Health & Family Welfare Department,

File No. HFWD/MIS/GOI/7/2026/2996/A

Sachivalay, Gandhinagar,

Date :- As per E-sign

ORDER

Subject :- Implementation of Guidelines Regarding Withdrawal / Withholding of Life Support in the Clinical Establishments in accordance with the order of the Supreme Court dated 24.01.2023, Miscellaneous Application No. 1699 of 2019 in Writ petition (Civil) No. 215 of 2005 and 11.03.2026 in M.A. No. 2238 of 2025 in SLP (C) No. 18225 of 2024.

In accordance with the order of the Supreme Court dated 24.01.2023, in Miscellaneous Application No. 1699 of 2019 in Writ Petition (Civil) No. 215 of 2005 and dated 11.03.2026 in M.A. No. 2238 of 2025 in SLP (C) No. 18225 of 2024 and in furtherance of the Supreme Court's guidelines, the District Registering Authorities, Gujarat Clinical Establishment (Registration & Regulation) Act, 2021 of all districts in the State are hereby required to nominate registered medical practitioners who can serve as members of the Secondary Medical Board that both clinical establishments and government hospitals are required to constitute.

With reference to the provisions of the Gujarat Clinical Establishments (Registration and Regulation) Act and in continuation of the Supreme Court’s directives for Withdrawal and Withholding of Life Support in Terminally Ill Patients.

In this regard, it is hereby informed that withdrawal or withholding of life support (including DNAR decisions) in terminally ill patients is legally permissible only when carried out strictly in accordance with the prescribed medical, ethical, and legal framework, ensuring patient dignity, autonomy, transparency, and proper documentation.

All Member Secretaries of the District Registering Authorities (DRA) as notified vide Government notification No. GHY/31/2024/GOI/132010/13/A dated 16/12/2024, are hereby directed to ensure the following compliance by all registered clinical establishments within their jurisdiction:

1. All decisions regarding withholding or withdrawal of life-sustaining treatment must be taken in the best interest of the patient, respecting autonomy, beneficence, and non-maleficence.
2. Such decisions shall be made only after due medical prognostication and consensus through a duly constituted Primary Medical Board (PMB) and Secondary Medical Board (SMB), as applicable.

Primary Medical Board (PMB):

- It is hereby directed that the Primary Medical Board be constituted by the concerned hospital/institution

for each case, consisting of the primary physician and at least 2 subject experts with >/= 5 years' experience. Other members of the PMB may be from the multidisciplinary treating team as required.

Secondary Medical Board (SMB):

- The Secondary Medical Board (SMB) constituted by the hospital/institution, consists of one Registered Medical Practitioner (RMP) nominated by the Member Secretory, District Registering Authorities (DRA) and at least 2 subject experts >/= 5 years' experience. The SMB is directed by the Supreme Court to opine within 48 hours of the referral.
- All Member Secretaries, District Registering Authorities (DRA) are hereby directed to prepare and maintained a panel consisting of registered medical practitioners possessing qualifications in accordance with the guidelines for the purpose of nomination to the secondary medical board.
- The panel so prepared shall be periodically reviewed and updated by the Member Secretaries at regular interval not exceeding 12 months.
- A member of the PMB cannot form part of the SMB.
- The doctor nominated by the Member Secretory, District Registering Authorities (DRA) may be from the same hospital.
- There is no bar on all doctors, in both Boards, being from the same hospital.
- It is hereby directed to all Member Secretory, District Registering Authorities (DRA) that a standing panel of approved doctors to be set up in every healthcare facility.
- Proper informed consent must be obtained from the patient or legally authorized surrogate, including recognition of valid Advance Medical Directives (AMD), wherever available.
- Complete documentation, transparency in communication, and strict compliance with the procedure prescribed by the Hon'ble Supreme Court of India shall be ensured.

3. Active euthanasia remains illegal and is strictly prohibited.
4. All clinical establishments shall facilitate a transition to palliative and compassionate care, prioritizing patient comfort and dignity and human end-of-life care.
5. DRAs shall inform, sensitize and guide clinical establishments regarding these guidelines (Annexure – A) and ensure adherence during inspections, renewals, and regulatory oversight.

All Member Secretaries are requested to refer the Guideline Regarding Withdrawal / Withholding of Life Support in the Clinical Establishments and circulate these instructions to all registered clinical establishments under their jurisdiction and ensure strict implementation.

Any deviation or non-compliance shall be viewed seriously and dealt with as per applicable provisions of law.

By order and in the name of the Governor of Gujarat,

File No: HFWD/MIS/GOI/7/2026/2996/A
Approved By: Additional Chief Secretary,HFWD
Open the document in Adobe Acrobat DC to verify the E-sign

(Manish Modi)

Additional Secretory to Government

To,

1. Member Secretaries, District Registering Authorities- Clinical Establishment Act, All District, Gujarat.
2. Chief District Health Officer, All
3. Chief District Medical Officer, All
4. Medical Superintendent, All Government Hospitals and MCH.
5. President, IMA, Gujarat.

Copy with compliments to:

- The Additional Chief Secretary, Health & Family Welfare Department, Gandhinagar
- The Commissioner of Health (Urban), Block No. 5, Dr. Jivraj Mehta Bhavan, Gandhinagar.
- The Judicial Magistrates of First Class (JMFC), All
- Additional Director (MS/ME/PH/FW), Dr. Jivraj Mehta Bhavan, Gandhinagar
- The District Collectors, All
- The District Development Officers, All
- The Municipal Commissioners, All

Annexure – A

GUIDELINES FOR WITHDRAWAL OF LIFE SUPPORT IN TERMINALLY ILL PATIENTS

BACKGROUND

Many patients in the ICU are terminally ill, and not expected to benefit from life sustaining treatments (LST) that include (but are not limited to) mechanical ventilation, vasopressors, dialysis, surgical procedures, transfusions, parenteral nutrition or Extracorporeal Membrane Oxygenation (ECMO). In such circumstances, LST are non-beneficial and increase avoidable burdens and suffering to patients and therefore, are considered excessive and inappropriate. Additionally, they increase emotional stress and economic hardship to the family and moral distress to professional caregivers. Withdrawal of LST in such patients is regarded as a standard of ICU care worldwide and upheld by several jurisdictions. Such decisions have medical, ethical and legal considerations. It may be considered that the above mentioned also applies at the time of initiating Life support treatments to individuals with.

DEFINITIONS

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 harm in terms of causing suffering and loss of dignity. The following conditions must apply:

1. Any individual declared brainstem death as per THOA Act.
2. Medical prognostication and considered opinion that patient's disease condition is advanced and not likely to benefit from aggressive therapeutic interventions
3. Patient/surrogate documented informed refusal, following prognostic awareness, to continue life support
4. Compliance with procedure prescribed by the honorable 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 above three conditions must apply.

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

Advance Medical Directives **(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 behoves physicians to ensure that potential benefits of treatments outweigh potential harms or to avoid treatments that serve no therapeutic purpose.

WD, WH and DNAR are collectively termed Foregoing of Life Support (FLST)

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

Beneficence: A principle that makes it obligatory on the part of physicians to act in the best interests of patients.

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

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

Surrogate: Surrogate is a person or persons other than the healthcare providers who is/are accepted as the representatives of the patient's best interests, who will make decisions on behalf of the patient when the patient loses decision-making capacity.

If the patient has made a valid AMD, the surrogate will be the person or persons named in the directive.

If there is no valid AMD, the surrogate will be the next of kin(family) or the next friend or guardian (if any) of the patient. To identify next of kin, one may refer to the definition of 'near relative' in Section 2(i) of the Transplantation of Human Organs and Tissues Act, 1994. Under this provision, 'near relative' includes**:** available spouse, son, daughter, father, mother, brother, sister, grandfather, grandmother, grandson or granddaughter.

Active Euthanasia is the intentional act of killing a terminally ill patient on voluntary request, by the direct intervention of a doctor for the purpose of the good of the patient. It is illegal in India.

PRINCIPLES OF FLST AND COMPASSIONATE CARE

1. Respect for patient Autonomy
2. Adherence to physician duties of Beneficence, Non-maleficence and Distributive Justice
3. Open, honest, timely and compassionate communication and care
4. Compliance with legal requirements

5. Transparency and documentation
6. Transitioning to palliative care

LEGAL PRINCIPLES OUTLINED BY THE HONORABLE SUPREME COURT

1. An adult patient capable of taking healthcare decisions may refuse LST even if it results in death
2. LST may be withheld or withdrawn lawfully under certain conditions from persons who no longer retain decision-making capacity, based on the fundamental right to Autonomy,

Privacy and Dignity

3. AMD that meets specified requirements is a legally valid document
4. For a patient without capacity, FLST proposals should be made by consensus among a group of at least 3 physicians who form the Primary Medical Board (PMB)
5. The PMB must explain the illness, the medical treatment available, alternative forms of

treatment, and the consequences of remaining treated and untreated to fully inform the surrogate

6. A Secondary Medical Board (SMB) of 3 physicians with one appointee by the Chief Medical Officer (CMO) of the district must validate the decision by the PMB
7. Active Euthanasia is not lawful

CONSTITUTION OF MEDICAL BOARDS AND HOSPITAL OVERSIGHT

Primary Medical Board (PMB)

The Primary Medical Board is constituted by the hospital/institution for each case, consisting of the primary physician and at least 2 subject experts with >/= 5 years' experience.

Members of the PMB may be from the multidisciplinary treating team.

Secondary Medical Board (SMB)

The Secondary Medical Board (SMB) constituted by the hospital/institution, consists of one Registered Medical Practitioner (RMP) nominated by the CMO and at least 2 subject experts >/= 5 years' experience. The SMB is directed by the Supreme Court to opine within 48 hours of the referral.

- A member of the PMB cannot form part of the SMB.
- The doctor nominated by the district CMO may be from the same hospital.
- There is no bar on all doctors, in both Boards, being from the same hospital.
- A standing panel of CMO-approved physicians may be set up in every healthcare facility.

Hospital Oversight

The hospital shall constitute a Clinical Ethics Committee of multi-professional members for audit, oversight and conflict resolution. Proposed members include: Director/ Chief Administrator or equivalent, or his nominee, of the healthcare establishment; a senior medical practitioner of the healthcare establishment, with expertise in end of life care (EOLC); one senior medical practitioner with relevant expertise in EOLC, to be nominated from outside the healthcare establishment; a legal expert, to be nominated by the healthcare establishment; a social worker nominated by the healthcare establishment.

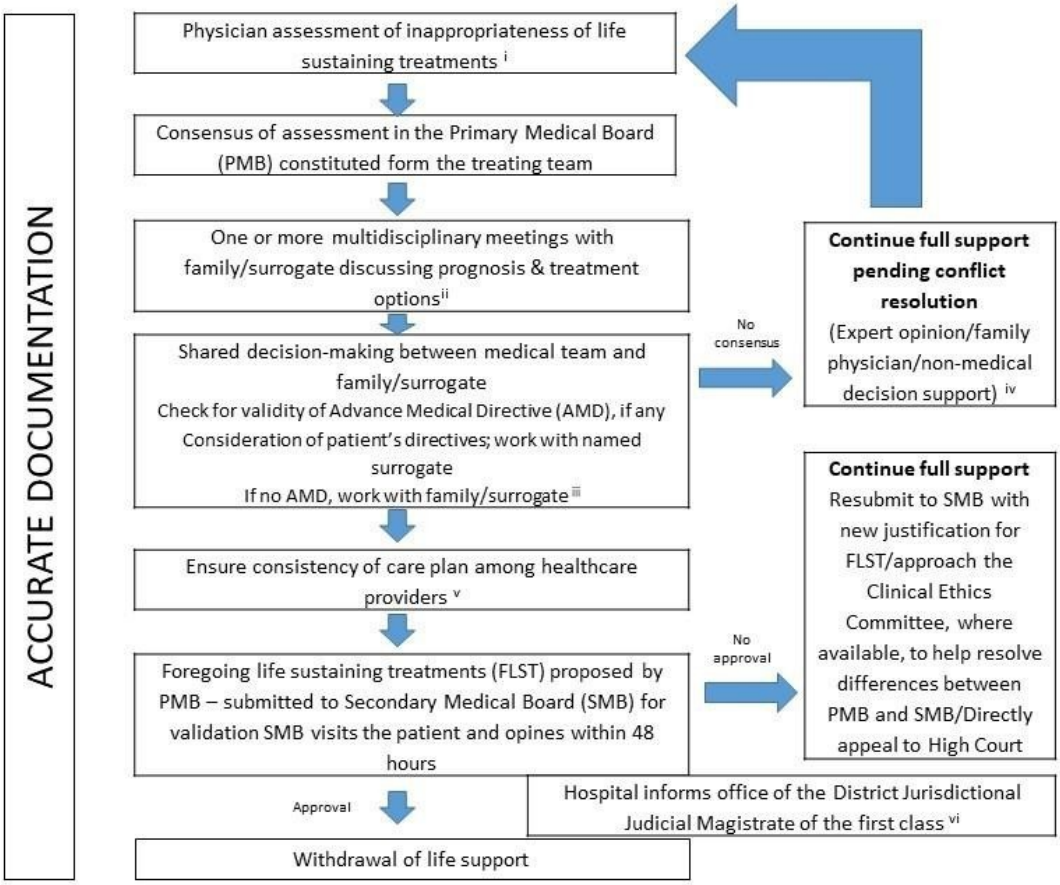
PATHWAY FOR WITHDRAWAL AND WITHHOLDING OF LIFE SUPPORT IN TERMINALLY ILL PATIENTS

The pathway includes decision-making combining professional consensus and the honourable Supreme Court directives

(Adapted from Figure 1: End of Life Care Pathway in: Indian Society of Critical Care Medicine (ISCCM) and Indian Association of Palliative Care (IAPC) Expert Consensus and Position Statements for End of Life and

Palliative Care in the ICU. Indian J of Crit Care Med [In Press])

PATHWAY FOR WITHDRAWAL OF LIFE SUPPORT IN TERMINALLY ILL PATIENTS



Other Important points to be considered:

1. Prognostication is best achieved through objective and subjective assessments
2. Initial meeting held at outset before adverse prognosis becomes apparent to build a relationship of trust. One may use the words "comfort care" in place of palliative care
3. Goals of care in patient's best interests are set through combining medical recommendations (Beneficence and nonmaleficence) with patient's choices (Autonomy) expressed either directly or if incapacitated, through valid AMD or in case of patient's delegation/incapacity without AMD, through family/ surrogate. Communication should be candid, realistic, respectful and sensitive. The benefits and burdens of each treatment or care option should be explored.
4. Caregiver team should be debriefed after each family meeting

Annexure – B

Format for intimating District Jurisdictional Judicial Magistrate of the first class

Model Intimation Form to be sent to the District Jurisdictional Judicial Magistrate of the First Class

[Following are the details that must be mentioned in the Form]

Name of the patient:

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

Medical treatment proposed to be withheld or withdrawn:

Date:

(Signature of the treating physician)

Attached copies of:

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 exist