Policy for End-of-Life Care

13th April 2025

SIR GANGA RAM HOSPITAL
Trust of Generations

"You matter because you are you, and you matter to the end of your life. We will do all we can not only to help you die peacefully but also to live until you die."

Dame Cicely Saunders

Foreword

In the rapidly evolving landscape of healthcare, effective policy guidelines serve as a cornerstone for ensuring high-quality care and operational excellence. This document reflects the collective expertise, dedication, and vision of the End-of-Life Taskforce, which was formed to thoroughly examine evidence-based practices and emerging trends to formulate comprehensive and actionable recommendations. This committee, consisting of 24 core members, worked for over three years to prepare a set of guidelines that serve as a cornerstone for consistency, excellence, and accountability in all aspects of our work.

The guidelines are designed to address current challenges and anticipate future needs while fostering a culture of adaptability and inclusivity. By prioritising patient-centred care, interprofessional collaboration, and systematic quality improvement, these policies aim to empower healthcare providers, administrators, and policymakers to deliver services that uphold the dignity, equity, and holistic well-being of terminally ill patients with life-limiting diseases. These guidelines align with the current Honourable Supreme Court and the Ministry of Health and Welfare. The policies aim to facilitate equitable access to quality end-of-life care across various urban and rural settings.

Dr. D.S. Rana
Chairman,
Sir Ganga Ram Trust Society
Sir Ganga Ram Hospital
New Delhi

Foreword

Healthcare today stands at a crossroads of challenges and opportunities that require strong, clearly defined policies to guide systems and practices towards excellence. These guidelines embody the collective dedication and interdisciplinary collaboration of the End-of-Life Taskforce Committee Members, whose commitment to evidence-based approaches and patient-centred outcomes forms the foundation of this document.

This policy guidelines document addresses existing gaps while providing insights into future developments. Each recommendation within these pages aims to balance clinical efficacy, administrative feasibility, and ethical integrity. The document seeks to empower all stakeholders—from healthcare providers to policymakers—to cultivate a healthier, more resilient society.

At Sir Ganga Ram Hospital, we recognize the profound importance of incorporating human dignity, empathy, and respect into healthcare processes. These guidelines are not merely procedural but transformational, aimed at inspiring the adoption of practices that honour both the science of healing and the art of compassion.

Dr. Ajay Swaroop
Chairman,
Board of Management
Sir Ganga Ram Hospital
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Foreword

In the culturally rich and diverse regions of India and Southeast Asia, end-of-life care holds profound significance, deeply intertwined with traditions, beliefs, and societal norms. This document provides policy guidelines tailored to the unique challenges and opportunities of palliative and supportive care in these areas, where the essence of care extends beyond the physical to encompass emotional, spiritual, and community dimensions

Acknowledging the region's strong emphasis on family involvement, these guidelines prioritize holistic approaches that honour cultural values while integrating evidence-based practices. They stress the importance of empowering families and caregivers, promoting open discussions about life's final stages, and fostering environments where death is viewed as a natural transition rather than a taboo subject. By incorporating locally rooted principles of empathy, dignity, and respect, the recommendations aim to connect traditional beliefs with contemporary healthcare strategies.

In presenting this document, we invite all stakeholders to embrace the vision of transforming end-of-life care in India and neighbouring areas into an experience defined by holistic well-being, cultural resonance, and profound humanity. May these guidelines serve as a beacon, inspiring individuals and organisations to join us in our shared commitment to enhancing the quality of life, even in its final stages.

As authors, we hope this document serves as a vital resource for those engaged in palliative and supportive care, assisting them in their mission to uphold the values of empathy, respect, and excellence. I envisage the medical fraternity embracing these guidelines and joining us in our shared commitment to transforming end-of-life care into an experience characterized by profound humanity and compassion.

Dr. Jayashree Sood
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Advisor, Institute of Anaesthesiology, Pain & Perioperative Medicine
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Foreword

End-of-life care represents one of the most delicate responsibilities within healthcare, requiring both compassion and precision. At Sir Ganga Ram Hospital, we have committed ourselves to developing policy guidelines that address this critical aspect of patient care, ensuring that every individual receives dignified, respectful, and holistic support during their final journey.

To develop the guidelines, an 'End-of-Life Care' taskforce committee was formed with 24 core members from various specialities of the hospital, led by its Chairperson, Dr. Jayashree Sood. The first meeting took place in April 2022, followed by several others. We engaged in numerous discussions with invited experts of national and international repute. Critical appraisals were gathered from experts both within and outside the hospital. These guidelines result from extensive collaboration, research, and careful consideration of the challenges faced by patients, families, and healthcare providers. They aim to provide clear protocols while respecting the unique needs and preferences of each patient. Our goal is to empower healthcare professionals to deliver care that prioritises physical comfort, psychosocial support, and ethical integrity.

We believe that by implementing these guidelines, we can create an environment where patients and their families feel supported, healthcare teams feel confident in their practices, and the values of empathy and dignity remain at the core of our services.

We are deeply grateful to everyone who contributed to this endeavour and look forward to enhancing end-of-life care together.

Dr. Bimla Sharma
Co-Chairperson, Taskforce, 'End-of-Life Care'
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The invaluable contributions of BLUE MAPLE, in collaboration with the Guidelines for End- of-life Care, AIIMS, New Delhi, have profoundly enriched the policy framework by providing a wealth of insights and diverse perspectives. These insights have been meticulously validated by the Vidhi Centre for Legal Policy, along with the dedicated efforts of the Ministry of Health and Family Welfare. Their commitment to addressing all aspects of healthcare has significantly improved the policy's effectiveness and ensured it meets community needs.

This policy reflects the combined efforts of healthcare professionals, legal experts, and ethical advisors, along with input from patients and their families who shared their stories. This document would not have been possible without their insights and contributions.

We extend our heartfelt gratitude to **Dr. Seema Bhargava** and **Dr. Mamta Kankra** for their thorough review and constructive feedback, which significantly enhanced the clarity and effectiveness of the policy. Additionally, we would like to express our special appreciation to **Dr. Puneet Rathore** and **Dr. Suruchi Sinha** for their dedicated efforts in compiling and preparing this comprehensive document.

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INTRODUCTION

As medical practitioners, we take the Hippocratic Oath, which includes the principle of non-maleficence, essentially the commitment to do no further harm to patients, especially when they are overmastered by their diseases.[1] Emphasizing this patient-centric commitment, many countries have implemented end-of-life policies, and this concept is gaining acceptance globally.

The Institute of Medicine guidelines define a good death as "free from avoidable distress and suffering for patients, families, and caregivers, and generally in accordance with the wishes of the patient and family.[2] India ranked 67th among the 80 countries in the 2015 Quality of Death (QOD) Index in providing palliative care.[3] In 2021, the Lien Centre conducted a cross-country comparison of expert assessments of QOD, and India ranked 59th among 81 countries, implying that patients are continued on disease-modifying treatment until the last few weeks of life and often receive futile life-sustaining interventions, causing needless suffering and pain in terminal illness.[4]

Providing supportive palliative care to terminally ill patients at the end of life enables them to die with dignity. Patient-centric, resource-appropriate end-of-life care (EOLC) offers dying patients and their families a comfortable and holistic environment. In our tertiary care centre at Sir Ganga Ram Hospital (SGRH), there were 1,117 patient deaths recorded in 2023, compared with 2,032 in 2024. Although we do not have data on how many patients suffered from life-limiting diseases, 233 (20.8%) patients in 2023 and 367 (18%) in 2024 were referred to the Palliative Medicine Department. This highlights the need to improve awareness and understanding of the principles of a good death and the role of timely palliative care among both healthcare professionals and the general public, thereby promoting appropriate referral and ensuring that patients with terminal illnesses receive dignified, compassionate, and patient-centred EOLC.

Providing EOLC is not a part of routine clinical practice. It must become an integral component of our daily operations. In India, there is no established legal framework governing EOLC. The Supreme Court guidelines from 2018, which were recently updated in 2023, will continue to apply until the Indian Parliament enacts a formal law.[5] Consequently, it is imperative that we formalise this procedure and establish our institutional guidelines for EOLC.

The focus of this document is to ensure that patients receive dignified end-of-life care and unnecessary harm from inappropriate interventions is prevented. Continuing to administer aggressive and invasive treatment at this stage would not only be futile but also a violation of the principle of non-maleficence as it would result in inappropriate and unnecessary suffering of the patient. We will interchangeably use futility, non-beneficence, or inappropriate treatment in this policy document for simplicity. Policy guidelines are intended to help physicians and should comply with all applicable laws, rules, and regulations when dealing with end-of-life situations.

This document has been prepared in consultation with experts from within and outside the hospital to provide dignified end-of-life care to all age groups, from neonatal to geriatric. An effort has also been made to highlight the end-of-life care issues in the paediatric population. Although paediatric deaths are rare and occur mainly in hospitals, children experience longer disease trajectories. In addition, in the paediatric population, the ability to communicate, comprehend, and participate in decision-making about the illness can vary with age or developmental stage.

These guidelines have been developed in accordance with recommendations from leading national and international organisations including the Indian Society of Critical Care Medicine (ISCCM), the Indian Association of Palliative Care (IAPC), the Indian Academy of Neurology (IAN), the Vidhi Centre for Legal Policy, the Ministry of Health and Family Welfare (MoHFW), the Indian Council of Medical Research (ICMR), and the National Institute for Health and Care Excellence (NICE, UK). [6–12.] They are evidence-based and will be periodically updated to reflect emerging evidence, evolving legal and ethical standards, and best clinical practices.

At SGRH, we have prepared this EOLC document based on recommendations from the 'Before Life Ends, Understand and Evaluate the Choice of Medical Treatment Offered: A Methodised Action Plan for Limitation of Life-Sustaining Treatment and End of Life Care' (BLUE MAPLE) document from the Kasturba Hospital and Guidelines for End-of-life Care, AIIMS, New Delhi.[13,14] This document emphasises the importance of providing patients with dignified EOLC while preventing unnecessary harm from inappropriate interventions. To uphold these principles, we aim to avoid the continuation of aggressive and invasive treatments at this stage, as they would not only be futile but also violate the principle of non- maleficence, potentially causing the patient unnecessary suffering.

DEFINITIONS [5-7,15]

Terminal illness: An irreversible or incurable condition from which death is inevitable in the foreseeable future. Severe, devastating traumatic brain injury, which shows no recovery after 72 hours or more, is also included.

Withdrawal (WD): A considered decision in a patient's best interests to stop or discontinue ongoing life support in a terminally ill disease that is no longer likely to benefit the patient or is likely to cause harm in terms of suffering and loss of dignity. The following conditions must apply:

1. Any individual declared brainstem dead as per the Transplantation of Human Organs and Tissues Act 1994
2. Medical prognostication and considered opinion that the patient's disease condition is advanced and unlikely to benefit from aggressive therapeutic interventions.
3. Patient/surrogate documented informed refusal, following prognostic awareness, to continue life support.
4. Compliance with the procedure prescribed by the Honourable Supreme Court.

Withholding (WH): A considered decision in a patient's best interests to not start a life-supporting measure in a terminally ill patient that is unlikely to benefit the patient and is likely to harm in terms of suffering and loss of dignity. The same aforementioned conditions must apply.

Do-Not-Attempt-Resuscitation (DNAR): A considered decision not to perform cardiopulmonary resuscitation (CPR) in the event of anticipated cardiac arrest if there is no realistic possibility of survival or meaningful recovery.

Advance Medical Directive (AMD): A written declaration made by a person with decision-making capacity documenting how they would like to be medically treated or not treated should they lose capacity.

Best Interests: A principle that behooves physicians to ensure that the potential benefits of treatments outweigh potential harms or to avoid treatments that serve no therapeutic purpose.
WD, WH and DNAR are collectively termed Foregoing Life Support treatments (FLST).

Autonomy: It is the right of an individual to make a free and informed decision.

Beneficence: This principle makes it obligatory for physicians to act in patients' best interests.

Non-maleficence: A principle that directs physicians to, first of all, not to harm the patient.

Distributive Justice: In the context of medical care, it requires that all people be treated without prejudice and that healthcare resources be used equitably.

Surrogate/Proxy: A person or persons, other than the healthcare providers, who is/are authorised or accepted to represent the patient's best interests and make healthcare decisions on the patient's behalf when the patient lacks decision-making capacity. If the patient has made a valid AMD, the surrogate will be the person or persons named in the directive. In the absence of a valid AMD, the surrogate shall ordinarily be the patient's next of kin (family member) or, where appropriate, the next friend or guardian. To identify next of kin, one may refer to the definition of 'near relative' in the Transplantation of Human Organs and Tissues (Amendment) Act, 2011 (THOTA). Under this provision, 'near relative' includes the spouse, son, daughter, father, mother, brother, sister, grandfather, grandmother, grandson or granddaughter, whoever may be available.

Active Euthanasia: The deliberate act of ending a patient's life, at the patient's voluntary request, through the direct intervention of a healthcare professional to relieve intractable suffering from an incurable or terminal illness. This practice remains illegal in India.

Guiding Principles of Foregoing Life Supportive Treatments (FLST) and Compassionate Care [5,7,13,14]

1. Respect for patient autonomy
2. Adherence to physician duties of beneficence, non-maleficence and distributive justice
3. Open, honest, timely, compassionate and empathetic communication and care
4. Compliance with legal requirements
5. Transparency and documentation
6. Transitioning to palliative care

AIMS

1. To develop an institutional policy to provide high-quality end-of-life care within a legal, ethical, and patient-centred framework.

2. To establish procedural guidelines to limit medically inappropriate or futile interventions and to facilitate appropriate end-of-life care.

OBJECTIVES

1. To assist in attaining a 'good death' for a dying person, regardless of the diagnosis, duration of illness, place and financial status.
2. To improve the quality of life as well as the quality of death for the individual.
3. Recognition of a peaceful, good, and dignified death as a human right.
4. To improve awareness of "End-of-Life Care" procedures and issues among the lay public, medical and paramedical personnel, lawmakers, and others concerned.

POLICY GUIDELINES

The pathway for withdrawal and withholding of life support in terminally ill patients encompasses decision-making combining professional consensus and the Honourable Supreme Court Directives[5,15,16]

The four steps for the "End-of-Life Care" policy are as follows:

1. Establishing futility/inappropriateness/non-beneficence of further management by the physicians
2. The caregivers' consensus on 'Inappropriateness/Non-beneficence for further management'
3. The pathway to initiate end-of-life care (EOLC)
4. Continuum of supportive care until death

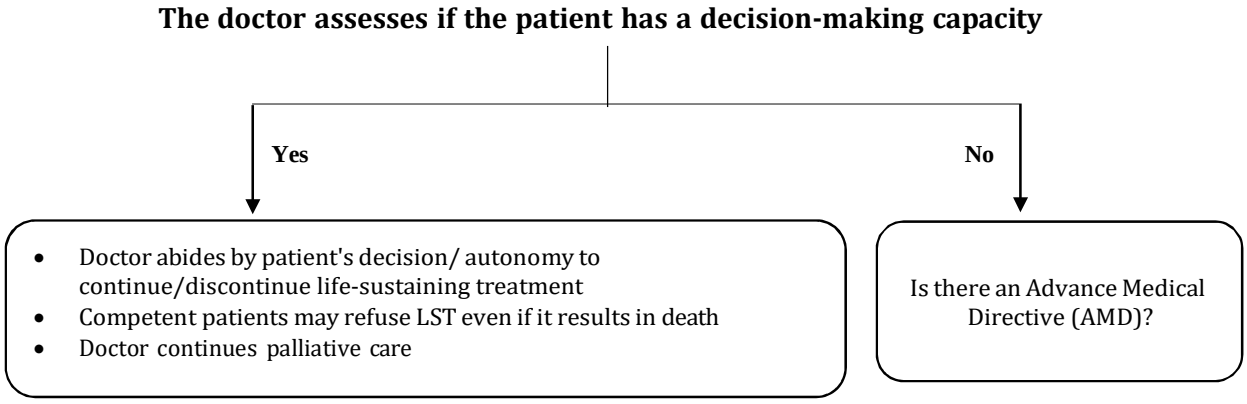
1. **Establishing 'Inappropriateness/Non-beneficence of further management' by the physicians**

   The primary/ treating physician(s) shall analyse the patient's routine vitals daily and recognise the 'Inappropriateness/Non-beneficence of further management' based on general and disease-specific criteria **(Annexure A).**

   If the patients can make healthcare decisions, their wishes must be respected and given primacy, even if their family members disagree. The doctor abides by the patient's decision/autonomy to continue or discontinue the life-sustaining treatment. The palliative

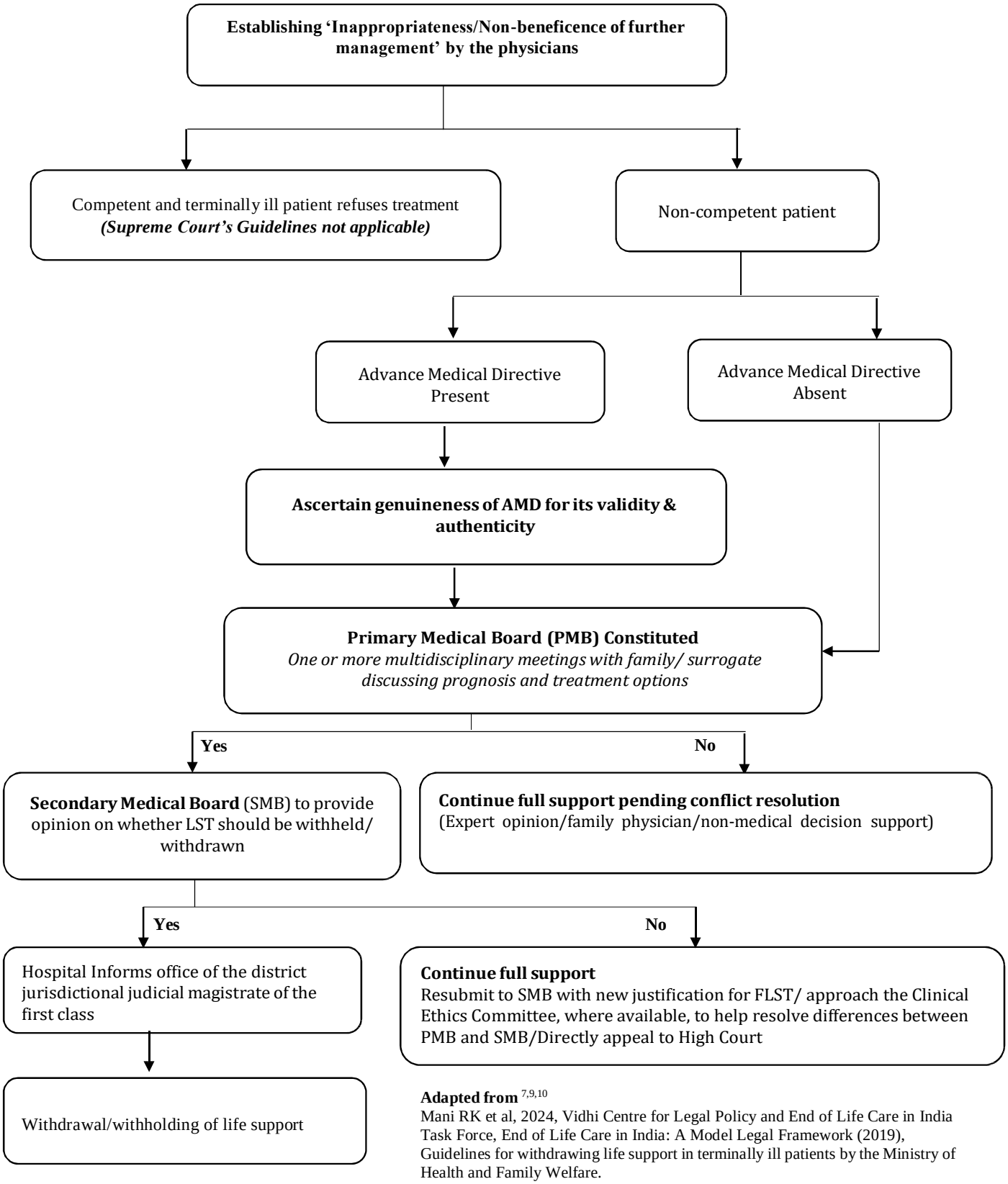
care is continued. (Flowchart 1) The guidelines set forth by the Supreme Court are applicable exclusively in circumstances where a patient has lost their decision-making capacity; they do not apply when the patient has the ability to make decisions.

Flowchart 1. Pathway for withdrawal/withholding of life-sustaining treatment (LST) in terminally ill patients



The Supreme Court guidelines are applicable for patients who (1) have lost decision-making capacity and (2) are terminally ill. The Supreme Court of India has laid down the following legal procedures for End-of-Life decisions (Flowchart 2).

Flowchart 2. Pathway for withdrawal/withholding of life-sustaining treatment (LST) in terminally ill patients (Supreme Court's Legal Guidelines 2023)



Adapted from [7,9,10]
Mani RK et al, 2024, Vidhi Centre for Legal Policy and End of Life Care in India Task Force, End of Life Care in India: A Model Legal Framework (2019), Guidelines for withdrawing life support in terminally ill patients by the Ministry of Health and Family Welfare.

a. The physician enquires whether an AMD exists and, if it does, verifies its validity and authenticity and complies with the instructions for withholding or withdrawing the treatment. This is done by shared decision-making in consultation with the appointed surrogate decision-maker/proxy. Shared decision-making is a dynamic process in which, for a patient without capacity, the healthcare team makes decisions with the appointed surrogate decision-maker/family regarding the patient's medical treatment.

b. After the primary physician is satisfied that further management is inappropriate or non-beneficial, the case will be referred to the Primary Medical Board (PMB), which the hospital will constitute. This can be constituted from the treating team of specialists. (The PMB will comprise three members: - the primary physician and two subject experts with five or more years of experience in the field).

The PMB will discuss the futility of further management (withholding or withdrawal) with family members and caregivers, converse with the family, and make a collaborative decision. A caregiver or family caregiver refers to people, with or without biological or legal connections to the patient.

c. The PMB must document, in a prescribed format, the reason justifying the inappropriateness/ non-beneficence of the further management decision, preferably within 48 hours of the case being referred to it by the hospital **[Annexure B].**

d. The PMB shall send the decision to the Secondary Medical Board (SMB), which will have three members: two subject experts with over five years of experience who are not PMB members; the third member will be a registered medical practitioner nominated/empanelled by the District Chief Medical Officer, who can be the doctor from within or outside the hospital.

e. The SMB shall visit the patient, review the PMB's decision and endorse it if the SMB agrees with the PMB, preferably within 48 hours of the case being referred to it **[Annexure B].**

f. The hospital shall record the SMB's decision to withhold/withdraw treatment and inform the judicial magistrate.

(Note: If the SMB does not concur with the PMB, the family, the treating team, or the hospital administration have three options: a) the PMB may reapply to the SMB with new justifications, b) they may refer the case to the hospital clinical ethics committee, c) they may approach the High Court.)

Hospital Oversight [5,7,9,10]

The hospital has the option to form a Clinical Ethics Committee comprised of members from various professions to tackle issues related to auditing, oversight, and conflicts. The suggested members for this committee include: the Director/Chief Administrator or an equivalent, or their appointee from the healthcare facility; a senior medical professional from the healthcare facility who specialises in EOLC; one senior medical professional with pertinent expertise in EOLC, selected from outside the healthcare facility; a legal expert appointed by the healthcare facility; and a social worker appointed by the healthcare facility. This committee will collaborate to uphold ethical considerations in patient care.

2. **The caregivers' consensus on 'Inappropriateness/Non-beneficence for further management'**

   Once the SMB has recognised the inappropriateness/non-beneficence of further management, it must be communicated to the patient's caregivers. A caregiver or family caregiver refers to and includes people with or without biological or legal connections to the patient, such as those nominated as surrogate decision-makers in the patient's AMD, where such a directive exists. If no such directive exists, the surrogate decision- maker shall include the patient's family or friends who are regularly attending to the patient in the hospital and otherwise making decisions on the patient's behalf.

   The primary physician, palliative care physician and a nursing officer will convene a meeting between the patient's family members and/or surrogate decision-makers to communicate and disclose the inappropriateness/non-beneficence of further management. The best supportive care options should be discussed.

   a. In the meeting:
      i. The treating physicians will initiate EOLC discussions, including the prognosis.
      ii. The family meetings should as far as possible, be jointly addressed by the primary physician and as many members of the treating team as possible.
      iii. Communication with family members/caregivers shall take place in the language they understand.
      iv. Communication regarding the terminal nature of illness should emphasise the following:
         - Terminal nature of the disease
         - Risks vs. benefits of further aggressive management

- Supportive care as an alternative
- Obtaining a second opinion or transferring the patient to another facility
- Change of focus from cure to care
- Comfort measuring strategies during this period
- Myths or misunderstandings to be clarified
- Ensure that the prognosis, the EOLC process, and the procedures outlined in this policy are clearly understood by the patient (where appropriate), family members, caregivers and surrogate decision-makers
- Prevent any inconsistencies in communication and address different family members together in the same setting
- Multiple meetings may be required to reach a consensus among all caregivers/family members/surrogate decision-makers

b. After the meeting:

i. At the end of each communication, the team shall complete the communication checklist **[Annexure C].**

ii. If the patient can make an informed decision, their wishes regarding withholding/ withdrawing life-sustaining support shall be duly recorded **[Annexure D].** Informed decision at the time of terminal illness is superlative and nullifies any other document (even a previously documented AMD) or decision by anyone else.

iii. If the patient does not have the capacity to make an informed decision about withholding or withdrawing life-sustaining treatment, efforts should be made to reach at a consensus amongst all relevant family members/ caregivers/ surrogate decision-makers. However, written consent for withholding or withdrawing life-supporting measures will be obtained after the medical boards' decision **[Annexure E].**

3. **Initiation of EOLC pathway**

Once the decision to initiate End-of-Life Care is reached by consensus among the treating physicians, consultants, and the patient and/or surrogate decision-makers, palliative care shall be provided under the supervision of the Palliative Care Team **[Annexure F].**

4. **Continuum of supportive care until death**
    a. A patient's holistic palliative care needs are assessed daily, including symptom management (e.g., pain, vomiting, breathlessness and delirium) and psychological and spiritual needs at the end of life **[Annexure G]**.
    b. Supportive care plans and treatments should be well-documented daily.
    c. The patient or surrogate decision-makers may be offered the option of home/ hospice if not on any life-sustaining support.

NOTE:

The end-of-life care should NOT be triggered in the following situations:

a. When the outcome is uncertain (may or may not improve the situation).
b. When there is a conflicting opinion among the family members concerning EOLC, they have the right to take a second opinion.
c. When the relevant family member/caregiver/surrogate decision-maker is not available for discussion.
d. When the patient does not consent (for example, if the patient is capable of exercising their judgment and making their wishes known about limiting life-sustaining treatment but not capable of signing a consent document). In such a case, an audio-visual recording of their consent may be used as a substitute for a signed consent document.
e. Authorised representative of the patient (family member/caregiver/surrogate decision-maker) has the right to follow socio-cultural and religious leaders' opinions on EOLC.

The patient's inability to pay for advanced care should never be a factor in determining whether their condition is medically inappropriate.

ADVANCE MEDICAL DIRECTIVE [9]

The Supreme Court of India, in the landmark judgment of Common Cause vs. Union of India (2018), recognised the right to die with dignity and allowed for AMD or living wills. The latest ruling has simplified the process, allowing individuals to specify their preferences for medical treatment in case they become terminally ill and are unable to communicate their wishes. It involves planning for future medical care in case a patient is unable to make their own decisions. This is a written, legal document created by a person who is at least 18 years old and has decision-making capacity. It is executed in the presence of two witnesses and a notary or gazetted

officer. It names two or more surrogate decision-makers. A person can refuse various types of medical treatment, such as CPR, ventilation, and dialysis, at the end of life. This document should be updated regularly, and patient's values and goals should be explored and documented. Designating a surrogate decision-maker is important. It is a process, not an event, that reduces confusion and conflict. A copy of the AMD is delivered to the custodian appointed by the local authority. It can also be kept in the patient's digital health records. A sample AMD developed by the Vidhi Centre for Legal Policy and adapted by SGRH, is attached **[Annexure K].**

Digital Record Disclaimer*: Sir Ganga Ram Hospital shall maintain a digital copy of this Advance Medical Directive solely as a record repository and shall not be responsible for verifying, monitoring, updating, interpreting or ensuring its validity, authenticity or continued effectiveness. The executor shall remain solely responsible for any modification, revocation or replacement of this AMD and agrees to indemnify and hold harmless the hospital from any claims, liabilities or disputes arising from its storage, retrieval or reliance upon the AMD, except in cases of willful misconduct or fraud by the hospital.*

ANNEXURES

SGRH/EOLC/CRT-IA-NB-FM/F-544/2025

Annexure A: Criteria for establishing 'Inappropriateness/Non-beneficence of further management' by physicians

1. **General criteria in adult patients that predispose to medical Inappropriateness/Non-beneficence of further management**
   a. Advanced age
   b. Limited functional capacity
   c. Poor performance status
   d. Multiple co-morbid illnesses
   e. One or more end-stage organ impairments (pulmonary, cardiac, renal, hepatic, etc.)

2. **Specific criteria**
   a. Patients admitted to an Intensive Care Unit
      i. Progressively worsening multiorgan dysfunction not responding to a reasonable duration of aggressive medical interventions
      ii. Coma due to causes with non-reversible effects like major infarcts, intracranial bleeding or traumatic brain injury
      iii. Metastatic malignancies in which there are no treatment options, or the treatment options cannot meet the goals of cure
      iv. Poor neurological outcomes after cardiac arrest (>72 hours post-cardiac arrest)
      v. Chronic neurological conditions where there is a progressive deterioration in cognition and functional ability leading to poor quality of life like progressive dementia, chronic vegetative state and quadriplegia
      vi. An illness in which a physician predicts a low likelihood of meaningful survival
      vii. Extreme drug-resistant infections

   b. Patients with neurological conditions
      i. Advanced cases of Alzheimer's disease with total dependence (Dementia Rating Scale 50 or above)
      ii. Stroke survivors with Glasgow Coma Scale (GCS) 4 after three days of absent corneal reflexes
      iii. Multiple Sclerosis *Expanded Disability Status Scale* (EDSS) 9.5 (totally dependent, bed bound, unable to communicate effectively, eat or swallow)
      iv. Amyotrophic Lateral Sclerosis (ALS) rating scale (< 6)
      v. Parkinson's disease *Unified Parkinson's Disease Rating Scale* (UPDRS) Scale < 150
      vi. CNS infections like meningitis and encephalitis with progressive worsening, multi-organ dysfunction that does not respond to a period of aggressive therapy
      vii. Poor neurological outcomes after cardiac arrest.
      viii. Low meaningful survival of a patient by a physician

ix. Super-refractory status epilepticus after three days of aggressive management

c. Patients with neurosurgical conditions

i. Severe traumatic brain injury (GCS < 6) with dilated fixed pupils > 48 hours
ii. High cervical spinal cord injury with quadriplegia and absence of any spontaneous respiratory effort > 7 days
iii. Patients with intracerebral haemorrhage (ICH) score > 5 for more than 48 hours
iv. Patients with malignant ischemic infarct (pre and post-operative) with GCS < 6 and fixed dilated pupils
v. Recurrent high-grade brain tumours with GCS < 6 and Karnofsky Performance Status Scale (KPS) < 70
vi. Metastatic brain disease with GCS < 6 and KPS < 70
vii. Patients with diffuse hypoxic injury secondary to any aetiology
viii. Congenital pediatric developmental abnormalities incompatible with prolonged survival

d. Patients admitted to the medical wards

i. Terminally ill patients with progressive multi-organ failure needing life support systems and medicines (sepsis and multiorgan dysfunction) not showing signs of response to therapy
ii. Advanced progressive organ failure (renal, liver, cardiac, neurological or respiratory failure) needing life support systems and medicines but not showing response to therapy, organ transplantation or replacement therapy
iii. Advanced malignancy on palliation with additional complications like severe infection, bleeding or organ failure
With (one or more aspects provided below)
    - Progressively dropping blood pressure despite all correctable measures
    - Progressively worsening neurological status
    - Progressively increasing need for ventilator support
    - Worsening multi-organ dysfunction
    - Progressively worsening metabolic parameters

e. Patients with malignancy

i. Metastatic cancer or advanced cancer with no scope for further disease-modifying treatment
ii. Expected survival from weeks to days
iii. Poor performance status and needing significant assistance with activities of daily living
iv. Multiple unplanned admissions and emergency room visits in the last 12 months with (one or more aspects provided below):
    - Progressively dropping blood pressure despite all correctable measures
    - Progressively worsening neurological status
    - Progressively increasing need for ventilator support

- Worsening multi-organ dysfunction
- Progressively worsening metabolic parameters

f. 'End-of-life Care' in Paediatrics

i. **Recognition of medical inappropriateness/non-beneficence of further management:**

- Permanent vegetative state – trauma, hypoxia, post-cardiac arrest
- "No chance" situation – merely delaying death without alleviating suffering - spinal muscular atrophy, end-stage cancers, etc.
- "No purpose" situation – severe physical or mental impairment - anencephaly, uncorrectable complex congenital heart disease, caudal regression syndrome, Prune belly syndrome, etc.
- "Unbearable" situation – a progressive, incurable disease where no definitive therapy is available, for example – end-stage renal disease (ESRD), severe inborn errors of metabolism, chronic interstitial lung disease, cardiomyopathy, biliary cirrhosis, and progressive worsening multiorgan dysfunction

ii. **Medically futile conditions at birth or during the neonatal period**

- Limits of viability-extreme prematurity (less than 24 weeks)
- Severe life-limiting anomalies (e.g. anencephaly)
- Severe neurological injury; intraventricular haemorrhage (IVH) Grade 4 with severe encephalopathy/severe hypoxia-ischemic injury on life support (not responding to treatment) with high chances of major neurological sequelae
- Inoperable surgical neonates (e.g. gangrene of the entire or major part of the gastrointestinal tract, hypoplastic left heart syndrome)
- Progressive multiorgan dysfunction unresponsive to at least 72 hours of aggressive intensive care therapy, with (one or more aspects provided below):
  - Severe refractory hypotension unresponsive to maximal inotropic support
  - Comatose or persistent severe encephalopathy despite supportive treatment
  - Persistent respiratory failure requiring high ventilator settings or an oxygenation index of > 40
  - Worsening multi-organ dysfunction
  - Progressively worsening metabolic parameters, e.g. severe, intractable metabolic acidosis not responding to treatment
  - The components of EOLC plans for neonates are highlighted in **[Annexure H]**
  - Peri-viable situations: In situations of peri-viability with a confirmed gestation of fewer than 24 weeks, antenatal counselling should be done whenever possible. The obstetrician, neonatologist and the team should counsel the parents on neonatal mortality and morbidity. A standard document for EOLC [Annexure I] is to be signed by the expectant parents/legal guardian, the neonatologist and obstetrician, and an independent witness. The obstetrics and neonatal team should be members of the PMB when the child is born. The baby will be assessed at birth, and if postnatally, gestation seems as expected and parents have given consent for DNAR, end-of-life care will be provided in the neonatal intensive care unit (NICU).
  - In situations of peri-viability where antenatal counselling is not feasible, resuscitation will proceed, and the baby will be shifted to the NICU. The baby will

be managed as per standard protocol for prematurity unless parents wish to withdraw care. In such situations, the EOLC pathway will be activated once the futility of care is established. The hospital will constitute the Primary and Secondary Medical Boards as per the Supreme Court guidelines. Further action on withdrawal of care will be taken in the NICU after the decision of the medical boards.

In the case of neonates, both parents should consent before withholding or withdrawing care. Pending this, all treatment should be continued. The parents' decision regarding withdrawal or withholding of treatment needs to be honoured.

g. Recommendations for treatment of the mentally ill under 'End-of-life Care'

i. Early referral of the mentally ill with serious disease for end-of-life care to build rapport and trust with a new therapeutic team
ii. An end-of-life mental health assessment supported by skilled care and planning is provided following a referral
iii. Care in a familiar milieu as long as possible
iv. Ensure the psychiatric team continuously supports the patient
v. Co-involvement of EOLC and psychiatric team
vi. Education, support and supervision of staff due to stigma, prejudice and discrimination against the mentally ill
vii. Palliative care physicians' and psychiatrists' skills are needed to improve the end-of-life care of the mentally ill

Annexure B: Endorsement of the medical inappropriateness/non-beneficence of further management

Endorsement of the medical inappropriateness/non-beneficence by the Primary Medical Board:

We certify that (patient's name) …… with UHID.....admitted at Sir Ganga Ram Hospital, New Delhi, is suffering from (…….. patient diagnosis) ….....We have examined the patient for the Inappropriateness/Non-beneficence of further management.

We feel that it is medically inappropriate or non-beneficial to initiate or continue life-sustaining treatment in this patient because:

_____

_____

_____

_____

We recommend withholding/ withdrawing all life-sustaining measures in this patient, such as:

_____

_____

_____

Names and signatures of Primary Board Members

1.

2.

3.

Date:

Place:

Endorsement of medical inappropriateness/non-beneficence of further management by the **Secondary Medical Board:**

Whether agree with the PMB (YES/NO) ……

We feel that it is medically inappropriate or non-beneficial to initiate or continue life-sustaining treatment in this patient because:

……
……
……
……
……
……
……..

In consensus with the Primary Medical Board, we recommend referring this patient for palliative care to control symptoms and provide end-of-life care.

Names and Signatures of Secondary Board Members

1.

2.

3.

Date:

Place:

Annexure C: Communication checklist for prognosis disclosure and inappropriateness/ non-beneficence of further management

Communication language for: ……

(Fill in Yes/ No as applicable)

1.	Ability to communicate in _____ language	Yes/No
2.	Introduction of self and team	Yes/No
3.	Whether a valid Advance Medical Directive exists	Yes/No
4.	Confirmation of decision makers (Patient/ Caregiver) Name and address checked Surrogate decision-maker noted	 Yes/No Yes/No
5.	Insight into the condition assessed Awareness of diagnosis and prognosis	Yes/No Yes/No
6.	Prognosis discussed Goals and plan of care explained and discussed	Yes/No Yes/No
7.	The plan of care and understanding of the prognosis are checked	Yes/No
8.	Religious/spiritual needs assessed/ offered	Yes/No

Signature of Primary Physician…….

Department……

Date ……..

Annexure D: Patient's consent form for withholding/withdrawing Life Support

(if the patient has decision-making capacity)

Patient's consent for withholding/ withdrawing Life Support

I (patient name) ……with UHID No .....admitted at Sir Ganga Ram Hospital, New Delhi, have a critical/terminal illness where disease- modifying options are no longer applicable and have complications related to the progressive nature of the disease, which is potentially life-threatening.

I am aware that my overall health is poor, and the disease is advanced, so I may develop/have developed serious life-threatening complications.

The futility of interventions such as endotracheal intubation and cardiopulmonary resuscitation, which will cause suffering without reasonable benefit, is also understood.

The goal of my care would be to relieve symptoms, provide comfort and improve quality of life.

If I get into cardiopulmonary arrest, please allow natural death, i.e. (no external chest compressions, no intubation, and no chemical or electrical cardioversion).

By signing this document, I agree to continue receiving necessary medical and nursing care, pain relief measures, and nursing care, with a high priority on maintaining my dignity.

My doctors have explained all the details in a language I understand, and I am making a well-informed decision. I understand the consequences of my decision.

I am making this declaration of my free will, and I am not being coerced, influenced, or manipulated.

Patient' name …….

Signature……..

Date/ Time …….

Doctor/ Department……..

Annexure E: Family's/ Caregivers' consent form for withholding/ withdrawing Life Support

Family's/ Caregivers' consent for withholding/ withdrawing Life Support

I/ We, the family members/ attendants/ caregivers of (patient name) ……with UHID No.....admitted at Sir Ganga Ram Hospital, New Delhi, acknowledge attending the family meeting convened by the Department of …… on …… at…….

I/We have been explained that the illness is in an advanced stage, prognosis is uncertain, and treatment outcomes remain uncertain.

In the meeting, I/ we asked questions and clarified our queries regarding the patient's clinical condition, prognosis and treatment outcome. We understand that the continued, aggressive use of life-sustaining medical treatment has the potential to cause suffering to the patient. My/our decision reflects what we know/have reason to believe this to be the patient's wishes, and there are no disagreements among the family members on the matter.

The doctors have been asked to withhold/withdraw lifesaving treatments as I/we have decided to make that request on behalf of the patient.

Upon signing this document, I/we understand that my/our patient will be entitled to all necessary medical care, pain management, and nursing care according to his/her individual needs. Maintaining the dignity of the patient is our highest priority.

If the patient goes into cardio-pulmonary arrest, I/we request you to please allow natural death (i.e. no external chest compressions and no chemical or electrical cardioversion).

Family members' signatures attending the meeting

S. No.	Name	Age/ Gender	Relationship	Signature

Clinicians' signatures conducting the meeting

S. No.	Name	Designation/ Department	Signature

Date: …….. Time: …… Place: ……..

Annexure F: Checklist for initiation of 'End-of-Life Care'

No potential reversible causes in the patient's condition	Yes	No
Treatment consensus among clinicians	Yes	No
Decisions are made with the patient's participation	Yes	No
The patient is aware that his/her condition is irreversible	Yes	No
Advance directive available	Yes	No
Family's active participation in decision-making	Yes	No
The family is fully aware of the patient's irreversible condition	Yes	No
Documentation of family meetings	Yes	No
Consensus and agreement among family members that further management is futile	Yes	No
A plan for further care was explained to the family	Yes	No
Explain and initiate guidance and care plans for the dying	Yes	No
Organ harvesting planned	Yes	No
Place of care opted by patient/caregiver	Hospital/ Home/ Hospice	

Palliative Care Team Signatures 1. 2. Date: Time:	Palliative Care Team Signatures 1. 2. Date: Time:

Annexure G: Daily supportive care plan and treatment for paediatric patients, excluding neonates

Ongoing assessment of the care plan **Patient's name:** **UHID:** **Date:**						
Time						
(Yes/No)						
The patient is conscious						
The patient is oriented						
The patient is communicative						
Does the patient have pain?						
Is the patient agitated?						
Does the patient have a respiratory tract infection?						
Does the patient have nausea?						
Is the patient vomiting?						
Is the patient breathless?						
Does the patient have urinary problems?						
Does the patient have bowel problems? (Bowels last opened.....)						
Does the patient have any other symptoms? If present, record ……..						
The patient's comfort and safety regarding the administration of medicines is maintained						
The patient receives food and fluids to support their individual needs						
The patient's behaviour is not abnormal						
The patient's memory is preserved						
The patient's mouth is moist and clean						
The patient skin integrity is maintained						
The patient personal hygiene needs are met						
The patient receives care in a physical environment adjusted to support their needs						
The patient's psychological well-being is maintained						
The patient spiritual well-being is maintained						
The well-being of the relative/ caregiver attending to the dying person is maintained						
Signature of the nurse after each assessment						

PROGRESS NOTES		
Date/ Time	Comments	Signature

Annexure H: End-of-life Care Components for Newborn

Ongoing assessment of the care plan

Counselling Responsibility-Senior/Unit in charge

Patient's name: newborn of (Mother's name)
UHID:
Date:

Time						
(Yes/No)						
Cry - absent/ present						
Respiration - absent/ present						
Spontaneous movements - absent/ present						
Normal muscle tone- absent/ present						
The newborn's comfort and safety regarding the administration of medicines is maintained						
The newborn receives feeds and fluids for support						
Warmth under a radiant warmer is provided Pain relief as per neonatal pain scores is provided						
The airway is clear of secretions						
The newborn's mouth is moist and clean						
Diaper care/skin care provided Parents allowed to hold the newborn/Kangaroo mother care/Non-nutritive sucking/Swaddle						
The newborn's personal hygiene needs are met						
The newborn receives care in a physical environment adjusted to support their needs						
Memory making, like taking a newborn's picture or footprints, allowed						
The well-being of the relative/ caregiver attending to the dying newborn is maintained						
Signature of the nurse after each assessment						

PROGRESS NOTES

Date/ Time	Comments	Signature

Annexure I: Consent for Resuscitation and Management /Do not resuscitate in extremes of prematurity

I/we understand that the resuscitation of an extremely immature newborn at the gestation of ……. has poor outcomes. The survival of newborns with a gestational age less than ……. weeks is reported to be between …… % in the best of centres internationally. Further, I/we recognise that the risk of morbidity (which includes such conditions as mental retardation, severe cerebral palsy, blindness or deafness) is very high at this gestation. The chances of survival without major neurological impairment are less than …..%. Also, I/we understand that despite all efforts by the resuscitation team, my/our newborn may not survive the delivery. If resuscitation is successful, my/our newborn will be admitted to the intensive care nursery, where treatment will continue. I/we also understand that after birth, following assessment by the treating team, the decision taken by me/us might be changed. I/we will be kept informed of all changes.

Finally, I/we state that before signing or declining this form, I/we have been given and have taken the appropriate time to read, reflect on, and ask questions about this information and the specifics of my/our newborn's condition.

In this light, I/we have read the above information and, in consultation with appropriate individuals, request that, though experimental, efforts to resuscitate my newborn …… be performed/not performed by the neonatology team at this Centre.

Signatures of the family members attending the meeting

S. no.	Name	Age/ Gender	Relationship	Signature

Signature of the clinicians conducting the meeting

S. no.	Name	Designation/ Department	Signature

Date: …….. Time: …… Place: ……..

Annexure J: ICMR Annexures

The ICMR guidelines on 'Do Not Attempt Resuscitation' orders (DNAR orders) continue to be valid for patients with decision-making capacity. However, for patients without decision-making capacity, the ICMR guidelines will have to be modified in light of the new guidelines laid down by the Supreme Court in 2023.

Patient/Surrogate(s) Information Sheet on 'Do Not Attempt Resuscitation' (DNAR)
This guidance is meant to help patients and their families understand cardiopulmonary resuscitation (CPR) and the decision regarding 'Do Not Attempt Resuscitation' (DNAR) if a patient's heart and/or breathing stops during treatment in the hospital setting.

What is CPR? CPR is an emergency medical procedure. It consists of one or all of the following: **repeated chest compressions; mouth-to-mouth and artificial breathing, usually with an airway tube in the windpipe (in the throat); electric shock/s on the chest; and injectable drugs.** This is an emergency treatment that is initiated immediately by the physician. In most patients, this needs to be followed by intensive care unit (ICU) admission and artificial ventilation if the patient is not already in the ICU. This is because CPR does not change the reason why heart and/or breathing stopped, and the main illness or condition still needs to be managed.

Are there problems with CPR in certain patients? CPR is most successful when it is done in time, in those with a reversible disease or in those with no accompanying incurable advanced chronic or acute disease(s). However, it may have serious side effects in other circumstances, such as those with advanced chronic diseases or those with catastrophic or unresponsive disease(s). The most **frequent potential harm** is that the heart may restart, but **the brain may be permanently damaged** because it had no circulation for some period of time during the process of CPR. This often means that the patient becomes dependent and, in some cases, even vegetative. Most often, the patients' misery and suffering get prolonged when the primary illness or general health condition is incurable. In old and frail people, the procedure may cause rib fractures and injury to the heart.

What is DNAR? It is a medical decision not to initiate or perform CPR on a patient suffering from an incurable disease/condition/terminal illness where medically meaningful survival is not expected.

When to take a decision about CPR and DNAR? Since CPR is an emergency medical procedure which needs to be done as quickly as possible, discussions on DNAR should ideally take place when the patient is in her/his full senses or if the patient is incompetent, *i.e.* not in a position to take such a decision, then with the family/surrogate(s) allowing a reasonable time for them to understand before the physician takes the decision.

Does the decision on DNAR affect the ongoing treatment? Signing the DNAR Form would not deprive the patient of any ongoing treatment aimed at cure and other supportive medical and nursing care.

Annexure J: ICMR Annexures (DNAR)

Logo	**DO NOT ATTEMPT RESUSCITATION (DNAR) FORM** **Name and address of Hospital:**.....

'In consideration of the medical status of Mr/Ms/Mrs....., the team of treating physicians finds that in the event of cardiac and respiratory arrest, any attempt at reviving the heart by cardiopulmonary resuscitation (CPR) (mouth-to-mouth respiration, artificial compression of the heart, artificial ventilation of the lungs, injectable medication and associated measures) is not likely to be beneficial and is likely to cause suffering rather than restoration of life of any significant quality. Hence, in the event of cardiac and respiratory arrest, while all appropriate care and treatment to maintain quality and dignity of life will be continued, no attempts at cardiopulmonary resuscitation will be made'.

Name of the Patient:	**Date of DNAR Decision:**
S/o, D/o, W/o.....	Hospital admission number: .....
Date of Birth: ..... Age:	Name of Physician In-charge: .....
Address:	Name of Department: .....
.....	

1.	Assessment of treating physician(s) decision on DNAR to the patient with summary of reasons:	
1.1	Does the patient have capacity to make/or willing to and communicate decisions about CPR? Comments if any:	YES / NO
1.2	If 'No' to 1.1, then is/are there a surrogate(s) available to receive information and to discuss DNAR on behalf of the patient? If yes, details of surrogate(s): Name..... Contact details: ..... Relationship:	YES / NO
2.	The details have been duly explained to the patient/surrogate(s) Comments if any:	YES / NO
3.	Names of members of treating team (if applicable): 1.....2..... 3. ..... 4.	

Name of patient..... **Signature (if patient has decision making capacity):**	**Name of surrogate (s) and relation with the patient** ..... **Signature:** .....
Name of Other Physician(s)/expert consulted who may or may not be in the treating team, if applicable: ..... **Signature:**	**Name of the Physician In-charge:** ..... **Signature:** .....
Date: .....**(dd/mm/yyyy) Time:** ..... **(00.00 h) Place:**	

.....

Annexure K: Advance Medical Directive

This directive is executed in accordance with the order dated January 24, 2023 of the Hon'ble Supreme Court of India in MA No. 1699/ 2019 in WP (C) No. 215/ 2005 (SC Order).

Personal details

This advance medical directive (living will) and healthcare attorney authorisation is made by me:

Full name	
Gender	
Date of Birth	DD/MM/YY
Government ID	Document Name: ID No.:
Full permanent residential address	
Full current residential address:	
Municipality/Panchayat	

If and when the time comes that I can no longer participate in decision-making regarding my own health and medical treatment, this directive should be treated as the final expression of my wishes.

[If you wish, you may provide more details about why you wish to make this directive, and any beliefs and values that you wish to be taken note of and respected during decision-making on your behalf]

I request that all concerned (including my named surrogate decision-makers, my treating team, and others involved) must treat my wishes in this document as the primary basis for any decision regarding my medical treatment, particularly decisions relating to life-sustaining treatment.

Directions relating to life-sustaining treatment

In situations where my treating physician or team have determined that:

- There is no reasonable medical probability of recovery from a terminal condition, end-stage condition,[1] or vegetative state;[2]
- Any further medical intervention or course of treatment would only serve the purpose of artificially prolonging the process of dying,

[1] 'End-stage condition' means an irreversible condition that is caused by injury, disease, or illness which has resulted in progressively severe and permanent deterioration, and which, to a reasonable degree of medical probability, treatment of the condition would be ineffective.

[2] 'Vegetative state' is one where a person is awake but does not show any signs of awareness. A person is unlikely to recover when they have been in a vegetative state for more than 6 months (if caused by a non-traumatic brain injury) or more than 12 months (if caused by a traumatic brain injury). *(Source: The National Health Services, The United Kingdom)*

I direct that any life-prolonging medical procedure/treatment be withheld or withdrawn, and the course of natural death be permitted.

Here, it is not necessary to do so, but you may provide specifics of health conditions that you anticipate, and/or the kind of life-sustaining treatment you would like to be withheld or withdrawn for each of these conditions. You may mention one or more points in the list below, to indicate what you want or do not want (e.g. you may refuse ventilation but want cardio-pulmonary resuscitation):

Specifically, I direct the withholding or withdrawal of the following medical procedures or forms of treatment:

1. Cardio-pulmonary resuscitation
2. Intravenous fluids and medications, including antibiotics; excluding those that would provide comfort or relieve suffering/pain
3. Dialysis
4. Ventilation or other kinds of artificial life support
5. Chemotherapy
6. Radiotherapy
7. Surgery, unless it is for symptom control or to improve the quality of my life
8. Artificial administration of nutrition and hydration through means such as Ryle's tube/PEG, if it serves only to artificially prolong the process of dying (unless it is provided as part of symptom control or for improving the quality of my life).
9. Others (please specify)

I direct the following medical procedures or forms of treatment to be provided or continued:

1. Cardio-pulmonary resuscitation
2. Intravenous fluids and medications, including antibiotics, and drugs that would provide comfort or relieve suffering/pain
3. Others (please specify)

Further, even when life-sustaining treatment is withheld/withdrawn, I direct the administration of medication or the performance of medical procedures for providing me with comfort care or to alleviate suffering in the form of pain, distress, or mental confusion [or to facilitate organ or body donation].

Wishes or desires during end-of-life-care

[This section is entirely optional, but you may choose to add what you do want in these situations. Some examples are provided below]

- *[choice of place of treatment]* For the duration of end-of-life-care, I wish to stay in a hospital or appropriate medical facility OR in a hospice or similar institution OR at home for the duration of such palliative/comfort care.

  OR

[you can also name your preferred institution(s)] Subject to feasibility as determined by my named surrogate decision-makers, I wish to stay in [name(s) of institution] for the duration of such palliative/comfort care.

- *[choice of treating physician]* I would like [name of physician, designation, name of institution] to take care of my health at this stage, subject to availability and feasibility.
- *[you can mention any special focus/priority]* In the course of EOLC, I wish for special attention towards alleviating mental distress or confusion, so that I am able to spend meaningful time with my loved ones.
- *[specifying gender identity]* Through the course of treatment, I would like my name [specify name] and gender [specify gender and/or pronouns] to be respected by all healthcare workers, caregivers, support staff, and others. This would be especially crucial for all forms of documentation, communication with me, communication about me with others, handling of my body, etc.
- *[for non-heteronormative relationships]* I would like [name of partner] to be referred to as [my partner or chosen term] in all communication by healthcare workers, caregivers, support staff, and others.

Authorisation of surrogate decision-makers

In order to ensure that my wishes here are the primary basis for taking any treatment decisions, and to make decisions on my behalf for my medical treatment as may be needed from time to time, I have nominated [Number in words (number in figures)] Surrogate Decision-makers in order of preference.

[*You should authorise at least two persons to be your surrogate decision-makers. If you wish to authorise more than two persons, you should list your order of preference.*]

I have had extensive discussions with those named regarding my wishes, their responsibilities, and the situations in which they may be expected to make decisions. They have expressed that they are willing to be nominated as my Surrogate Decision-makers.

I authorise my Surrogate Decision-makers to exercise the following powers:

- They can obtain medical information from the treating team regarding my treatment, my health records, and any communications with the treating team;
- They can make decisions and act on my behalf regarding my wishes in this document as necessary. These decisions would include, but are not limited to, providing consent, refusing, or withdrawing consent to any care, treatment, service, or procedure, guided primarily by my wishes as expressed in this directive.

The decisions taken by my Surrogate Decision-makers should be respected regardless of any contrary views held by others.

I authorise the following persons as my **Surrogate Decision-mak**ers in the following order of preference and availability.

1.

S No	Particulars	Information
a	Full Name	
b	Gender	
c	Relationship with the executor	
d	Date of Birth	DD/MM/YY
e	Government ID	Document name: ID no.:
f	Mobile Number(s)	Primary: Any other:
g	Email ID(s)	Primary: Any other:
h	Permanent Residential Address	
i	Residential Address on the date of signing this document	

Signature or Thumb Impression

2.

S No	Particulars	Details
a	Full Name	
b	Gender	
c	Relationship with the executor	
d	Date of Birth	DD/MM/YY
e	Government ID	Document name: ID no.:
f	Mobile Number(s)	Primary: Any other:
g	Email ID(s)	Primary: Any other:
h	Permanent Residential Address	
I	Residential Address on the date of signing this document	

Signature or Thumb Impression

3.

S No	Particulars	Details
a	Full Name	
b	Gender	
c	Relationship with the executor	
d	Date of Birth	DD/MM/YY
e	Government ID	Document name: ID no.:
f	Mobile Number(s)	Primary: Any other:
g	Email ID(s)	Primary: Any other:
h	Permanent Residential Address	
i	Residential Address on the date of signing this document	

Signature or Thumb Impression

Total Number of Surrogate Decision-Makers
This will be calculated based on the forms you fill.
Number in words and figures: _____

Directions to be followed upon my death

[This section is entirely optional, but you may choose to add what you do want in these situations. Some examples are provided below]

- *[reference to organ donation etc.]* ***a.)*** I am a registered organ donor in accordance with the Transplantation of Human Organs and Tissues Act, 1994. My choices as an organ donor have been noted in Form 7 of the Act, as per prescribed procedure. I am enclosing the form with this document for reference and implementation. My loved ones, including my surrogate decision- makers, have been informed of my wishes regarding organ donation. **b)** Those who have not previously pledged for organ donation, the designated consent form is available at the following link: https://notto.abdm.gov.in/register.
- *[body/cadaver donation]* I wish for my body to be donated for the purpose of medical research and education. In this regard, I have communicated my wish to [name of medical college or body donation NGO], submitted the necessary consent forms, and completed the relevant procedure on my part. My loved ones, including my surrogate decision-makers, have been informed of my wishes regarding body donation.
- *[wishes pertaining to last rites/funeral - especially important for atheists or those with chosen religions]* I would like my last rites to be performed in accordance with practices of [name of religion] OR I would not like any religious rituals to be performed upon my death. I wish for my mortal remains to be cremated/buried/[any other process] upon completion of all necessary medical or legal procedures.

Declaration

I declare that at the time of signing and executing this document,

- [*Please add this first point in case the executor is illiterate*] This document has been drafted as per my directions and its contents have been read out to me in the language I understand.
- I have the capacity and competence to understand the meaning and implications of everything mentioned in this document;
- I have given careful thought and consideration to everything mentioned in this document;
- I have willingly and voluntarily articulated and consented to everything mentioned in this document, without any coercion, duress, or undue influence from any person or entity.
- *I state that in the event of non-availability of all aforementioned nominated surrogates despite attempts at communication, then the terms of treatment as stipulated and selected by me in the AMD shall be honoured forthwith.*

This directive is executed in accordance with the order dated January 24, 2023 of the Hon'ble Supreme Court of India in MA No. 1699/ 2019 in WP (C) No. 215/ 2005 (SC Order).

Further, a copy of this directive and healthcare power of attorney has been forwarded to:

- Surrogate decision-maker(s) mentioned in this directive
- [name of family/chosen physician - optional]
- The Competent officer/custodian of the relevant local government - panchayat, municipality, district administration, municipal corporation, etc. *[It is necessary to send the executed AMD to the custodian, but it is optional to mention this here]*

Validity of directive

I declare that this directive, and my authorisations for surrogate decision-makers, shall be valid and remain in force throughout my lifetime, unless I modify or revoke it.

In any case, I reserve the right to execute a revised version of this document, which makes changes to my directions/wishes, or revoke this document in its entirety. I shall also share copies of the revised version with:

- Surrogate decision-maker(s) mentioned in this directive
- [name of family/chosen physician - optional]
- The Competent officer/custodian of the relevant local government - panchayat, municipality, district administration, municipal corporation, etc. *[It is necessary to send the executed AMD to the custodian, but it is optional to mention this here]*

Digital Record Disclaimer*: Sir Ganga Ram Hospital shall maintain a digital copy of this Advance Medical Directive solely as a record repository and shall not be responsible for verifying, monitoring, updating, interpreting or ensuring its validity, authenticity or continued effectiveness. The executor shall remain solely responsible for any modification, revocation or replacement of this AMD and agrees to indemnify and hold harmless the hospital from any claims, liabilities or disputes arising from its storage, retrieval or reliance upon the AMD, except in cases of willful misconduct or fraud by the hospital.*

Signature of the executor
[Full signature or Thumb impression] Full name:
Date:
Place:

Signature of witnesses
I, as a witness, record my satisfaction that the document has been executed voluntarily and without any coercion, duress, inducement, or compulsion.

Witness 1	Signature
Name: Gender: Address: Government ID: Email ID: Mobile No.:	

Signature or Thumb Impression

I, as a witness, record my satisfaction that the document has been executed voluntarily and without any coercion, duress, inducement, or compulsion.

Witness 2	Signature
Name: Gender: Address: Government ID: Email ID: Mobile No:	

¶

Signature or Thumb Impression

Date:
Place:

Notarisation
This directive and authorisation of surrogate decision-makers has been signed in the presence of the undersigned by (Declarant) and I record my satisfaction that the document has been executed voluntarily and without any coercion or inducement or compulsion.

SIGNED BEFORE ME

(Full name of notary)

APPROPRIATE AUTHORITY, STAMP

Date:
Place:

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