the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT), is encouraged.
- The rationale informing recommendations should be documented. This might include, but is not limited to, the person’s values and preferences, their diagnosis and prognosis or the likelihood of success of attempted CPR.
- Emergency care and treatment plans should be accessible across all care settings.
- Emergency care and treatment plans should be reviewed at the request of the person or those close to them, when a person’s situation changes, or if the clinician thinks it would be appropriate. It is not necessary to repeat the discussion on every hospital admission, particularly if the person has expressed a definitive and informed view to refuse a treatment.

The interpretation

- Emergency care and treatment plans help provide immediate guidance and treatment recommendations to help guide decision-making in an emergency, documenting the person’s voice and previous clinical reasoning. Clinical recommendations are not legally binding.
- The final decision regarding whether or not an emergency treatment is clinically appropriate and lawful rests with the healthcare professionals responsible for the person’s immediate care at that time when treatment is provided, unless there is a legally binding document in place.
- Legally binding documents vary across the nations of the UK. Healthcare professionals should familiarise themselves with those in use in the nations in which they practice.

The implementation

- Healthcare organisations should have policies and procedures to govern and inform the use of emergency care and treatment plans.
- Healthcare organisations should provide clinicians with communication skills training to improve clinicians’ skills and comfort in supporting patients to define care and treatment goals.
- Healthcare organisations should ensure staff receive training so they understand their roles and responsibilities in relation to emergency care and treatment planning, and how they should respond to medical emergencies.

- Healthcare organisations should have processes in place which ensure emergency care and treatment planning processes and education are audited to ensure they meet defined standards and undertake quality improvement projects when required.

Ethics of bystander and first responder involvement

- Ensure that bystanders are not forced or unduly compelled into performing CPR, respecting their personal autonomy in resuscitation decision-making, while acknowledging the 'duty to help'.
- Offer ethical guidance for navigating situations involving difficult or distressing interventions to reduce moral distress among bystanders and first responders.
- Healthcare systems should implement measures to facilitate psychological support for bystanders and first responders following out-of-hospital cardiac arrest (OHCA).
- Policy makers should provide guidance on the legal and ethical protection for bystanders to reduce hesitation due to fear of liability or moral responsibility.
- Healthcare systems should implement strategies to minimise the impact of biases in bystander intervention, ensuring that protected characteristics (e.g. age, sex, gender, ethnicity) or socio-economic status do not influence resuscitation decisions.

Family presence

- Resuscitation teams should offer the family of people who have had cardiac arrests the choice to be present during the resuscitation attempt.
- Healthcare systems should establish clear, contextualised, and culturally sensitive procedures for the involvement of family members.
- Healthcare systems should specifically train their teams to support family members during resuscitation.
- As far as reasonably practicable, healthcare systems should have a trained team member who can be designated to this task as part of the overall CPR strategy.

Termination of resuscitation (TOR)*

- Organisations caring for people who may have a cardiac arrest should implement criteria for the withholding and termination of CPR for both in-hospital cardiac arrest (IHCA) and out-of-hospital cardiac arrest (OHCA), taking into consideration the specific local, legal, organisational, and cultural context.
- Make a team-based decision to terminate resuscitation based on a holistic approach, considering patient values and preferences, and the combined picture of prognostic factors, including duration of CPR, the absence of reversible causes, and the absence of response to advanced life support.
- TOR rules may be used to aid decision-making for adult patients with OHCA following local validation and considering local values and preferences.
- TOR rules should not be used for in-hospital cardiac arrest (IHCA) and for paediatric or neonatal patients in any setting due to insufficient evidence.
- Clinicians should clearly document reasons for the withholding or termination of CPR, and these reasons should be audited by healthcare organisations.
- TOR should be carried out in a planned manner, and all team members should have the opportunity to be involved in decision-making. TOR may be considered when the patient has persistent asystole (from the time of confirmation of cardiac arrest), despite at least 45 minutes of advanced life support in the absence of any reversible cause, when no other clinical factors suggest against it.
- Persistently low end-tidal CO_2 ($ETCO_2$) is a strong prognostic marker that may be used to aid decision-making on top of other factors, but should not be used in isolation.
- Factors such as cardiac ultrasound, blood gases, and pupil reactiveness should not be used as the basis for terminating resuscitation.
- The team should conduct a debriefing immediately following termination of resuscitation.

*Guidance on withholding or discontinuing resuscitation in neonates is included in the 2025 Resuscitation Guidelines for Newborn resuscitation and support of transition of infants at birth.

Organ donation after cardiac arrest

- Systems that offer organ donation following cardiac arrest should ensure the development of transparent processes for the identification of potential donors, the obtaining of consent and organ preservation.

Ethics of education and systems

- Establish ethical reasoning as a core competency in resuscitation training to strengthen critical thinking, ethical judgment, and decision-making that respects patient autonomy, follows medical best practices, and aligns with societal values.
- Implement simulation-based ethics training to provide healthcare professionals with hands-on experience in ethically complex resuscitation scenarios, including cases involving communication and decision-making regarding advance care planning, DNACPR decisions and TOR decisions.
- Introduce ethical preparedness training for resuscitation providers to develop strategies for managing moral distress, addressing ethical dilemmas, and overcoming institutional constraints that impact decision-making in high-pressure situations.
- Standardise institutional policies on emergency and future care planning, CPR recommendations, and TOR by embedding structured ethical frameworks that provide clear, legally and professionally aligned guidance for resuscitation decisions.
- Develop formal training programs to equip healthcare professionals with the skills to navigate institutional constraints, legal uncertainties, and policy inconsistencies in ethically complex resuscitation cases.
- Ensure ethical considerations are embedded within resuscitation policies to promote patient-centred, transparent, and ethically sound decision-making at institutional levels.

Resuscitation research ethics

- Systems should support the delivery of high-quality emergency research, as an essential component of optimising patient-centred cardiac arrest outcomes.
- Regulatory and procedural barriers to high-quality emergency research related to consent models should be minimised. For observational research (e.g. in the context of registry data collection and/or DNA biobank data

sampling and analyses), we suggest consideration of a deferred consent model, with concurrent implementation of appropriate safeguards aimed at preventing data breaches and patient reidentification.

- Researchers should involve patients and members of the public as community advisors throughout the research process, including design, delivery and research dissemination.
- The use of a core outcome set, along with standardised corresponding terminology, should be harmonised across trials investigating clinical effectiveness.
- Communities or populations in which research is undertaken and who bear the risk of research-related adverse events should be given the opportunity to benefit from its results.
- Researchers should comply with best practice guidance to ensure the integrity and transparency of research, including study protocol registration, prompt reporting of results, allocation of authorship according to international criteria for authorship, and data sharing.
- Policies of governments, public health bodies, international societies, and non-profit organisations should aim to ensure that funding for cardiac arrest research is sufficient to effectively address the high societal burden caused by cardiac arrest-associated morbidity and mortality.
- Use of artificial intelligence (AI) in research should be regulated according to rigorous ethical and scientific safeguards for beneficence, autonomy/privacy and justice. As an example, development of new AI algorithms should be based on broad datasets in which the participants are representative of the broader population. from the general population, rather than datasets from socioeconomically privileged groups.

Related content
ReSPECT
Guidance: DNACPR and CPR decisions