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06/08/26
Time.....
DIRECTOR'S CAMP OFFICE
SGPGIMS, LUCKNOW

IOM No. : PGI/CCM/ 546 /2026

To : The Director

From : Prof. Banani Poddar, HOD, CCM

Date : August 6, 226

Subject : Permission to upload the EOLC SOP on institute' website

Please find enclosed the SOP of End-of-life care (EOLC).

Kindly give your permission to upload the SOP of EOLC on our institute's website.

Banani

Banani Poddar

Yes..
Mr Ravindra Agrawal. | 8/8/26..
upload

CC : Prof. Uttam Singh, HOD, BHI

08/8/26

DIRECTOR
S.G.P.G.I.M.S., Lko.

STANDARD OPERATING PROCEDURES FOR END-OF-LIFE CARE (EOLC)

Proposal for the Government of Uttar Pradesh

Mission: ***Provide care and comfort at the end of life***

"Every human has a right to die with dignity"

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Preamble

'End-of-life care' is a person-centred, personalised perception of "good death" which encompasses all aspects of comprehensive care of an individual at the end of his or her life. It involves

- Applicability to any person, place or illness
- Relief of physical, psychological, social, spiritual and existential symptoms
- To die at the preferred place of choice
- To receive appropriate care from a trained healthcare provider
- To have access to palliative care at the end of life

It is based on the premise that every individual has the right to a good, peaceful and dignified end-of-life care and death. The Supreme court of India, in its landmark judgement in 2018, has recognised the 'right to die with dignity' as a fundamental right of every citizen.

Clinical decision making in advanced and critical illness is often technologically and ethically complicated. As multiple stake holders are involved in clinical decision making, it is easy to lose perspective of the illness, futility, outcomes of interventions and patient autonomy. This document has been created to guide the processes involved in these critical and urgent decisions.

The aim is to achieve a systematic execution of the process with adequate safeguards in place to balance between the ease of use and prevention of abuse.

Background

Patients with terminal and critical illness are given inappropriate life sustaining interventions without any clinical benefit. The patients experience poor control of symptoms; families receive incomplete health-related communication, and often the health care providers lack training in providing end-of-life care. The patients are continued on organ supports, until the last weeks of life and often receive futile life-sustaining interventions. These patients are seldom referred to palliative care or for end-of-life care. Moreover, goals of care discussion, advanced care planning and anticipatory directives are rarely addressed.

Providing aggressive life-sustaining treatment is often futile and may cause needless suffering in a terminally ill patient. It may be against the patient's interest and may contribute to needless pain, burden and suffering. Limiting life sustaining treatment in terminally ill patients at the end of life allows the individual to die with dignity. Moreover, in countries like India with limited ICU beds it shall ensure optimal bed utilisation.

Following the Supreme Court's landmark ruling on March 11, 2026, AIIMS, New Delhi was directed to oversee the dignified passing of a patient who had been in a persistent vegetative state for 13 years. The patient passed away peacefully on March 24, 2026, marking the first time the 2018/2023 'withdrawal of life sustaining treatment' guidelines[1] were successfully navigated in a clinical setting in India. This sets an example for all times to come and encourages us to pursue this for the state of Uttar Pradesh.

The document aims to make this process simple and safe to protect patients' right to receive a dignified end-of-life care and limit needless harm due to inappropriate interventions[2].

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[1] Supreme Court of India. Common Cause (A Regd. Society) v. Union of India and Another (Miscellaneous Application No. 1699 of 2019 in Writ Petition (Civil) No. 215 of 2005). 2023 Jan 24.

[2] Guidelines for withdrawal of life support in terminally ill patients by Ministry of Health and Family Welfare https://dghs.mohfw.gov.in/uploads/assets/Ym7COsjGbBsOkMxYuLRUlrO3j3ZE0Bn7HTXpuyDV.pdf

Overview of the structure and steps

The structure of this document closely follows the joint society guidelines on "End-of-life care Policy: An integrated care plan for the dying" developed by the Indian Society of Critical Care Medicine (ISCCM) and Indian Association of Palliative Care (IAPC).

The purpose was to develop an end-of-life care (EOLC) policy for patients who are dying with advanced life-limiting illnesses and provide practical procedural guidelines for limiting inappropriate therapeutic medical interventions. It is an attempt to improve the quality of care of the dying within an ethical framework and through a professional and family/patient consensus process. It follows a stepwise approach, and this document encompasses those steps.

Listed below and published in the Indian Journal of Critical Care Medicine[3]. (All the terminologies used in this document are as per the guidelines on the website of the Ministry of Health and Family welfare, Government of India)

Stepwise Pathway: medical futility to end-of-life care

A. Recognition of medical futility

Step 1: Physician's objective and subjective assessment of medical futility.

B. Physician consensus

Step 2: Consensus among healthcare providers.

C. Communication, decision making, and documentation

This section involves transparent discussion and shared decision-making with the patient and family.

Step 3: Honest, accurate and early disclosure of prognosis to the best available knowledge of physicians.

Step 4: Discussion and communication of all modalities of end-of-life care.

Step 5: Shared decision making and achieving consensus between healthcare providers and patients through repeated and open discussion.

Step 6: Transparency and consistency in documentation.

Step 7: Ensuring consistency among the caregivers through a family meeting.

D. Implementation of withholding and withdrawing

Step 8: Implementing the process of withholding and withdrawal of life-sustaining treatment.

E. End-of-life care (EOLC)

Step 9: Palliative Care in End of Life.

Step 10: After death care.

Step 11: Bereavement support.

Step 12: Review of the care process.

[3] Mani RK, et al. Indian Society of Critical Care Medicine and Indian Association of Palliative Care Expert Consensus and Position Statements for End-of-life and Palliative Care in the Intensive Care Unit. Indian J Crit Care Med. 2024;28(3):200-250

Method of developing standard operating procedures

The hospital end-of-life care (EOLC) task force shall consist of critical care physicians, neurologists, neurosurgeons, pediatricians, palliative care specialists, lawyers and hospital administrators. In addition, it may include any specialty or super specialty clinician or surgeon who may be dealing with terminally ill patients.

Proposed algorithm (Stepwise approach)

See diagram on the next page

1. **Recognition of medical futility in various settings**

2. **Ascertain medical futility**
   - Physician consensus on medical futility
   - Procedure for obtaining physician consensus
   - Documentation of medical futility in the medical record
   - Endorsement of the medical futility

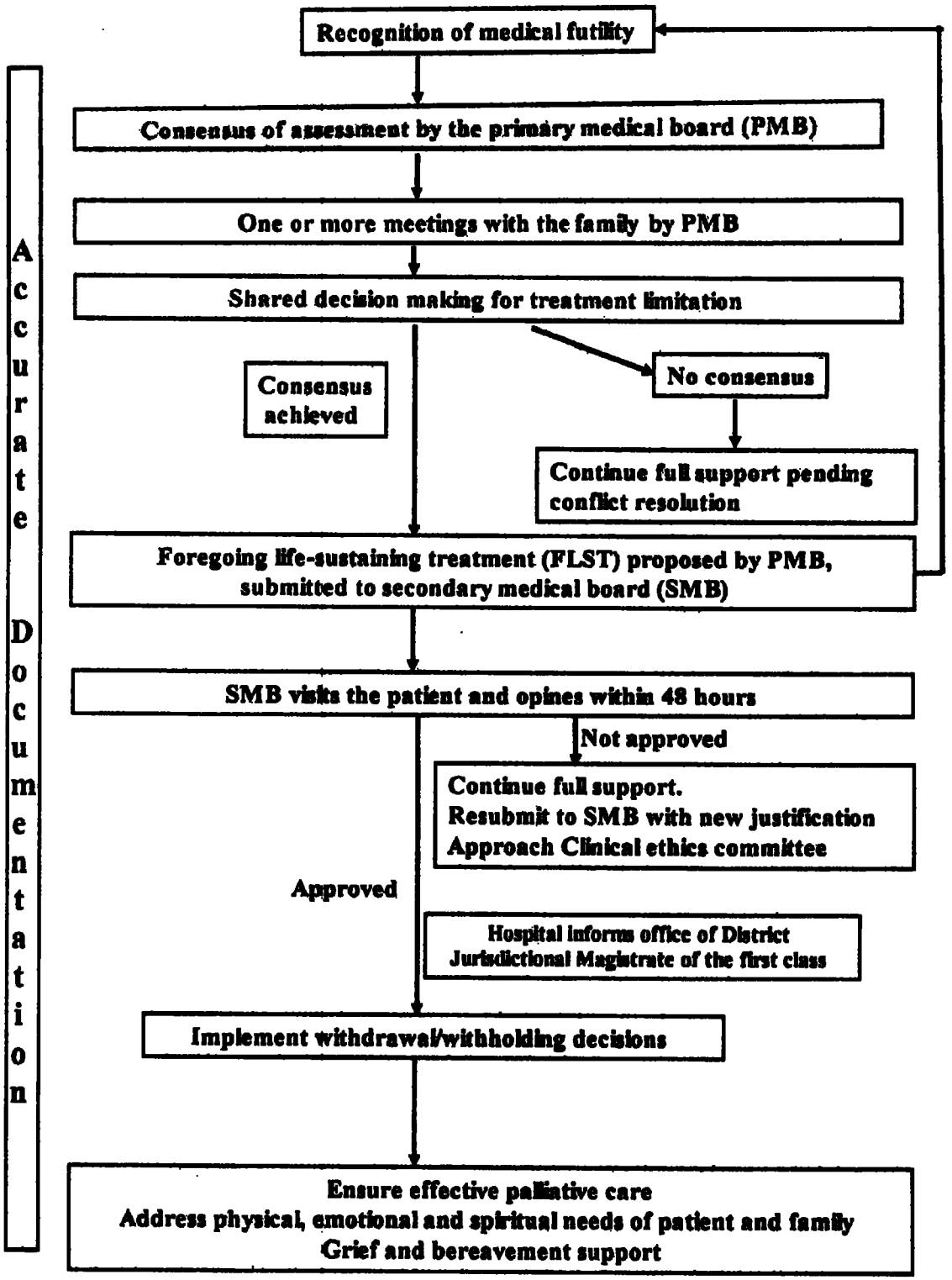
3. **Ascertaining physician consensus on medical futility**
   - Standardized forms for foregoing life sustaining treatment (FLST)
   - Withholding life sustaining treatment
   - Withdrawing life sustaining treatment

4. **Communicating prognosis**
   - Checklist for communicating with family
   - Template for family meeting
   - Medical record update

5. **End-of-life care**
   - Implementation of the death declaration protocol
   - Brain death protocol
   - After death protocol

   These latter three will be as per the existing norms of the Institute

Pathway for withdrawal and withholding of life support



Adapted from - Indian J Crit Care Med. 2024;28(3):200-250

Recognition of medical futility

A. General criteria in adult patients that predispose to medical futility:

- Advanced age
- Limited functional capacity
- Poor performance status
- Multiple co-morbid illnesses
- Metastatic malignancies where there are no treatment options or where the treatment options cannot meet the goals of care
- One or more end-stage organ impairment (pulmonary, cardiac, renal, hepatic etc) not amenable to organ transplantation

B. In patients admitted to an intensive care unit (ICU)/wards, despite adequate resuscitation and organ support, having

- Progressive worsening of multi-organ dysfunction/failure
- Post-cardiac arrest status with poor neurological outcomes
- Chronic neurological conditions where there is a progressive deterioration in cognition and functional ability leading to a poor quality of life like permanent vegetative state
- Chronic progressive neurological illnesses who are confined to bed and totally dependent
- Coma due to causes with non-reversible effects like major infarcts, intracranial bleed or traumatic brain injury
- Stroke survivors with Glasgow Coma Scale (GCS) < 4 after three days or absent brainstem reflexes
- Infections of central nervous system such as meningitis or encephalitis unresponsive to treatment
- Severe traumatic brain injury (GCS < 6) with fixed dilated pupils> 48 hours
- High cervical spinal cord injury with quadriplegia and absence of any spontaneous respiratory effort more than a week
- Recurrent high-grade brain tumors or metastatic brain disease with GCS < 6, and confined to bed and totally dependent
- Any condition where the physician reasonably predicts a low probability of meaningful survival

C. In children admitted to the ward or pediatric intensive care, despite adequate resuscitation and organ supports having

1. Medically futile condition:
   a. *The child in a permanent vegetative state:* Permanent vegetative state can occur as a result of a variety of insults, such as hypoxia or trauma. The child is totally dependent on others for all aspects of care and does not react to, or interact with, the outside world.

   b. *The "no chance" situation*: The "no chance" category covers the child for whom life sustaining treatment will merely delay death, without significantly relieving the suffering caused by the disease e.g. end stage solid organ tumors /leukemias with worst prognosis with relapses.

   c. *The "no purpose" situation*: "No purpose" refers to when a child's life may be saved by medical treatment, but the degree of mental or physical impairment may be so great that the quality of life for the child is intolerable e.g. meningomyelocele/cauda equina syndrome

   d. *The "unbearable situation":* In the face of progressive disease, additional treatment may only cause further suffering, despite the possibility that it might have some potential benefit on the underlying condition without curing it. e.g. severe inborn errors of metabolism

In addition to all the above, all the conditions mentioned in B (patients admitted to an ICU/ward), would

be applicable to children too.

2. Medically futile conditions at birth
   a. *Lethal or life-limiting congenital anomalies*: A baby with congenital anomaly or anomalies that are incompatible with life or with poor expected quality of life. It includes situations where survival is impossible or extremely short even with maximal support; e.g., anencephaly, lethal skeletal dysplasias

   b. *Extreme prematurity with non-survivable prognosis*
      End-of-life discussions are appropriate when:
      1. <22 weeks gestation: routine palliative care recommended
      2. 22–23 weeks with poor prognostic indicators, such as severe growth retardation, severe congenital anomalies, severe intraventricular hemorrhage (IVH) etc.
      3. 24–25 weeks but with catastrophic early complications, e.g.,
         i. Grade III–IV IVH or periventricular hemorrhagic infarction
         ii. Massive pulmonary hemorrhage
         iii. Refractory hypotension with multi-organ failure

   c. *Catastrophic acquired conditions with no reasonable chance of recovery*
      End-of-life care should be considered when the baby has a non-recoverable injury and continued intensive care is futile. Example- severe hypoxic ischemic injury Stage 3 with absent electrical activity, persistent coma, and no brainstem reflexes/absent evoked potentials; massive IVH with hydrocephalus and brainstem compression.

Although there may be consensus about medical futility, end-of-life care should not be triggered in the following situations.

a. When the outcome is doubtful (the medical condition may or may not improve)
b. When there is conflicting opinion among the family members
c. When the next of kin responsible is not available for discussion
d. When the patient does not consent (if the patient is capable of exercising his/her judgement and making his/her wishes known about limiting life-sustaining treatment, but not capable of signing a consent document, then an audio-visual recording of his/her consent may be used as a substitute to informed consent)
e. When the treating doctors do not agree to do-not-resuscitate (DNR) decisions, it should never be accepted based on the suggestions of parents or relatives

The inability of the patient to pay for advanced care should never be a factor in determining whether or not his/her condition is medically futile

Documentation and framework for the various steps

Physician consensus on medical futility

Procedure for obtaining physician consensus

1. Agreed upon by the primary treating physician(s) involved in the care and the futility is documented in the medical case records and signed
2. The futility is endorsed by 3 physicians of at least 5 years of experience who are involved in the care of the patient. This is the **primary board**.
3. In the case of children, futility is assessed by two pediatricians of at least 5 years' experience; adult physicians cannot endorse futility in children.
4. In the setting of cancer, futility of care has to be endorsed by two oncologists of at least 5 years' experience or preferably by the hospital tumor board.
5. If there is no consensus on futility, the situation can be reviewed again after a time-limited trial.
6. Once there is consensus on medical futility, there should be detailed documentation justifying the futility decision.
7. Once there is consensus on futility by the primary board
   The decision to withhold/withdraw life-sustaining treatment has to be referred to the **secondary board**.
   The secondary board consists of three subject experts with >/= 5 years' experience, and one of them is nominated by the Chief Medical Officer of the district.
   The futility is endorsed by this secondary board in a time bound fashion.
8. In case there is no consensus on futility, it should be referred to the hospital**'s clinical ethics committee**. This committee is constituted by the chief administrator of the hospital, two senior medical practitioners with expertise in end-of-life care (one from within the hospital and one from outside the hospital), a legal expert and senior social worker. This committee will help resolve the differences between the primary and secondary medical boards.
9. After consensus on medical futility, a mandatory referral has to be made to palliative care services for assessment of palliative care needs, if such a service is available.
10. Further to this, the hospital informs the jurisdictional **judicial magistrate of the first class (JMFC)**. The hospital documents the official order of this communication in the medical records.
11. **Communication of medical futility to the families/caregivers must be made by the primary board during a family meeting.**

Documentation of medical futility in the medical records

The futility documentation should comprise the following

1. Procedures confirming diagnosis/prognosis that satisfy the requirements of medical futility
2. Statements stating that the patient has a terminal or critical illness with no reasonable chance of recovery and the burden and/or harm of the medical interventions outweigh the benefit.
3. Summary of treatment provided till date and outcomes
4. Life sustaining treatments currently being provided
5. Life sustaining treatments proposed to be withheld/withdrawn
6. Alternatives to life sustaining treatment proposed

Form 1

Endorsement of medical futility by the primary board

We hereby certify that.....bearing C.R No..... admitted at.....has.....

We have arrived at a consensus that initiating or continuing life sustaining treatment in this patient is medically futile because.....

We recommend withholding/withdrawing of all life sustaining measures in this patient such as.....

We recommend palliative care referral for symptom control and end-of-life care for this patient.

Place:

Date:

Name and signature of the members of the primary board:
(along with official seal)

1.

2.

3.

Communication of medical futility

The communication and discussion of limitation of life sustaining treatment should comprise of

1. Refractory nature of the illness
2. Burden versus benefit of continuation of aggressive medical management
3. The transition of care to a quality-of-life centred approach
4. End-of-life care (EOLC) as an alternative to futile aggressive medical interventions
5. Discussion on aspects related to prognosis, life expectancy, future course of illness, and what to expect in the future
6. Addressing fears and providing reassurance and taking steps towards conflict resolution
7. Introducing palliative care services and explaining their scope in the management
8. Exploring any myths, misunderstandings about the limitation of treatment and clarifying.
9. Discussing the process of dying, optimization of medications, nutrition and hydration at the end of life and exploring any religious/cultural preferences
10. The option of transferring to another clinical establishment may be presented if the patient or the family is unable to agree with the treating team about medical futility.

Form 2

Family meeting during the medical futility discussion

We the family members of the patient....., bearing hospital number.....hereby acknowledge that we have attended the family meeting on the below mentioned date and time convened by the department of .....

In this family meeting, the treating physicians have explained and apprised us the above mentioned patient's current clinical condition, the nature of the diagnosis, prognosis and the likely treatment outcome.

During the family meeting, we asked questions and clarified our queries regarding the patient's clinical condition, the nature of the diagnosis, prognosis and outcomes of the treatment.

We understand from this family meeting that the patient has advanced critical/terminal illness where the benefit of initiating or continuing life sustaining medical interventions has a higher potential to cause harm and suffering without any reasonable clinical benefit.

We acknowledge that the patient is able /unable to participate in his/her clinical decision making.

We, the family of the patient, collectively and consensually make treatment decisions for /with the patient. We state that there is no conflict in the family regarding treatment decision making for the patient.

The family meeting was conduoted: In person ☐ phone ☐ video consultation ☐

Signatures of the family members (02) attending the meeting

Relationship	Name	Signature/verbal consent	Date/Time

Signature of the doctors (03) with official seal conducting the meeting.

1.

2.

3.

Capacity to make medical decisions and surrogate decision making

During the process of consenting, it is important to determine whether the patient has the capacity to make medical decisions or whether a surrogate should make decisions on his/her behalf

The capacity of the person to make healthcare related decisions should be assessed by the healthcare provider. The capacity for healthcare is determined using the four component model of decision capacity.

a. **Understanding**: Understanding refers to the ability of the individual to comprehend the information being disclosed in regard to his/her condition as well as the nature and potential risks and benefits of the proposed treatment and alternatives (including no treatment).
b. **Appreciation**: Appreciation refers to the ability to apply the relevant information to one's self and own situation.
c. **Reasoning**: Reasoning refers to evidence that the person's decisions reflect the presence of a reasoning process, i.e. ability to engage in consequential and comparative reasoning and to manipulate information rationally.
d. **Expression of a choice**: At its most basic level, it simply refers to the ability to communicate a decision. However, no adverse inference should be drawn from an inability to communicate verbally.

If the patient does not have the capacity to make medical decisions or is unable to participate in the decision making, the process of decision making rests on patient surrogates, usually the patient's family or friends who make the medical decision in consultation with the treating team in the best interest of the patient.

If there are no documented surrogate decision makers, the next of kin according to the 1994 Transplantation of Human Organs Act i.e. hierarchically, spouse, son, daughter, father, mother, brother, sister, grandfather, grandmother, grandson or granddaughter will be the surrogate decision makers.

The surrogate(s), acting in the best interest of the patient, is expected to

a. Consider all relevant circumstances and options without discrimination
b. Consider any beliefs or values likely to influence the individual if they had capacity
c. Consult with family members as to whether the individual previously had expressed any opinions or wishes about his/her future care.
d. Consult with the clinical team caring for the individual
e. If there is an advance directive made by the patient, the surrogate should use that as one of the main factors in guiding his/her decision as well.

The surrogate(s) should neither make any judgement using clinician's view of quality of life, nor be motivated by a desire to hasten or prolong the person's death.

Form 3

Ratification of the decision of withholding /withdrawing life sustaining treatment by the secondary board

We hereby certify that.....bearing
CR No.....is admitted at.....

We concur with the decision of the primary treating physician(s) and the two consultants involved in the care of the patient endorsing futility of life sustaining treatment.

We concur with the family/patient decision on withholding /withdrawing life sustaining treatment.

We agree that the decision to withhold/withdraw life sustaining treatment is done in the best interest of the patient with no coercion, malaise, undue influence or fraud.

We recommend withholding /withdrawing of life sustaining treatment and recommend palliative care involvement to facilitate end-of-life care.

Place:

Date:

Name & signature of the secondary board:
(along with official seal)

1.

2.

3.

Form 4

Family directive for withholding life sustaining treatment

We understand that our patient.....Ms / Mr /Master....., bearing hospital number is admitted at.....and has a critical/terminal illness where the disease modifying treatment options are no more relevant and he/she has complications related to the progressive nature of the disease which is potentially life threatening.

We understand that as the disease is advanced and the general health is poor, he/she has developed/could develop serious life threatening complications that could threaten the quality of life. We understand that these complications are seldom reversible and the burden of treating these complications using life sustaining measures has a higher potential to cause harm and suffering without any reasonable clinical benefit. Considering these circumstances, our goal of care for our patient would be symptom relief, comfort measures and quality of life.

We understand the futility of critical care interventions for supporting life such as endotracheal intubation, cardiopulmonary resuscitation and aggressive intensive care measures including life support therapies. We have considered the decision to withhold new interventions or not to escalate existing interventions for life support as mentioned above with the understanding that the overall disease process has progressed beyond the possibility of reasonable recovery.

We understand that signing this document would not deprive our patient of any necessary medical and nursing care, pain and symptom relief measures, and specific supportive care measures as appropriate with the highest priority to maintain dignity and quality of life. We request for not initiating life sustaining measures for our patient.

We hereby request you to allow natural death in the event of cardio-pulmonary arrest i.e. (no external chest compressions, no intubation, no electrical cardioversion). After extensive discussion with the treating doctors, we have decided and requested the treating doctors to withhold life sustaining treatments, on behalf of the patient.

Also, at our request, we have been permitted to consult another physician outside the hospital and

1. We have decided not to consult another physician outside this hospital or
2. Having considered his/her recommendation, we have decided to permit the treating team to withhold life-sustaining treatment.

We have also been given the option of shifting the patient to another clinical establishment if we desire to do so.

We have discussed all the details with the doctors in the language we understand, and I/we are making an informed decision. We confirm that we are making this declaration out of free will and there is no coercion, undue influence or fraud.

Signatures of the family members (02) attending the meeting

Relationship	Name	Signature/verbal consent	Date/Time

Signature of the doctors (03) with official seal conducting the meeting.

1.

2.

3.

Form 5

Family directive for withdrawing life sustaining treatment

I/we understand that our.....Ms /Mr/Master....., bearing hospital number..... is admitted at....., has a critical/terminal illness where disease modifying treatment options are no more relevant and has complications related to the progressive nature of the disease which are potentially life threatening.

We understand that as the disease is advanced and the general health is poor, he/she has serious life threatening complications threatening the quality of life. We understand that these complications are seldom reversible and the burden of treating these complications using life sustaining measures has a higher potential to cause harm and suffering without any reasonable clinical benefit. Considering these circumstances, our goal of care for our patient would be symptom relief, comfort measures and quality of life.

We understand that as the disease is advanced, he/she has developed serious complications such as difficulty in breathing and/or cardio-respiratory arrest, which was/were addressed urgently through cardio-pulmonary resuscitation and advanced life support measures including intubation and ventilation. We understand the futility of continuing above critical care interventions, as there are no realistic hopes of our patient returning to pre-arrest state and we acknowledge that continuing these life sustaining interventions amounts to prolongation of the process of dying.

We care deeply for the dignity and comfort of our beloved.....We have considered the decision to withdraw the existing artificial life support measures with the understanding that the treatment has a higher potential to cause pain and suffering than resolution of the multiple organ system failure as the disease process has progressed and is likely to have reached a point of no return.

We understand that signing this document would not deprive our patient of any necessary medical and nursing care, pain and symptom relief measures, and specific supportive care measures as appropriate with the highest priority to maintain dignity and quality of life.

After extensive discussion with the treating doctors, we have decided and requested the treating doctors to withdraw the life sustaining treatments on behalf of the patient.....Further, we hereby request you to allow natural death in the event of a cardio-pulmonary arrest i.e. (no external chest compressions, no intubation, no electrical cardioversion).

Family directive for withdrawing life sustaining treatment (continued)

Also, at our request, we have been permitted to consult another physician outside the hospital and

1. We have decided not to consult another physician outside this hospital or
2. Having considered his/her recommendation, we have decided to permit the treating team to withhold life sustaining treatment.

We have also been given the option of shifting the patient to another clinical establishment if we desire to do so.

We have discussed all the details with the doctors in the language we understand and I/we are making an informed decision. We confirm that we are making this declaration out of free will and there is no coercion, undue influence or fraud.

Signatures of the family members (02) attending the meeting

Relationship	Name	Signature/verbal consent	Date/Time

Signature of the doctors (03) with official seal conducting the meeting.

1.

2.

3.

Implementation of withholding and withdrawing life sustaining measures

Procedure of implementing withholding and withdrawing life sustaining treatment

1. The first step is to establish the medical futility decision made by the primary treating physician, which is endorsed by two consultants of the same or related specialty not directly involved in the care of the patient. This forms the Primary medical board (PMB), the constitution of which is discussed in page no:9.
2. The second step is communication of the medical futility decisions and limitation of life sustaining treatment to the family/patient during the family meeting and obtain consent to withhold/withdraw from the family/patient
3. The third step is the ratification of the decision to withhold/withdraw treatment by the end-of-life care (EOLC) review committee. This forms the secondary medical board (SMB), the constitution of which is discussed in page no:9.
4. In case of any conflict between the PMB, SMB and the patient's family, the decision can be resolved by the hospital clinical ethics committee, the constitution of which is discussed in page no:9.
5. The family/patient should be informed prior to the initiation of the withholding / withdrawal process.
6. If palliative care services are available, withholding/withdrawal of life sustaining treatments should be done under palliative care supervision to ensure maximum symptom relief and comfort during and after the process.

Documentation in the medical records during the process of withholding /withdrawing of the life sustaining treatment

The documentation of the process of withholding /withdrawing should comprise of

1. Reasons underpinning the withholding/withdrawal decision
2. Nature of life sustaining treatment withheld /withdrawn
3. The exact process involved in withholding /withdrawal of treatment
4. Alternative palliative care measures provided during the process of withholding /withdrawal
5. Information provided to families /patient prior, during and after the process of withholding /withdrawal

Person's Full Name: Male/female Hospital ward:	C.R Number: DOB:
Diagnosis:	

Protocol for EOLC

Checklist for initiation of EOLC

All potentially reversible causes of patient's condition excluded	Yes	No
Consensus among clinicians involved in the treatment	Yes	No
Patient is able to take part in the decision making	Yes	No
Patient is aware of irreversibility of his/her condition	Yes	No
Any advance directive available	Yes	No
Family is able take active part in decision making	Yes	No
Family is able to comprehend fully about irreversibility of the patient's condition	Yes	No
Family meeting documented	Yes	No
Family consensus and agreement of futility of further management	Yes	No
Family explained about further course of care plan	Yes	No
Guidance and care plan for the dying explained and initiated	Yes	No

Documentation of daily progress note after implementation of EOLC

Outcomes should be assessed on a daily basis and denoted as "Y" for yes and "N" for no. If the outcome is not achieved, then an explanation or comment will be recorded in the progress note.

Timings:				
The person does not have pain				
The person is not agitated				
The person does not have respiratory tract secretions				
The person does not have nausea				
The person is not vomiting				
The person is not in respiratory discomfort				
The person does not have urinary problems				
The person does not have bowel problems				
The person does not have other symptoms. If present, record:----------				
The person's comfort food and fluids to support his/her individual needs is maintained				
The person's mouth is moist and clean				
The person's skin integrity is maintained				
The person's perianal hygiene needs are met				
The person receives care in a physical environment adjusted to support his/her individual needs				
The person's psychological wellbeing is maintained				
The person's spiritual wellbeing is maintained				
The wellbeing of the relative/family member attending to the dying person is maintained				
Signature of the nurse/ Doctor on duty (Each assessment)				

Form 6

End-of-life care intimation form to be submitted to the Judicial Magistrate of the First Class (JFMC)

Date:

To,
The District Magistrate,
Office of the District Magistrate,
Qaiser Bagh, Lucknow,
Uttar Pradesh, 2226001

Subject: Information regarding a patient for end-of-life care decision

Dear Sir/Madam,
This is to inform your office regarding a patient currently admitted to our facility for whom a decision regarding end-of-life care (EOLC), specifically the withholding or withdrawal of further life-sustaining treatment, has been made in accordance with the prevailing legal guidelines and institutional policy.

The details of the process and supporting documents are enclosed:

Name of the patient: Age/Sex:
CR No: Name of the ward/ICU
Diagnosis:

Procedures confirming diagnosis/prognosis that are able to confirm that further medical treatment is not likely to be beneficial:

Statements stating that the patient has a terminal illness with no reasonable chance of recovery and the burden and/or harm of the medical interventions outweigh the benefit

Life sustaining treatment proposed to be withheld or withdrawn:

(Signature of the treating physician)

The hospital requests your office to take note of this information, and the decisions made in compliance with legal mandates.

Thanking you,

Sincerely,

Signature along with stamp of chief medical superintendent of the hospital
Date:

Enclosures:
1. Dated and signed decision of Primary Medical Board
2. Dated and signed decision of Secondary Medical Board
3. Dated and signed consent of the person named in the advance medical directive of the patient, if any
4. Dated and signed consent of the next of kin/next friend/guardian, if no valid advance medical directive exists

Copy to: The Chief Medical Officer (CMO), Lucknow

Faculty Members who endorse the implementation of 'End of life care' in the Institute

1.	Dr. Banani Poddar, Dept. of Critical Care Medicine	
2.	Dr. Afzal Azim, Dept. of Critical Care Medicine	
3.	Dr. Mohan Gurjar, Dept. of Critical Care Medicine	
4.	Dr. P.V. Sai Saran, Dept. of Critical Care Medicine	
5.	Dr. Jitendra Chahar, Dept. of Critical Care Medicine	
6.	Dr. Sangam Yadav, Dept. of Critical Care Medicine	
7.	Dr. Amit Srivastava, Dept. of Critical Care Medicine	
8.	Dr. Sachin Wali, Dept. of Critical Care Medicine	
9.	Dr. Sanjay Dhiraj, Dept. of Anaesthesiology	
10.	Dr. Amit Rastogi, Dept. of Anaesthesiology	
11.	Dr. Tapas K Singh, Dept. of Anaesthesiology	
12.	Dr. Jayanti Kalita, Dept. of Neurology	
13.	Dr. Vimal Paliwal, Dept. of Neurology	
14.	Dr. Alok Nath, Dept. of Pulmonary Medicine	
15.	Dr. Arun Srivastava, Dept. of Neuro Surgery	
16.	Dr. Kuntal Kanti Das, Dept. of Neuro Surgery	
17.	Dr. Ved Prakash Maurya, Dept. of Neuro Surgery	
18.	Dr. Soumen Kanjilal, Dept. of Neuro Surgery	
19.	Dr. Narayan Prasad, Dept. of Nephrology	
20.	Dr. Anupama Kaul, Dept. of Nephrology	
21.	Dr. Shaleen Kumar, Dept. of Radiotherapy	
22.	Dr. Punita Lal, Dept. of Radiotherapy	
23.	Dr. Tanmoy Ghatak, Dept. of Emergency Medicine	
24.	Dr, Rakesh Aggarwal, Dept. of Gastroenterology	
25.	Dr. Samir Mohindra, Dept. of Gastroenterology	
26.	Dr. Supriya Sharma, Dept. of Gastro Surgery	
27.	Dr. Rajneesh Singh, Dept. of Gastro Surgery	
28.	Dr. Aditya Kapoor, Dept. of Cardiology	
29.	Dr. Rajesh Kashyap, Dept. of Hematology	
30.	Dr. Sanjeev, Dept. of Hematology	
31.	Dr. Amit Goel, Dept. of Hepatology	
32.	Dr. Amita Aggarwal, Dept. of Immunology	
33.	Dr. Able Lawrence, Dept. of Immunology	
34.	Dr. Kirti Naranje, Dept. of Neonatology	
35.	Dr. Anita Singh, Dept. of Neonatology	
36.	Dr. Suruchi, ATC	
37.	Dr. Amit Kumar, ATC	
38.	Dr. R. Harsvardhan, Hospital Administration	

Through due medium to DME, CCDR