

EDITORIAL

## Withdrawal of care at end of life: Ethical and legal perspectives

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The Supreme Court (SC) of India's judgment on March 11, 2026, in *Harish Rana vs Union of India*, brought greater clarity on the complex issue of end-of-life decisions; specifically on withdrawal of care from persons in a "permanent vegetative state" [1]. In an earlier landmark judgment in *Aruna Shanbaug vs Union of India* in 2011, the Court had allowed petitions in favour of "withholding or withdrawal of life support" to allow "a dignified death"; in very rare cases, following specific procedures outlined in that judgment [2]. In 2018, in *Common Cause vs Union of India*, the SC recognised the "right to die with dignity" as an extension of the fundamental "right to live with dignity" under Article 21 of the Indian Constitution. Patients who were terminally ill could refuse futile or burdensome treatment and could register Advance Directives, against unnecessary suffering caused by such treatment [3]. That judgment detailed the decision-making process to be followed for withdrawal of treatment, in order to protect vulnerable patients and prevent misuse. These procedural steps were later simplified by the SC in 2023 into what is termed "Common Cause Guidelines 2023" [4].

The recent SC judgment of March 11, 2026, is the first such judgment of the apex court in which the *Common Cause Guidelines* have been fully applied [1: para 241]. It clarified the rationale and process for withdrawal of medical interventions from a person in a permanent vegetative state, Harish Rana, being cared for at home. Keeping the best interest of Harish Rana in mind, the SC examined the appropriateness of artificially prolonging his life; one marked by continued suffering in the form of infections, lung aspirations, convulsions, and need for repeated hospitalisations, when his underlying neurological condition was irreversible. The SC allowed the withdrawal of medical interventions in a hospital setting where palliative care could be provided to him until the end, stating:

*This decision is not about choosing death, but is rather one of not artificially prolonging life. It is the decision to withdraw life-sustaining treatment when that treatment no longer heals, restores, or meaningfully improves life. It is allowing nature to take its course when medicine can only delay the inevitable because survival is not always the same as living [1: para 332].*

The judgment repeated certain principles: (a) that the specifics of the case are crucial in arriving at the decision; (b) the focus should remain on the "best interest of the patient", protecting patient dignity and autonomy; (c) the patient should never be abandoned after withdrawal of treatment; palliative care is mandatory and (d) emphasised that euthanasia (actions directed at ending life) continues to be illegal in this country.

**Misuse of terms**

It was disappointing to note the persistent use of the obsolete term "passive euthanasia" which only leads to misunderstanding. The judgment retains this legacy obfuscatory term and applies it to the act of "withdrawing or withholding inappropriate care", even though such action is neither passive nor is it "euthanasia". In fact, the Indian Council of Medical Research (ICMR), in 2018, released a document specifically to address this confusion that emerged after *Common Cause vs Union of India* in 2018 [5]. It says, "The term *passive euthanasia* is an obsolete terminology and should be avoided as *euthanasia* cannot be passive and withholding or withdrawing a potentially inappropriate treatment in a patient dying with a terminal illness that only prolongs the dying process, cannot be construed as an intention to kill." [5: p 14] It also says, "Euthanasia is the intentional act of killing a dying patient with terminal illness by the direct intervention of a doctor, for the purpose of good of the patient. However, allowing natural death, withholding and withdrawing of life sustaining treatment to limit harm and suffering in a dying patient should not be construed as Euthanasia." [5: p 14]

The significance of the "intention" in euthanasia is crucial, as it is directed at ending the patient's life as a means to end suffering. Further, the Indian Medical Council Ethics Regulation 2002, says: "Practising euthanasia shall constitute ethical misconduct" [6: 6.7]. One can see how use of the term "passive euthanasia" is problematic, as physicians may face moral distress if called upon to perform the unethical and illegal act of "euthanasia". The judgment reaffirms the role of medical expertise at every stage [1: para 228]. It recognises that the moral agency of the doctor cannot be overridden in such decisions and continual conversations with the patient and family may be needed to ensure alignment of the values of all parties. The judgment acknowledges that in *Harish Rana's* case, this alignment was achieved [1: para 330].

Professional “conscience” and respect for the “sanctity of life” formed through culture and training, is generally inconsistent with euthanasia [7]. In fact, even countries that have legalised euthanasia tend to use gentler terms, like Medical Assistance in Dying (MAID) and Physician assisted Suicide (PAS), to take the edge off the action of ending life [8].

Use of the term “passive euthanasia” can also lead to apprehension in vulnerable patients who entrust themselves to physicians for healing and care; knowing that doctors have the capacity to euthanise can be extremely unsettling. Not every person may understand that the term “passive euthanasia” in the SC judgments actually refers to “withdrawal of inappropriate treatment”. A judgment as important as this should have aligned its terminology with scholarly work as reflected in the ICMR document and dropped the misleading term altogether. That would have helped educate patients, as well as protect doctors engaged in distressing end of life communication with dying patients and their families.

### **Insensitive reporting**

In such cases, more balanced and less sensational media reporting could have stemmed public confusion. Headlines like “*Right to Die*” and “*SC allows Passive Euthanasia*” with almost voyeuristic video snippets of Harish, make the task of doctors that much harder, and can deepen distrust in the health system [9,10]. Irresponsible reporting without factual discussion points can have a detrimental impact on citizen understanding of the judgment and its implications.

### **Withdrawal of and withholding care**

In fact, what the SC is permitting in this judgment is withdrawal of futile treatments in consultation with the patient or family, which is not uncommon in end-of-life medical care. It respects the patient’s right to refuse non-therapeutic procedures, and to be allowed to die with dignity from the underlying illness, receiving palliative care till the end [11]. The intention here is to prevent unnecessary suffering from aggressive medical interventions when death is foreseen and inevitable; the patient is never abandoned, and the dying process is eased through palliation. This situation could arise in terminally ill patients with late-stage cancer, renal failure where dialysis is no longer effective, progressively debilitating disease, advanced heart disease, irreversible brain injury, and patients in permanent vegetative states, among others. “Futility” implies a clinical judgement that a therapy will not improve the patient’s condition and will instead risk causing suffering. It acknowledges the limits beyond which science and medicine cannot deliver benefit to the patient, despite the best efforts [12,13,14].

As the judgment states

*Medical futility is to be understood not in terms of the inability of treatment to cure the underlying disease but in the absence of any benefit being conferred to the patient. Likewise, recovery does not connote restoration to full health or avoidance of death but rather the resumption of a quality of life which the patient himself would regard as worthwhile* [1: para 183].

Prognosis at the end of life is based on evidence and experience, evaluation of the patient’s condition and response to treatment. Though scoring, grading and scales used in evaluation are fairly accurate, it is an inexact science. Communication becomes crucial here to convey limitations, outcomes, reassurance and options to the patient and family, as well as to propose the need for a transition to comfort care, when necessary.

The importance of unraveling these strands lies in the demand for ethical actions in end-of-life treatments and decisions. Continuing futile interventions would violate the Hippocratic dictum “*Primum non Nocere*” (First, do no harm). To prolong futile treatment in order to “keep the patient alive” amounts to an assault on the dignity of the patient and can cause unwarranted suffering. If this stems from medical hubris or a form of “therapeutic obstinacy” it must be denounced. Finding the right balance between non-maleficence and autonomy may be challenging; doctors are not obliged to continue futile treatments that may only cause suffering, and patients can refuse treatments when they no longer hold any hope of benefit. Medical humility may be what is called for, when all efforts fail, and the patient needs reassurance against abandonment. Sensitive communication, and informed consent are key to respectful withdrawal of treatment and transfer to comfort care; the conversation is not about ending life, though death is foreseeable and inevitable, but rather about easing the suffering of the dying patient.

On the other hand, doctors must prepare to face heightened family emotions, pleas to “do everything,” and unreasonable expectations that cause moral distress, and confuse decision making. Here, as always, it is good communication and trust in healthcare systems that holds the key to satisfactory outcomes; trust that can only be built on a track record of committed and inclusive care. It is thus impossible to separate this question from the larger question of the state of healthcare in India [15].

Court judgments are directed to the specifics of the case; in *Harish Rana*, the plea centred on the removal of the medical feeding device Percutaneous Endoscopic Gastrostomy (PEG) that provided Clinically Administered Nutrition and Hydration (CANH). This tilted the controversy towards whether nutrition and hydration should ever be withdrawn; if so, under what conditions, and by whom. In *Rana’s* case, these were the wrong questions; the parents had come to realise that persisting with painful medical interventions was “not in his best interest,” and “inappropriate,” since chances of neurological recovery were remote, and they

were only prolonging his suffering [1: para 208]. The pathos of long-term care provided by the hopeful parents, the depletion of resources, emotional trauma, fears over future care, and final acceptance of medical limits, scripts a story of emotional suffering and grief, both particular and profound. Its moral complexity is knotted within cultural constructs, socio-economic realities, and structural vulnerabilities, interrogating our concepts of human dignity, familial duties, and quality of life [16]. The judgment has depicted the case sympathetically, as illustrative of the many difficult questions around healthcare, and in the present context, around end-of-life care, in India [1: para 60].

### Healthcare and legal systems

With every successive court judgment on withdrawal of care, we are reminded of the inequities and deficiencies in our healthcare system; a painful factor in our end-of-life decisions. We still await a systematic approach to healthcare access that ensures affordable quality care for all [17]. Not everyone can afford expensive treatments at end of life, ICU care, or life sustaining care for persons in persistent vegetative states. In the absence of universal care, it is ultimately up to families and societies to decide on the limits of financial resources available. Studies show that significantly higher individual health expense is incurred at end of life [18]. The family may opt for a “discharge against medical advice” and move to an affordable hospital or even return home [19]. This is morally distressing for health workers and catastrophic for patients with no safety net, or access to palliation. The push for palliative care in all hospitals and every district is a welcome move that is yet to materialise; only 4% of those who need palliative care can access it [18] [1: para 23]. On the other hand, the call for reining in escalating healthcare costs and improvement of government hospitals appears to go unheeded. Given our ageing population, this need for resources and communicative structures directed at end-of-life care, will only increase. One option is to establish Hospital Ethics Committees or Clinical Ethics Committees (CEC) within hospitals to sensitise doctors to clinical ethics and advise and support health teams and patients in difficult end of life decisions.

The *Harish Rana* judgment calls for legislation to ease the procedural burdens of families faced with withdrawal of futile treatment. In the case of Harish Rana, the path to withdrawal of medical care through pleas, specialist opinions, high court refusals and SC appeals took almost two years of persistence and legal costs; this itself is cause for concern. Para 289 notes that in the absence of legislation, end-of-life decisions risk being shaped by considerations “*wholly extraneous to medical science or the patient's autonomy*” — particularly financial distress and the inability to sustain expensive medical care — “*blurring the line between a genuine best-interest determination and one compelled by economic exhaustion*” [1: para 289].

### Advance directives

End of life decisions are complex as they require a holistic evaluation of the patient's condition; a pragmatic determination of harms and benefits, including burdens, on the caregivers and family. Advance Medical Directives (AMD), while recommended as a way of addressing the issue of the individual's consent, can have limitations, as it is not always possible to foresee and plan for every medical eventuality. In this context, the value and legal force of these “living wills” is still debated; they often remain intentionally or unintentionally broad, leaving specific decisions to be made by named surrogates when patient “capacity” is lost [20]. AMDs that are drawn up at the start of a progressively debilitating illness, and are updated by the patient until there is loss of capacity, are more useful. They can assist doctors by providing an idea about the wishes of the patient, and are reassuring to surrogate family decision makers. In the Indian context, where talk of death is taboo, it may take a while for acceptance of this legal concept. The judgment is not against respectful constructive debate on suffering and individual autonomy at end of life [1: para 60].

### Need for broad public discourse

We need a broader constructive public and professional discourse on end-of-life decisions, the limitations of medical interventions, and the need for palliative or other care options for the sick and elderly. What is a “good death” and can we prepare for it? In India there are several concepts and ideals, both secular and religious, on the subject. Should we leave it to fate, or courageously reflect on choices around dying?[21] Disinformation and reactive condemnation make this difficult conversation that much harder [22].

This case is riveting because it speaks directly to each of us. No one can preclude the possibility of being either patient, caregiver or surrogate decision maker; it is in our collective and individual interest that we prepare for this eventuality that can confront us sooner or later. The judgment itself opines that court appeals should be a last resort. Now may be a good time to talk about death.

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## References

- Supreme Court of India. *Harish Rana v Union of India*. Special Leave Petition (Civil) No. 18225 of 2024 [Cited 2026 March 31]. Available from: [https://api.sci.gov.in/supremecourt/2025/60980/60980\\_2025\\_7\\_1501\\_69246\\_Judgement\\_11-Mar-2026.pdf](https://api.sci.gov.in/supremecourt/2025/60980/60980_2025_7_1501_69246_Judgement_11-Mar-2026.pdf)
- Supreme Court of India. *Aruna Ramchandra Shanbaug vs Union Of India & Ors* (2011) Writ Petition (Criminal) no. 115 of 2009 [Cited 2026 March 31]. Available from: <https://api.sci.gov.in/jonew/judis/37709.pdf>
- Supreme Court of India. *Common Cause (A Regd. Society) v. Union of India and Another*, 2018. Writ Petition (Civil) 215 of 2005 [Cited 2026 Mar 31]. Available from: [https://api.sci.gov.in/supremecourt/2005/9123/9123\\_2005\\_Judgement\\_09-Mar-2018.pdf](https://api.sci.gov.in/supremecourt/2005/9123/9123_2005_Judgement_09-Mar-2018.pdf)
- Supreme Court of India. *Common Cause (A Registered Society) v. Union of India*. MA No. 1699 of 2019 in WP (C) No. 215 of 2005. 2023 Jan 24 [Cited 2026 Mar 30]. Available from: [https://api.sci.gov.in/pdfdate/index1.php?filename=supremecourt/2019/25360/25360\\_2019\\_3\\_504\\_41295\\_Judgement\\_24-Jan-2023.pdf&dno=253602019&dt=2023-01-24](https://api.sci.gov.in/pdfdate/index1.php?filename=supremecourt/2019/25360/25360_2019_3_504_41295_Judgement_24-Jan-2023.pdf&dno=253602019&dt=2023-01-24)
- Mathur R, editor. Indian Council of Medical Research (ICMR). Definition of Terms Used in the Limitation of Treatment and Providing palliative Care at End of Life. New Delhi: ICMR;2018 Mar [Cited 2026 Mar 30]. Available from: [https://www.icmr.gov.in/icmrobject/custom\\_data/pdf/downloadable-books/Definition\\_of\\_terms\\_used\\_in\\_limitation\\_of\\_treatment\\_and\\_providing\\_palliative\\_care\\_at\\_end\\_of\\_life.pdf](https://www.icmr.gov.in/icmrobject/custom_data/pdf/downloadable-books/Definition_of_terms_used_in_limitation_of_treatment_and_providing_palliative_care_at_end_of_life.pdf)
- National Medical Commission. Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations 2002 [Cited 2026 Mar 30]. Chapter 6. Unethical Acts. (6.7). Available from: <https://www.nmc.org.in/rules-regulations/code-of-medical-ethics-regulations-2002/>
- Hernandez-Ojeda J. The Physician's Conscience and Virtue in Defending the Right to Life and Human Dignity. *Linacre Q*. 2025 Nov 19:00243639251390439. <https://doi.org/10.1177/00243639251390439>
- Government of Canada. Medical Assistance in Dying: Overview. Modified 2025 Aug 27 [Cited 2026 Mar 31]. Available from: <https://www.canada.ca/en/health-canada/services/health-services-benefits/medical-assistance-dying.html>
- Jeelani G. In a first, Supreme Court approves passive euthanasia for 31-year-old man in coma since 2013. *Live Mint*. 2026 Mar 11 [Cited 2026 Mar 31]. Available from: <https://www.livemint.com/news/india/supreme-court-allows-passive-euthanasia-for-31-year-old-man-in-coma-for-over-12-years-11773209187694.html>
- Sharma P. India Allows First-ever Passive Euthanasia for a Man in Vegetative State. *Firstpost*. 2026 Mar 11 [Cited 2026 Mar 31]. Available from: <https://www.firstpost.com/vantage/-india-allows-first-ever-passive-euthanasia-for-a-man-in-vegetative-state-vd1831214/>
- Mani RK, Amin P, Chawla R, Divatia JV, Kapadia F, Khilnani P, et al. Guidelines for end-of-life and palliative care in Indian intensive care units' ISCCM consensus Ethical Position Statement. *Indian J Crit Care Med*. 2012 Jul;16(3):166-81. <https://doi.org/10.4103/0972-5229.102112>
- Schneiderman LJ, De Ridder M. Medical futility. *Handb Clin Neurol*. 2013;118:167-79. <https://doi.org/10.1016/b978-0-444-53501-6.00014-7>
- Chakravarty A, Kapoor P. Concepts and debates in end-of-life care. *Indian J Med Ethics*. 2012 Jul-Sep;9(3):202-6. <https://doi.org/10.20529/ijme.2012.066>
- Sasidharan S, Dhillon H. Ethics of Futile Care: Who Decides When Enough Is Enough? – A Commentary from the Indian Context on Moral Distress in ICU Staff. *Dev World Bioeth*. 2025 Jun 11. <https://doi.org/10.1111/dewb.12492>
- Yadav J. 37. Public trust in healthcare systems in India. *BMJ Open*. 2021;11(Supplement 1): A13-14. [Cited 2026 Mar 29]. Available from: [https://bmjopen.bmj.com/content/bmjopen/11/Suppl\\_1/A13.3.full.pdf](https://bmjopen.bmj.com/content/bmjopen/11/Suppl_1/A13.3.full.pdf)
- Rajagopalan RE, Kapadia F. The ISCCM/IAPC Position Statement: Ending the Sisyphean Struggle to Practice Ethical End-of-life Care in India. *Indian J Crit Care Med*. 2024 Mar;28(3):189–190. <https://doi.org/10.5005/jp-journals-10071-24660>
- Swaminathan S, David R. Delivering on a citizen-centred health system for India *The Lancet*. 2026 Jan 24;407(10526):318-320. [https://doi.org/10.1016/s0140-6736\(25\)02589-9](https://doi.org/10.1016/s0140-6736(25)02589-9)
- Sallnow L, Smith R, Ahmedzai S, Bhadelia A, Chamberlain C, Cong Y, et al. Report of the Lancet Commission on the Value of Death: bringing death back into life. *The Lancet*. 2022 Feb 26; 399 (10327): 837-884. [https://doi.org/10.1016/s0140-6736\(21\)02314-x](https://doi.org/10.1016/s0140-6736(21)02314-x)
- Ramakrishnan N, Ranganathan L, Abraham BK, Rajagopalan S, Venkataraman R. What Happens to Patients Discharged Against Medical Advice? *Indian J Crit Care Med*. 2018 Aug;22(8):580-584. [https://doi.org/10.4103/ijccm.ijccm\\_101\\_18](https://doi.org/10.4103/ijccm.ijccm_101_18)
- Mani RK, Simha S, Gursahani R. Simplified Legal Procedure for End-of-life Decisions in India: A New Dawn in the Care of the Dying? *Indian J Crit Care Med*. 2023 May;27(5):374-376. <https://doi.org/10.5005/jp-journals-10071-24464>
- Shukla, R. Passive euthanasia in India: a critique. *Indian J Med Ethics*. 2016 Jan-Mar; 1(1) NS: 35-38. <https://doi.org/10.20529/ijme.2016.008>
- Yachu S. The media must be careful with cases of end-of-life care. *Mint*. 2026 Mar 20 [Cited 2026 Mar 31]. Available from: <https://www.pressreader.com/india/mint-kolkata/20260320/282114938097118>

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