

Role of Do Not Escalate Treatment (DNET) Consent in End-of-Life Care: A Clinical, Ethical and Legal Perspective in India

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Abstract

Background: Advances in medical technology have improved survival in critically ill patients; however, aggressive treatment escalation may not always provide meaningful improvement in quality of life or clinical outcomes. In advanced or irreversible illness, continued escalation may impose treatment burden without achieving the goals valued by the patient.

Aim: To highlight the importance of Do Not Escalate Treatment (DNET) consent in clinical practice and to examine its relationship with patient autonomy, informed consent, end-of-life care, and the Indian legal framework governing withholding or withdrawal of life-sustaining treatment.

Methodology: A descriptive review was undertaken based on the structure and application of a DNET consent process used in healthcare practice. The review considers clinical, ethical and legal principles relevant to decisions about limitation of invasive interventions when treatment is unlikely to improve prognosis or quality of life.

Conclusion: DNET can support ethical, compassionate and patient-centred care when it is used as part of a structured clinical process. Clear communication, capacity assessment, documentation, multidisciplinary review, appropriate legal safeguards and continuing palliative care are essential. In India, the Supreme Court's decisions in *Common Cause v. Union of India* and *Harish Rana v. Union of India* provide an important legal context for end-of-life treatment decisions.

Keywords: Do Not Escalate Treatment, End-of-Life Care, Patient Autonomy, Informed Consent, Palliative Care, Healthcare Ethics, Life-Sustaining Treatment, India, Medical Law

1. Introduction

Modern healthcare aims not only to prolong life but also to maintain dignity and quality of life. Advances in intensive care, mechanical ventilation, dialysis, vasopressor therapy, invasive procedures and artificial nutrition can prolong biological survival in patients with severe disease. However, in advanced illness or

irreversible clinical conditions, escalation of treatment may sometimes increase treatment burden without providing meaningful clinical benefit.

Do Not Escalate Treatment (DNET) is a decision-making approach in which a patient, or an appropriate representative where legally and clinically applicable, communicates preferences regarding limitation of further aggressive medical interventions. DNET does not mean withdrawal of all treatment or abandonment of the patient. Rather, it seeks to establish which treatments should not be escalated while continuing appropriate nursing, symptom control, psychosocial support, and palliative or end-of-life care.

The importance of a structured DNET process lies in communication. During acute deterioration, uncertainty may lead to unwanted procedures, conflict between family members and clinicians, or inconsistent decisions between different members of the healthcare team. Advance discussion and documentation can provide clearer guidance and support treatment that remains aligned with the patient's goals.

2. Importance of DNET Consent

DNET consent provides clear guidance during medical deterioration and may help the clinical team distinguish between treatment that is beneficial and treatment that is unlikely to achieve the patient's goals.

- Intubation and mechanical ventilation
- Dialysis
- Major surgery
- Vasopressors or inotropic support
- Other invasive or burdensome treatment measures
- Transition from disease-directed treatment to comfort-focused and palliative care when clinically appropriate

The scope of a DNET decision should be individualised. A DNET document should identify the specific interventions covered and should not be interpreted as a blanket refusal of all future medical treatment.

3. Ethical Considerations

DNET decisions are based on the ethical principles of autonomy, beneficence, non-maleficence and dignity. Patients have the right to participate in decisions regarding their healthcare and treatment preferences, subject to applicable law and clinical circumstances.

Autonomy requires that patients receive understandable information and have an opportunity to express their preferences. Beneficence requires clinicians to act for the patient's welfare. Non-maleficence requires consideration of avoidable harm and treatment burden. Respect for dignity requires attention not only to survival but also to the patient's values, comfort and quality of life.

Where a patient lacks decision-making capacity, clinicians should follow the applicable legal and institutional framework, consider previously expressed wishes and involve the appropriate representative and multidisciplinary professionals as required.

4. Indian Legal and Regulatory Perspective

DNET is not a separate statutory category of treatment in Indian law. It is better understood as a clinical communication and documentation approach that operates within the broader legal framework concerning informed consent, refusal of treatment, advance medical directives, withholding or withdrawal of life-sustaining treatment, patient dignity and palliative care.

4.1 Article 21 – Right to Life and Dignity

Article 21 of the Constitution of India protects life and personal liberty. The Supreme Court of India has interpreted the protection of life to include the concept of dignity. In the end-of-life context, the Court has recognised a right to die with dignity within the constitutional framework. This is relevant to DNET because end-of-life care is not solely a question of prolonging biological survival; it also involves dignity, suffering, treatment burden, prognosis and the patient's treatment preferences.

4.2 Common Cause v. Union of India – 2018

In *Common Cause (A Regd. Society) v. Union of India*, the Supreme Court recognised the legal significance of advance medical directives and laid down safeguards concerning withholding or withdrawing life-sustaining treatment in specified circumstances. The Court recognised that a person with decision-making capacity can refuse medical treatment and that an adult may make an advance medical directive for future circumstances. The judgment also established safeguards for decisions involving persons who subsequently lack decision-making capacity.

For hospital practice, the Common Cause framework highlights the importance of patient autonomy, informed communication, documentation, appropriate medical review and procedural safeguards. A DNET document should therefore not be treated as an independent authorisation to stop treatment; it should be considered together with the patient's clinical condition and the applicable legal and institutional process.

4.3 Subsequent Clarification and Practical Implementation

The Supreme Court subsequently modified and clarified aspects of the procedural framework associated with the 2018 judgment. These developments are important for hospitals because end-of-life decisions may involve the treating physician, specialists, medical boards, the patient and family members. Clear documentation and a defined institutional pathway can reduce uncertainty and improve consistency in clinical decision-making.

4.4 Harish Rana v. Union of India – 2026

A significant recent development occurred in *Harish Rana v. Union of India*, decided by the Supreme Court on 11 March 2026. The case concerned a patient in a permanent vegetative state who had been receiving clinically assisted nutrition and hydration through a PEG tube. The Supreme Court considered whether such clinically assisted nutrition and hydration constituted medical treatment and whether its withdrawal could be considered under the framework developed in *Common Cause*.

The Court held that clinically assisted nutrition and hydration through a PEG tube involves medical intervention, specialised techniques and continuing monitoring and therefore can constitute medical treatment. The Court permitted withdrawal or withholding of the relevant treatment in the circumstances

of that case after medical-board evaluation and directed that the transition be implemented through a robust palliative and end-of-life care plan.

The judgment also emphasised that withdrawal of life-sustaining treatment should not be equated with abandonment. A patient continues to require appropriate medical supervision, symptom management, comfort care and dignity. The Court further streamlined aspects of the Common Cause procedure and urged the Union Government to consider comprehensive legislation on end-of-life care.

This development has practical significance for DNET because it demonstrates that limitation of life-sustaining treatment requires more than a signed document. Clinical assessment, appropriate medical opinion, consideration of the patient's best interests and the relevant safeguards remain essential.

4.5 Practical Legal-Clinical Example

Consider a patient with an irreversible neurological condition who is dependent on mechanical ventilation and has no reasonable prospect of meaningful recovery. The patient has previously expressed a clear preference not to undergo prolonged invasive treatment in such circumstances.

The healthcare team should not rely solely on a signed DNET form. The team should assess the patient's current clinical condition and decision-making capacity, review previously expressed wishes, explain prognosis and treatment options, and follow the applicable institutional and legal safeguards. Where withholding or withdrawal of life-sustaining treatment is being considered, the required medical review or board process should be followed.

If treatment limitation is determined to be appropriate, the care plan should specify which interventions are to be withheld or withdrawn and which treatments will continue, including symptom control, nursing care, psychosocial support and palliative care. This illustrates that DNET is not equivalent to 'stopping treatment'; it is a structured approach to avoiding non-beneficial escalation while continuing appropriate care.

4.6 DNET, DNR and Advance Medical Directives

DNET should be distinguished from other end-of-life terms. A Do Not Resuscitate (DNR) decision generally concerns cardiopulmonary resuscitation following cardiac or respiratory arrest. DNET may have a broader scope and may address escalation of interventions such as mechanical ventilation, dialysis, vasopressors, major surgery or other invasive procedures.

An Advance Medical Directive is a mechanism through which an individual can record treatment preferences for a future situation in which the individual may lose decision-making capacity. Therefore, DNET, DNR and an Advance Medical Directive should not be used interchangeably. The medical record should clearly identify the specific treatment decision applicable to the individual patient.

5. Role of Healthcare Professionals

- Explaining diagnosis, prognosis and available treatment options
- Assessing and documenting decision-making capacity where relevant
- Ensuring informed and understandable communication
- Supporting patients and families through shared decision-making
- Maintaining accurate and contemporaneous documentation
- Respecting applicable patient preferences and legally valid decisions
- Obtaining appropriate multidisciplinary or medical-board review where required
- Providing comfort-focused and palliative care when appropriate
- Reviewing the decision when the clinical situation or patient wishes change

The treating team should ensure that DNET documentation is visible and appropriately communicated within the healthcare team so that emergency escalation does not occur solely because the treating staff are unaware of the documented plan.

6. Proposed Hospital-Level DNET Framework

Step 1 – Clinical Assessment: Evaluate diagnosis, prognosis, reversibility, treatment burden and available options.

Step 2 – Capacity Assessment: Determine whether the patient has decision-making capacity for the relevant decision.

Step 3 – Communication: Explain the clinical condition, expected outcomes, benefits, burdens and alternatives.

Step 4 – Patient Preference: Identify current wishes or previously documented preferences.

Step 5 – Multidisciplinary Review: Involve relevant specialists, palliative-care professionals and medical boards where required.

Step 6 – Documentation: Record the decision, rationale, participants, scope and treatments to be limited or continued.

Step 7 – Implementation: Communicate the decision to all relevant healthcare professionals and document implementation.

Step 8 – Comfort and Palliative Care: Continue appropriate symptom management, nursing care, psychosocial support and palliative care.

Step 9 – Review: Reassess the decision when the patient's condition, capacity, wishes or relevant circumstances change.

7. Documentation and Patient Safety

A structured DNET process can improve patient safety by reducing ambiguity during clinical deterioration. Without clear documentation, different clinicians may interpret patient wishes differently, potentially resulting in unwanted invasive treatment or conflict between family members and healthcare providers.

Hospital policy should therefore define who can initiate a DNET discussion, who documents the clinical rationale, how capacity is assessed, when specialist or medical-board review is required, how the decision is communicated, and how the plan is reviewed. Documentation should include the date and time of discussion, participants, clinical condition, prognosis, patient preferences, scope of the decision, agreed treatment limits, continuing care plan and review requirements.

8. Discussion

A structured DNET policy improves communication between healthcare teams and families. Documentation reduces uncertainty and may prevent unwanted interventions during critical situations. Shared decision-making promotes ethical and compassionate healthcare delivery.

The Indian legal framework adds an important dimension to this clinical discussion. The Supreme Court's jurisprudence recognises patient dignity and provides a structured framework for certain decisions concerning life-sustaining treatment. The 2026 Harish Rana decision further illustrates the importance of medical-board assessment, patient best interests, and transition to palliative and end-of-life care.

However, DNET should not be interpreted as a universal instruction to withhold treatment. Clinical circumstances vary, and a patient's wishes, capacity, prognosis and applicable legal safeguards must be considered in each case. Hospitals should also ensure that DNET processes are regularly reviewed and updated in response to changes in law, professional guidance and institutional policy.

9. Conclusion

Do Not Escalate Treatment consent is an important clinical tool that can help balance medical treatment with patient preferences, dignity and quality of life. Its value is greatest when it is incorporated into a structured process rather than used as a standalone form.

An effective DNET pathway should include clear communication, assessment of capacity, informed decision-making, accurate documentation, multidisciplinary review where appropriate, compliance with applicable legal safeguards, and continuing palliative and supportive care. Indian Supreme Court decisions, including *Common Cause v. Union of India* and *Harish Rana v. Union of India*, provide important legal context for withholding and withdrawal of life-sustaining treatment.

Healthcare institutions should therefore develop clear policies, train healthcare professionals and establish standard documentation for end-of-life decision-making. The objective should be neither indiscriminate treatment escalation nor abandonment, but patient-centred care that is clinically appropriate, ethically justified, legally compliant and respectful of human dignity.

References

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5. Supreme Court of India. Common Cause v. Union of India – subsequent orders/clarifications concerning advance medical directives and withholding/withdrawal of life-sustaining treatment.
6. Supreme Court of India. Harish Rana v. Union of India, 2026 INSC 222, judgment dated 11 March 2026.
7. Constitution of India, Article 21 – Right to Life and Personal Liberty.

Appendix: Do Not Escalate Treatment (DNET) Consent Form

The following form is retained from the original paper and may be used as a proposed clinical documentation template. It should be reviewed and approved by the hospital's clinical, legal and ethics authorities before institutional use.

I, [Patient's Name/Next of Kin], hereby consent to the following treatment directive regarding my medical care:

1. Purpose: The purpose of this directive is to communicate my desire to limit or refrain from certain medical treatments that could prolong my life in certain situations.
2. Definition of Do Not Escalate Treatment (DNET): DNET means that, in the event of a medical crisis or deterioration of my health, I do not wish to undergo specified invasive or aggressive treatments that are unlikely to significantly improve my quality of life or prognosis.
3. Scope of DNET Directive:
 - Intubation and mechanical ventilation
 - Other treatment limitations as specified
 - Hemodialysis
 - Major surgery
 - Use of vasopressors or inotropes
 - Other: _____
4. Exceptions: Any exceptions or conditions should be clearly outlined.
5. Duration and Review: This directive should be reviewed according to the patient's clinical condition and applicable legal/institutional requirements. Where applicable, the patient should be informed of the process for modifying or revoking the decision.
6. Patient/Representative Signature: _____ Date: _____
7. Witness Signature: _____ Date: _____
8. Healthcare Provider Signature: _____ Date: _____