Abstract

Background: In India, many patients including Geriatric patients die in hospitals. However, there is very little information on how physicians working in Indian hospitals make end-of-life decisions (EoLDs). **Objectives:** To explore challenges and difficulties in end-of-life decision-making (EoLDM) in a select few hospitals and identify factors that influence end-of-life decisions. **Methodology:** A two-step methodology was followed. Firstly, the national level policies, position statements and, medical laws were critically reviewed to understand how these texts conceptualise EoLC. This is followed by an exploration in five hospitals of Kolkata (West Bengal, India) to find out the implications of the policies and the law on end-of-life decision-making. Observation and in-depth interviews were used as methods to collect primary information from 60 physicians and 20 nurses. Analysis of 56 medical records of EoLC patients was also done to understand the nature of end-of-life decisions. **Findings:** A critical analysis of national policies and position papers shows that a clinical model of EoLDM is suggested that did not consider patient autonomy, advanced age, and medical futility as factors to initiate EoLC. The model also do not provide scope to the nurses, other non-clinical staff, and family members to be involved in decision-making. Similarly, the medical law makes a poor response towards EoLDM, particularly in making treatment-limiting decisions. It does not address ethical complexities associated with EoLDs. Its position on patient autonomy is also not clear. These lacunae were reflected at the hospital level. The hospitals under study lacked EoLC-specific infrastructure, protocols, architecture, and skilled physicians and nurses. Due to stringent medico-legal structures, physicians felt incompetent to withdraw treatment even for medically futile patients. There was also lack of coordination among physicians who worked in medical teams. As a result, terminally ill patients were subjected to fuzzy care plans and erratic referrals. Palliation was initiated very late in the treatment trajectory of these patients, and often spiritual and psychological support was missed out. The medical teams also excluded Geriatricians due to which elderly patients were especially affected. Overall, the hospitals were not conducive to EoLC. **Conclusion:** Hospitals need to make adequate structural and organisational reforms to improve end-of-life decisions. However, improvements at the institutional level cannot sustain if necessary changes are not made at the level of national policies, law, and inter-professional relationships.

Key words: *End-of-life decision-making, Geriatrics, Hospitals, Physician*