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**Editorial**

# From Legal Recognition to Institutional Preparedness: Are Indian Hospitals Ready for End-of-Life Care?

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Consider a hypothetical scenario. A 68-year-old man with a severe traumatic brain injury and no realistic prospect of neurological recovery is admitted to the intensive care unit. He has no Advance Medical Directive. His family reports that he had previously expressed a wish not to be kept alive by machines in such circumstances. The treating physician judges that continued escalation of care would not serve the patient's interests. Yet no written institutional policy governs the request. No medical board is empanelled. No documentation template exists. The physician must navigate a legally consequential decision without institutional support. This scenario, while hypothetical, captures a systemic question that India's evolving end-of-life jurisprudence has made increasingly difficult to ignore.

The constitutional foundation for withholding or withdrawing life-sustaining treatment (WLST) was laid in *Common Cause vs Union of India* (2018), where the Supreme Court held that the right to die with dignity forms part of Article 21, recognised Advance Medical Directives (AMDs), and established a procedural framework involving Primary and Secondary Medical Boards. Withholding means not initiating a potentially life-sustaining intervention; withdrawal means discontinuing one already initiated. The original framework required judicial magistrate oversight, which proved procedurally cumbersome. In January 2023, the Court modified these procedures by reducing the experience requirement for board members from twenty to five years, specifying that boards should preferably provide their opinions within 48 hours, and dispensing with the requirement of prior approval by the Judicial Magistrate First Class. However, it retained the requirement to inform the magistrate subsequently. The revised framework placed hospitals at the centre of the operational process.

On 11 March 2026, in *Harish Rana v Union of India*, the Supreme Court applied the *Common Cause* framework to a case involving withdrawal of clinically assisted nutrition and hydration (CANH) from a man in a permanent vegetative state since 2013. The judgment built upon the established framework while clarifying two points of practical significance. First, the Court held that CANH constitutes medical treatment rather than basic care in the circumstances considered, permitting its withdrawal when it no longer serves the patient's best interests. Second, it clarified that best-interest assessment must account for the patient's known wishes, the burdens and benefits of continued treatment, and the proportionality of intervention. The judgment also emphasised that withdrawal of life-sustaining treatment does not equate to abandonment and should be accompanied


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by appropriate palliative and end-of-life care.

Legal recognition, however, does not guarantee institutional capability. Recent literature has begun to bridge this gap. Vallath and colleagues have described sequential institutional processes for validating AMDs, constituting medical boards, and reporting to the judicial magistrate, drawing on an implementation case study from a tertiary hospital in Karnataka. Their work illustrates how the framework may be operationalised when state-level administrative mechanisms are activated. Karnataka's experience, where the Health and Family Welfare Department issued Government Order No. HFW 256 FPR 2024 dated 30 January 2025 concerning nomination of registered medical practitioners to the Secondary Medical Board, offers an illustrative state-level model. Because implementation also depends on state-level administrative mechanisms, the extent and consistency of activation across jurisdictions remain incompletely characterised. The procedural guidance now available is necessary but insufficient. It does not establish whether hospitals possess the workforce, governance structures, documentation systems, palliative-care capacity, and monitoring mechanisms required to implement those procedures consistently.

Evidence on hospital preparedness is limited and largely drawn from critical-care settings. A 2023 survey of Indian intensivists found broad acceptance of the ethical validity of limiting non-beneficial treatment, yet substantial variability in practice, with perceived legal uncertainty and the absence of formal decision-making frameworks cited as barriers. Although only a small proportion of reported cases involved medicolegal concerns, the survey was not designed to quantify medicolegal risk or establish its incidence across Indian hospitals. It nevertheless illustrates the extent to which perceived legal uncertainty is reported as a barrier to end-of-life decision-making. The findings should not be generalised to all Indian hospitals, particularly district hospitals, rural facilities, and smaller private institutions where specialist availability may be constrained.

Medical boards are central to the legal framework. Their effective functioning matters because they provide multidisciplinary assessment, independent review, transparent documentation, and a mechanism for managing disagreement. Recent commentary has highlighted practical difficulties in constituting Secondary Medical Boards, particularly where specialist availability is limited. In resource-constrained settings, assembling the requisite expertise within the indicated timeframes may be challenging. This raises a policy question that India has not yet systematically addressed: should regional or shared Secondary Medical Board mechanisms, or hub-and-spoke arrangements, be developed for hospitals that cannot independently maintain the required specialist pool? Such arrangements would require careful design to preserve independence and accountability, but they merit evaluation as a pragmatic response to heterogeneous institutional capacity.

Advance Medical Directives illustrate the distance between legal recognition and bedside implementation. Their practical value depends on whether institutions can reliably identify, verify, and apply them. This requires a defined workflow: identification at admission, assessment of authenticity and applicability to the current clinical situation, documentation, communication with the treating team, and activation of the relevant decision-making pathway where indicated. When family members disagree about an AMD's interpretation, a structured conflict-


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resolution mechanism becomes necessary. An advance directive can have limited practical value if institutions lack a reliable process to identify, authenticate, interpret, and incorporate it into clinical decision-making.

Best-interest assessment requires similar institutional support. Family members often provide essential information about the patient's values, prior statements, and acceptable outcomes. Their involvement is both culturally appropriate and clinically valuable. Family preference, however, should not automatically be equated with the patient's wishes or best interests. A structured best-interest determination integrates the clinical condition, prognosis, treatment burdens and benefits, the patient's known wishes and values, family knowledge, and considerations of proportionality. This is neither a unilateral clinical judgment nor a simple ratification of family preference. It is a deliberative process that requires communication skills and ethical reasoning rarely formalised in Indian medical training.

Withdrawal of life-sustaining treatment represents a transition in the goals of care, not an abandonment of the patient. Ongoing care includes symptom management, nursing care, comfort measures, psychosocial support, and continued communication with the family. A hospital cannot be considered adequately prepared for end-of-life decision-making if it can authorise a treatment limitation but cannot provide competent care after the treatment goal changes.

What would a prepared hospital look like? A proposed institutional preparedness framework might be organised across three levels. Level one comprises legal and administrative capability: a written WLST policy, a defined medical-board pathway, AMD identification and verification procedures, standardised documentation, and a reporting pathway to the judicial magistrate. Level two comprises clinical and ethical capability: structured family communication, an integrated palliative-care pathway, multidisciplinary support, and a conflict-resolution mechanism. Level three covers quality and accountability: clinician and board training, simulation exercises, case audits, documentation audits, and process monitoring. These levels are proposed as an editorial framework, not as an established national standard.

Measurement is the missing element. India currently lacks comprehensive national data on hospital preparedness for WLST. Candidate indicators might include time from recognition of a potentially eligible case to constitution of the Primary Medical Board, time to constitution of the Secondary Medical Board, documented AMD assessment, documentation completeness, documented family communication, availability of palliative-care support, and procedural delays. These should be considered candidate indicators rather than validated national standards. A multicentre national assessment of institutional WLST preparedness should measure board availability and constitution times, written WLST policies, AMD integration, palliative-care access, documentation quality, and variation across urban and rural settings, public and private sectors, and states.

Procedural delays carry clinical, emotional, and financial consequences that deserve systematic measurement: prolonged ICU utilisation, continuing treatment burden, family financial strain, and delayed transition to palliative care. These are not arguments for hastening decisions but for ensuring that institutional systems do not themselves become barriers to timely, lawful, and compassionate care.


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Recent judicial decisions have clarified important aspects of the framework and substantially simplified its procedures. They cannot constitute medical boards, train clinicians, build palliative-care services, or write hospital policies. That work belongs to hospital administrators, professional societies, state health departments, and medical educators. India's next step should be to move beyond legal recognition and procedural availability toward measurable institutional preparedness. The legal framework has progressively established safeguards for dignity-based end-of-life decision-making. Hospitals should now be equipped to translate those safeguards into consistent clinical practice. Legal rights acquire meaning only when institutions can operationalise them consistently while preserving dignity, autonomy, clinical integrity, transparency, family communication, and continuity of care.

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