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India's New Criminal Laws and Medical Professionals: A Structured Legal–Health Policy Analysis of Liability, Evidence, Emergency Care and System Readiness

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ABSTRACT:

Objective: The purpose of this study is to find out how three laws introduced into effect in 2024 regarding Indian criminal law change exposure and accountability of doctors. **Methods:** We performed an analysis of Bharatiya Nyaya Sanhita, 2023 (BNS), Bharatiya Nagarik Suraksha Sanhita, 2023 (BNSS) and Bharatiya Sakshya Adhiniyam, 2023 (BSA) in a structured legal-health policy framework. Articles were considered in this study if they directly related to registered medical practitioners, hospitals, examination, treatment or expert opinion or where they regulated clinical documentation, forensic evidence or judicial processes relating to clinicians. The unit was categorized on basis of statute, domain of impact and whether there had been continuity, modification or innovation of provision. Primary legal material, Supreme Court case law, government implementing documents and Indian health literature were utilized in this study up to 31 July 2026. **Results:** A total of thirty-seven provision units qualified for inclusion criteria: eleven in BNS, sixteen in BNSS and ten in BSA. The most explicit substantive protection is provided in BNS, section 106(1), which restricts maximum sentence to two years when an NMC-registered practitioner causes death by rash or negligence during carrying out of a medical procedure as compared to five years applicable for all others. But crime is still cognizable and bailable, statutory preliminary-enquiry period in BNSS, section 173(3) only applies to crimes that attract punishments of three to less than seven years and medical exemption does not expressly cover practitioners that are registered under non-NMC systems. The operational amendments go further than liability amendments since forensic attendance at crime scenes, timed sexual-assault reports, electronic proceedings, successor testimony and electronic record authentication could change hospital operations. The majority of examination, emergency treatment and expert witness duties remain substantially similar to previous laws. There is no offense that protects health care workers against workplace

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violence in entire nation. **Conclusions:** These revised codes will not bring about an entirely new medicolegal framework. The new codes integrate special sentencing of registered practitioners with NMC along with important procedural and digital evidence reforms. For safe and effective implementation, specialized screening prior to prosecuting crimes related to medical negligence, medico-legal documentation that is harmonized, management of evidence-grade electronic records, forensic staffing that is protected, practitioner-wide training and monitoring of arrests, delay in reporting and attending courts will be required. Prospective multicenter studies are necessary before any cause-and-effect relationship can be established.

INTRODUCTION:

Three laws of nineteenth and twentieth century were replaced by India on 1st July 2024 by introducing following three new laws – Bharatiya Nyaya Sanhita, 2023 (BNS), Bharatiya Nagarik Suraksha Sanhita, 2023 (BNSS) and Bharatiya Sakshya Adhiniyam, 2023 (BSA) ^[1-4]. These statutes superseded Indian Penal Code, 1860 (IPC), Code of Criminal Procedure, 1973 (CrPC) and Indian Evidence Act, 1872 (IEA). The effect of all these statutes except that of BNS 106(2) was simultaneous. The impact is not only felt in police station and courts but extends further to hospitals, which are places for emergency treatment, detention examination, sexual assault treatment, post-mortem examination, expert opinion and digital evidence production. A medical practitioner can, therefore, play different roles in a criminal proceeding like treating physician, accused, forensic examiner, expert witness, custodian of documents and an institutional decision-maker simultaneously.

The change takes place in a health sector of unusual size and unequal capacity. According to government statistics, number of registered allopathic doctors and AYUSH doctors reached 1,388,185 and 751,768 respectively by early 2026 ^[5]. However, coverage of statute does not equate with this population because BNS and BNSS provide definitions of “registered medical practitioner” based on qualifications and registration in National Medical Commission Act, 2019. This definition is significant because a specific provision regarding sentencing when death occurs negligently as a consequence of a medical procedure has been included in it.

This shift coincides with a profession that is already preoccupied with issues related to violence, litigation and law-related preparations. A cross-sectional study can never provide an estimate of national prevalence, yet findings are noteworthy nonetheless. According to a survey of 658 doctors in India conducted in 2025, 60.9% experienced workplace violence and 48% of those who were subjected to violence failed to report it ^[6]. In a study conducted at a Delhi tertiary-care center on 326 residents, 80.4% had experienced verbal aggression, 21.7% experienced physical aggression and 73.3% thought it affected patient ^[7]. A survey at two emergency departments of 200 healthcare professionals found 68% reported verbal violence and 26% physical violence ^[8], while a 2020 tertiary hospital survey revealed that 54.6% of 353 physicians surveyed had suffered from violence within last six months^[9]. The varied studies have different population samples and different recall periods; however, these studies have shown that occupational safety is not an area that should be considered secondary to any other. The new codes alone cannot provide national law on workplace violence specific to field of medicine as desired by some segments of medical profession.

The medicolegal preparedness too is far from uniform in its levels. In a study carried out in neurosurgeons across nation, as many as 66.4% found their residency training inadequate in medicolegal affairs ^[10]. Although professional indemnity insurance was well known by 109 surveyed ophthalmologists, there was a lack of knowledge regarding medicolegal system^[11]. There is also diversity in digital preparedness: an empirical study of 75 primary health centers in one district of southern India revealed that only 19.14% had electronic medical records^[12]. However, where digital systems are employed, issues of governance, cybersecurity and integrity of evidence become significant^[13]. It appears that new rules of evidence run risk of exacerbating rather than remedying capability disparities without adequate funding and standardisation of implementation process.

The early analysis of Bill has tended to focus on section 106(1) of BNS, which has been either described as an effective shield for doctors or as an added burden in criminal law. However, both descriptions are insufficiently complete. The maximum punishment for an NMC registered practitioner under amended law is two years – former IPC maximum – but there is now a distinction made between practitioners and other persons, a combination of punishment by imprisonment with liability to fine and inclusion in new process framework. At same time, procedural and evidentiary provisions will probably have more impact in practice than offence itself.

However, no identified study has provided a reproducible synthesis at provision level for three codes and health

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system capability to put those codes into effect. In view of this scenario, this paper raises three questions: (1) What are provisions that directly and/or operationally impact medical professionals? (2) What are impacts that are continuity, modification or a different mechanism from that of previous law? and (3) What actions should health system leaders take to protect patients, professionals and evidence integrity? It is not about making predictions or estimating a causal effect yet, but about turning statutory change into impact pathways and an implementation agenda.

MATERIALS AND METHODS:

Study design and analytic perspective:

The methodology adopted was a structured mapping of law coupled with health policy implementation analysis. The unit of analysis was statutory provision or part thereof if one provision was divisible into separate provisions with different rules. The legal comparison was a doctrinal comparison involving interpretation of enacted statute in light of its predecessor and binding principles of Supreme Court. Following from this, policy analysis determined how a rule changed activities, resources, timing, responsibility or risk at health care institution level.

Corpus, eligibility and sources:

The main corpus consisted of English versions of acts BNS, BNSS, BSA, documents relating to their enactment and also English versions of IPC, CrPC and IEA^[1-4,14-16]. A provision was considered eligible if it satisfied one of four conditions, including that it (a) referred specifically to a registered medical practitioner, medical officer, hospital, examination, treatment, autopsy or medical report; (b) related to an offence that is likely to be committed through course of medical practice, such as death through negligence or infliction of grievous harm; (c) dealt with evidence, whether expert, documentary or electronic, made or maintained by a health institution; or (d) regulated proceedings likely to change clinician workloads, such as electronic testimony and testimony by a successor officer. Generic offences were not included unless pathway through which offence was reached was directly linked with clinical pathway.

Secondary primary sources include judgments from Supreme Court relating to criminal medical negligence, emergency treatment and state duty^[17-20], Ministry of Home Affairs (MHA), Bureau of Police Research and Development (BPR&D), Ministry of Health and Family Welfare (MoHFW) and Press Information Bureau implementation materials^[21-25], and National Medical Commission material on registration^[26]. Indian peer-reviewed research was utilized for understanding occupational safety, medicolegal preparedness and digital preparedness, but not for identifying effect of legislation passed subsequent to collecting data^[6-13]. Search of government websites, PubMed and references was updated to 31 July 2026. Only English-language sources were included, with statutory language taking precedence over alternative descriptions.

Coding and comparison:

Each unit that qualified was isolated into a structured matrix comprising: current section; predecessor; impacted role; primary domain; procedural versus substantive nature; extent of change; operational consequence; and dependence for implementation. Four exclusive categories of primary domain were established a priori: (1) liability, defences and duties; (2) medicolegal exam, victim management and forensic evidence collection; (3) expert opinion, testimony and court process; and (4) electronic record and electronic evidence. Where there were multiple impacts for a rule, that rule was coded to domain where its primary operational act existed, but other impacts were retained narratively.

“Substantial continuity” signified that relevant duty, protection or evidentiary rule remained materially intact through renumbering or drafting differences. “Modified” referred to a situation where scope, penalty, actor, time frame, verification act or procedural consequence was modified. “New mechanism” was where no functionally equivalent general rule was found in previous code. Extracts and match to predecessor were done in two passes, one of which was reviewed against official versions. Since this was a one-reviewer legal coding exercise, no inter-rater agreement statistic is provided; a complete crosswalk is provided in Supplementary Table S1.

Descriptive analysis and impact framework:

Counts and proportions characterize coded corpus only and not legal significance or population impact of provisions. Three comparisons were visualized, including: Distribution of units of included provisions according to domains and statutes; Maximum prison term for negligence causing death as per IPC 304A and BNS 106(1); and Relevant practitioner register populations in response to textual scope question. The implementation results

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were characterized using framework of structures, processes and outcomes. Structures comprised of forensic facilities, health information systems, training and legal infrastructure; processes included expert review, report delivery time, evidence certification and court appearance; and outcomes for future evaluation included pre-expert arrest, incomplete evidence certificate, lost clinician time, delayed treatment, patient complaints and disposition of cases.

Ethics and reporting:

Legal sources that are freely accessible were utilized in this study, including legislation, court decisions, official papers, as well as aggregate research. Since there is no participation of human subjects, confidential information or intervention of any kind, there is no need for institutional ethics clearance and consent process in this study. All numeric claims were accepted only in cases when they were traceable to cited sources. This paper was drafted in accordance with requirements of Chinese Journal of Health Management regarding original article.

RESULTS:

Composition of legal dataset:

A total of 37 provision units satisfied eligibility criteria: 11 BNS, 16 BNSS and 10 BSA units (Table 1; Supplementary Table S1). There were 13 units (35.1%) for liability, defence and duty, 10 (27.0%) for medico-legal examination, victim treatment and forensic collection, 7 (18.9%) for expert evidence, testimony and process and 7 (18.9%) for digital records and electronic evidence (Figure 1). The pattern of allocation to code was as predicted: liability was dominated by BNS code, examination and procedure by BNSS and electronic evidence by BSA. A total of 22 units (59.5%) were classified as substantial continuity, 12 (32.4%) as modified and 3 (8.1%) as a novel mechanism. This distribution shows that transition costs cannot be estimated based on simple renumbering of units, since only a few provisions bear brunt of operational changes.

Criminal liability: a targeted distinction with unresolved edges:

The most glaring change in BNS 106(1) that affects doctors is that one faces a penalty of up to five years' imprisonment plus liable to fine for committing death through a rash or negligent act that does not constitute culpable homicide; however, this reduces to two years plus liable to fine when committed by a registered medical practitioner during a "medical procedure"^[1]. It means that definition of 'practitioner' is confined to a person who possesses a recognized qualification in accordance with provisions of National Medical Commission Act, 2019 and who is registered with National or State Medical Register. Section 304A of IPC had earlier imposed a uniform maximum imprisonment of two years^[14]. Therefore, in comparison to former act, upper limit of imprisonment of said medical specialty remains same, but upper limit of other category gets increased from two to five years (see figure 2).

There are three essential points to note here. First, according to First Schedule of BNSS, medical specialty of BNS section 106(1) is a cognizable and bailable case which can be tried by a Magistrate of first class^[2]. However, an investigation may proceed without a warrant since arrest will depend on necessity and reason-recording provisions under BNSS Section 35. Second, use of phrase "shall be punished with imprisonment and shall also be liable to fine" varies from that found in IPC Section 304A where it says "imprisonment or with fine or with both." This may be interpreted as restricting possibility of imposing only a fine; it remains uncertain whether courts will consider mandatory nature of imprisonment in each conviction^[27]. Thirdly, NMC-linked definition does not contain in its text a practitioner registered only under a statute dealing with AYUSH, dental, nursing or allied health professionals. This is more than mere semantics since, as of early 2026, 751,768 AYUSH practitioners had been registered, while there were 1,388,185 allopathic doctors^[5] (Figure 3). Whether five-year general branch can be applied to non-NMC medical practitioners is a matter that will be informed by facts as well as interpretation. This is because of coverage disparity that needs to be addressed through legislation or authoritative clarifications.

The definition of term "while performing medical procedure" is not specified. Depending on how it is interpreted, it can be actual medical procedure involved or something that includes whole process including preparation and immediate follow-up. It becomes relevant when dealing with cases that involve anesthesia, emergency medicine, obstetrics, telemedicine and team approach since there may be several acts and professionals that can be involved in causing harm. Narrow interpretation may result in exposure to sentencing depending on task labels rather than culpability.

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This standard was first established in *Jacob Mathew v State of Punjab*. The Supreme Court ruled that criminal liability depends on very high or gross negligence, not only an error of judgment or negligence that is sufficient for civil liability; and that investigating officer should get a second opinion from a competent person and no doctor should be arrested casually^[17]. These principles are not displaced explicitly by BNS. There are also general exemptions that still apply: BNS sections 26, 27 and 30 protect those specific actions undertaken in good faith for benefit of an individual with consent, by a guardian or in emergencies where consent is not possible, while BNS section 28 outlines instances where consent is not valid. "In good faith" still means exercise of proper care and diligence.

For non-fatal harm, section 125 of BNS incorporates old IPC Sections 336 to 338. While minimum still stays at three months when danger to life or safety is there without any harm and six months when there is an injury caused, maximum for grievous injury has been raised from two years to three years and also fine amount has been increased [1,14]. This may be of some relevance in regard to adverse events of high harm, which cause injury, but not death. Section 200 in BNS continues criminal liability in respect of failure by a hospital to administer necessary treatment as per section 397 of BNSS; section 241 continues destruction of a document or electronic record to defeat production; and sections 271-273 continue offenses relating to negligent or malignant transmission of infection and noncompliance with quarantine regulations.

Procedure: screening, examinations and forensic workload:

In BNSS Sections 35 and 173, there is a clash between process and security that ought to prevail in negligence cases involving medicine. Section 35 states that an arrest has to be accompanied by recorded reasons and necessity in any case of offence punishable within seven years^[2]. However, these are not specific to any clinician in particular. Section 173(3) provides an opportunity for conducting a fourteen-day preliminary enquiry only for offenses that are cognizable and which attract punishment of more than three but less than seven years. Since medical component of BNS section 106(1) punishes any violation with a maximum of two years, it is outside scope of this statutory provision. The exclusion must not in any way be confused with repeal of requirement of independent medical opinion as laid down in *Jacob Mathew*. Inconsistency in interpretation of statute by police cannot be ruled out^[17,27].

Though examination obligations still exist with some modifications in terms of who can demand them and speed at which these reports must be forwarded. Examination in BNSS section 51 can be done by an NMC-designated registered practitioner upon demand of any police officer provided same can offer evidence while old CrPC needed a sub-inspector^[2,15]. Female examinations shall be conducted only by a female practitioner or under her supervision. Similarly, BNSS section 52 provides that a rape accused can be examined on requisition of any police officer and continues to retain preference for practitioner from government or local authority along with fallback provision of 16 km and specifies recording of injuries, material collected, DNA specific details, reasons and precise time when it began and ended. Higher ranking requesting officer will help collect evidence quickly, but there will be increased requirement for establishing identity and standard requisition procedure in case of dispute over legality and consent.

BNSS section 184 provides for examination of a survivor of rape. It continues with requirement of consent and reporting, but adds a specific requirement of sending medical report to investigating officer within seven days^[2]. It is an outer boundary and not a license to delay medical care and evidence collection. The MoHFW guidelines correctly make informed consent, treatment, dignity, non-discrimination and chain of custody focus^[23]. The hospital must identify three different clocks: clock for stabilisation, prompt forensic samples depending on consent and clinical conditions and completing/filing of statutory report. Taking entire seven days as one workflow process is risky.

Section 397 of BNSS is very much similar to Section 357C of CrPC. It mandates that all private/public hospitals shall immediately provide free first aid or medical attention to victim of sexual offences including acid attack or offences against children^[2,15]. 200 of BNS punishes someone in control of a hospital for failing to do that duty^[1]. The obligation is one of those which falls within broader consideration of Supreme Court regarding fact that life preservation cannot be thwarted by proceduralities and State has responsibilities in providing emergency treatment^[18,19]. Intimation from police should thus operate in tandem with care and should not form part of preconditions or an automatic replacement of survivor's own consent to a forensic procedure. The most significant demand for new capacity comes from Section 176(3) of BNSS. In cases where there is an offence punishable by

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imprisonment for seven years or more, a forensic scientist is supposed to go to crime scene, collect forensic material and video procedure." [2]. In case a facility cannot be made available within a state, it can borrow facilities from other states. The provision does not concern only hospitals' forensics departments, but hospital deaths, assaults, poisonings and sexual crimes might render health campuses crime scenes and key evidence sources. Clinical and forensics officials require protected rosters, scene kits, safe transportation, contamination controls, video-retention policies and interfaces between state forensics laboratories, law enforcement and hospitals' laboratories. Official accounts point to quick development—seven operational Central Forensic Science Laboratories and seven more labs approved by March 2026—but fail to indicate universal sub-national readiness or healthcare workforce [24,25].

Death in custody and inquests continue to have medical consequences. As per BNSS, relevant police officer is supposed to submit information and, where necessary, ensure that body is examined by a civil surgeon or any other medical expert under Section 194. In Section 196, there is a requirement of magistrate's inquiry in cases of death, disappearance or alleged rape of a prisoner and, where possible, delivery of body for examination within 24 hours. The above provisions safeguard evidential independence of medical professionals whose credibility hinges on accurate injury recording, sample integrity, photography and absence of custodial pressure.

Testimony and digital evidence: potential efficiency, higher governance burden:

However, BNSS sections 329, 330 and 336 could help reduce unnecessary court appearances. Reports of government scientific experts listed in BNSS are still admissible and documents must usually be either admitted or excluded within 30 days of their submission and expert witnesses do not have to appear unless challenged or required by court [2]. In cases where original officer or scientific and medical expert cannot be called upon due to death, incapacity, retirement, transfer, lack of trace or any form of delay, court may allow for testimony of a succeeding officer who knows how that particular procedure was carried out. However, succeeding officer will only give an explanation regarding validation of such process; succeeding officer will not be able to solve any missing observation or chain of custody problems.

Section 530 BNSS allows for trials, investigations and processes including questioning of witnesses and recording of evidence electronically [2]. Remote testimony can ease burden of travel and clinic cancellations, along with minimizing geographic disparities for clinicians. This advantage depends on factors such as efficient scheduling, privacy, identity verification, visibility of exhibits, confidentiality and procedures for interruptions. The proposed dual strategy should consider remote participation as preferable approach for unchallenged and procedural testimony with in-person participation for cases where exhibits, credibility and cross-examination require it.

The BSA makes health information governance a part of criminal evidence by defining "document" as a category that encompasses all electronic and digital documents, emails, server logs, computer material, smartphones, messages, websites, locational evidence and voicemail [3]. Under Section 57, scope of primary evidence is expanded to cover various electronic documents, concurrent storage, transmitted video and temporary files. Section 61 to 63 continue to provide route of admissibility of electronic documents but shift requirements for certificate to statute. The certificate includes source and machine, mode of production and system condition and second part of certificate requires expert and hash report, algorithms in Schedule [3]. As compared to IEA section 65B, this is more explicit in terms of its operability, although a lot of logic behind it—usage, input in ordinary course of events, etc.—remains same. [16].

In other words, for hospitals, printed discharge summary becomes a surface feature of an evidence object which has many layers to become an evidence-grade artifact. These layers include actual record, timestamp, user and access log, record amendment history, identification of devices/sources, export technique, time synchronization, retention schedule, certificate authority and reproducible hash. The cryptographic hash itself is not proof of veracity of content at moment it was entered into record; it allows demonstrating that certain file has not been modified after its hash creation. Hospitals should use strong algorithms accepted presently (such as SHA-256), keep native file and its metadata intact and avoid transformation of records routinely done. BSA s. 132 establishes advocate-client privilege but there is no doctor-patient privilege created in law. While confidentiality is important, disclosure in a legal proceeding has to be done by necessity and least scope.

Implementation readiness and measurable gaps:

Implementation is large-scale but less visible in health sector. As per 24 October 2024, total number of trained officials by States and UTs was 1,081,819, including 1,049,895 police personnel, while BPR&D reported 351 [21].

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These denominators cannot be combined due to possibility that populations and report routes intersect. What is more important is that there is no count at all of number of trained health professionals, forensic physicians, medical record officers or information security officers within hospitals. The funding and lab development provided by government is just a portion of what is necessary under BNSS section 176(3)^[24,25].

Health-related empirical literature indicates where friction can happen. In surveys, clinicians have expressed inadequacies in their medicolegal education and preparedness^[10,11]; primary-care digitisation can be limited^[12]; and violence exposure is frequently under-reported^[6-9]. Not one of above studies considers new laws. All of them must be used as background information and hypothesis-generating material. Table 5 consequently keeps observation from conclusion drawn from it and prevents pooling a national average from different samples.

DISCUSSION:

Principal findings

These results at level of provisions give rise to four main conclusions. Firstly, process of transformation of criminal law is largely one of continuity, although changes in it are focused on operationally critical points. Three codes retain provisions on good faith and emergency care, nearly all of medical examination duties, as well as general rules for admitting expert and electronic evidence. They include changes to maximum penalty, requisition powers, deadline for reporting, proving of reports and electronic authentication, as well as introducing statutory preliminary investigation period.

Secondly, protection provided by BNS 106(1) is limited in its scope. The provision provides protection to a practitioner registered with NMC only in regard to new five-year general maximum penalty where act was committed during conduct of a medical procedure, but leaves old maximum penalty of two years and a cognisable offence intact. It depends on a professional registration, medical procedure, causation and meeting standard of criminal negligence. It fails to clarify status of non-NMC practitioners, members of multidisciplinary teams and limits of procedure. It also does not codify independent expert screening test laid down in Jacob Mathew case.

Third, process can determine exposure in reality rather than punishment nominally. The burden on doctor arises from complaints process, policing, documentation seizure, arrest procedures, expert analysis, reporting and court proceedings. The disparity in two year provision for medical stream and three to less than seven years for BNSS section 173(3) preliminary inquiry provisions is a case in point. While not creating any necessary conflict with Jacob Mathew, there is a clear communication danger – officer relying solely on BNSS will see that no preliminary steps can be taken. An obligatory or national procedure must require an independent specialty-specific determination prior to initiation of criminal medical negligence prosecution, with exception of those cases where matter is unrelated to professional discretion – fraud, malice or concealment of evidence.

Fourth, BSA incorporates information architecture into patient-safety and legal-quality architecture. The ethical and clinical significance of proper record keeping and audit trails had already been established. With introduction of certificate model, same now determines ability of hospital to be able to authenticate its evidence. It is not merely a task for information technology department. Meaning and authorship belong to clinical departments; retention and disclosure belong to medical records departments; security belongs to information security group; collection and chain of custody to forensic experts.

Balancing accountability and clinical decision-making:

There is no question that criminal law plays its place in cases involving gross recklessness, destruction of evidence and refusal of urgent treatment mandated by law. It is not a good way to deal with all negative consequences. Medicine functions in situations with uncertainties and resource limitations. Knowledge of outcome makes it seem like something that had to be decided before event. The Jacob Mathew standard addresses such an imbalance by distinguishing between gross negligence and other types of mistakes^[17]. In *Kusum Sharma v Batra Hospital*, civil counterpart of same principle was applied, wherein one should not decide against a professional on sole ground that another way could have been taken into account.^[20] These principles remain important to avoid defensive refusal of high-risk patients.

On other hand, discipline-specific maximum should not diminish patient's redress and should not ignore institutional factors. There can be a number of serious cases where there are problems related to staffing, supervision, equipment, referrals, procurement, infection control or computer failure besides last clinical decision. A criminal proceeding that emphasizes only on final clinical decision might not even explain what went wrong or

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how can matter be prevented in future. It is important that healthcare facilities conduct a safe patient review independently from any criminal proceedings and ensure that no tampering of original documents takes place.

There is also an equity issue with practitioner definition based on text. Allopathy practitioners, AYUSH practitioners, dental professionals, nursing and other allied health practitioners can do some invasive procedures, emergencies and medical procedures in line with various laws. The definition of sentencing provision based only on NMC register will create an ambiguity for genuine practitioners and practitioners from other systems. There is no point in extending it automatically without considering scope of profession. It would be advisable for Union Government to provide an interpretation and consider amending provision, if necessary.

Emergency care, survivor rights and forensic quality:

It must be remembered that BNSS Section 397 and BNS Section 200 need to be followed for patient protection purposes rather than as a means to police. The first job at hand is that of stabilization without money or filling out of police reports being necessary conditions. The treatment of sexual assault victims includes informed consent, treatment and referrals^[23]. There are ways that hospital can ensure compliance with mandate of police intimation, while at same time respecting authority of survivor to make decisions about her health care.

The seven-day reporting timeframe specified in BNSS, Section 184 is expected to enhance accountability only when measured from time of examination to completion of report, along with diagnostics, staffing and transport. Failure to do so may lead to pre-fabricated conclusions, inadequate laboratory integration and retrospective data entry. Some suggested measures could be median and 90th percentile time taken from examination to dispatch of report; proportion of reports having separate consents for each procedure; proportion recording time of starting and ending; rejected or leaking kits; and proportion with signatures on handover. These measures should be calculated with stratification by gender, age, disability, facility level and rurality.

Similarly, mandate for forensic scene under section 176(3) requires quality measures, not just numbers of deployment. Laboratory deployment or mobile unit deployment alone cannot demonstrate that a suitably qualified expert arrives at scene quickly enough to prevent contamination, take right samples, film scene and get an adequate laboratory test result. Forensic medicine units cannot be made responsible for crime scenes unless they have workload standards. Protective teams may consist of forensic physicians, forensic scientists, photographers, technicians and an on-call leader for transfer to investigators. Shared services at regional level may be a more practical approach than trying to duplicate all services in every hospital, especially if time to access is published and rural population is not discriminated against.

Occupational safety remains a policy gap:

The new codes have general offenses that can be applicable in cases of assault, injury, threat, vandalism and obstruction. The new codes will not provide for a specific offense against health care workers and institutions with specific requirements for reporting, investigation and preventive mechanisms within institutions. State laws protecting medical personnel and institutions are not standardized and it will not solve problems such as overcrowding, communication breakdowns, delay in care, poor staffing or poor security^[6-9], but they do not set a national minimum rate or prove that harsher sanctions deter violence.

A good safety strategy will be based on a combination of law and design: zero tolerance in reporting without blaming staff; swift responses and safe exit; staffing and queuing in emergency zones; family communication in case of deterioration or death; post-event treatment and psychological help; legal help; storage of CCTV and incident reports; and a feedback on course of events. A minimal national dataset will register type of event, its location, injury, relationship to alleged offender, police notification, charge, service disruption and its resolution. Reporting will show if there is any progress towards less underreporting and swifter reactions. Professional associations have called for greater central protection; this call has to be considered against backdrop of preventive responsibilities and evidence from state enforcement^[28].

A health-system implementation package

The analysis leads to a six-element package (Table 6). Firstly, all states must have a joint circular of health, home and prosecution departments on harmonization of BNS Section 106(1), BNSS arrest guidelines and Jacob Mathew test. Independent panels should be independent of both complainant and facility accused, based on specialty and level of care, conflict-of-interest-free and deadline-driven. It is not responsibility of such panels to determine guilt

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but only to advise on whether alleged act, if proven, constitutes a gross deviation from reasonable competence of a professional.

Secondly, hospitals require a universal medicolegal operating system rather than form by form. Uniform modules for system include management of victim's emergency, accused, survivor's examination, custodial injury, inquest and post-mortem services, specimen sealing, police requisitions, photo documentation, reporting and court summons. The forms should indicate their corresponding section and purpose whereas old form numbers should be mapped in transition in order to prevent referral problems. Translation will be necessary but clinical terminology and compulsory data should be standardized.

Thirdly, electronic records systems should be evaluated based on readiness for evidentiary purposes. The minimum functions to be performed are user identification, role-based access, synchronization of time, audit log with no deletions, amendment without deleting, preservation in original format, hold for litigation, documentation for export, identification of origin/source/device, reproduction of hash values and designation of signatory certificates for competence. Small providers need a shared service or government-provided tool; a compliance requirement for an enterprise-level electronic record would place primary care at a disadvantage due to their dependence on paper.

Fourthly, medicolegal work requires protected human resources. Task descriptions must take into account attendance at scene, examination, report writing, consultations and testimony. Remote testimony using BNSS 530 should be done via courtrooms with protected clinical time. Successor testimony using 336 should be facilitated through department methods, competencies and quality control.

Fifth, training needs to be role-specific and evaluated. Clinicians require consent, good faith, gross-negligence requirements, documentation and evidence preservation; nurses require injury/specimen documentation and escalation; records and IT staff require certification, audit logs and legal holds; administrators require duties for providing emergency treatment and incident command; police require clinical uncertainty, consent limitations and screening by experts. Completion rates must be complemented by scenario-based evaluation and auditing.

Sixth, implementation must be evaluated. A national observatory could link police, prosecution, court and health facility data anonymously without establishing a public registry of accused clinicians. Core indicators would include complaints under BNS sections 106 and 125; proportion of cases screened by an independent expert prior to coercive measures; arrests and notices; time taken to receive expert opinion; deficiencies of reports and certificates; remote versus live testimony; days lost by clinician; outcomes; and patient-safety steps. Denominators include procedures, admissions and facility type. Such a design would allow conduct of interrupted time series or difference-in-difference analysis as states introduced protocols, recognizing that statutes were in effect nationally.

Research agenda:

The initial study requirement is a pre-defined national sample of criminal cases derived from healthcare context, along with their reliably classified characteristics of complaint type, specialty, facility type, patient injury, review by experts, arrest, charges laid, resolution and case time. First-information reports by police alone would overestimate uninvestigated claims; reported decisions would underestimate unresolved and lower court cases. Linkage would therefore require full pathway and use anonymous identification methods. Simultaneously, a sentinel prospective network of public and private hospitals could track incident report frequency, documentation burden, turnaround of reports, legal cost, clinician time and referral changes in high-risk patients.

Qualitative investigation should study concepts of "gross negligence", "medical procedure" and NMC-based definition by patients, healthcare providers, police, prosecutors and judges. Simulation studies should test effects of normal requisition, rape kit module and BSA certificate on completeness of report without delay in medical care. The economic analysis would include forensic cost and evidence-based information system cost relative to reduction in recollection, adjournment, clinician attendance and unsuccessful prosecution. Patient outcomes are essential: an efficient legal process that delays emergency care or discourages care for complicated patients is a policy failure.

STRENGTHS AND LIMITATIONS:

Strengths of study include incorporation of statutory texts, clear criteria for inclusion of articles, predecessor

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mapping within all three codes, differentiation between legal change observed and predicted health effects and auditable provision level data set. The study is not limited to analyzing section 106(1), but considers liability together with process, evidence and implementation. Tables provide an easy distinction between statutory data and survey data.

A number of issues need to be highlighted. This analysis of doctrine and policy is not a comprehensive review of all case reports and state legislations that have been discussed. Classification was done only once by one person, hence classification error and subjectivity is still present. The numbers are relative to unit of analysis and do not indicate significance. Only English official documents were analyzed and not state regulations, translations, notifications and operating orders. Implementation statistics could include overlapping denominators and does not focus only on health practitioners. Empirical studies used for citation are mostly cross-sectional, geographically and professionally restricted and conducted prior to implementation of law; therefore, no causality between defensive practice, violence, prosecution and patients' outcomes can be inferred. Judicial interpretations would change with time, particularly regarding mandatory sentencing language, "medical procedure" clause, e-certificates and relationship of BNSS section 173(3) to Jacob Mathew.

CONCLUSIONS:

The new criminal law for India will change medicolegal climate by making several significant changes that are contained within a great deal of continuity. While BNS section 106(1) maintains two-year maximum for an NMC-registered practitioner during a medical procedure while increasing general maximum, there is still a question about cognizability, coverage and procedure. However, BNSS and BSA will have greater day-to-day impact through forensic-scene involvement, deadlines for reporting, electronic processes, evidence successor and authentication of electronic evidence. Implementation must include independent expert screening, prompt patient care, evidence-based record keeping, protected forensic personnel, remote testimony, occupation-based protection and results monitoring. The key is not how many new rules there are but that patients get prompt care, that good evidence gets to court, gross malpractice is held accountable and competent clinicians are not subject to coercive criminal procedures for mere medical errors.

DECLARATIONS

Ethics approval and consent to participate: Not applicable; only public legal and policy documents and published aggregate data were analysed.

Consent for publication: Not applicable.

Data availability: The complete provision-level coding matrix is provided in Supplementary Table S1. Official legal texts are available from India Code and Ministry of Home Affairs at URLs in reference list.

Conflict of interest: All authors declare no conflicts of interest.

Author contributions: Conceptualisation: [Author 1], [Author 2]; methodology and legal mapping: [Author 1]; health-policy analysis: [Author 2]; data verification and visualisation: [Author 3]; original draft: [Author 1]; critical revision: all authors. All authors approved final manuscript and accept accountability for work.

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Tables

Table 1. Corpus and coding summary

Statute	Principal function	Included units, n	Substantial continuity	Modified	New mechanism
Bharatiya Nyaya Sanhita, 2023	Offences, defences and penalties	11	8	3	0
Bharatiya Nagarik Suraksha Sanhita, 2023	Investigation, examination and proceedings	16	7	6	3
Bharatiya Sakshya Adhiniyam, 2023	Expert, documentary and electronic evidence	10	7	3	0
Total		37	22	12	3

Note: A unit is one section or a separable rule. Counts are descriptive, unweighted and depend on prespecified eligibility and primary-domain coding. Full audit trail: Supplementary Table S1.

Table 2. High-impact legal crosswalk for medical practice

Current rule	Predecessor	Change classification	Practical implication
BNS 106(1): negligent death	IPC 304A	Modified	Two-year maximum retained for NMC-registered practitioner during medical procedure; five-year general maximum; fine wording changed
BNS 125: endangering life/hurt	IPC 336-338	Modified	Grievous-hurt maximum rises from 2 to 3 years; updated fines
BNS 26-30: benefit, consent and emergency	IPC 88-92	Substantial continuity	Good-faith protection remains conditional on due care, benefit and consent rules
BNS 200 + BNSS 397:	IPC 166B + CrPC	Substantial continuity	Public and private hospitals must provide

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required victim treatment	357C		immediate, free first aid/treatment for specified victims and inform police
BNSS 51-52: accused examination	CrPC 53-53A	Modified	Request can come from any police officer rather than one not below sub-inspector; reports must move without delay
BNSS 173(3): preliminary enquiry	No equivalent statutory window	New mechanism	Applies to cognizable offences punishable 3 to <7 years; 2-year medical branch of BNS 106(1) falls outside it
BNSS 176(3): forensic scene visit	No general equivalent	New mechanism	Forensic expert visit, collection and videography for offences punishable ≥ 7 years, subject to notified rollout
BNSS 184: survivor examination	CrPC 164A	Modified	Report must reach investigating officer within 7 days; consent and reasons remain central
BNSS 330 and 336: proof and successor testimony	CrPC 294 and 293	Modified/new mechanism	Uncontested reports may be proved without calling expert; successor may testify when original medical officer is unavailable
BNSS 530: electronic proceedings	Dispersed predecessor provisions	Modified	Witness evidence and proceedings may be electronic, potentially reducing travel but adding privacy and infrastructure needs
BSA 57 and 63: electronic records	IEA 62 and 65B	Modified	Expanded primary-evidence rules; prescribed certificate includes source/device information and hash report

Abbreviations: BNS, Bharatiya Nyaya Sanhita; BNSS, Bharatiya Nagarik Suraksha Sanhita; BSA, Bharatiya Sakshya Adhiniyam; CrPC, Code of Criminal Procedure; IEA, Indian Evidence Act; IPC, Indian Penal Code; NMC, National Medical Commission.

Table 3. Provision units by primary impact domain

Primary domain	BNS, n	BNSS, n	BSA, n	Total, n (%)
Liability, defences and duties	11	2	0	13 (35.1)
Examination, victim care and forensic collection	0	10	0	10 (27.0)
Expert evidence, testimony and court process	0	4	3	7 (18.9)
Digital records and electronic evidence	0	0	7	7 (18.9)
Total	11	16	10	37 (100.0)

Table 4. Statutory penalty comparison for rash or negligent harm

Scenario	Provision	Maximum imprisonment	Fine wording	Classification under current schedule
Negligent death, old general rule	IPC 304A	2 years	Fine only, imprisonment only or both	Repealed comparator
Negligent death by NMC-registered practitioner while performing medical procedure	BNS 106(1), medical branch	2 years	Imprisonment and also liable to fine	Cognizable; bailable; Magistrate first class
Negligent death, other persons	BNS 106(1), general branch	5 years	Imprisonment and also liable to fine	Cognizable; bailable; Magistrate first class
Rash/negligent act causing grievous hurt	BNS 125(b)	3 years	Fine up to ₹10,000 or both	Cognizable; bailable; Magistrate first class

Note: Maximum penalty is not a measure of charging, conviction or sentence probability. BNS section 106(2) was not commenced as at search cut-off [4].

Table 5. Contextual readiness indicators and cautious interpretation

Indicator	Source/year	Observed value	What it supports	What it does not prove
Registered allopathic doctors	Government of India, 2026 [5]	1,388,185	Scale of NMC-linked workforce	Active practice or individual legal exposure
Registered AYUSH practitioners	Government of India, 2026 [5]	751,768	Material size of workforce outside textual NMC definition	That every practitioner falls under five-year branch
Doctors reporting workplace violence	Paliwal et al., 2025 [6]	60.9% of n=658	Occupational-safety implementation context	National prevalence or legal causation
Respondents not reporting violence	Paliwal et al., 2025 [6]	48% of exposed respondents	Need for reporting and institutional support	Police or court performance under new law
Neurosurgeons reporting inadequate medicolegal residency training	Garg et al., 2020 [10]	66.4% of n=214	Need for structured training	Readiness of all specialties

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Primary health centres with electronic medical records	Barigela et al., 2021 [12]	19.14% of 75 PHCs in one district	Risk of uneven digital-evidence capability	Current national adoption
Officials trained on new laws	Government of India, to Oct 2024 [21]	1,081,819 reported by states/UTs	Large general rollout	Healthcare-specific competence
Central Forensic Science Laboratories	Government of India, Mar 2026 [25]	7 operational; 7 additional approved	National infrastructure expansion	State-level access or turnaround quality

Table 6. Recommended implementation and evaluation framework

Priority	Lead actors	Minimum action within 12 months	Suggested indicator
Negligence-case screening	State health and home departments; prosecutors	Joint protocol requiring independent, conflict-checked specialty opinion before coercive action in clinical-negligence allegations	% cases with expert opinion before arrest/charge; time to opinion
Medicolegal pathways	Hospitals; forensic medicine; nursing	Unified current-section forms, consent modules, chain-of-custody and report-dispatch tracking	Completeness score; median report turnaround; rejected specimens
Electronic evidence	Hospital CIO/CISO; medical records; legal	Audit logs, legal hold, native export, SHA-256 hashing, named BSA certificate signatories and tested retrieval	% sampled exports reproducible; % certificates complete
Forensic capacity	States; forensic laboratories; medical colleges	Protected multidisciplinary scene-response rota with rural access standards	Median dispatch/arrival time; contamination and recollection rate
Court participation	Judiciary; health departments; hospitals	Secure remote-testimony rooms and protected scheduling; successor method files	Clinician-days saved; adjournments due to technical failure
Workforce safety	Health departments; facilities; police	Standard incident reporting, rapid response, aftercare and preservation of CCTV/records	Reporting rate; injury rate; response time; service disruption
Training	NMC and other councils; universities; employers	Role-specific, scenario-tested modules for all practitioner systems and support staff	Competency pass rate and six-month retention, not attendance alone
Equity and scope	Union ministries and professional regulators	Clarify “registered medical practitioner” and “medical procedure”; assess effects across practitioner systems	Cases by register, role, procedure and facility type

Figures

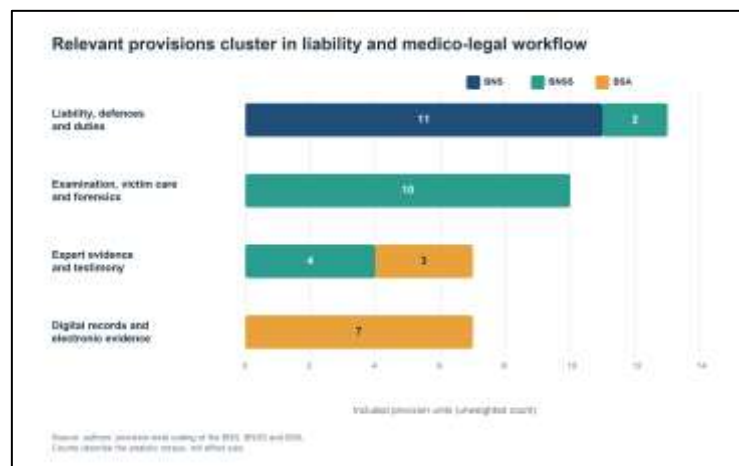


Figure 1. Distribution of included provision units by primary impact domain and statute.

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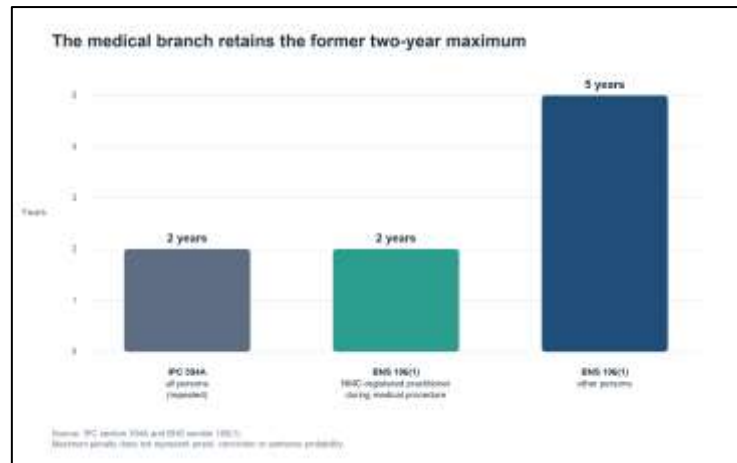


Figure 2. Statutory maximum imprisonment for causing death by negligence before and after BNS.

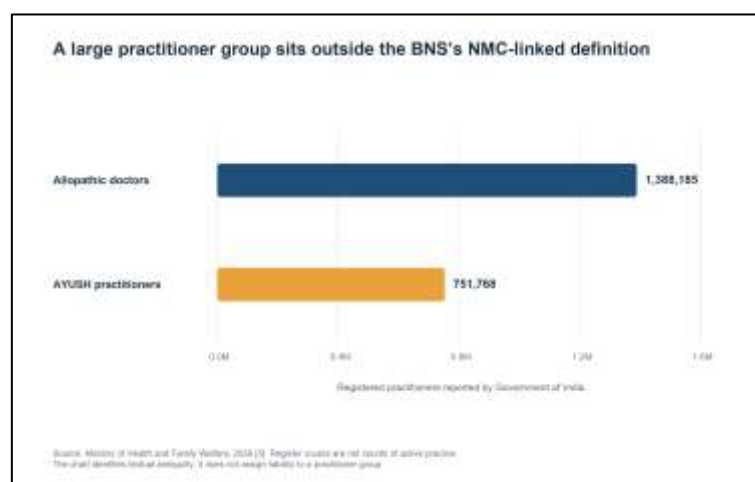


Figure 3. Registered practitioner populations relevant to NMC-linked statutory definition.

Supplementary material

Supplementary Table S1. Provision-level coding matrix

Statute/section	Predecessor	Primary domain	Change	Main operational relevance
BNS 26	IPC 88	Liability, defences and duties	Continuity	Good-faith act for benefit with consent
BNS 27	IPC 89	Liability, defences and duties	Continuity	Guardian consent for child/person of unsound mind
BNS 28	IPC 90	Liability, defences and duties	Continuity	Invalid consent conditions
BNS 30	IPC 92	Liability, defences and duties	Continuity	Emergency benefit without consent
BNS 106(1)	IPC 304A	Liability, defences and duties	Modified	NMC-practitioner two-year branch; five-year general branch
BNS 125	IPC 336-338	Liability, defences and duties	Modified	Rash/negligent danger and non-fatal injury; higher grievous-hurt maximum
BNS 200	IPC 166B	Liability, defences and duties	Continuity	Punishes breach of specified victim-treatment duty
BNS 241	IPC 204	Liability, defences and duties	Continuity	Destruction of document/electronic record to prevent production
BNS 271	IPC 269	Liability, defences and duties	Continuity	Negligent spread of dangerous infection
BNS 272	IPC 270	Liability, defences and duties	Continuity	Malignant spread of dangerous infection
BNS 273	IPC 271	Liability, defences and duties	Modified	Quarantine-rule offence; penalty updated
BNSS 35	CrPC 41/41A	Liability, defences and duties	Continuity	Necessity, reasons and notice framework for arrest
BNSS 173(3)	No direct general equivalent	Liability, defences and duties	New mechanism	Fourteen-day preliminary-enquiry option for 3-to-<7-year offences
BNSS 51	CrPC 53	Examination, victim care and forensic collection	Modified	Any police officer may request accused examination; prompt report
BNSS 52	CrPC 53A	Examination, victim care and forensic collection	Modified	Any police officer may request rape-accused examination

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BNSS 53	CrPC 54	Examination, victim care and forensic collection	Continuity	Arrested-person examination and injury documentation
BNSS 56	CrPC 55A	Examination, victim care and forensic collection	Continuity	Custodian's duty to protect health and safety of accused
BNSS 176(3)	No direct general equivalent	Examination, victim care and forensic collection	New mechanism	Forensic expert at ≥7-year offence scenes; collection and video
BNSS 184	CrPC 164A	Examination, victim care and forensic collection	Modified	Consent-based survivor examination; seven-day report limit
BNSS 193	CrPC 173	Examination, victim care and forensic collection	Modified	Investigation report includes medical report and electronic-device custody sequence
BNSS 194	CrPC 174	Examination, victim care and forensic collection	Continuity	Inquest and dispatch for medical examination
BNSS 196	CrPC 176	Examination, victim care and forensic collection	Continuity	Magistrate inquiry and prompt post-mortem in custodial cases
BNSS 397	CrPC 357C	Examination, victim care and forensic collection	Continuity	Immediate free treatment and police intimation for specified victims
BNSS 329	CrPC 293	Expert evidence, testimony and court process	Continuity	Government scientific-expert reports
BNSS 330	CrPC 294	Expert evidence, testimony and court process	Modified	Thirty-day admission/denial; expert not called unless disputed/required
BNSS 336	CrPC 293 (partial function)	Expert evidence, testimony and court process	New mechanism	Successor testimony for unavailable public servant/expert/medical officer
BNSS 530	Dispersed CrPC provisions	Expert evidence, testimony and court process	Modified	General electronic-mode authority for proceedings and witnesses
BSA 39	IEA 45	Expert evidence, testimony and court process	Continuity	Relevance of medical/scientific expert opinion
BSA 45	IEA 51	Expert evidence, testimony and court process	Continuity	Grounds supporting expert opinion are relevant
BSA 132	IEA 126	Expert evidence, testimony and court process	Continuity	Advocate privilege; no general doctor–patient evidentiary privilege
BSA 2(1)(d)	IEA 3	Digital records and electronic evidence	Modified	Express, extensive electronic/digital document examples
BSA 57	IEA 62	Digital records and electronic evidence	Modified	Expanded primary evidence for electronic records
BSA 61	IEA 65A	Digital records and electronic evidence	Continuity	Electronic records not denied effect solely for form
BSA 62	IEA 65A	Digital records and electronic evidence	Continuity	Electronic-record proof governed by section 63
BSA 63	IEA 65B	Digital records and electronic evidence	Modified	Certificate at each submission; party/expert parts and hash report
BSA 73	IEA 73A	Digital records and electronic evidence	Continuity	Verification of digital signature
BSA 90	IEA 88A	Digital records and electronic evidence	Continuity	Presumption regarding electronic messages

Coding note: “Continuity” includes renumbering and non-material drafting updates. “Modified” identifies an operationally relevant change. “New mechanism” means no functionally equivalent general provision was identified in predecessor code. Legal importance is not proportional to number of units.

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