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Commentary

Medico-legal responsibilities of obstetricians in caring for minor survivors of sexual assault with advanced pregnancy: key lessons from recent court judgments

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ABSTRACT

Recent high court rulings have clarified how clinicians should manage pregnancies in minor survivors of sexual assault under the medical termination of pregnancy (MTP) act when read with the protection of children from sexual offences (POCSO). These rulings have clarified ambiguities in the acts and removed procedural barriers that delay essential care: when an investigating officer (IO) or child welfare committee (CWC) presents the survivor, ultrasound and other indicated evaluations should proceed without insisting on identity cards; termination within 24 weeks may be undertaken by the requisite registered medical practitioners with guardian consent and the survivor's informed assent. The judgments also affirm the documentary first hierarchy for age proof under the Juvenile Justice Act and discourage non-essential radiological age estimation in pregnancy. For pregnancies over 24 weeks, the Delhi High Court has ruled for immediate constitution of a medical board to examine the survivor and place its opinion before the competent authority or court, enabling timely judicial decisions; the Gujarat High Court emphasized reproductive autonomy and a broad, lived-experience view of mental health harm. For obstetric services, these instructions read as plain functional requirements: standard operating procedure (SOPs) that codify the ≤24-week protocol, readiness to constitute a medical board only for >24 week cases, standardized dual-consent forms, complete records, coordinated communication with IO/CWC, and routine psychological counselling. Implementation of these directions can limit avoidable delays, align practice with law, and safeguard the dignity and safety of this vulnerable population.

Keywords: Abortion, Minor, POCSO act, Judgments, Consent, Legislation

INTRODUCTION

The Ministry of Health and Family Welfare, Government of India, issued comprehensive guidelines and protocols for the medico-legal care for survivors/victims of sexual violence in 2017.[1] These guidelines require registered medical practitioners (RMPs) to provide treatment with dignity, empathy, and without discrimination. Yet, significant ambiguities remain when the survivor is a minor and the pregnancy has advanced beyond the 24-week limit permitted under the Medical Termination of Pregnancy (MTP) Act, 1971, as amended in 2021.[2] Key areas of uncertainty include the procedures for consent and age verification, the necessity of obtaining court orders before medical evaluation, and the interpretation of "mental health" as a ground for termination in such cases.

The most difficult medico-legal and ethical dilemmas for clinicians arise in the minor survivors of sexual assault, with pregnancies >24 weeks. While this will be experienced infrequently in busy public hospitals, the lack of clarity regarding the protocols for consent,

documentation, and the perceived necessity for court orders, lead to unnecessary waiting times for the survivor, potentially exacerbating the physical and mental consequences of the assault.

In a recent Delhi High Court Judgment dated 29 May 2025, in Minor S (through mother M) v. State and Anr., a 17-year-old rape survivor was denied ultrasound for nearly two weeks because she lacked an identity (ID) card for age proof, despite being produced by the investigating officer (IO) with a copy of the FIR. The delay pushed the pregnancy beyond 24 weeks, necessitating urgent court intervention. The Delhi High Court held that in such cases, IO or Child Welfare Committee (CWC) identification is sufficient for Form-F completion under the pre-conception and pre-natal diagnostic techniques (PC and PNDT) Act, 1994, and lack of an identity document cannot justify refusal of essential investigations.[3]

The MTP act permits termination up to 20 weeks with the opinion of one RMP, and up to 24 weeks for specified categories including minors and rape survivors with opinion of two RMPs.[2] Beyond 24 weeks, termination is legally possible in cases of substantial fetal abnormality or to save the woman's life, and courts have extended this in exceptional circumstances to protect mental and physical health.[4,5]

In its judgment dated 08.11.2024 in XYZ (through her father) versus State of Gujarat and Anr. the Gujarat High Court underscored that determination of mental health capacity and reproductive autonomy in termination cases must extend beyond narrow medical criteria under Section 3(2-b) of the MTP Act. Medical boards were directed to evaluate not only the physical condition but also the emotional and psychological well-being of the pregnant person, with specific attention to whether continuing the pregnancy would cause harm. The Court reaffirmed that reproductive choice is integral to dignity under Article 21 of the Constitution, and that the opinion of the woman including minors capable of expressing an informed preference must be given primacy. This approach aligns with Supreme Court jurisprudence recognizing "mental health" in its broad, lived-experience sense, and holding that the state cannot compel continuation of an unwanted pregnancy, particularly when it results from sexual assault.[6] This interpretation aligns with Explanation 2 to Section 3(2) of the MTP Act, which expressly presumes that where a pregnancy is alleged to have been caused by rape, the anguish it causes constitutes a grave injury to the woman's mental health.[2]

The Protection of Children from Sexual Offences (POCSO) Act, 2012 as amended in 2019, requires immediate medical examination of minor victims without waiting for an FIR.[7] Denial of care in these circumstances is a punishable offence under Section 431 of BNSS (Corresponding to Section 357C of CrPC) read with Section 200 of BNS (corresponding to Section 166B of IPC).[8,9]

On age determination, the Court reiterated the hierarchy under the Juvenile Justice (Care and Protection of Children) (JJ) Act, 2015; first, school or municipal birth certificates or matriculation records; only if these are absent medical age estimation be considered. In pregnant minors, ossification tests may expose the fetus to unnecessary radiation and rarely change immediate care decisions.[10]

KEY LEGAL DIRECTIONS

Recent pronouncements by the Delhi High Court and the Gujarat High Court have provided clear, actionable guidance for the management of cases involving minor survivors of sexual assault who present with advanced pregnancies.

Firstly, in all such cases, essential medical investigations, particularly ultrasound must be conducted without delay. Hospitals and doctors should not insist on identity proof when the survivor is accompanied by an IO or representative of the CWC. Identification through the IO or CWC, along with the FIR details, is sufficient to complete statutory documentation under the PC&PNDT Act. The courts have stressed that administrative or institutional protocols cannot override the survivor's right to timely medical care, and unwarranted delays may amount to denial of treatment.

Secondly, where the gestational age is within 24 weeks, termination may be undertaken by one or two registered medical practitioners as per Section 3(2) of the MTP (Amendment) Act, 2021. Judicial approval or a Medical Board opinion is not required in such cases. The practitioner(s) must ensure informed consent from both the guardian and the minor's own assent, and complete documentation in compliance with statutory requirements.

In cases where pregnancy exceeds 24 weeks or older in gestational age, the direction of the Delhi High Court is that a Medical Board is to be constituted without a court order, without delay, to examine the survivor and prepare a medical report as soon as possible. The report must be submitted by board, appropriately to the Court to enable this expedited route for medical termination of pregnancy. The Court stated that utilizing this process to prepare the report avoids delay for an otherwise procedural process and ensures a thoughtful, coordinated response for those victimized by sexual assault.

The Gujarat High Court further clarified that for pregnancies beyond 24 weeks in minors, the court can permit termination where continuation poses physical or psychological harm, relying on medical opinion and the victim's informed choice.

Thirdly, the courts reiterated that as per the established hierarchy under the JJ Act, priority must be given to documentary proof such as birth certificates, school or municipal records, and only in their absence, doctors may

consider medical age estimation. In pregnant minors, unnecessary radiological exposure should be avoided as it rarely alters clinical management.

Finally, the judgments reinforced that in the case of minors, the written consent of the guardian along with the survivor's own informed assent obtained after explanation in a language and manner appropriate to her understanding shall be valid and sufficient for both medical evaluation and termination procedures. Documentation should always be comprehensive, contemporaneous, and internally consistent, especially with respect to gestational age, findings, and the justification for any departure from the protocol.

Collectively, these directions create a strong medico-legal framework: hospitals must act without delay, respect the reproductive autonomy of the victim under statute law, and follow the procedural safeguards in a way that enhances their access to legally permitted and compassionate care, rather than restricts it.[3,6]

RECOMMENDATIONS

In order to implement the judicial directions and to minimize procedural delay, health care institutions should institutional own clear standard operating procedures (SOPs), and regular staff sensitization, and training. The following strategies are recommended for hospitals to use regarding pregnancies in minors who are survivors of sexual assault.

Immediate clinical response

All indicated medical investigations, including ultrasound and relevant diagnostic procedures, must be initiated promptly when the survivor is brought by an IO or representative of CWC. Non-availability of an identity card should never delay or prevent necessary care.

Institutional readiness for advanced gestation cases

Hospitals should maintain preparedness to constitute a Medical Board without delay only when gestational age exceeds 24 weeks, as mandated by the Delhi High Court. The Board's purpose is to examine such cases promptly and provide an opinion to facilitate judicial decisions. For pregnancies within statutory limits i.e. within 24 weeks, the opinion of one or two RMP(s), as defined under Section 3(2) of the MTP Act, is sufficient.

Age-proof hierarchy as per the law (must be reflected in SOPs)

All healthcare workers should be trained to prioritise documentary evidence for age and avoid non-essential radiological tests in pregnant minors.

Prioritize documentary proof under the JJ Act in this order: birth certificate/school/municipal/matriculation records; only if unavailable, consider medical age estimation; avoid non-essential radiological exposure in pregnancy and document clinical justification if any imaging is unavoidable; and record all attempts to trace documents (school/CWC/guardians), and treat the survivor as a child where doubt persists until verified. Ensure the case file notes who verified identity/age (IO/CWC), FIR number, and the basis used.

Consent and communication protocols

Institutions should adopt uniform templates for obtaining dual consent: guardian's written consent and the minor's informed assent, recorded after counselling in a language the survivor understands. All consent forms should reflect statutory compliance and acknowledge the survivor's reproductive autonomy.

Documentation and record integrity

It is important to ensure meticulous, contemporaneous documentation and records that reflect the survivor's history, clinical findings, gestational assessment, the consent process, and decisions of the RMPs. Avoid discrepancies in medical opinion and make every effort to explain any unavoidable deviations from standard procedure in the clinical record.

Training and sensitization

Obstetricians, radiologists, and nursing staff should be trained regularly in medico-legal duties under the POCSO act, limits of gestational termination under the MTP Act, and empathetic & informed communication with survivors. Such sessions should emphasize practical decision-making, documentation standards, and coordination with investigating authorities.

Psychological and social support

The survivor should also receive psychological counseling and be linked to other mental-health services as part of care. Survivors and their families must receive structured support to mitigate the psychological trauma associated with sexual violence and termination procedures.

Coordination and accountability

Each institution should designate a nodal officer to coordinate between clinical departments, law-enforcement agencies, and the CWC to ensure seamless communication and compliance with judicial directions.

Preservation of evidence

Where medical termination is carried out, biological material should be properly labelled, sealed, and preserved for DNA profiling in the criminal investigation, ensuring an unbroken chain of custody as per hospital SOPs.

Child welfare coordination

If the child is born alive during attempted termination, ensure immediate referral to the CWC with all supportive care provided.

By adopting these measures, institutions can ensure timely, lawful, and compassionate care that upholds both patient rights and institutional integrity, while avoiding procedural lapses that have drawn judicial censure.

CONCLUSION

The recent Delhi and Gujarat High Court rulings make the ≤24-week pathway unequivocal: when a minor survivor is produced by the IO/CWC, essential care (including ultrasound) must proceed without insisting on ID documents; termination within statutory limits may be undertaken by the requisite RMP(s) with guardian consent and the survivor's informed assent, and age must be verified per the JJ Act's documentary-first hierarchy. These clarifications remove administrative barriers and reduce delays that compound harm.

For pregnancies beyond 24 weeks, the Delhi High Court mandates immediate constitution of a Medical Board to examine the survivor and place its opinion before the competent authority/court, enabling timely judicial decisions; this operates alongside the Gujarat High Court's emphasis on reproductive autonomy and the broad, lived experience understanding of "mental health." Hospitals should therefore maintain readiness for board activation only in >24 week scenarios while ensuring survivor-centric, well-documented care across settings.

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