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Special Article

Procedures to implement the Supreme Court of India directives to withdraw/withhold life-sustaining medical treatment

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In 2018, the Supreme Court of India legally recognised the rights of patients with terminal illness through the judgement in Common Cause (A Registered Society) v. Union of India and Another, (2018) 5 SCC 1. The processes prescribed to withhold or withdraw artificial life-support medical treatments became practical after the 2023 amendment. The law aimed to ensure the dignified dying of sick individuals whose condition was deemed terminal and irreversible. Healthcare institutions can comply with the Court's guidelines in their entirety only after the concerned State Governments activate specific processes. Karnataka state activated the legal mandates by early 2025. Using an implementation case study, we describe the institutional processes to uphold the ethical and legal mandates when withholding/withdrawing life-support treatment (WH/WD-LST) in a mentally incompetent, terminally ill elderly patient, admitted to a tertiary care hospital in Karnataka. It aims to clarify, (***i***) validation of 'Advance-Medical-Directive', or the living will; (***ii***) sequential institutional processes for WH/WD-LST as per ethical and legal mandates; (***iii***) constitution of the primary, secondary medical boards (PMB, SMB); (***iv***) reporting formats for PMB, SMB evaluations, and (***v***) the templates relevant to institutional administrators to convey the mandated details of WH/WD-LST to their jurisdictional judiciary magistrate of first class. The impressions and impact of activating the living will and WH/WD-LST on the family, on patient care, for the professionals, and for the institution are described in brief.

Keywords Advance directives; End-of-life-policy; Living wills; Medical futility; Supreme court-judgment; Terminally ill

This implementation case study from a tertiary healthcare setting describes the stepwise procedures to respond to the request for withdrawal (deactivating the defibrillator function of the implantable cardioverter-defibrillator (ICD) and withholding life-support treatments (non-escalation to intensive care facility) by the legal decision-makers on behalf of a terminally ill in-patient with advanced dementia. After a written informed consent from the patient's legal representative, the study proposal was reviewed and approved by the Institutional Ethics Committee.

Case Vignette

An elderly 83-year-old male, a US citizen with an overseas-citizen-of-India (OCI) card, was hospitalised under the department of Palliative Medicine on September 9, 2025, for management of his agitated delirium, optimising comorbidities, and seeking a continuum of supportive care beyond institutional stay. He had had two acute coronary events in 1988 and in 1993, following which he underwent coronary artery bypass graft surgery. An implantable cardioverter-defibrillator with pacemaker function was placed in 2014 for recurrent unexplained syncopal episodes associated with arrhythmia, as a precautionary measure, as he was also an avid trekker.

In 2019, he developed cardiac failure with progressive cardiomyopathy. His multi-morbidities included long-standing diabetes mellitus, hypertension (both for 50 yr), depression, paranoia, and panic attacks since 1988, along with a gradually progressive neurodegenerative condition with dementia (2016), and stage 4 chronic kidney disease (2021). The couple arrived in India in 2022 for socio-cultural reasons, to

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Table I. Stepwise institutional processes for activating the request for withholding/withdrawal of life support medical treatment (WH/WD-LST))

Step	Description
Step 1	The enquiry for WH/WD-LST as a request from the family/caregiver OR in the course of family - clinician discussions
Step 2	Checking for/validation of the Advance Medical Directive (Living Will -AMD) by the treating physician
Step 3	Signed request and consent from the surrogate for WH/WD quoting reasons and with signatures of witnesses (**Supplementary Material 1**).
Step 4	Discussions between the treating physician and the family. A) Establish irreversibility of the condition; B) Evaluate healthcare decision making capacity; C) Evaluate full comprehension of consequences of the request for WH/WD-LST & D) specific to the patient, *e.g.*, family awareness; ICD interrogation- report
Step 5	An official email request from the treating physician to the Chief Administrator of the institution, to activate the institutional procedures processes for WH/WD-LST
Step 6	Constitution of the Primary Medical Board (PMB) by the Chief Administrator of the institution including i) the treating physician and two subject experts: all with more than five years of post-qualification clinical experience.
Step 7	The PMB evaluates the patient, interacts with family, documents and signs their report in the suggested format (**Supplementary Material 2**) and submits to the Chief Administrator within 48 h.
Step 8	Constitution of the Secondary Medical Board (PMB) by the Chief Administrator of the institution, with a different set of clinicians having more than five years of post-qualification clinical experience; with one empanelled by the State (alternative in Karnataka - empaneled member of the Brain Death Declaration Committee)
Step 9	The SMB evaluates the patient, interacts with family, documents and signs their report in the suggested format (**Supplementary Material 3**), and submits to the Chief Administrator within 48 hours of their formation.
Step 10	The Chief Administrator conveys of the PMB, and SMB concurrence reports to the Judicial Magistrate of 1st Class (JMFC) and conveys the following documents to the jurisdictional JMFC: 1) The concurrence reports of PMB and SMB – in the prescribed format; 2) The copy of the AMD OR, the request and consent of the surrogate decision maker, in the prescribed format; and 3) And a cover letter explaining the background circumstances.

be with their extended family. They stayed on in view of his worsening medical condition and to maintain family-connectedness.

As his dementia with delirium deteriorated, his wife and daughter sought the best supportive care. During the inpatient admission, they shared their fear that automated ICD defibrillation could prolong and add suffering to his dying process. They expressed their wish to protect him by deactivating the defibrillator function of his ICD and by withholding artificial life-sustaining medical treatment (WH/WD-LST), including intubation, dialysis, mechanical ventilation, and tube feeding.

Our institution was adequately prepared with mandated procedures: (*i*) the Karnataka Health-Secretariat had circulated orders (February 2025), to implement the due processes as per the amended Supreme Court judgment,[1-8] (*ii*) there was a State-empanelled brain death declaration committee (BDDC), that fulfilled the legal mandate for forming the two medical boards required as per the Supreme-Court directives (SC-Directives),[6] and (*iii*) it had well-integrated, palliative care services. The hospital administration had also received the official email ID of their jurisdictional judicial magistrate of first Class (JMFC) from the Bengaluru metropolitan magistrate's office. The transformed legal scenario in the State allowed the institution to proceed with the request for WH/WD-LST, by applying the ethical, legal, and central-state-government mandates, when considering the request for deactivating the defibrillator and withholding other LST for this patient.

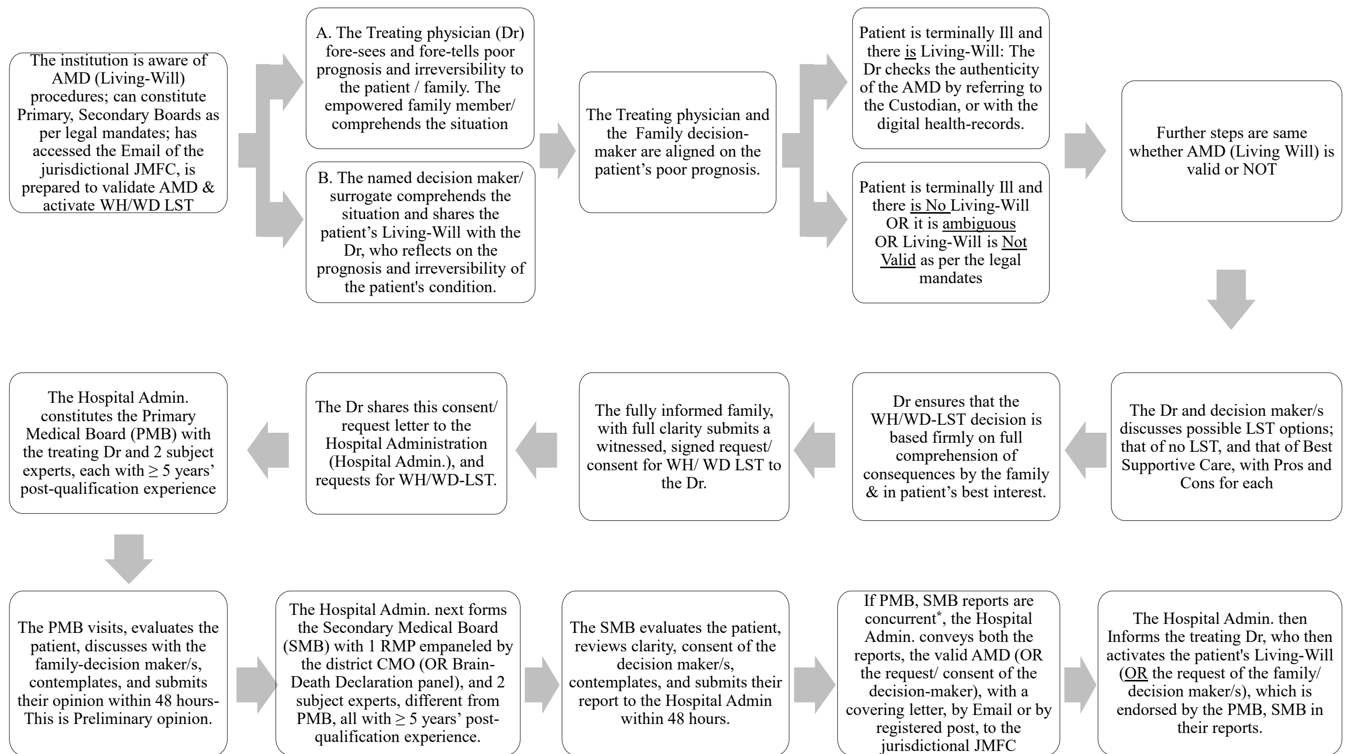

Figure. The sequential institutional processes, including the central legal mandates and Karnataka State processes. This Flowchart depicts the sequential processes required in healthcare institutions in India, to withhold/withdraw life-sustaining medical treatment. It integrates the legal mandates, with the procedures recommended by the central government and prescribed by the State government of Karnataka. WH/WDLST, withholding/withdrawing life sustaining treatment; JMFC, judicial magistrate of first class; AMD, advance medical directive; PMB, primary medical board; SMB, secondary medical board. *When there is non-concurrence between the PMB, SMB reports, the Supreme-court recommends alternative pathways involving the High court and senior subject-experts, from outside the institution.

Procedural intervention

Table I and Figure briefly depict the stepwise institutional processes for activating the request for withholding/ withdrawal of life support medical treatment (WH/WD-LST as per the legal mandates of the land.

Step 1. Request from the family/caregiver: Patient's wife and daughter, both medical professionals, were the legal decision-makers. They shared a living will, recorded earlier by the patient, and requested deactivating the defibrillator function of the ICD.

Step 2. Validation of the advance medical directive (AMD/living-will): His AMD was recorded and authenticated in 2017, in California, USA, as per the regional mandates. It contained clear instructions not to initiate/escalate futile medical interventions when his health condition became irreversible or terminal. He had expressed his wish to avoid life-support machines if his condition became such that he was unable to talk to family, friends, or wake up from a coma, feed, bathe, or take care of himself, and live without being hooked up to machines. He had named his wife and daughter (both physicians) as his surrogate decision-makers.

Yet, as this living will was not executed according to the SC-Directives, and as per the notification by the Karnataka government with regard to validating advance medical directives[4,5,7,8], it was not legally valid. Nevertheless, as the patient held an OCI card and had been residing in India continuously since 2022,[9] Indian civil and healthcare laws were applicable and procedures for situations without AMD were followed.

Step 3: Signed request and consent from the surrogate: The patient's wife submitted a signed request and a witnessed consent form for deactivation of the defibrillator function of the ICD, while preserving the pacemaker function. This was done in the format recommended by the Government of India[10] **(Supplementary Material 1)**. The reason quoted was to protect her husband from needless pain and suffering and a prolonged dying process resulting from defibrillator activation during the terminal phase and other life-sustaining treatments.

Step 4. Discussions between the treating physician and the family:

Step 4A: Establishing irreversibility of the condition: The treating team evaluated the patient with reference to the ICMR definitions and consensus documents[11,12] that helped to standardise, update, and remove ambiguities with regard to terminal illness, withholding/withdrawal, and end-of-life care (EOLC). Despite multi-specialty input from neurology and psychiatry, his multi-morbidities could neither be reversed nor optimised, and his multi-system deterioration was irreversible. His palliative performance scale (PPS) score[13] was 30, as he was bedbound, with total dependency for self-care, minimal oral intake, fluctuating consciousness, and delirious episodes, which justified his status as terminally ill.

Step 4B: Evaluating healthcare decision-making capacity: His cognition and orientation to time and person remained poor, despite neuro-psychiatry specialist involvement. He lacked the mental capacity to make an independent, informed decision regarding his own healthcare.

Step 4C: Evaluating comprehension of consequences of WH/WD-LST: The team discussed the pros and cons of continuing with the ICD and the consequences of deactivating the defibrillator function with the primary decision-maker, his wife, herself a medical doctor. The treating team ensured her insight and full comprehension of the consequences of WH/WD-LST.

Step 4D: ICD interrogation report: The team ordered a non-invasive electronic evaluation of the ICD to check its battery life, lead functions, and heart rhythm data, to document the historical dependence of the patient on the device.

Then, the treating physician concurred with the request of the family and proceeded with the mandated institutional steps to activate the WH/WD-LST in the best interest of this patient.

Step 5: Request from the treating physician to the hospital administrator for withdrawal of life-support device: The treating physician then sent an email request to the chief of medical services (CMS) to activate the due processes recommended for WH/WD-LST.[5-8,10-12]

Step 6: Constitution of the primary medical board: The CMS constituted the primary medical board (PMB), which included the treating physician and two subject experts: one cardiologist and one intensivist, all with more than five years of post-qualification clinical experience.[3]

Step 7: Evaluation of the clinical situation and submission of report by the PMB: The PMB came together to clinically evaluate the patient in the presence of his wife. The investigations and medications were reviewed, and reversible causes for his poor mental capacity were assessed and excluded. They noted minimal use of pacing and nil usage of defibrillator function in the ICD interrogation report.

The PMB also ensured that the wife comprehended the consequences of deactivating the ICD and confirmed her consent to proceed. They then signed their evaluation report in the format suggested by the Government of India[10] **(Supplementary Material 2)** in support of the family's request for deactivating the defibrillator and WH other LST and submitted it to the CMS by email and as a hard copy.

Step 8: Constitution of the secondary medical board: The CMS then constituted the secondary medical board (SMB) with a different set of clinicians having more than five years of post-qualification clinical experience.[8] One was a neurologist who was also an empaneled member of the BDDC of the State, as required by the legal and government mandates for forming the SMB.[6] The other subject experts included a senior intensivist and a senior physician.

Step 9: Evaluation by the SMB and submission of their report: The SMB evaluated the patient, noted the psychiatrist's opinion, and medications. They administered the Addenbrooke cognitive test[14] in which he scored 26/100. Once the irreversibility of his mental condition and lack of decision-making capacity were established, the SMB interviewed his wife and confirmed her comprehension of the consequences of discontinuing the defibrillator, before concurring with the PMB decision. The SMB then signed their evaluation report in the suggested format[10] **(Supplementary Material 3)** and submitted their report to the CMS by email and as a hard copy. They advised continuation of the best supportive treatment for the symptoms and for the underlying medical comorbidities.

Step 10: Conveyance of the PMB and SMB concurrence reports by the CMS to the judicial magistrate of first class (JMFC): Submission of reports of the PMB and SMB each were achieved within 48 hours of their constitution, as required by the SC-directives. The CMS completed the legal requirements to deactivate the defibrillator function of the ICD and not to escalate the patient's care to artificial support by conveying the following documents to the official email of the jurisdictional JMFC[10] (**Supplementary Material 4**).

(*i*) The reports of both the PMB and SMB, that concurred to deactivate the defibrillator function of the ICD– in

the prescribed format; (*ii*) the request and consent of the patient's wife in the prescribed format; and (*iii*) a cover letter explaining the background circumstances.

Follow-up and outcomes: The technologist was subsequently summoned to deactivate the defibrillator function. The patient continued as an inpatient for two weeks more, to optimise his care, for educating the personal caregiver, and to optimise his agitation and sleep. He was discharged once symptoms were controlled, medications reconciled, and the family felt confident to manage his care at home. The palliative home care team provided weekly reviews to maintain his care continuum. The patient died pain-free, at home, surrounded by his family, on the 45th morning after deactivating the defibrillator.

Discussion

With the advent of advanced technology to support most vital functions, the processes to identify which patient is critically ill and who is terminally ill have become blurred.[15] Medicalised death, with terminally ill patients dying with futile intensive interventions, has resulted in immense emotional and financial hardship for the families, moral distress for the healthcare providers, and a painful death for the patients.[16-18]

India's trajectory towards dignified end-of-life care (EOLC) has taken a major leap with the 2023-amendment of the Supreme Court (SC) judgement 2018,[1-3] that simplified the processes to evaluate and proceed with WH/WD-LST. The judgment upheld the right to life with dignity of a terminally ill patient and granted legal recognition to Advance-Medical-Directives–AMDs (living Will). The SC-Directives could be activated in Karnataka, only when the State-Health Secretariat filled in the last-mile gaps for implementing the legal procedures **(Table II)**.[4-8]

As WH/WD-LST is a crucial need, many institutions have developed pathways to support de-escalation of care, even before the SC-directives came into effect. Several studies explaining the advance care-planning and operational procedures for WH/WD-LST have also been published,[19,20] since the SC-judgement. Although there are significant variations when making decisions around WH/WD-LST, the legal-ethical processes in India reflect some of the core recommendations being considered across the globe.[21,22]

This implementation case study is unique in its diligent recording of specifics when adhering to the legal mandates of implementing WH/WD-LST in an institution, including the practical, ethical, and governmental legal nuances, demonstrating feasibility and practicality. What did this implementation mean for the patient-family, the professionals, and the institution?

- It prevented the needless suffering of the patient due to a prolonged dying process. The family felt listened to, cared for, and treated beyond the physical domain, towards maintaining the dignity of their loved one.
- The two ICMR publications; (*i*) Definition of terms used in limitation of treatment, and (*ii*) on Do-Not-Attempt-Resuscitation,[11,12,] not only clarified those terminologies but also encouraged reflective thinking when making decisions for the irreversibly ill. This helped resolve the hesitation of professionals to engage with terminal-care decision-making.
- The decision-responsibility shared with the primary and secondary medical boards brought objectivity and normalised the approach to an otherwise complex situation. The procedures supported clinicians to safeguard their patients' best interests, alleviate their own ethical-moral distress, while still being within legal boundaries.
- Timely WH/WD of inappropriate, non-beneficial, expensive, and burdensome interventions permitted transitions to proportionate care alternatives. For example, it helped transition 'discharge against medical advice' (DAMA) situations, to palliative home-based-end-of-life care. It prevented suffering of the patient, reduced the angst of the family,[16-18] avoided moral distress of clinicians, while averting catastrophic healthcare expenses.[18]
- The streamlined processes have since enabled identification of futility, WH/WD-LST decisions, and care transitions at other settings, including neonatal and paediatric ICUs and inpatient settings.
- Acknowledging the essentiality of WH/WD-LST, the administration of our institution has launched workshops for post-graduates and faculty on the ethical and legal pathways to end-of-life decisions for terminally ill patients.

The stepwise processes of ethical, medical reasoning to determine futility/burden of procedural interventions described here, and the templates shared for recording living will (AMD), PMB, SMB reports, the surrogate request/consent, and for communicating to the JMFC (**Supplementary Materials 1-5**), can assist other institutions with BDDC, to activate WH/WD–LST.

One foreseeable barrier would be at the prognostication level of PMB/SMB, which needs to differentiate a critically ill person from one who

Table II. Implementation steps required at the state-level in India in-order to active the Supreme-Court directives regarding the living will and withholding, withdrawing life-support-treatments, and the solutions activated by the Karnataka State health secretariat

Legal requirement as per the supreme court judgement	Solution by the health secretariat of Karnataka
1. The Custodian (the competent officer) is designated by the local government such as the municipal corporation, municipality, or panchayat. The Custodian is responsible for securely maintaining the Advance Medical Directive AMD-living will document in a registry.	• AMD custodians in Rural Areas: Executive Officer of the concerned Taluk Panchayath[7] • AMD custodians in urban areas: Joint commissioners of BBMP zones for Bengaluru[4,8]
2. Physician empanelled by the district Chief Medical Officer is mandatory to form the three-member Secondary Medical Board	• Clinicians already approved under the Transplantation of Human Organs and Tissues Act (1994, amended 2011) for certifying brain-stem death will be deemed to be nominated by the District Health Officer to serve as a member of the Secondary Medical Board for WLST/AMD cases.[6] • Being a multi-specialty medical college hospital, our institution had empanelled members for certification of Brain Death as per the Section 3[6] of the Transplantation of Human organs and Tissues Act 1994, as amended in 2011.[23] The recognition of this set of empanelled members as adequate for the SMB by the Karnataka state health secretariat helped the institution to activate the required legal mandates.
3. The institution administration has to 'convey' the concurrence reports of both, the Primary and Secondary Medical Boards and the surrogate request/consent to the Jurisdictional JFMC, before acting upon the decisions.	• The Chief of Medical Services of our institution received the E-mail ID of the Jurisdictional Judicial Magistrate of First Class, in response to an official request for the same, sent to the official E- mail of the Bengaluru Metropolitan Magistrate
4. General awareness of the concerned officials (*e.g.* Chief District Health Officers, the JMFCs, clinical establishments, government hospitals, local governments, high-court registry, and public information officers), through communication-orders, explaining their roles in executing the Supreme Court mandates.	The respective communications are getting prepared/ underway from the State Government offices to the officials and establishments concerned with the implementation of the SC directives *viz.* the district chief medical officer, clinical establishments, government hospitals, local governments, JMFCs, high-court registry and public information officers.

is terminally, irreversibly ill. Clinicians may find it difficult to diverge from conventional practices focusing on organ functions, the 'effect' of the LST on parameters (blood-pressure, partial-pressure of oxygen (PaO2), or creatinine), to discern the overall 'beneficence' to the whole person. The nuanced legal procedures may stimulate deeper, mature, reflective, and ethical enquiries to clarify what will best serve in the 'best interest' of that patient-person.

The steps required at the state-level, for implementing SC-Directives on the living will, are at four levels, and **Table II** indicates the implementation steps required at the state-levels and lists the developments at the Karnataka state-health-secretariat. Besides what is operationalised, there are certain state-level actions required before the WH/WD-LST pathway can be utilised by all institutions. The state has yet to officially communicate the legal mandates, SOPs, and templates to make its healthcare institutions aware of the recent developments. District medical officers need official orders explaining their role for empanelling the SMB members, without which healthcare institutions that do not have the 'brain death declaration committee' cannot activate WH/WD-LST.[23] The SC-mandated procedures for resolving decision-conflict-situations, (*i*) between the family and treating physician, or (*ii*) non-concurrence of PMB and SMB reports, require actions involving the high court. The stakeholders at the state department, the JMFCs, and the judiciaries including the Registrar (High Court), need official communications from state authorities on their roles/ duties in connection with the AMDs and WH/WD-LST.

India consistently ranks low on the quality of death index, at 67th out of 80 countries in 2015 and 59th out of 81 in a 2021 review.[24,25] As described through this case vignette, adhering to the prescribed legal, ethical mandates can help improve the quality of death of individuals and transition an isolated, sterile, painful, expensive[15-18] and undignified death with intensive care, to caring intensively at their preferred place, surrounded by their loved ones.

शोध-संदेश

भारत के सर्वोच्च न्यायालय ने वर्ष 2018 में गंभीर और असाध्य बीमारी से पीड़ित मरीजों को सम्मानजनक मृत्यु का अधिकार दिया तथा कुछ परिस्थितियों में कृत्रिम जीवन-रक्षक उपचार (life-support) को रोकने या वापस लेने की अनुमति प्रदान की। वर्ष 2023 में किए गए संशोधन के बाद इन प्रक्रियाओं को लागू करना अधिक व्यावहारिक हो गया। इस लेख में कर्नाटक के एक बड़े अस्पताल के उदाहरण के माध्यम से बताया गया है कि जीवन-रक्षक उपचार को रोकने या वापस लेने की प्रक्रिया को अस्पताल स्तर पर किस प्रकार लागू किया जा सकता है। इसमें जीते-जी लिखी गई वसीयत (living will) की पुष्टि, विभिन्न स्तरों पर मेडिकल बोर्ड का गठन, मूल्यांकन और रिपोर्टिंग की प्रक्रिया, तथा न्यायिक मजिस्ट्रेट को आवश्यक जानकारी भेजने की व्यवस्था को स्पष्ट किया गया है। यह लेख यह भी दर्शाता है कि इन प्रक्रियाओं का मरीज के परिवार, स्वास्थ्यकर्मियों, और अस्पताल पर क्या प्रभाव पड़ता है।

***Author contributions*:** ·NV: Concepts, design, definition of intellectual content, literature search, data acquisition, manuscript writing; PV: Concepts, design, definition of intellectual content, literature search, data acquisition, manuscript writing; PP: Literature search, data acquisition, manuscript writing; AJT: Literature search, data acquisition, manuscript writing; MK: Concepts, design, manuscript writing; VPS: Definition of intellectual content, manuscript writing. All authors have read and approved the final printed version of the manuscript.

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References

1. Supreme Court of India, Criminal Original Jurisdiction. *Writ Petition (Criminal) No. 115 of 2009*. Available from: https://api.sci.gov.in/jonew/judis/37709.pdf, accessed on December 17, 2025.
2. Supreme Court of India. Government of India. *Common Cause (A Registered Society) v. Union of India & Another, (2018) 5 SCC 1.* Available from: *https://cdnbbsr.s3waas.gov.in/s3ec0490f1f4972d133619a60c30f3559e/documents/aor_notice_circular/44.pdf*, accessed on December 17, 2025.
3. Supreme Court of India. *Order modifying advance medical directive/withholding and withdrawing of life-sustaining treatment procedures (Common Cause case). Miscellaneous Application No. 1699 of 2019 in Writ Petition (Civil) No. 215 of 2005. Order dated 24 Jan 2023. New Delhi: Supreme Court of India; 2023*. Available from: *https://main.sci.gov.in*, accessed on December 29, 2025.
4. Government of Karnataka, Urban Development Department. *Proceedings of the Government of Karnataka Government Order No. UDD 184 BBL 2024*. Available from: *https://hfwcom.karnataka.gov.in/334/government-orders/en*, accessed on Decmber 5, 2025.
5. Government of Karnataka. *Circular No. HFW 256 FPR 2024: Salient features of the orders of the Hon'ble Supreme Court dated 24 Jan 2023 in Miscellaneous Application No. 1699 of 2019 in Writ Petition (Civil) No. 215 of 2005 with regard to withholding/withdrawing of life-sustaining treatment (WLST). Bengaluru: Department of Health and Family Welfare; 2025 Jan*. Available from: *https://hfwcom.karnataka.gov.in/storage/pdf-files/SalientFeaturesofSCJudgmntonWLST_merged.pdf*, accessed on December 29, 2025.
6. Health and Family Welfare Department (Karnataka). *Nomination of registered medical practitioners to the secondary medical board to certify withholding/withdrawing of life-sustaining treatment (WLST) [Internet]. Bengaluru: Health and Family Welfare Department; 2025 Jan 30*. Available from: *https://hfwcom.karnataka.gov.in/storage/pdf-files/NomineeofDHOonSecondaryBoard-1-1.pdf*, accessed on December 29, 2025.
7. Government of Karnataka, Department of Rural Development and Panchayat Raj. *Notification No. RDPR 729 GPA 2024. Bengaluru: Government of Karnataka; 2025 Feb 14*. Available from: *https://rdpr.karnataka.gov.in/storage/pdf-files/Panchayatraj/No_729_24_14_02_25.pdf*, accessed on December 29, 2025.
8. Government of Karnataka, Urban Development Department. *Corrigendum to Government Order No. UDD 184 BBL 2024. Bengaluru: Government of Karnataka; 2025 Feb 15*. Available from: https://hfwcom.karnataka.gov.in/uploads/udd%20184%20bbl%202024%20corregendum%20Tranlate_1767521190.pdf, accessed on December 17, 2025.
9. Ministry of Home Affairs, Government of India. *Overseas Citizenship of India (OCI) cardholder – frequently asked questions (FAQs). New Delhi: Ministry of Home Affairs; 2021 Jul 22*. Available from: *https://www.mha.gov.in/sites/default/files/2022-09/OCIFAQs_23072021%5B1%5D.pdf*, accessed on December 29, 2025.
10. Directorate General of Health Services, Ministry of Health and Family Welfare. *Circular on implementation of Supreme Court guidelines on withdrawal of life support. New Delhi: Ministry of Health and Family Welfare; 2023*. Available from: *https://dghs.mohfw.gov.in/uploads/assets/Ym7COsjGbBsOkMxYuLRUlrO3j3ZE0Bn7HTXpuyDV.pdf*, accessed on December 29, 2025.
11. Salins N, Gursahani R, Mathur R, Iyer S, Macaden S, Simha N, *et al*. Definition of terms used in limitation of treatment and

providing palliative care at the end of life: The Indian council of medical research commission report. *Indian J Crit Care Med.* 2018;22:249–62.
12. Mathur R. ICMR consensus guidelines on do not attempt resuscitation. *Indian J Med Res.* 2020;151:303–10.
13. Anderson F, Downing GM, Hill J, Casorso L, Lerch N. Palliative performance scale (PPS): A new tool. *J Palliat Care.* 1996;12:5–11.
14. Hsieh S, Schubert S, Hoon C, Mioshi E, Hodges JR. Validation of the Addenbrooke's cognitive examination III in frontotemporal dementia and Alzheimer's disease. *Dement Geriatr Cogn Disord.* 2013;36:242–50.
15. Toffart AC, Gonzalez F, Hamidfar-Roy R, Darrason M. ICU admission for cancer patients with respiratory failure: an ethical dilemma. *Rev Mal Respir.* 2023;40:692–99.
16. Mehta AB, Lockhart S, Reed K, Griesmer C, Glasgow RE, Moss M, *et al*. Drivers of burnout among critical care providers: A multicenter mixed-methods study. *Chest.* 2022;161:1263–74.
17. Salama H, Al Mutairi N, Damlaj M, Alolayan A, Binahmed A, Salama H, *et al*. Reducing futile acute care services for terminally Ill patients with cancer: The dignity project. *JCO Oncol Pract.* 2021;17:e1794–802.
18. Oyama Y, Yamase H, Fujita K, Tashita H, Honda T, Yoshida K, *et al*. Critically ill patients' experiences of discomfort and comfort in the intensive care unit: A qualitative descriptive study. *Aust Crit Care.* 2025;38:101115.
19. Damani A, Ghoshal A, Rao K, Nair S, Gursahani R, Simha S, *et al*. Enhancing advance care planning in India through a 12-step Pathway. *Indian J Crit Care Med.* 2025;29:301–7.
20. 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;27:374–6.
21. Choi HR, Ho MH, Lin CC. Navigating tensions when life-sustaining treatment is withdrawn: a thematic synthesis of nurses' and physicians' experiences. *J Clin Nurs.* 2024;33:2337–56.
22. Edwardson S, Kellichan R, Reid C, Baruah R, Hall C. Withdrawal of life-sustaining therapies for awake patients in critical care: The benefits of a collaborative intensivist and palliative care approach. *J Intensive Care Soc.* 2025;26:353–62.
23. India. The Transplantation of Human Organs and Tissues Act, 1994 (as amended up to Act 16 of 2011). New Delhi: Government of India, Legislative Department; 1994.
24. Mir WAY, Misra S, Sanghavi D. Life before death in India: A narrative review. *Indian J Palliat Care.* 2023;29:207–11.
25. Butola S, Gursahani R. Advance care planning and the ethical obligation of death literacy as a public health initiative in India. *Indian J Med Ethics.* 2024;IX:308–12.

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