Ashwini

REPORTABLE

IN THE HIGH COURT OF JUDICATURE AT BOMBAY
CIVIL APPELLATE JURISDICTION
WRIT PETITION (ST) NO. 1357 OF 2023

ABC,
[*Age and Address withheld for privacy*] **...PETITIONER**

~ VERSUS ~

STATE OF MAHARASHTRA,
Through Principal Secretary
Public Health Department,
Mantralaya, Mumbai – 400 023. **...RESPONDENT**

APPEARANCES

FOR THE PETITIONER	**Ms Aditi Saxena**, *with Rachita Padwal.*
FOR RESPONDENT-STATE	**Mr VM Mali, AGP**.

CORAM : G.S. Patel &
S.G. Dige, JJ.

DATED : 20th January 2023

ORAL JUDGMENT (*Per GS Patel J*):-

1. The name, age and address of the Petitioner are withheld to protect her privacy. **Rule**, returnable forthwith.

2. The Petitioner first came to this Court in mid-January 2023. By then, she was in roughly her 32nd week of pregnancy. The Petitioner said that a routine medical check up showed serious foetal anomalies and abnormalities. On 13th January 2023 we passed the following order:

> "2. On 7th September 2022, the Petitioner underwent a sonography and a foetal anomaly scan at 14 weeks. This test result was normal. **A few months later, on 22nd December 2022, the Petitioner underwent a follow-up sonography and foetal anomaly scan, by which time, her gestation period was 29 weeks. This test showed that foetus suffers from multiple anomalies. Among the anomalies noted was microcephaly and lissencephaly. There was mild uteroplacental insufficiency noted.** On 30th December 2022, the Petitioner was admitted to the Sassoon General Hospital, Pune. On 30th December 2022 a Medical Board was constituted as required by the Medical Termination of Pregnancy Act 1971. As opinion confirmed the diagnosis of anomalies, added the possibility of intellectual disability but said both conditions are not life threatening. It denied the request for a medical termination of pregnancy in view of the advanced gestation period.
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> 3. Paragraph 4(a) of the Petition says that the Petitioner and her husband have taken counselling from registered medical professionals. They say that they are from a humble background with severe financial constrains. They will not be able to provide additional care and meet the expenses of an infant born with such conditions. She therefore seek the intervention of Court to permit a termination of the pregnancy. Leaving aside the submission in the Petition on

> the rights of the Petitioner, and to which we will return at a later date if necessary, we immediately require a follow-up opinion after a examination by the Medical Board at the Sassoon General Hospital, Pune.
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> 4. In doing so, the Board must specifically address the questions of whether an infant born with these conditions is likely to require extensive and continuous or live long medical intervention, and the possible costs associated with these. There must be an assessment of the physical and mental health condition of the mother as well. We note the previous opinion that condition of the foetus is not presently life threatening. But the opinion that is required is whether a medical termination of the pregnancy at this stage poses a risk or danger to the Petitioner either physically and mentally. This means that she needs also to be evaluated and assessed by a qualified psychiatrist attached to the Sassoon General Hospital. The Petitioner must be admitted to the hospital today itself so that she can be examined in the course of tomorrow morning. A copy of the report may be transmitted to the email address of the learned AGP [***redacted***]. A CC is to be marked to [***redacted***]. We do not provide the email address of the Writ Cell and the Court Registry in order to protect privacy of the Petitioner. We note that the Petition raises grounds and issues about the Petitioner's right to privacy as well."
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> (*Redactions and emphasis added*)

3. On 16th January 2023, we took on record the report of the Sassoon Hospital. That is marked "X" in our records. That report does not controvert the medical position or the result of the tests. The condition of the foetus is undisputed, viz., the detection of microcephaly and lissencephaly. What the report says is this:

> "Key recommendations of the panel (if any) with justifications:
>
> On clinical and sonographic examination mother has pregnancy of gestational age by dated 33 weeks and gestational age by scan 32 weeks and 6 days by 14 weeks and 4 days scan. She has no major medical, obstetric, Psychiatric complications at present. **In view of above observations by medical board faculty, deformity being correctable at government and major municipal Corporation hospitals free of cost and considering the advanced gestational age the Medical Termination of pregnancy is not recommended with kind permission of Hon'ble High Court**."
>
> (*Emphasis added*)

4. Ms Saxena take exception to this recommendation. She submits that this Court is not bound by these recommendations at all. She draws attention to the undisputed medical condition of the foetus.

5. Section 3 of the Medical Termination of Pregnancy Act 1971 ("**the MTP Act**"), as amended, reads:

> "**3. When pregnancies may be terminated by registered medical practitioners.—**
>
> (1) Notwithstanding anything contained in the Indian Penal Code (45 of 1860), a registered medical practitioner shall not be guilty of any offence under that Code or under any other law for the time being in force, if any pregnancy is terminated by him in accordance with the provisions of this Act.

(2) Subject to the provisions of sub-section (4), a pregnancy may be terminated by a registered medical practitioner,—

(a) where the length of the pregnancy does not exceed twenty weeks, if such medical practitioner is, or

(b) where the length of the pregnancy exceeds twenty weeks but does not exceed twenty-four weeks, in case of such category of woman as may be prescribed by rules made under this Act, if not less than two registered medical practitioners are,

of the opinion, formed in good faith, that—

(i) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or

(ii) there is a substantial risk that if the child were born, it would suffer from any serious physical or mental abnormality.

Explanation 1.— For the purposes of clause (a), where any pregnancy occurs as a result of failure of any device or method used by any woman or her partner for the purpose of limiting the number of children or preventing pregnancy, the anguish caused by such pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman.

Explanation 2.— For the purposes of clauses (a) and (b), where any pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by the pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman.

(2A) The norms for the registered medical practitioner whose opinion is required for termination of pregnancy at different gestational age shall be such as may be prescribed by rules made under this Act.

(2B) The provisions of sub-sections (2) relating to the length of the pregnancy shall not apply to the termination of pregnancy by the medical practitioner where such termination is necessitated by the diagnosis of any of the substantial foetal abnormalities diagnosed by a Medical Board.

(2C) Every State Government or Union territory, as the case may be, shall, by notification in the Official Gazette, constitute a Board to be called a Medical Board for the purposes of this Act to exercise such powers and functions as may be prescribed by rules made under this Act.

(2D) The Medical Board shall consist of the following, namely:—

(a) a Gynaecologist;

(b) a Paediatrician:

(c) a Radiologist or Sonologist; and

(d) such other number of members as may be notified in the Official Gazette by the State Government or Union territory, as the case may be.

(3) In determining whether the continuance of a pregnancy would involve such risk of injury to the health as is mentioned in sub-section (2), account may be taken of the pregnant woman's actual or reasonable foreseeable environment.

(4) (a) No pregnancy of a woman, who has not attained the age of eighteen years, or, who, having attained the age of eighteen years, is a mentally ill person, shall be terminated except with the consent in writing of her guardian.

> (b) Save as otherwise provided in clause (a), no pregnancy shall be terminated except with the consent of the pregnant woman."
>
> (*Emphasis added*)

6. On any reading of the controlling section, Ms Saxena points out, the medical termination of a late pregnancy beyond 24 weeks is *not* absolutely prohibited. The statute does not say what is to happen if late in the pregnancy a foetal abnormality is indeed detected. This is why the writ jurisdiction of the Court is invoked. Given the present situation, she submits, the Court must intervene.

7. Her point, however, is more fundamental. This case, she says, speaks directly to what has been described as the *reproductive autonomy* of the woman; specifically, the expectant mother. It is important to see this in context. We have not understood Ms Saxena to suggest, as an advocate at our Bar — and as an officer of our Court we expect nothing less — that a late termination of pregnancy is to be rubber stamped simply because the petitioner wants it. The law will not pander to whimsy or caprice.

8. The timelines in Section 3 are a complete answer. Leaving aside the cases of pregnancies of sexual assault survivors and minors, she invites us to consider the case of the pregnancy of a married adult woman. Again, we are not asked to consider the situation where the pregnancy is of an *unmarried* adult woman. We are only considering, against the Section 3 timelines, the pregnancy of an adult married woman. A pregnancy may or may not be planned. A 'normal' human gestation runs for about 280 days or 40

weeks. Up to 20 weeks and before 24 weeks, the statute permits a termination of the pregnancy, vide Section 3(2)(a) on a good faith opinion of a sole medical practitioner. If the woman is past the 20th week of her pregnancy, but less than 24 weeks, and for certain classes, the good-faith opinions of two medical practitioners are needed. The opinions must be addressed to an assessment of a likely risk to the life of the woman, or of grave injury to her physical or mental health; or a likelihood of the child being born with serious physical or mental abnormalities. Explanation 1 deals with an unplanned pregnancy of up to 20 weeks: if it is the result of contraceptive failure by either partner, the 'anguish caused by such pregnancy' *may* be presumed to constitute precisely the grave mental health injury that must be part of the medical opinion. The second Explanation tells us that, for either time-period (less than 20 weeks, or between 20 and 24 weeks), if the pregnancy is the result of sexual assault, it *must* be presumed to constitute a grave injury to the woman's mental health.

9. Then we have Section 3(2B), and Ms Saxena asks us to note it once again:

> **(2B) The provisions of sub-sections (2) relating to the length of the pregnancy shall not apply to the termination of pregnancy by the medical practitioner where such termination is necessitated by the diagnosis of any of the substantial foetal abnormalities diagnosed by a Medical Board.**
>
> (*Emphasis added*)

10. Therefore, Ms Saxena submits, once a medical report confirms 'substantial foetal abnormalities', the time-limits of up to 20 weeks but less than 24 weeks, and beyond 24 weeks *simply do not apply*. The Act is being persistently misread and misunderstood, she says. In case after case, Section 3(2-B) is either being ignored or is being rendered subject to Section 3(2)(ii): the forming of a good faith opinion that *there is a substantial risk that if the child were born, it would suffer from any serious physical or mental abnormality*. Section 3(2B) has nothing to do with practitioners. It speaks to the opinion of the Medical Board; and that is the Medical Board to be constituted under Sections 3(2C) and 3(2D) of the Act. The trend and practice to seek the 'opinion' of the Board or its recommendations for a termination even when substantial abnormalities are detected is widely misunderstood. The statutory Medical Board is required to assess and report:

(i) whether there is a substantial foetal abnormality; and

(ii) whether the medical termination is safe on an assessment of the mother's mental and physical health.

11. In this particular case, she submits, the Medical Board has wholly misdirected itself. Conditions *(i)* and *(ii)* are both satisfied. There are serious or substantial foetal abnormalities. The mother is physically and mentally able to undergo the procedure. The moment those conditions are satisfied, the Board *cannot* in law, she submits, and we think correctly, render any other opinion as to whether the termination should be performed, and certainly not because the baby — bound to be born with abnormalities and severe conditions — can be treated or provide medical intervention, even if it is free,

only on account of the length of the pregnancy. Consider the intelligence of the statute, Ms Saxena submits. Section 3(2B) is alive to a situation where, even with a planned pregnancy, the inherent uncertainties of pregnancy and parturition can sometimes confront a woman very late in her pregnancy with having to make a choice she never anticipated. No Medical Board can wander outside the remit of the statute that creates it. Yet, that is precisely what this Medical Board has done.

12. Ms Saxena takes us to the medical report. The existence of the foetal anomaly is certain. That it is substantial and severe is also certain. That it was detected late is equally certain. Ms Saxena invites our attention to a Guideline Note for medical records for termination of pregnancy beyond 20 weeks' gestation in cases referred by court. This note is issued by the Government of India through the Department of Health and Family Welfare under the National Health Mission. There is in this a reference about the procedure for termination: stopping the foetal heartbeat is a possible procedure. Annexed to this guidance note in Annexure II is a list of major foetal abnormalities. This is an indicative list that experts on the Medical Board may reference while reviewing cases of late term termination of pregnancy requests on a High Court referral. These major abnormalities are sub-classified. *Category A* is those abnormalities that affect the central nervous system. Item 15 in that list is 'microcephaly'.

13. This is precisely the condition of the Petitioner's foetus. It has also been detected with *lissencephaly*. The first report of with

which the Petitioner came to Court is by a private clinic. A copy is at page 49. It notes the foetal anomaly of microcephaly and says that there are symptoms of lissencephaly. This is repeated twice. Mild utero placental insufficiency is also noted. In the report of the Medical Board to which we made a referral, Item 6 of the foetal antenatal MRI done on 7th January 2023 shows both microcephaly and lissencephaly.

14. The Centers for Disease Control or Prevention[1] or CDC on its website[2] tells us that microcephaly is a birth defect where a baby's head is smaller than expected. Babies with microcephaly often have smaller brains. These might not have developed properly. During pregnancy, typically, a baby's head grows as its brain grows. Microcephaly can occur because a baby's brain has not properly developed during the pregnancy. This results in a smaller head size. It may or may not be an isolated condition. Its causes are mostly unknown and not well understood. They may be attributable to certain infections during pregnancy such as rubella or may be attributable to severe malnutrition, exposure to harmful substances or other causes. Incidents of microcephaly during viral infections have been reported. In its severe form, microcephaly is more extreme and serious. It has been linked in medical studies with the following problems: seizures, developmental delays, speech and other issues such as sitting, standing, walking, intellectual

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1 Centers for Disease Control & Prevention (CDC), is the USA's foremost science-based, data-driven service organisation that protects public health: https://www.cdc.gov/, accessed on 20th January 2023.

2 "*Facts about Microcephaly*", CDC: https://www.cdc.gov/ncbddd/birthdefects/microcephaly.html accessed on 20th January 2023.

disabilities, problems of movement and balance, feeding problems and difficulty in swallowing, hearing loss and vision problems. The CDC says that these problems can range from mild to severe — and are often lifelong. In its severe form, it can be life-threatening. Because it is difficult to predict at birth what problems will occur, microcephalic babies need constant and regular follow up and check ups with health care providers. There is no known cure or standard treatment for it. In more extreme cases, microcephalic babies need intervention almost constantly.

15. 'Lissencephaly' literally means 'smooth brain'. It is a rare gene-linked brain malformation characterized by the absence of normal convolutions (or 'folds') in the cerebral cortex and an abnormally small head or microcephaly. It is caused by defective neuronal migration during development of the embryo. Symptoms include an unusual facial appearance, difficulty in swallowing, a failure to develop or thrive, muscle spasms, seizures, and severe psychomotor retardation. Hands, fingers, or toes may be deformed. It is often associated with other conditions. Supportive care is certainly needed. There is no cure. Seizures may be particularly problematic.

16. Most disturbingly, the prognosis for children with lissencephaly depends on the degree of brain malformation. The National Institute of Neurological Disorders and Stroke, NINDS,[3] is part of the US Government's National Institutes of Health.[4] NINDS tells us that *many with lissencephaly will die before the age of*

3 https://www.ninds.nih.gov/, accessed on 20th January 2023.

4 https://www.nih.gov/, accessed on 20th January 2023.

10.[5] The cause of death is usually aspiration of food or fluids, respiratory disease, or severe seizures. Some may survive but show no significant development, usually not beyond a three– to five–month–old level. Others may have near–normal development and intelligence, and because of this range it is important to seek the opinion of specialists.

17. The Petitioner's foetus is detected with both microcephaly and lissencephaly. And this is what the future portends.

18. This much, Ms Saxena says is therefore certain. There is no prospect at all of the baby being born in a normal condition or having a normal healthy balanced life. The Medical Board has totally overlooked this.

19. The three-Judge decision of the Supreme Court in *X v Principal Secretary, Health & Family Welfare Department, Government of NCT of Delhi & Anr*,[6] has an elaborate of the various jurisprudential facets underlying and informing the MTP Act. As we noted, we are not concerned in the case before us with unmarried women, minors, or sexual assault survivors.

20. In *X v Principal Secretary*, the Supreme Court elucidated the Constitutional values that it said animated the proper interpretation of the MTP Act. We find these in paragraphs 98 to 102 of the judgment:

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5 https://www.ninds.nih.gov/health-information/disorders/lissencephaly, accessed on 20th January 2023.

6 2022 SCC OnLine SC 1321.

"98. Certain constitutional values, such as the right to reproductive autonomy, the right to live a dignified life, the right to equality, and the right to privacy have animated our interpretation of the MTP Act and the MTP Rules. A brief discussion of these values is undertaken below.

i. The right to reproductive autonomy

99. The ambit of reproductive rights is not restricted to the right of women to have or not have children. It also includes the constellation of freedoms and entitlements that enable a woman to decide freely on all matters relating to her sexual and reproductive health. Reproductive rights include the right to access education and information about contraception and sexual health, the right to decide whether and what type of contraceptives to use, the right to choose whether and when to have children, the right to choose the number of children, the right to access safe and legal abortions, and the right to reproductive healthcare. Women must also have the autonomy to make decisions concerning these rights, free from coercion or violence.

100. Zakiya Luna has, in a 2020 publication, argued that reproduction is both biological and political. According to Luna, it is biological since physical bodies reproduce, and it is political since the decision on whether to reproduce or not is not solely a private matter. This decision is intimately linked to wider political, social, and economic structures. A woman's role and status in family, and society generally, is often tied to childbearing and ensuring the continuation of successive generations.

101. To this, we may add that a woman is often enmeshed in complex notions of family, community, religion, and caste. Such external societal factors affect the way a woman exercises autonomy and control over

her body, particularly in matters relating to reproductive decisions. Societal factors often find reinforcement by way of legal barriers restricting a woman's right to access abortion. The decision to have or not to have an abortion is borne out of complicated life circumstances, which only the woman can choose on her own terms without external interference or influence. **Reproductive autonomy requires that every pregnant woman has the intrinsic right to choose to undergo or not to undergo abortion without any consent or authorization from a third party.**

102. The right to reproductive autonomy is closely linked with the right to bodily autonomy. As the term itself suggests, bodily autonomy is the right to take decisions about one's body. The consequences of an unwanted pregnancy on a woman's body as well as her mind cannot be understated. The foetus relies on the pregnant woman's body for sustenance and nourishment until it is born. The biological process of pregnancy transforms the woman's body to permit this. The woman may experience swelling, body ache, contractions, morning sickness, and restricted mobility, to name a few of a host of side effects. Further, complications may arise which pose a risk to the life of the woman. A mere description of the side effects of a pregnancy cannot possibly do justice to the visceral image of forcing a woman to continue with an unwanted pregnancy. Therefore, the decision to carry the pregnancy to its full term or terminate it is firmly rooted in the right to bodily autonomy and decisional autonomy of the pregnant woman."

(*Emphasis added*)

21. Paragraphs 105 and 107 say this:

> "**105**. In *Suchita Srivastava* (*supra*) this Court explicitly recognized the concept of reproductive autonomy. In this case, the victim, an orphaned woman of around 19 years, with mental retardation, became pregnant as a result of a rape that took place while she was an inmate at a government-run welfare institution. After the discovery of her pregnancy, the Chandigarh Administration approached the High Court of Punjab and Haryana seeking approval for the termination of her pregnancy. The High Court constituted an expert body to conduct an enquiry into the facts. The expert body recorded that the victim had expressed her willingness to bear the child and accordingly recommended the continuation of the pregnancy. However, the High Court directed the termination of the pregnancy on the ground that the victim was mentally incapable of making an informed decision on her own.
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> **107.** *Suchita Srivastava* (*supra*) **rightly recognised that the right of women to make reproductive choices is a dimension of personal liberty under Article 21. It held that reproductive rights include a woman's entitlement to carry the pregnancy to full term, give birth, and raise children. More importantly, it also recognised that the right to reproductive choice also includes the right not to procreate. In doing so, it situated the reproductive rights of women within the core of constitutional rights.**"
>
> (*Emphasis added*)

22. Then the Supreme Court went on to consider the facets of *decisional autonomy* in paragraphs 108, 109 and 111:

"**108.** Decisional autonomy is an integral part of the right to privacy. Decisional autonomy is the ability to make decisions in respect of intimate relations. In *Puttaswamy* (*supra*) this Court held that personal aspects of life such as family, marriage, procreation, and sexual orientation are all intrinsic to the dignity of the individual. The right to privacy safeguards and respects the decisional autonomy of the individual to exercise intimate personal choices and control over the vital aspects of their body and life. In *Common Cause v. Union of India*, this Court observed that right to privacy protects decisional autonomy in matters related to bodily integrity:

> "441. The right to privacy resides in the right to liberty and in the respect of autonomy. The right to privacy protects autonomy in making decisions related to the intimate domain of death as well as bodily integrity. Few moments could be of as much importance as the intimate and private decisions that we are faced regarding death. Continuing treatment against the wishes of a patient is not only a violation of the principle of informed consent, but also of bodily privacy and bodily integrity that have been recognised as a facet of privacy by this Court.

109. The right to decisional autonomy also means that women may choose the course of their lives. <u>Besides physical consequences, unwanted pregnancies which women are forced to carry to term may have cascading effects for the rest of her life by interrupting her education, her career, or affecting her mental well-being.</u>

111. A woman can become pregnant by choice irrespective of her marital status. In case the pregnancy is wanted, it is equally shared by both the partners. However, in case of an

unwanted or incidental pregnancy, the burden invariably falls on the pregnant woman affecting her mental and physical health. Article 21 of the Constitution recognizes and protects the right of a woman to undergo termination of pregnancy if her mental or physical health is at stake. **Importantly, it is the woman alone who has the right over her body and is the ultimate decision-maker on the question of whether she wants to undergo an abortion**.

(*Emphasis added*)

23. Paragraphs 112 and 113 say:

"**112. The right to dignity encapsulates the right of every individual to be treated as a self-governing entity having intrinsic value. It means that every human being possesses dignity merely by being a human, and can make self-defining and self-determining choices.** Dignity has been recognized as a core component of the right to life and liberty under Article 21.

113. If women with unwanted pregnancies are forced to carry their pregnancies to term, the state would be stripping them of the right to determine the immediate and long-term path their lives would take. Depriving women of autonomy not only over their bodies but also over their lives would be an affront to their dignity. The right to choose for oneself — be it as significant as choosing the course of one's life or as mundane as one's day-to-day activities — forms a part of the right to dignity. It is this right which would be under attack if women were forced to continue with unwanted pregnancies."

(*Emphasis added*)

24. In refusing a medical termination of pregnancy only on the ground of delay, this Court would not only be condemning the foetus to a less than optimal life but would also be condemning the Petitioner-mother to future that will almost certainly rob her of every positive attribute of parenthood. It would be a denial of her right to dignity, and her reproductive and decisional autonomy. The mother knows today that there is no possibility of having a normal healthy baby at the end of this delivery.

25. Ms Saxena submits that no statute like the MTP Act, one that was far ahead of its time, should be read in so misogynistic or patriarchal a fashion as to force on the Petitioner mother a choice that is emphatically not hers, and to deny her the informed choice that circumstances have compelled her to make. She points out that at the very head of the Petition, the Petitioner has said that she and her husband are of very modest means. In these conditions, a rejection of the Petition based only on the opinion of the Medical Board — in itself contrary to law — would rob the Petitioner of not only her reproductive autonomy but her fundamental right to privacy, her right to self-determination, and her right to make an informed choice about herself and her body. A refusal to grant relief would effectively strip the Petitioner of all agency as a mother and as a woman; and more importantly as a human being capable of carrying a pregnancy to term. This is no whimsical choice, argues Ms Saxena. This is an informed decision, for good, if tragic, reason. It is in fact one of the hardest decisions a person could ever have to make. To say that free care is provided does not take into account the associated trauma and difficulty of parents having to care for this baby twenty-four hours a day, day after day, week after week and

month after month—and that too with such a prognosis, the distinct possibility of a violent death before the age of 10, of certain sub-optimal development and worse.

26. Accepting the Medical Board's view is therefore not just to condemn the foetus to a substandard life but is to force on the Petitioner and her husband an unhappy and traumatic parenthood. The effect on them and their family cannot even be imagined.

27. Ms Saxena is appropriately restrained in what she says. But there is no mistaking her true message. Hers is an appeal not only to the judicial mind but to the moral conscience that must accompany it.

28. We are mindful of our limitations in writ law although our powers under Article 226 of the Constitution of India are indeed wide. They are discretionary. They are equitable. But every petition under Article 226 invoking fundamental rights under Part III of the Constitution is an appeal to the judicial conscience. Cases such as this often raise profound moral questions and dilemmas. But this is immutable: that the arc of the moral universe always bends towards justice.

29. Through Ms Saxena, this is what we hear the Petitioner to say:

> "If my petition be dismissed, I am fated to deliver a child who has no prospect of a normal childhood or anything remotely resembling a normal life, one who will not live fully and in heath, one who may not even survive beyond

> the age of 10. I found out about this very late in my pregnancy. No one is to blame. But at least cede to me the choice to determine what I — and I alone — may decide should be done with and to my body. Do not deny to me my right to dignity, my various autonomies and freedoms. Do not deny my the right to determine the trajectory of my life and my marriage. Do not deny me my freedom of choice."

30. When it is put to us like this, whether from habit or training or received wisdom, we turn to the Act for answers. You will find none there, Ms Saxena tells us, and we do believe she is correct. The Act is of 1971. It was ahead of its time. But in the cold sterility of a legislation, we must discern where justice lies when it is to be applied to the human condition. This is not a case where a blanket invocation of this or that provision will provide an answer. We must ensure above all that the rights of the Petitioner — including those enunciated by the Supreme Court — are never compromised in the sometimes blind application of a statute. Justice may have to be blindfolded; it can never be allowed to be blindsided. We are agnostic about the relative positions of parties. We can never be agnostic about where justice needs to be delivered.

31. Another question has greatly troubled us. What if after carrying this foetus to term, the Petitioner finds she cannot tend to it? Is she then to be forced to make the next decision, to give up a child in adoption? How is that to be done? More importantly, why should that have to be done? The opinion of the Medical Board is oddly silent on this. It only addresses itself to medical interventions, the availability of incessant and ongoing treatments and nothing more. It does not take into account the social and economic position

of the Petitioner and her husband. It ignores their milieu entirely. It does not even attempt to envision the kind of life — one with no quality at all to speak of — that the Petitioner must endure for an indefinite future if the Board's recommendation is to be followed. The Board really does only one thing: *because late, therefore no*. And that is plainly wrong, as we have seen. Given a severe foetal abnormality, *the length of the pregnancy does not matter*.

32. In cases such as these, we believe Courts must calibrate themselves to not only the facts as they stand but must also consider that what these cases present are, above all, profound questions of identity, agency, self-determination and the right to make an informed choice. We will not ignore the Petitioner's social and economic condition. We cannot. We believe Ms Saxena is correct in her submissions. The Petitioner takes an informed decision. It is not an easy one. But that decision is hers, and hers alone to make, once the conditions in the statute are met. The right to choose is the Petitioner's. It is not the right of the Medical Board. And it is also not the right of the Court to abrogate the Petitioner's rights once they are found to fall within the contemplation of the law.

33. The recommendation of the Board does not appeal to us at all.

34. In these circumstances, we allow the Petition and permit the medical termination of the Petitioner's pregnancy.

35. To protect the Petitioner's privacy, we are making a separate operative order. The operative order is not to be uploaded.

36. We should be remiss if we did not commend Ms Saxena for the manner in which she has conducted this case. We discern her profound engagement with the issue at its broadest level, and we believe we can gauge at least to some extent the depth and intensity of her concern. But she has most admirably tempered both emotion and passion, throughout maintaining the necessary reserve and addressing herself to the state of the law. For his part, Mr Mali, learned AGP, is to be appreciated for his restraint. A referral to the Board may be mandated by statute, but he himself is also conscious of the condition of the Petitioner. His only duty, he submits, is to bring to the notice of the Court that a certain procedure needs to be followed. His second duty is of course to assure the Court that the Petitioner will get whatever support she needs from the hospital. There will be no compromise in that regard. We express our appreciation of the stand he takes.

37. Rule is made absolute in these terms. No costs.

(S. G. Dige, J) **(G. S. Patel, J)**