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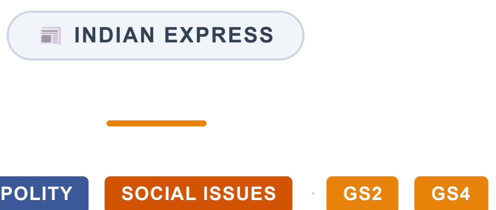
Compassion in the Court: Re-Reading Abortion as a Constitutional Right



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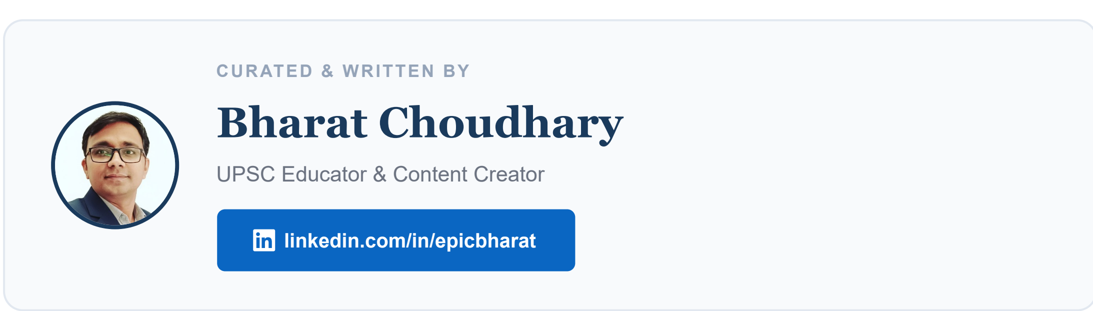

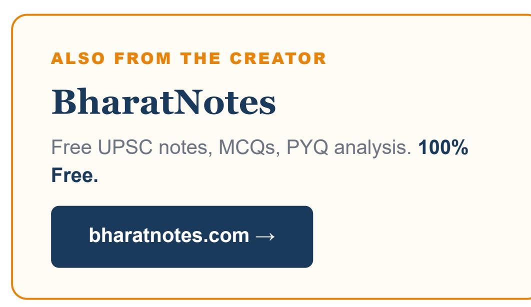

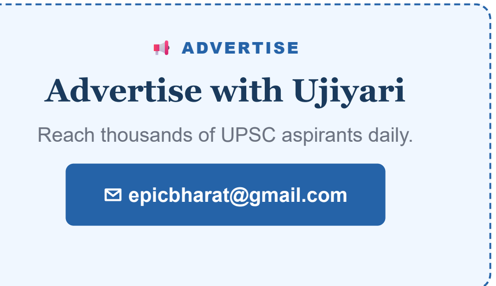

Compassion in the Court: Re-Reading Abortion as a Constitutional Right

The Indian Express 21 May 2026

GS2 GS4

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INTERVIEW ANGLE

"Where do you locate the ethical line between a doctor's conscience, a woman's reproductive autonomy, and the state's interest in foetal life under Article 21?"

EDITORIAL SUMMARY:

The Indian Express argues that compassion is not a judicial deviation but a constitutional value rooted in Article 21 jurisprudence. The Medical Termination of Pregnancy framework must be aligned with reproductive autonomy as a fundamental right rather than left to ad-hoc litigation in each tragic case.

A LANDMARK THAT HAS OUTLIVED ITS LIMITS

The Medical Termination of Pregnancy Act, 1971 was a landmark of Indian liberal legislation. Passed two years before the United States Supreme Court decided Roe v. Wade (1973), it legalised medical termination of pregnancy on enumerated grounds — risk to the woman's life, grave injury to her physical or mental health, substantial risk of foetal abnormality, and pregnancy from rape or contraceptive failure — and established a regulatory framework of registered medical practitioners and approved facilities.

The MTP Amendment Act 2021 carried the framework forward. It raised the gestational limit from 20 to 24 weeks for specified categories — rape survivors, minors, women with mental or physical disabilities, and cases of substantial foetal abnormalities. It introduced a Medical Board mechanism for terminations beyond 24 weeks on grounds of substantial foetal abnormalities. It removed the spousal-consent requirement: the woman's consent alone now suffices. And it provided confidentiality safeguards for unmarried women's terminations.

What the 2021 amendment did not do is align the statutory framework with the constitutional jurisprudence on reproductive autonomy that had developed in parallel.

THE CONSTITUTIONAL ARC

The Supreme Court has, over fifteen years, built reproductive autonomy into the architecture of Article 21.

JUDGMENT	YEAR	CONSTITUTIONAL HOLDING
Suchita Srivastava v. Chandigarh Administration	2009	Reproductive choice is part of personal liberty under Article 21
Justice K.S. Puttaswamy v. Union of India	2017	Bodily autonomy is within the right to privacy as a fundamental right
X v. Union of India	2022	Marital-status distinction in MTP Rules struck down; unmarried women entitled to equal access
Article 142 late-term cases	2024-2026	Supreme Court has, in individual cases, permitted terminations beyond statutory limits where Medical Board mechanism caused delay or denial

The arc is unmistakable. The Court has moved from treating reproductive choice as a derivative liberty to placing it within the core privacy doctrine, and then extending it to unmarried women as an equality matter. The MTP Act sits as a statute beneath this jurisprudence — and increasingly, beneath it.

THE MEDICAL BOARD PROBLEM

The Medical Board mechanism for terminations beyond 24 weeks was, in 2021, presented as a safeguard ensuring expert medical assessment in cases of substantial foetal abnormality. In operation, it has often functioned differently.

The mechanism requires a Board typically comprising a gynaecologist, a paediatrician and a radiologist (in many states, with a representative of the state government). The Board must convene, examine the woman, review medical records and decide. The process can take days or weeks. For rape survivors who delay disclosure, for minors whose pregnancies become known only late in the second trimester, for cases of foetal abnormality detected on second-trimester anomaly scans, this time cost is critical — every week of delay reduces the safety margin for termination and increases the probability that the procedure crosses into post-viability territory where new ethical and legal complexities arise.

There is also state variation. Medical Board composition, convening practice, and decision tendencies vary across states. A pregnancy that one state's Board would authorise for termination, another state's Board might deny — producing a federalism of access that constitutional jurisprudence has not addressed.

The result is that the Supreme Court has, with growing frequency, intervened in individual cases under Article 142 to permit late-term terminations that the Medical Board mechanism delayed or denied. Compassion, in these cases, is not a deviation from law — it is the Court applying Article 21 in the gap that the statute leaves.

THE CONSCIENCE QUESTION

Conscientious objection by doctors — the refusal to perform terminations on grounds of personal moral or religious conviction — has been treated more narrowly in India than in some comparative jurisdictions. The Bombay High Court has held that a doctor at a registered MTP facility cannot refuse abortion services solely on grounds of personal conscience; the patient's right of access has institutional priority. Conscientious objection remains available as a personal choice — a doctor may decide not to perform terminations — but cannot be invoked to deny services within the public or accredited private provider system.

This narrows the conscience space without eliminating it, and reflects the Indian approach to balancing professional autonomy against patient rights — a different equilibrium from the US, where conscience clauses have expanded post-Dobbs.

ACCESS AND THE RURAL-URBAN GAP

The legal framework matters only if access is real. National Family Health Survey data and Ministry of Health and Family Welfare reports indicate that a substantial share of registered MTP providers operate in urban areas. Rural women are dependent on Community Health Centre and District Hospital referrals that impose travel, cost and time burdens at precisely the gestational stage when delay is most dangerous. Unsafe abortion remains a contributor to maternal mortality despite the statutory legal regime.

Decentralisation, accreditation and training of providers — particularly at the Primary Health Centre level — is therefore not a separate question from constitutional rights. It is the operational substance without which the rights remain paper.

COMPARATIVE JURISPRUDENCE POST-DOBBS

The June 2022 US Supreme Court decision in Dobbs v. Jackson Women's Health Organisation reversed Roe v. Wade (1973) and Planned Parenthood v. Casey (1992), returning abortion regulation to the states. The consequence in the US has been a fragmentation of access by state, with some jurisdictions imposing near-total bans and others codifying constitutional protections.

By comparison, India's MTP framework, when read with Article 21 jurisprudence, is structurally more progressive than the post-Dobbs US position. Yet structural superiority by comparison should not become complacency. India's framework still requires the woman in difficult cases to litigate her pregnancy, depends on

Medical Board discretion that varies by state, and leaves rural access to providers thinly distributed.

ETHICAL DIMENSIONS

The GS-IV dimension of this debate is not ornamental. It is structural to how the framework should evolve.

- **Autonomy (Kantian):** The woman is an end in herself, not a means to potential foetal life. Forced continuation of pregnancy treats her as a means; her autonomous decision treats her as an end.
- **Beneficence (medical ethics):** The medical profession's duty to prevent harm includes the harms — physical, psychological, social — of forced continuation in cases of rape, foetal abnormality, or grave risk.
- **Non-maleficence:** The framework must also weigh foetal life, particularly at later gestational stages where viability shifts the ethical balance.
- **State interest (parens patriae) versus liberty paternalism:** The state has a legitimate interest in protecting potential life and ensuring medical oversight. This interest does not licence delay, denial, or moralising paternalism that converts a constitutional right into a discretionary privilege.

The constitutional balance the Supreme Court has struck — woman's autonomy as default, state interest expressed through medical regulation rather than veto — should structure the statutory framework, not be undone by it.

WAY FORWARD

A legislative course correction is overdue. Parliament should amend the MTP framework along four lines:

1. **Recognise the woman's autonomous reproductive right** as the statutory default, with Medical Board consultation reframed as advisory medical assessment rather than gatekeeping authority.
2. **Decentralise Medical Boards to district level** with standardised composition, defined turnaround timelines, and appellate review — eliminating the present time costs and federalism of access.
3. **Expand provider accreditation and training**, particularly at the PHC and CHC level in rural areas, so that registered MTP services are available within reasonable travel distance.
4. **Align the statutory framework with Article 21 jurisprudence** so that no woman is forced to litigate her pregnancy to obtain a right the Constitution already recognises.

The alternative — leaving each tragic case to ad-hoc litigation under Article 142 — is not a sustainable rights architecture. Compassion in the court is necessary; compassion in the statute is overdue.

UPSC MAINS ANALYSIS

GS Paper 2 — Government Policies, Rights Issues, Welfare Schemes for Women GS Paper 4 — Ethics in Public Administration, Medical Ethics, Constitutional Values

- **MTP Act 1971:** Landmark liberal legislation; predates Roe v. Wade (1973); grounds — risk to woman's life, grave injury to physical/mental health, foetal abnormality, rape, contraceptive failure.
- **MTP Amendment Act 2021:** Gestational limit raised from 20 to 24 weeks for specified categories; Medical Board mechanism for terminations beyond 24 weeks on grounds of substantial foetal abnormalities; spousal-consent requirement removed; confidentiality for unmarried women.
- **Suchita Srivastava v. Chandigarh Administration (2009):** Reproductive choice is part of personal liberty under Article 21.
- **Justice K.S. Puttaswamy v. Union of India (2017):** Bodily autonomy within the right to privacy.
- **X v. Union of India (2022):** Marital-status distinction in MTP Rules struck down; equal access for unmarried women.
- **Article 142 late-term cases (2024-26):** Supreme Court has permitted terminations beyond statutory limits in cases where the Medical Board mechanism caused delay or denial.
- **Conscientious objection:** Bombay High Court — doctors at registered MTP facilities cannot refuse abortion services solely on grounds of personal conscience.
- **Rural-urban access gap:** Substantial share of registered MTP providers in urban areas; unsafe abortion remains a maternal mortality concern.
- **Dobbs v. Jackson Women's Health Organisation (2022):** US Supreme Court reversed Roe v. Wade (1973); India's framework structurally more progressive than the post-Dobbs US position.
- **Ethical framework:** Kantian autonomy, beneficence and non-maleficence in medical ethics, state's parens patriae interest versus liberty paternalism.

Mains Questions:

1. "Compassion is not a deviation from the law but a constitutional value under Article 21." Examine with reference to the MTP framework and the Supreme Court's reproductive autonomy jurisprudence.
2. The Medical Board mechanism under the MTP Amendment Act 2021 has been criticised for producing delay and denial. Suggest reforms that balance medical oversight with reproductive autonomy.
3. Compare and contrast the Indian Supreme Court's reproductive rights jurisprudence with the US position after Dobbs v. Jackson Women's Health Organisation (2022).

4. Discuss the ethical dimensions of conscientious objection by medical practitioners in the context of abortion services, with reference to the Bombay High Court's position.

Keywords: MTP Act 1971, MTP Amendment Act 2021, Article 21, Suchita Srivastava 2009, K.S. Puttaswamy 2017, X v. Union of India 2022, Medical Board mechanism, gestational limit 24 weeks, foetal abnormality, rape survivors, minors, marital-status distinction, Article 142 late-term rulings, Bombay High Court conscientious objection, rural-urban access gap, registered MTP providers, Dobbs v. Jackson 2022, Roe v. Wade 1973, parens patriae, Kantian autonomy, medical beneficence, non-maleficence, reproductive autonomy

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> *Indian Express's underlying argument is that the most progressive abortion statute in the post-colonial world is being held back not by ideology but by procedural inertia. The MTP Act 1971 broke ground when much of the world prohibited termination. The Constitution, through fifteen years of Article 21 jurisprudence, has placed reproductive autonomy at the centre of personal liberty. The gap is the statute itself — the Medical Board gatekeeping, the rural-urban access asymmetry, the absence of a statutory default in favour of the woman's autonomous decision. Compassion in the court is necessary but not sufficient. Compassion in the statute is what would finally let Indian women stop litigating their own pregnancies.*

Source: Indian Express — Editorial Pages

KEY ARGUMENTS AT A GLANCE

Supreme Court rulings on late-term and conscience-based abortion show that rigid statutory gestational limits under the MTP Act 1971 (as amended in 2021) can produce inhumane outcomes; compassion is not a judicial deviation but a constitutionally grounded value under Article 21, which the legislature should now operationalise rather than leave each woman to litigate.

✓ SUPPORTING

- The MTP Amendment Act 2021 raised the gestational limit from 20 to 24 weeks for special categories (rape survivors, minors, women with disabilities, foetal abnormalities), removed the spousal-consent requirement, and made confidentiality available for unmarried women — a significant but partial liberalisation.

- Constitutional jurisprudence has progressively framed reproductive choice as a fundamental right — Suchita Srivastava v. Chandigarh Administration (2009) treated reproductive choice as personal liberty under Article 21, Justice K.S. Puttaswamy v. Union of India (2017) located bodily autonomy within the right to privacy, and X v. Union of India (2022) struck down the marital-status distinction in MTP Rules.
- The Medical Board approval mechanism for terminations beyond 24 weeks produces practical delays that, in cases of substantial foetal abnormality or rape survivors, push pregnancies past the point of safe termination — converting a statutory safeguard into an instrument of denial.
- Comparative jurisprudence after the US Supreme Court's Dobbs v. Jackson Women's Health Organisation (2022) decision reversing Roe v. Wade (1973) makes India's MTP framework one of the more progressive in operation, yet ad-hoc litigation under Article 142 cannot substitute for legislative clarity on reproductive autonomy as a fundamental right.

COUNTER

The Medical Board mechanism reflects a legitimate state interest in protecting potential foetal life and ensuring medical assessment of viability and risk; eliminating it entirely without a substitute safeguard risks creating an unregulated space in which late-term terminations occur without adequate medical oversight.

→ WAY FORWARD

Parliament should amend the MTP framework to recognise the woman's autonomous reproductive right as the default, with Medical Board consultation as advisory rather than gatekeeping; decentralise Medical Boards to district level to eliminate practical delays; accredit and train more registered MTP providers, particularly in rural areas; and align the statutory framework with Article 21 jurisprudence so that compassion does not depend on litigation.

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MAINS ANSWER FRAMEWORK

QUESTION

"Compassion is not a deviation from the law — it is a constitutional value under Article 21." Examine this proposition with reference to the Medical Termination of Pregnancy framework and the Supreme Court's reproductive autonomy jurisprudence. (250 words)

INTRODUCTION

The Indian Express argues that recent Supreme Court rulings on late-term and conscience-based abortion reveal a structural gap between the statutory framework of the Medical Termination of Pregnancy Act and the constitutional jurisprudence on reproductive autonomy under Article 21 — a gap that compassion in the courtroom has narrowed in individual cases but that the legislature must close systemically.

BODY

The MTP Act 1971 — passed before Roe v. Wade (1973) — was a landmark liberalisation that legalised medical termination on grounds of risk to the woman's life, grave injury to her physical or mental health, foetal abnormality, and pregnancy from rape or contraceptive failure. The MTP Amendment Act 2021 raised the gestational limit from 20 to 24 weeks for special categories (rape survivors, minors, women with disabilities, foetal abnormalities); introduced a Medical Board mechanism for terminations beyond 24 weeks on grounds of substantial foetal abnormalities; removed the spousal-consent requirement (the woman's consent alone now suffices); and provided confidentiality for unmarried women's terminations.

Parallel constitutional jurisprudence has expanded the woman's autonomy claim. In Suchita Srivastava v. Chandigarh Administration (2009), the Supreme Court held that the right to make reproductive choices is part of personal liberty under Article 21.

In Justice K.S. Puttaswamy v. Union of India (2017), the nine-judge bench located bodily autonomy within the fundamental right to privacy. In X v. Union of India (2022), the Supreme Court struck down the marital-status distinction in the MTP Rules, holding that unmarried women are entitled to the same access as married women.

Subsequent 2024-26 rulings have used Article 142 powers to permit late-term terminations in individual cases where the Medical Board mechanism had produced delay or denial in circumstances involving rape survivors, minors and substantial foetal abnormalities. The Bombay High Court has held that doctors cannot refuse abortion services on grounds of personal conscience alone, narrowing the conscientious-objection space within the registered provider system.

Access remains uneven: a substantial share of registered MTP providers operate in urban areas, leaving rural women dependent on referrals that impose travel, cost and time burdens at precisely the gestational stage when delay is most dangerous. The ethical dimensions — Kantian autonomy treating the woman as an end in herself rather than a means, medical beneficence in preventing the harms of

forced continuation, the state's parens patriae interest weighed against liberty paternalism — are now structured by constitutional jurisprudence rather than left to legislative discretion.

CONCLUSION

Compassion is not a judicial favour to individual petitioners; it is a constitutional value rooted in Article 21 jurisprudence. The MTP framework must be aligned with reproductive autonomy as a fundamental right — advisory Medical Boards rather than gatekeeping, district-level decentralisation, expanded provider accreditation, and a statutory default in favour of the woman's autonomous decision — so that no woman is forced to litigate her pregnancy to obtain a right the Constitution already recognises.

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