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Periviable birth: Legal landscape in Indian jurisprudence

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ABSTRACT

Periviability represents a complex threshold where there is a triangulation of medical capabilities, ethical judgement and the right of the infant to live. In India, with its disproportionate burden of preterm births, the management of infants born at the margins of viability (typically <28 weeks of gestation) remains fraught with legal and ethical challenges. We critically explore the legal contours surrounding the care of periviable neonates from an Indian medico-legal perspective in this article. Despite lacking a uniform national consensus on viability thresholds, Indian jurisprudence confers personhood to neonates at birth, irrespective of gestational age, thereby guaranteeing constitutional protection under Article 21. However, in the absence of explicit guidelines and robust systemic infrastructure, physicians and families must navigate resuscitation decisions amid legal uncertainty, cost constraints and moral complexity. Judicial precedents have mandated life-saving interventions for viable neonates born alive post medical termination attempts, reinforcing the right to care. We discuss the limitations of legal doctrines such as parental autonomy, leave against medical advice and advance directives when applied to neonates who cannot consent for obvious reasons. We also highlight challenges arising from evolving tort liability, procedural lapses and resource inequity in neonatal care.

KEY MESSAGES

⇒ Periviability presents several legal challenges in India, where extreme premature neonates are conferred personhood and constitutional rights despite lacking a clear viability threshold.
⇒ Indian courts mandate life-saving care for liveborn infants post-termination, reinforcing the duty of care under Article 21, making nuanced/pragmatic decisions for periviable infants more challenging.
⇒ Parental consent is necessary but not absolute; in periviable cases, decisions must prioritise the infant's best interests through shared judgement with legal and ethical oversight.
⇒ Leave against medical advice protocols offer limited clarity in neonatal contexts; current frameworks inadequately address consent, liability and end-of-life decisions for sick neonates.
⇒ High financial burden and limited infrastructure challenge equitable neonatal care; pragmatic, virtue-driven and legally informed decision-making is vital in resource-constrained Indian settings.

INTRODUCTION

Globally, 13.4 million babies are born preterm, of which 4% are labelled extreme preterm babies (<28 weeks), which corresponds to nearly half a million babies every year. This burden is predominantly borne by low- and middle-income countries (LMICs), especially India (about 20% of the global burden). As of 2020, in India, 3.2 million babies (13% of all live births) are born preterm every year, with 120 000 babies (4%) of those being <28 weeks. A caveat is that these numbers are not precisely enumerated in the national statistics.[1] A joint workshop, supported by the Society for Maternal-Fetal Medicine, the Eunice Kennedy Shriver National Institute of Child Health and Human Development, the Section on Perinatal Paediatrics of the American Academy of Paediatrics and the American College of Obstetricians and Gynaecologists, defined periviable birth as delivery occurring between 20 0/7 weeks and 25 6/7 weeks of gestation.[2] While advances in neonatal care over the past two decades have resulted in increased survival at lower extremes of gestation, long-term outcomes and, more importantly, the ethical, social and legal aspects of periviable birth must be considered. Periviable infants who survive continue to have high odds of adverse neurodevelopmental issues, which will impact their long-term future, and there has been little improvement in neurological outcomes of periviable infants in many settings despite increasing survival.[3]

The precarious situation in which a premature infant is born and the economic and social factors raise a host of legal challenges with respect to the care to be provided for periviable births. Some of the common concerns regarding periviable births are whether doctors should have a legal obligation to resuscitate? Whether physicians are legally obligated to provide evidence-based interventions like antenatal steroids, which can determine the survival outcome in the periviable period? Whether parental consent is required for such resuscitation? Can the doctor resuscitate such an infant in

the absence of consent by the parents, or in situations of explicit refusal by the parents to perform resuscitation? Do parents have the final say in medical decisions regarding their child? Who decides if there is a variance between medical opinion and parental decision regarding the treatment to be provided to such an infant, and what are the relevant parameters for such decision-making? The answer to many of these questions depends on the legal status of a periviable infant, fundamental and constitutional rights of a child, including an infant, limits of parental decision-making in medical and paediatric settings, parens patriae jurisdiction and the best interests of the child. In this review, we touch on the legal status of extremely preterm infants during birth in India, and the controversies surrounding it.

VIABILITY AND PERIVIABILITY: INDIAN CONTEXT

The literal or the medical boundary of the term 'viability' is obscure and differs in different regions globally. The advancement in medical care has challenged this boundary more than ever. In LMICs like India, this is usually around 25–28 weeks. There is no established consensus on defining viability by the Indian Academy of Pediatrics (IAP) or National Neonatal Forum (NNF). In 2017, a consensus statement by the Indian medico-legal and ethics association and the medico-legal group of IAP stated that "*tertiary neonatal intensive care units can use a gestational age criterion of 24 weeks, others like special care neonatal units being setup in district hospitals should use a gestational age cut-off of 28 weeks*".[4] On the contrary, countries like Japan, where there is universal national policy and a clear cut-off from 22 weeks of gestational age under the Maternal Protection Act to give active care for infants since the 1990s.[5] These stark differences within a country and between countries highlight that it has less to do with development of the fetus and more so with medical advancement and resources available.

HOW DOES THE LAW TREAT AN EXTREMELY PRETERM INFANT?

While it is debatable whether a fetus in the womb is a person or not, there is no iota of doubt that Indian law confers personhood on human beings on birth. In fact, Section 299 of the Indian Penal Code (IPC), 1860 and now the corresponding section of the Bharatiya Nyaya Sanhita (BNS), 2023,[6] that is, Section 100 suggests (though for limited purpose of determining criminal liability for causing death) that personhood is conferred the moment "any part of the child is brought forth, though the child may not have breathed or been completely born". This follows from the reading of the word 'death', which is an essential element of the offence of culpable homicide under IPC/BNS, as referring to death of a human being only (Section 46, IPC and Section 2 (6) BNS). It will be treated as a case of death of a child only if "any part of the child is brought forth, though the child may not have breathed or been completely born"; otherwise, it will be miscarriage-related offence. If the fetus is killed while in the womb, it is not considered as homicide.[7]

The concept of personhood is not dependent on the gestational age at which the birth takes place. Hence, an extreme preterm baby is also a person before the eyes of the law. To substantiate this argument, it will be useful to refer to the decision in Rita Kirit Joshi v New India Assurance Company 2023,[8] where the question before the Bombay High Court was whether a distinction could be made between newborn babies and a premature baby or a baby born 'preterm' for the purpose of insurance coverage. The High Court rejected the classification and held that,

> The further distinction between a 'newborn' and a 'premature baby' or a baby born 'preterm' is also baseless as a newborn baby can be one which is born 'full term' or 'preterm'. A full-term baby does not become more 'newer' any more than a 'preterm' baby becomes an 'earlier born' or, to make it even more pointed, 'old born'. The approach is unreasonable, unjust.

As a corollary, an extreme preterm infant has all rights as any other person under the Indian Constitution, including the right to life under Article 21.[9] However, treating physicians face a dilemma while dealing with these infants as they have bleak chances of survival and are at an increased risk of having mental and physical disabilities. The USA enacted Born-Alive Infants Protection Act of 2002 that clarifies that the words 'person', 'human being', 'child' and 'individual' include 'every infant member of the species homo sapiens who is born alive at any stage of development'. 'It further mandates every healthcare person to help the preterm infant as they would do to a full-term infant'[10] (table 1).

MEDICAL CARE TO PERIVIABLE INFANTS: LEGAL OBLIGATION

Under the Indian Constitution, every person, including children, has the right to health and medical care. India is under an international obligation to provide medical care to children as it has ratified the Convention on the Rights of the Child in 1992 whose Article 24, while recognising the right of the child "to the enjoyment of the highest attainable standard of health", ordains the state parties to take appropriate measures to reduce infant and child mortality.

Despite this constitutional position, questions have arisen on the medical care to be provided to extreme preterm infants, specifically in the context of termination of viable pregnancies under the MTP Act, 1971, after 24 weeks, and the child being born alive despite the attempt to terminate the pregnancy.[11] In *XYZ v State of Gujarat, 2023*, the Supreme Court while permitting the termination of a viable pregnancy held that, "*in the event, the foetus is found to be alive, the hospital shall give all necessary medical assistance including incubation either in that hospital*

Table 1 Key legal doctrines in periviable neonatal care

Legal doctrine	Summary of principle	Indian legal support	Relevance to periviability
Viability in Indian context	Tertiary units—24 weeks SNCU—28 weeks	Indian medico-legal and ethics association and the medico-legal group of IAP consensus statement	Outdated (from 2017) and may not apply to all SNCUs. Almost a decade old, perinatal care and laws have changed since then.
Personhood at birth	A child becomes a legal person once any part is brought forth from the womb	Explanation 3 to IPC Sec. 299; BNS Sec. 100. Rita Kirit Joshi v New India Assurance Company 2023	Even extreme preterm infants are recognised as legal persons entitled to equal care.
Right to life (Article 21)	Duty to save life; right to healthcare	Parmanand Katara v UOI, 1989; Paschim Banga Khet Mazdoor Samity & Ors v State of West Bengal, 1996	Denial of resuscitation/antenatal steroids (evidence based interventions) may violate this right.
Right to equality (Article 14)	Non-discrimination in access to healthcare facilities	Mohd. Ahmed v UOI (2014). Rights of Persons with Disabilities Act, 2016, especially Sections 3 (4) and 26	The concern that the infant, if saved, would be riddled with multiple disabilities should not be the reason for denying medical treatment.
State responsibility	State must provide medical care postbirth to reduce mortality	Convention on the Rights of the Child in 1992 Article	Stronger duty when parents refuse or cannot afford.
Principle of necessity or emergency principle	In order to save the life or preserve the health of the patient and it would be unreasonable to delay the intervention because of lack of consent	Samira Kohli v Dr. Prabha Manchanda, 2008	No criminal liability will be attracted in such cases as the law protects acts done in good faith for the benefit of a person without consent (Section 92 of IPC and 30 of BNS, 2023).
Parental consent limits	Parental refusal not always final	Aarushi Dhasmana v UOI, (2013)	Courts may override the decision in child's best interest. Parental rights and powers are not sovereign or beyond review or control.
LAMA and risk disclosure	LAMA does not absolve the liability of the physician for acts/treatment already provided if there was any negligence in providing care in the first place; must be documented	Common Cause vs UOI; 2018 Samira Kohli v Dr Prabha Manchanda, 2008 Right to refuse medical treatment—Article 21	Crucial for protecting physician in neonatal exits. Clinical establishment must provide adequate referral and transfer services to patients obtaining LAMA.
Best interests of the child	Decisions must protect child's health and life	Aarushi Dhasmana v UOI (2013)	Overrides physician/parental autonomy in emergencies.
Medical negligence and SOPs	Negligence evaluated with reference to clinical SOPs	Max Hospital case (2017); Jacob Mathew case (2005)	Absence of SOPs in <24 weeks' care may contribute to liability.

BNS, Bharatiya Nyaya Sanhita; IAP, Indian Academy of Pediatrics; IPC, Indian Penal Code; LAMA, leave against medical advice; SNCU, special care newborn unit; SOP, standard operating procedure; UOI, Union of India.

or any other hospital where incubation facility is available in order to ensure that the foetus survives".[12] Similar directions have been passed by various High Courts imposing a duty on the attending medical practitioner and the hospital to save the life of the child, if born alive. Few illustrative cases are *X70 v Union of India 2024*, where the Kerala High Court, while directing termination of pregnancy, held that

> In case after the procedure, the child born is alive, the Medical Practitioner carrying out the procedure shall ensure that necessary facilities are provided to such child to save the life.[13] If the child is born alive and the minor or parents are not willing to take responsibility for the child, then the state and its agency will have to assume full responsibility for the child.

Similarly, the Bombay High Court, while permitting medical termination of pregnancies in *Farzana Ali Ahmed Sayyed v State of Maharashtra, 2020* held that, "in case, if the child is born alive, *the Medical Practitioner who conducts the procedure will ensure that all necessary medical facilities are made available to such child for saving its life*".[14] Another such instance in *Juveria Farooque Pokar v Union of India, 2021*, the Bombay High Court directed the state to provide medical facilities to the child, if born alive, while permitting termination of pregnancy at 26 weeks of gestation. The court stated,

Table 2 Major Indian court precedents on periviable neonatal care

Case name	Court and year	Gestational age	Court direction	Legal principle established
XYZ v State of Gujarat	Supreme Court, 2023	~26 weeks	Mandated neonatal care and incubation if child is born alive post-MTP	Article 21 right to life extends to viable fetus born alive
X70 v UOI	Kerala HC, 2024	28 weeks	Mandated care if child survives termination; state assumes responsibility if parents unwilling	State duty in live birth post-MTP
Farzana Sayyed v State of Maharashtra	Bombay HC, 2020	~25–26 weeks	Required all necessary medical facilities if child is born alive	Medical duty to support neonate post-MTP
Juveria Farooque Pokar v UOI	Bombay HC, 2021	26 weeks	Directed state to ensure neonatal care; assume custody if parents unable to take care	State guardianship of neonates in absence of parental support
L (Minor) v State	Delhi HC, 2023	25 weeks	Hospital must provide all feasible medical care; Child Welfare Commission to take action	Best interests and CWC jurisdiction
Rita Kirit Joshi v New India Assurance	Bombay HC, 2023	Not gestation-specific	Rejected insurer's denial based on preterm status	No legal distinction between term and preterm newborns under law

CWC, Child Welfare Committee; HC, High Court; MTP, medico-legal termination of pregnancy; UOI, Union of India.

> We direct that in the event the child is born alive, the State of Maharashtra shall ensure that all necessary medical facilities are provided to the child. If the Petitioners are not willing or not in a position to take responsibility for the child, then the State and State Agencies will have to assume full responsibility for the child.[15]

In *L v State, 2023*, Delhi High Court remarked that,

> If the child is born alive, despite the attempts at medical termination of the pregnancy, the Superintendent, Guru Teg Bahadur Hospital, Delhi, shall ensure that everything, which is reasonably possible and feasible in the circumstances is offered to such child, and the Child Welfare Committee concerned shall do the needful in accordance with law[16](table 2).

The fact that the periviable babies have very bleak chances of survival should not be the sole reason for denying care to them. It would be contrary to the right to life, which includes the right to survival and access to medical care. Holding otherwise will also be in teeth with the principles enunciated by the Supreme Court in Parmanand Katara v Union of India, 1989,[17] where it was stated that, "that preservation of human life is of paramount importance". That is so because once life is lost, the status quo ante cannot be restored, as resurrection is beyond the capacity of man. Article 21 of the Constitution casts the obligation on the State to preserve life. Every doctor, whether at a government hospital or otherwise, has the professional obligation to extend his services with due expertise for protecting life. Furthermore, the concern that the infant, if saved, would be riddled with multiple disabilities should not be the reason for denying medical treatment. Any contrary view would be against the constitutional guarantee of the right to equality and non-discrimination and a violation of the provisions of the Rights of Persons with Disabilities Act, 2016, especially Sections 3 (4) and 26.[18]

Despite the clarity in the legal position, doctors continue to face a dilemma due to the lack of specific guidance on the extent of medical intervention and the nature of facilities required to save the life of an extremely premature infant. One of the critical questions in such situations is whether resuscitation should be attempted, and if so, whether parental consent is mandatory. Although the Good Clinical Practice Recommendations on neonatal resuscitation issued by the Federation of Obstetric and Gynaecological Societies of India and the Indian College of Obstetrics and Gynaecology are endorsed globally, they are not considered the definitive or gold standard frameworks in such ethically and medically complex cases.[19 20]

The level of medical care that can be provided to a newborn, especially at the extreme gestational age of 22–24 weeks, can vary from the basics to state-of-the-art care. But the expectations of the mother and her family remain sky high; during such times, it is always better to counsel in a non-hurried quiet manner, in the language used by the patient. All documentation formalities should be completed with the notes of the neonatologist, too. A realistic account of the future scenario of the neonate after 2–5 years should be given along with the financial costs, which may be incurred by the family during treatment. *Ultimately, it is the mother (with father) who will decide on treatment, we as the healthcare providers are supposed to make arrangements for the same and not take a decision on behalf of the family solely.* The maximum criticism that arises if we vest more control to physicians in the decision-making is that there are high chances of conflict of interest which are not made explicit in the first place, second it could be driven by their personal experience, cultural and religious beliefs, fear of wrongdoing under law, financial incentives, etc.

However, there is seemingly a conflict with the Indian Council of Medical Research Consensus Guidelines on 'Do Not Attempt Resuscitation', which provides that responsibility for the final decision on resuscitation vests with the treating physician.[21] However, his/her decision is not a personal decision, but always a 'shared decision' taken in consultation with the patient/surrogate. In the case of conflict, an independent second opinion of a specialist can be obtained. Furthermore, if the decision is contrary to the wishes of the patient/surrogate, then it must be based on relevant criteria and properly documented. It is therefore submitted that, while shared decision-making is the best case scenario, the physician should not abandon the child in case consent is not forthcoming.

CONSENT OF PARENTS

Medical decisions regarding infants must be made by the parents, as they are entrusted by law with the care and custody of the child. In the case of an infant, any medical procedure generally must be performed after obtaining the informed consent of the parent or guardian; however, consent can be dispensed with under the principle of necessity where in "order to save the life or preserve the health of the patient and it would be unreasonable to delay such unauthorized procedure" (Samira Kohli v Dr Prabha Manchanda, 2008).[22] No criminal liability will be attracted in such cases as the law protects acts done in good faith for the benefit of a person without consent (Section 92 of IPC and 30 of BNS, 2023).[6] However, questions arise on the duty of the physicians to provide treatment where the parents have refused to give consent and may have expressed their desire to discharge the baby and let nature take its course.

LEAVE AGAINST MEDICAL ADVICE AND ITS LEGALITY?

It is quite often a scenario that parents would want to leave the healthcare facility with the infant against the physician's advice by obtaining what is popularly called 'leave against medical advice (LAMA)/discharge against medical advice. Although these terms are not explicitly defined under any Indian statutory law, nevertheless, the terms are widely used in clinical settings in India. It generally refers to the 'voluntary discharge sought by a patient which may not be in his/her best interests'. Such a patient is already under the medical care and supervision of a doctor; however, due to reasons best known to him, he does not wish to continue the medical treatment. While LAMA does not absolve the liability of the physician for acts/treatment already provided if there was any negligence in providing care in the first place,[23] it shields the physician from the consequences that may ensue after the treatment has stopped. Furthermore, even if a decision is taken to obtain LAMA, proper counselling should be provided to the patient seeking LAMA so that they are able to make an informed decision. Adequate information about risks must be provided to the patient so that they can make a balanced decision (Samira Kohli v Dr Prabha Manchanda, 2008).[22] Even if, after the counselling, the patient wants to get a discharge, then the physician must properly document that the discharge is being done against medical advice and at the risk and responsibility of a competent patient. The clinical establishment must provide adequate referral and transfer services to patients obtaining LAMA. The National Council for Clinical Establishments approved the additional charter of patient's rights in 2021 and expressly provides for the right to proper referral and transfer even for patients obtaining LAMA.[24] It may also be useful to refer to the AIIMS Protocol for Admission/Discharge/Transfer/LAMA/Death 2024, that recognises:

> The patient has the right to leave the ward if they are not satisfied with the care, patient is counselled and is allowed to leave. If the patient is terminally ill or on a ventilator, staff must ensure that the patient is shifted in an ambulance safely with oxygen and other necessary equipment.[25]

The exercise of LAMA is in consonance with the 'right to refuse medical treatment' recognised as a part of the right to life and personal liberty guaranteed under Article 21 of the Indian Constitution. In Common Cause v Union of India (2018),[26] the Constitutional Bench of the Supreme Court held that:

> A competent person who has come of age has the right to refuse specific treatment or all treatment or opt for an alternative treatment, even if such decision entails a risk of death. The 'Emergency Principle' or the 'Principle of Necessity' has to be given effect to only when it is not practicable to obtain the patient's consent for treatment and his/her life is in danger.

But an 'infant/baby' is not a competent person. The exercise of LAMA in neonatal care raises an ethical minefield for the treating physician as it militates against the duty to protect the best interests of patients. With respect to incompetent persons, the decision in Common Cause's case assumes further significance as the court does separately analyse the issue of the cessation of medical treatment with respect to a person who is incompetent to take an informed decision. The court clarifies that in such cases the decision has to be taken 'in the best interest of the patient' by 'competent medical experts'. It is not the decision of the treating doctor alone but that of a medical team. Furthermore, the medical team must consider 'the opinion of the blood relatives of the patient and other relevant facts and circumstances'. So it is neither the decision of the treating physician nor that of the parent alone.

It may also be relevant to note that the Supreme Court in *Aarushi Dhasmana v The Union of India*[27] had recognised that parental rights and powers are not sovereign or

beyond review or control. The Court can, in suitable cases, exercise Wardship Jurisdiction. The rights of parents cannot override the 'welfare of the children'. In case of a conflict between the views of the medical team and parents regarding the continuation or cessation of treatment, judicial review under Article 226 is always possible.[28] From the perspective of contract law, the basis of medical treatment is the continuing consent of the patient, but once the patient decides to obtain LAMA, the consent is revoked and the contractual relationship between the doctor and patient ceases. However, notwithstanding such revocation, the liability is not extinguished for past deeds/services provided (table 1).

MEDICAL NEGLIGENCE IN PERIVIABILITY

Case details

A poignant case which drew the attention of neonatologists, bio-ethicists, the human rights commission and the public at large in India occurred at a reputed and well-known private hospital in Delhi in November 2017, involving twins born at just 23 weeks of gestation. The hospital, adhering to the standard protocol, provided the best possible care under the circumstances. However, amid the intensive treatment, one of the twins was mistakenly declared dead and handed over to the family in a plastic bag. This grave error came to light when the infant showed signs of life on the way to the cremation ground. The infant was rushed back to the hospital but tragically passed away a few days later. This incident sparked a public outcry and led to a legal investigation. The Delhi government temporarily revoked the hospital's licence, citing negligence and critical lapses in medical care. Delhi police registered the case under Section 308 of the IPC (attempt to culpable homicide) citing criminal act. The father filed a case and stated "grave medical criminal act, with an intention to cause the death of two infants" on the hospital's part, claiming that his babies were allowed to die because he "was not in a position to fulfil the extortion demand of Rs 50 lakh (US$55 000–60 000)" for their care. The Delhi Medical Council (DMC) disciplinary committee took up an independent inquiry (suo moto), interviewed 18 individuals and examined the conduct of the doctors and hospital and concluded there was '*no medical negligence*' in terms of clinical management, and parents were involved in decision making. However, there were procedural lapses and poor communication, for example, a failure to formally certify the boy's death and the hasty handover of the bodies without a senior doctor's sign-off. These lapses were attributed to the '*absence of standard operating guidelines*' for handling such periviable births (under 24 weeks). More importantly, they emphasised that the treatment decisions were appropriate given the circumstances: *"the babies were not admitted to the NICU, as per the directions of the family*", and the decision not to resuscitate was in line with existing norms for gestations under 24 weeks. It stated that *"in the present instance, the decision for management of the baby was as per the existing guidelines… no medical negligence can be attributed on the part of the doctors*".[29]

Any case of alleged criminal negligence by a doctor in India has to undergo a 'mandatory preliminary enquiry' by a recognised medical body (DMC in this case) before the First Investigation Report (FIR) is filed by the police. This safeguarding measure is mandated as per the Supreme Court of India in Jacob Mathew v State of Punjab, and was upheld in Lalita Kumari v State of Uttar Pradesh.[30 31] This is to ascertain that the alleged negligence warrants any further investigation under Section 304A (s.106 BNS). BNS states "*if such act is done by a registered medical practitioner while performing a medical procedure, he shall be punished with imprisonment of either description for a term which may extend to 2 years, and shall also be liable to fine*". The recent BNS 2023, s 173(3) has changed the 'mandatory preliminary enquiry' to 'may be preliminary enquiry' before FIR for the cognisable offence punishable from 3 to 7 years. This is of concern for the treating doctors as the punishment for such negligence is supposed to be up to 2 years only. So, the role of preliminary enquiry as a defence for the doctors may not assist them, as the new legislation prevails over any previous judgement by the court.[6]

FINANCIAL BURDEN AND ITS ROLE IN DECISION-MAKING IN INDIA: THE ELEPHANT IN THE ROOM

Addressing the elephant in the room is the economic burden of saving these babies and how it can facilitate or hinder the decision-making process. Most public sector hospitals have suboptimal infrastructure to care for these 'tiny babies' and although the number may sound inflated, 90% of them do not survive, as per a WHO document in LMICs.[32] On the contrary, the best of the private sector hospitals and a few public sector hospitals can give care and outcomes more or less like the global standards. The flip side of this is that it comes with immense cost. As per recent reports, only 12% of the total population in India (168 million) have some commercial insurance and 42% (588 million) of them are covered by government schemes like Janani Shishu Surkasha Karyakram or Ayushman Bharat scheme or employee schemes like Central Government Health Scheme, etc.[33] The rest 46% (644 million) are uncovered and severely vulnerable, as the entire cost of saving one EPT (just direct cost) can cost them their fortune! Needless to say, it does not involve the indirect costs like travel, food, stay, etc (₹1080 per day out-of-pocket expenditure).[34] Studies from India have reported a per-day cost of US$90–US$107 (₹7000–₹9000) and a cumulative cost of US$8000–US$11 000 (₹6.5–₹9 lakh).[35] The data are lacking from high-end private hospitals where the cumulative cost can go up to US$30 000 (₹25 lakh). This cost, as compared with developed countries like the USA with a mean cost of US$300 000 (US$600 000–US$1 000 000),[36] may seem considerably less but is still catastrophic for middle- and low-income families in India. The survival outcome of infants

at periviable gestation is barely encouraging. Survival at 24–25 weeks is under 30% in the best of the public sector hospitals, up to 70% in infants <28 weeks.[37 38] Moreover, the long-term neurodevelopmental outcomes of these surviving infants are lacking as well. Adding to this financial quandary for the parents is the burden of decision-making about active care or palliative care. Considering such financial vulnerability, parents will be compelled to decide against the active care, about which neither they nor the physicians are uncertain. Some experts would refer to this decision as the 'zone of parental discretion' and must be respected in the 'shared decision' model concept.[39 40] It is also the state's responsibility as per Indian law to take care of these infants when they opt for active resuscitation but cannot afford the care. So, transferring these babies to government-run hospitals by an expert team is practised widely in India. However, public sector hospitals are overburdened with such cases on a daily basis. In this context, the principle of 'health equity' can appear only aspirational, where allocation of resources needs to be prioritised pragmatically dealing with periviability.

WAY FORWARD

Role of 'advance directives' for minors, especially infants, and in situations like periviability could possibly help physicians and distressed parents. There is a pressing need to establish context-sensitive national guidelines from NNF/IAP and the state that integrate legal mandates, ethical principles and pragmatic clinical frameworks. Future policy must explicitly define viability thresholds, clarify roles in shared decision-making and institutionalise protocols for situations like LAMA and disputed consent. Embedding legal literacy into neonatal and obstetric care, along with providing financial support from the state to vulnerable families, are critical steps forward.

CONCLUSION

In the legally evolving landscape of periviable care in India, clinical decisions cannot rest solely on gestational age or survival probabilities. This review highlights that periviable infants, despite their precarious prognosis, are constitutionally recognised persons entitled to life-saving interventions. As jurisprudence increasingly mandates state responsibility and parental authority is tempered by the infant's best interests, it becomes imperative to establish legally informed, ethically sound and contextually adaptable national guidelines. The way forward must integrate virtue-driven clinical judgement, equitable allocation of scarce resources and robust legal frameworks to support both families and healthcare professionals. Ultimately, advancing neonatal justice in India demands medical sophistication and a principled commitment to dignity, transparency and shared responsibility in the grey zones of life.

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