FORMEDEX

NEWS ARTICLE REVIEW 2

MTP Law, Medical Assent, and Women's Reproductive Autonomy

A Forensic Medicine & Medicolegal Perspective

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1. Overview & Context

The article under review addresses a growing discourse among medical and legal professionals in India regarding the Medical Termination of Pregnancy (MTP) Act and its 2021 amendment. The central argument is that the current statutory framework remains provider-centric — placing medical assent above a woman's autonomous right to terminate a pregnancy — and that this structure demands urgent legislative reform.

Two high-profile cases frame the debate and bring the medicolegal tension into sharp focus:

The Satara Incident

A gynaecologist in Satara faced an FIR following a late-term MTP performed on a 16-year-old rape survivor. The procedure resulted in a live birth; the infant subsequently died without medical intervention. This incident raises critical questions about:

- The standard of care applicable during late-term MTP procedures.
- The legal definition of a 'failed' termination procedure and attendant criminal liability.
- Whether feticide protocols must be institutionally mandated in late-term cases.

The AIIMS Contempt Warning

The Supreme Court issued a contempt warning to AIIMS doctors who declined to perform a 30-week termination for a minor rape survivor. This case underscores the escalating judicial pressure on medical professionals to interpret the MTP Act through a humanitarian lens rather than a strictly statutory one — a distinction that places practitioners in a professionally and legally vulnerable position.

2. Statutory Framework vs. Judicial Practice

The MTP (Amendment) Act, 2021 expanded gestational limits for specific categories of women, including minors and rape survivors, to 24 weeks. However, a significant and widening gap exists between the written law and judicial practice:

Gestational Limits Under the MTP Act (2021)

Category	Gestational Limit	Opinion Required
General Category	Up to 20 weeks	One Registered Medical Practitioner (RMP)
Specific Categories (Minors, Rape Survivors)	20 – 24 weeks	Two Registered Medical Practitioners
Fetal Abnormalities	No statutory limit	State-level Medical Board
Late-term (non-abnormality)	Not defined by Act	Requires Court Intervention

Key Tensions Identified

- **The 24-Week Barrier:** The Act provides for termination up to 24 weeks for rape survivors and minors, but does not explicitly authorise late-term abortions beyond this threshold in the absence of substantial fetal abnormalities.
- **Judicial Overreach:** Courts are increasingly granting permissions for terminations at 30 weeks and beyond on social or mental health grounds, effectively bypassing statutory limits. This leaves medical boards caught between conflicting mandates — statutory compliance versus judicial orders.
- **Provider-Centric Design:** The MTP Act continues to vest gatekeeping power in Registered Medical Practitioners. Women's access to termination depends on physician approval, not autonomous request — a design that reproductive rights advocates and many legal experts argue is fundamentally inconsistent with constitutional principles under Articles 14 and 21.

3. Forensic Medicine Perspective: Areas of Concern

3.1 Medical Boards as Arbitrators

State-level Medical Boards, as currently constituted, often include practitioners who lack specialised expertise in fetal medicine or obstetric emergencies. From a forensic medicine standpoint, this raises significant concerns:

- No standardised Mental Health Assessment protocol exists for boards evaluating late-term termination requests.
- The absence of uniform criteria creates inconsistent outcomes across states and institutions.
- Board composition is frequently left to institutional discretion, without mandatory inclusion of relevant specialists (e.g., fetal medicine, maternal-fetal medicine, psychiatry).

3.2 The 'Live Birth' Dilemma

In late-term MTP procedures, the probability of a live birth is clinically significant. This creates a critical medicolegal scenario:

- **Legal Status Transition:** Once a live infant is delivered, it acquires legal personhood under Indian law, irrespective of gestational age or the intent of the procedure.
- **Criminal Exposure:** If care is withheld following a live birth — even in the context of an intended termination — medical professionals may face charges of culpable homicide or criminal negligence.
- **Feticide Protocols:** Where pre-procedure feticide (e.g., ultrasound-guided KCl injection) is not performed, practitioners assume heightened legal risk. The absence of institutional feticide protocols for late-term cases represents a major gap in both clinical governance and legal protection.

3.3 The Decriminalisation Imperative

As long as abortion remains embedded within the criminal framework — whether the Indian Penal Code (IPC) or its successor, the Bharatiya Nyaya Sanhita (BNS) — medical practitioners will continue to practise defensively. The chilling effect of criminal liability causes:

- Practitioners to prioritise legal self-protection over patient-centred care.
- Institutional reluctance to perform procedures near gestational thresholds.
- Women being compelled to approach courts for procedures that are clinically indicated, causing harmful delays.

3.4 Definitional Ambiguity in the Act

The term 'Medical Termination of Pregnancy' as currently defined fails to distinguish between:

- Therapeutic termination of a viable or non-viable fetus.
- Emergency surgical interventions such as ectopic pregnancy management, which share procedural overlap but operate under distinct clinical and legal frameworks.

This ambiguity creates interpretive difficulties for practitioners and exposes them to inconsistent legal treatment across jurisdictions.

4. Critical Recommendations

4.1 For Forensic Medicine Practitioners on Medical Boards

- **Comprehensive Documentation:** Documentation must extend beyond physical and fetal parameters to capture the patient's mental anguish, psychosocial vulnerability, and socioeconomic circumstances. This is essential to justify late-term interventions and to provide a defensible medicolegal record.
- **Standardised Assessment Tools:** Advocate for the adoption of validated Mental Health Assessment instruments within Board evaluation protocols.
- **Specialist Inclusion:** Recommend that Medical Boards for late-term cases mandatorily include a fetal medicine specialist, a psychiatrist, and a forensic medicine expert.

4.2 Institutional Policy Reforms

- **Feticide Protocols:** Institutions performing late-term MTPs must establish clear, evidence-based feticide protocols to prevent the medicolegal complications arising from live births in intended terminations.

- **Indemnity Frameworks:** Legal protection for practitioners acting in compliance with judicial orders that conflict with statutory limits must be explicitly codified.

4.3 Legislative Advocacy

- **Decriminalisation:** Advocate for removing MTP from the criminal code entirely. Abortion should be regulated as a health matter, not a criminal one.
- **Definitional Clarity:** Push for legislative amendments that clearly differentiate between therapeutic MTP and emergency obstetric interventions.
- **Autonomy-Centred Reform:** Support the transition from a provider-centric to an autonomy-centric model in which the woman's informed decision is the primary and sufficient legal basis for termination, at least up to defined gestational thresholds.

5. Commentary & Critical Appraisal

The article accurately reflects a systemic fault line in India's abortion law architecture: a statute designed around physician gatekeeping is increasingly at odds with evolving judicial recognition of reproductive autonomy as a fundamental constitutional right. The Supreme Court's 2022 judgment in X v. Principal Secretary acknowledged the right to reproductive decisional autonomy as grounded in Articles 14 and 21 of the Constitution — yet the MTP Act, as amended in 2021, continues to subordinate that right to medical and institutional approval.

From a forensic medicine perspective, the cases cited in the article are not anomalies — they are the predictable consequence of a regulatory gap. When the law does not anticipate late-term judicial mandates, and institutions lack the protocols to safely execute them, practitioners are exposed with neither clinical guidance nor legal protection. The article is correct to identify documentation, feticide protocols, and decriminalisation as the critical tripod on which reform must rest.

The shift from a Doctor-Centric Model to an Autonomy-Centric Model is not merely a philosophical evolution; it has practical medicolegal implications. As the judiciary continues to expand access in individual cases, statutory reform must catch up — or the gap between law on paper and law in practice will continue to produce exactly the kind of crisis illustrated by the Satara Incident and the AIIMS contempt proceedings.

Conclusion

The medicolegal environment surrounding MTP in India is at an inflection point. The article under review raises issues of direct relevance to forensic medicine practitioners, particularly those serving on Medical Boards or advising on late-term termination cases. The principal findings of this review are:

- The MTP Act (2021), while an improvement, remains structurally provider-centric and does not adequately address late-term scenarios outside fetal abnormality grounds.
- Judicial overreach — while well-intentioned — creates unmanageable legal exposure for practitioners acting without clear statutory authority.
- Institutional protocols for feticide, mental health assessment, and board composition are urgently required.
- Long-term reform must include decriminalisation of abortion and a shift toward an autonomy-centred legal framework consistent with constitutional guarantees.

The evolving jurisprudence demands that forensic medicine professionals engage proactively with legislative advocacy, institutional policy development, and the education of fellow practitioners — not merely as technical experts, but as architects of a safer, more equitable medicolegal environment for women seeking reproductive healthcare in India.

References & Source Material

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