Natural Resources for Human Health

eISSN: 2583-1194

Original Research

Received 09 July 2026
Revised 08 Aug 2026
Accepted 21 Aug 2026

Natural Resources for Human Health 2026, Vol. 6 (17s): 223–245

KEYWORDS:
Doctors' Rights, Workplace Violence, Dignity, right to health And Human Right.

Shattering the Silence: The Fight for the Protection of Human Rights & Dignity of Doctors in India

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ABSTRACT: "Medicine is a science of uncertainty and an art of probability." – Sir William Osler. Violence against healthcare professionals has become a persistent and systemic concern in India, affecting the safety, dignity, and functioning of the healthcare system. Despite multiple state enactments, proposed central bills, judicial interventions, and regulatory guidelines, a comprehensive and uniform national framework remains absent. This paper examines the constitutional basis of legislative competence, evaluates existing criminal law provisions under the Bharatiya Nyaya Sanhita, 2023, analyses relevant judicial precedents, and assesses recent policy developments including the National Task Force constituted by the Hon'ble Supreme Court of India in 2024. It identifies key policy gaps relating to fragmented legislation, weak enforcement, absence of centralised data, inadequate institutional infrastructure, gender-specific vulnerabilities, and regulatory limitations in telemedicine. The study argues that violence against healthcare professionals cannot be effectively addressed through penal measures alone and requires a coordinated central legislation combined with structural and institutional reforms to ensure sustainable protection and improved healthcare governance.

INTRODUCTION:

The history of doctors dates back thousands of years, with early evidence found in cave paintings showing the use of plants for medicinal purposes.[1] From early times, the medical profession has been considered one of the most noble professions. Consequently, doctors have been accorded the highest respect in society and are often viewed as second only to God.[2] In the early and mid-twentieth century, most doctors in India were rural general practitioners who built strong, trust-based relationships with patients while providing continuous and affordable care as family physicians.[3] The Industrial Revolution and later technological developments significantly changed the doctor–patient relationship by increasing patient numbers, promoting specialization, and limiting the physician's personal involvement in care. Over time, the relationship has further declined due to poor public healthcare systems, disproportionate doctor-patient ratio, easy access to medical information, and the inclusion of healthcare services under the Consumer Protection Act, 1986, resulting in increased legal disputes and defensive medical practices. Moreover, commercialization of healthcare, corruption, unequal access to services, rising educational expenses, high patient expectations, and workplace pressures have intensified mistrust and contributed to

[1]Barton Associates (2026) *The History of Physicians and Doctors: A Visual Timeline*, Barton Associates. Available at: https://www.bartonassociates.com/history-of-physicians/ (Accessed: 15 February 2026).

[2]JuhiTripathi, ShalabhRastogi& Ashok Jadon, "Changing Doctor–Patient Relationship in India: A Big Concern", *International Journal of Community Medicine and Public Health* (2019), available at: http://dx.doi.org/10.18203/2394-6040.ijcmph20192868 (Accessed: 15 February 2026).

[3]Sourabh Paul &Vikas Bhatia, "Doctor–Patient Relationship: Changing Scenario in India", 7(4)*Asian Journal of Medical Sciences* (2016), https://doi.org/10.3126/ajms.v7i4.13929(Accessed: 15 February 2026).

growing instances of conflict and violence against doctors.[4] A study from 2015 conducted by the Indian Medical Association (IMA) reports that 75% of doctors in India have faced violence at some point of time.[5] This widespread violence is not merely an occupational hazard but a serious human rights concern, making it necessary to examine the legal framework that protects doctors' safety, dignity, and professional security.

SCOPE AND METHEDOLOGY:

Scope-

This paper examines the legal and institutional framework for the protection of doctors and healthcare professionals in India against violence, harassment, and other threats affecting their safety, dignity, professional autonomy, and right to secure working environment. It also examines the need for a comprehensive and uniform legal framework that combines penal protection with preventive, institutional and remedial measures.

Accordingly, the paper adopts a broad legal-policy perspective and treats violence against medical practitioners not merely as an issue of criminal law or law and order, but as a question involving human rights, dignity, professional autonomy, workplace safety, healthcare governance and constitutional values.

Research Methodology-

This study adopts mixed methodology i.e. doctrinal and empirical socio-legal research.

The doctrinal component examines the constitutional, statutory, criminal, regulatory and judicial framework, state laws, professional regulations and proposed central legislation governing the protection of doctors and healthcare professionals from violence in India. The selection of materials was guided by their direct relevance to the protection of healthcare professionals, regulation of medical practice, prevention of workplace violence, professional autonomy, institutional safety, and the development of a possible national legal framework. Particular attention has been given to recent developments under the Bharatiya Nyaya Sanhita, 2023, the National Medical Commission framework, State laws dealing with violence against healthcare professionals, proposed central legislation, and the recommendations of the National Task Force constituted by the Hon'ble Supreme Court of India in 2024. The methodology therefore, require doctrinal legal analysis with policy-oriented evaluation rather than treating violence against healthcare professionals exclusively as a criminal-law issue.

The empirical component is based on a survey of 50 medical professionals to understand their experiences and perceptions regarding violence to the healthcare professionals. The survey focuses on three broad aspects: (i) the prevalence and nature of violence experienced or witnessed by doctors; (ii) awareness and perceived effectiveness of existing legal protections; and (iii) doctors' views regarding the need for a comprehensive and uniform law for their protection. The responses are analysed through simple random sampling, including frequencies and percentages, to identify recurring patterns and perceptions.

Nature of Research- Doctrinal + Empirical Socio-Legal

Sample Size- 50 Medical Professionals

Primary Data- Structured questionnaire through Google form.

Secondary Data- Statutes, regulations, government reports, judicial decisions, proposed legislation and relevant academic literature.

Method of Analysis- Qualitative legal analysis and descriptive statistical analysis of survey responses.

[4]JuhiTripathi, ShalabhRastogi& Ashok Jadon, "Changing Doctor–Patient Relationship in India: A Big Concern", *International Journal of Community Medicine and Public Health* (2019), available at: http://dx.doi.org/10.18203/2394-6040.ijcmph20192868 (Accessed: 15 February 2026).

[5]SushmiDey, *Over 75% of doctors have faced violence at work, study finds*, *The Times of India* (May 4, 2015) https://timesofindia.indiatimes.com/india/over-75-of-doctors-have-faced-violence-at-work-study-finds/articleshow/47143806.cms (Accessed: 15 February 2026).

CURRENT LEGAL FRAMEWORK & CHALLENGES:

India's legal framework protects doctors through constitutional guarantees, criminal law, special statutes, and professional regulations. While patient rights receive significant attention, the law also safeguards doctor's dignity, equality, autonomy, and workplace safety. These protections are grounded in fundamental rights and reinforced by recent statutory developments. Together, the framework seeks to balance professional accountability with protection against arbitrariness, exploitation, and violence.

I. CONSTITUTIONAL RIGHTS OF DOCTORS:

The constitutional framework in India safeguards the rights of both patients and doctors. While judicial and academic discourse has often prioritised patient rights, the Constitution equally guarantees medical professionals protection in terms of equality, professional autonomy, dignity, and freedom from exploitation.

a) Article 14 – Right to equality and protection against arbitrariness:

Article 14 of the Constitution of India incorporates the principles of natural justice and guards against arbitrariness in State action. Therefore, any disciplinary action, suspension, or cancellation of a doctor's licence by the National Medical Commission or a State Medical Council must adhere to procedural fairness, including providing a fair hearing, issuing a reasoned order, ensuring timely completion of proceedings, and appeal mechanism.

These safeguards are reflected in the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002. Regulation 8.2 requires that upon receiving a complaint of professional misconduct, the concerned Medical Council conduct an inquiry, provide the doctor an opportunity of hearing (personally or through a pleader). Regulation 8.4 further mandates to decide the matter within six months.[6]

Additionally, Section 30(3) of the National Medical Commission Act, 2019 grants an aggrieved doctor the right to prefer an appeal to the Ethics and Medical Registration Board against any action taken by a State Medical Council. Under Section 30(4), a further appeal lies to the National Medical Commission, constituted under Section 3 of the Act, within sixty days from the date of communication of the decision of the Ethics and Medical Registration Board.[7]

b) Article 19(1)(g) – Right to Practise Medical Profession:

Article 19(1)(g) guarantees the fundamental right to practise any profession, including medicine, subject to valid registration under the National Medical Commission Act, 2019 and reasonable restrictions imposed in the interest of the general public under Article 19(6). Although public health should be of utmost importance, it should not impose exploitative restrictions on doctors such as excessive working hours, compulsory service bonds, coercive service condition etc.

Although *Indian Medical Association v. V.P. Shantha & Ors. (1995)*[8]brought doctors providing paid medical services under the Consumer Protection Act, the Court clarified that they are liable only if they fail to exercise the reasonable skill and care expected of a competent medical practitioner.

c) Article 19(1)(c) – Right to Form Associations:

Article 19(1)(c) guarantees the fundamental right to form associations and unions, subject to reasonable restrictions under Article 19(4). In exercise of this right, doctors may establish and join professional bodies (such as the Indian Medical Association established in 1928 for maintenance of honour and dignity of medical profession)[9] to safeguard their professional

[6]Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, Regs. 8.2 and 8.4, Gazette of India, Part III, Section 4 (6 April 2002), available at: https://www.nmc.org.in/wp-content/uploads/2017/10/Ethics-Regulations-2002.pdf (Accessed: 16 February 2026).

[7]National Medical Commission Act, 2019, ss. 30(3)–30(4), available at: https://www.indiacode.nic.in/bitstream/123456789/15316/1/nmc_act2019.pdf (Accessed: 16 February 2026).

[8]Indian Medical Association v. V.P. Shantha&Ors., (1996) AIR 550, (1995) SCC (6) 651, available at https://indiankanoon.org/doc/723973/ (accessed 23 February 2026).

[9] Indian Medical Association – "Who We Are / About IMA" (India), available at: https://www.ima-india.org/ima/left-side-bar.php?pid=299 (Accessed 17 February 2026).

and service-related interests.The IMA aims to uphold the honour and dignity of the medical profession, safeguard its interests, and promote cooperation among doctors.[10]

d) Article 21 - Right to Life and Personal Liberty:

Although Article 21 of the Constitution of India is often invoked to protect patients' lives, it equally safeguards doctors who act in good faith. It guarantees their right to dignity, reputation, and a safe working environment, including protection from violence, defamation, and unwarranted media scrutiny.

In *Jacob Mathew v. State of Punjab* (2005),[11] the Supreme Court of India clarified that criminal liability for doctors arises only in cases of gross or reckless negligence, not for mere errors of judgment, accidents, or undesired outcomes. A doctor owes an implied duty of care whenever undertaking a patient's examination, diagnosis, or treatment, including deciding whether to accept a case, choosing appropriate treatment, and administering it with reasonable skill and caution. The Court endorsed the Bolam test, holding that a doctor is not negligent if the treatment aligns with a practice accepted as proper by a responsible body of medical professionals. Criminal sanctions under IPC Section 304A (Now BNS Section 106) apply only when conduct shows a gross departure from accepted standards or reckless disregard for patient safety. Courts must rely on prima facie evidence supported by independent expert opinion to prevent frivolous complaints, and the doctrine of *res ipsa loquitur* has limited application, ensuring doctors are legally protected while maintaining accountability.

e) Article 23 – Protection against Exploitation and Forced Labour:

The Constitution secures the enforcement of fundamental rights by conferring writ jurisdiction upon the Supreme Court under Article 32 and the High Courts under Article 226. Doctors may invoke these constitutional remedies when their fundamental or legal rights are violated, seeking relief appropriate to the nature of their grievance.

In this regard, a writ of mandamus may be sought to compel public authorities to discharge statutory duties, such as ensuring hospital security or conducting a fair disciplinary inquiry. A writ of certiorari may be invoked to quash unlawful or arbitrary disciplinary orders. A writ of prohibition may be issued to restrain proceedings conducted without jurisdiction or in excess of authority. Further, a writ of quo warranto may be sought to challenge unlawful appointments to regulatory or statutory bodies governing the medical profession.

II. BHARATIYA NYAYA SANHITA (BNS) :

Section 106 of the BharatiyaNyayaSanhita, 2023 replaces Section 304A of the Indian Penal Code, 1860 and governs the offence of causing death by negligence. The provision recognises the inherent risks, uncertainty, and complex decision-making involved in medical practice and accordingly prescribes a comparatively lesser punishment for registered medical practitioners where death is caused by a rash or negligent act in the course of performing a medical procedure.[12]

The protective scheme under the BNS is further strengthened by the General Exceptions. Sections 18 and 19, which incorporate the principles of accident and absence of criminal intent, protect acts done without criminal intention or knowledge in the course of lawful conduct exercised with due care and caution, an important safeguard in cases involving unforeseen medical outcomes. Section 26 protects acts done in good faith for a person's benefit without consent where obtaining consent is impossible and immediate action is necessary, thereby shielding doctors performing life-saving emergency interventions. Section 30, in turn, safeguards acts done in good faith with the patient's consent for their benefit,

[10]Indian Medical Association, "Objectives of the Indian Medical Association," available at https://www.ima-india.org/ima/free-way-page.php?pid=2 (Accessed 17 February 2026).

[11] Jacob Mathew v. State of Punjab &Anr., AIR 2005 SC 3180, available at https://indiankanoon.org/doc/871062/ (accessed 23 February 2026).

[12]Bureau of Police Research and Development, *Medical Professionals and New Criminal Laws in India: Impact and Legal Implications* (Feb. 2024) https://bprd.nic.in/uploads/pdf/20240224043111264955OMedicalProfessionals.pdf (accessed 15 February 2026)

even where the procedure carries inherent risks, provided there is no intention to cause unlawful harm. Collectively, these provisions recognise good faith, due care, and informed consent as central defences available to medical practitioners.[13]

Beyond professional liability, the BNS also affords protection to doctors against violence encountered in the discharge of their duties. Medical practitioners subjected to assault, hurt, or intimidation may invoke Section 115 (voluntarily causing hurt), Section 117 (voluntarily causing grievous hurt), Section 132 (assault or criminal force to deter a public servant from discharge of duty), and Section 351 (criminal intimidation). Thus, the BNS not only delineates the contours of criminal negligence in medical practice but also reinforces legal safeguards against both unwarranted prosecution and workplace violence.[14]

III.THE EPIDEMIC DISEASES (AMENDMENT) ACT, 2020:

In the wake of the COVID-19 pandemic, the Government of India notified the Epidemic Diseases (Amendment) Act, 2020 on 28 September 2020. It was introduced to safeguard Healthcare professionals from violence, intimidation, and harassment during epidemic situations.[15] The Amendment makes acts of violence against healthcare personnel during epidemic, cognizable and non- bailable offences. Commission or abetment of such acts of violence shall be punished with imprisonment for a term of three months to five years, and with fine of Rs.50,000/- to Rs.2,00,000/-. In case of causing grievous hurt, imprisonment shall be for a term of six months to seven years and with fine of Rs.1,00,000/- to Rs.5,00,000/-. In addition, the offender shall also be liable to pay compensation to the victim and twice the fair market value for damage of property.[16] To strengthen the safety of healthcare workers, the Union Ministry of Health & Family Welfare has advised States and UTs to implement measures such as enhanced hospital security, CCTV surveillance, quick response mechanisms, institutional action against assaulters, display of protective laws, appointment of nodal officers, filling of medical vacancies to reduce workload, improvement of infrastructure, and incentives for service in remote areas. The Ministry has consistently reiterated the need to ensure the safety of healthcare personnel at their workplaces and residences, as stated in a written reply in the RajyaSabha by BharatiPravinPawar, Union Minister of State for Health and Family Welfare.[17]

IV.STATE ENACTMENTS:

As per the Indian Constitution, 'Health' and 'Law & Order' fall within the State List.[18] As per the report of the Supreme Court-constituted National Task Force on the safety of healthcare professionals, 24 States in India have already enacted specific laws to address violence against medical professionals and healthcare institutions, providing statutory protections and penalties for such offence.[19] The States of Andhra Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Karnataka, Kerala, Maharashtra, Manipur, Goa, Odisha, Rajasthan, Telangana, Tripura, Uttar Pradesh, Uttarakhand and West Bengal generally prescribe imprisonment extending up to three years, along with a fine that may extend to Rupees Fifty Thousand (Rs. 50000).

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[13]*The New Criminal Law Regime and Its Implications for Medical Practitioners*, 61 *Journal of the Indian Medical Association* 501 (2003), available at http://pmc.ncbi.nlm.nih.gov/articles/PMC11495828/ (accessed 15 February 2026)

[14]Government of India, *BharatiyaNyayaSanhita, 2023* (Act 45 of 2023), available at https://www.indiacode.nic.in/bitstream/123456789/20062/1/a202345.pdf (accessed 15 February 2026).

[15]Mahani A and Zadu R, *Ensuring the Safety of Healthcare Professionals: A Review of Current Challenges and Legal Frameworks in India* (IJFCM, Vol 11, Issue 4) https://ijfcm.org/archive/volume/11/issue/4/article/14721/pdf (Accessed 19 February 2026).

[16]Epidemic Diseases (Amendment) Act, 2020 (No. 17 of 2020) https://prsindia.org/files/bills_acts/acts_parliament/2020/Epidemic%20Diseases%20(Amendment)%20Act,%202020.pdf (Accessed 19 February 2026).

[17]Ministry of Health & Family Welfare, Government of India, *Mechanism to Prevent Violence Against Doctors* (Press Information Bureau, 15 March 2022) https://www.pib.gov.in/PressReleseDetailm.aspx?PRID=1806206&reg=3&lang=2 (Accessed 19 February 2026).

[18]Constitution of India, art. 246 read with Seventh Schedule, List II, entries 1, 2 & 6, *pdf*https://www.indiacode.nic.in/bitstream/123456789/19150/1/constitution_of_india.pdf (Accessed 19 February 2026).

[19]*Report of the National Task Force (NTF) constituted by the Hon'ble Supreme Court of India on 20 August 2024 in SuoMotu Writ Petition (Criminal) No. 2/2024*, Government of India (14 January 2025), *pdf* (on file with cdnbbsr.s3waas.gov.in) https://cdnbbsr.s3waas.gov.in/s31177967c7957072da3dc1db4ceb30e7a/uploads/2025/01/20250114182169320 0.pdf(Accessed 19 February 2026).

Certain States adopt distinct penal structures. Himachal Pradesh, through its 2017 amendment, provides for imprisonment extending up to three years, without prescribing any monetary fine. Arunachal Pradesh and Tamil Nadu prescribe more stringent penalties, stipulating a minimum term of imprisonment of three years, which may extend up to ten years; additionally, Arunachal Pradesh provides for a fine that may extend to Rupees Five lakhs (Rs.5,00,000). In contrast, Punjab provides for imprisonment extending up to one year or a fine extending up to Rupees Fifty Thousand (Rs. 50000), or both. Madhya Pradesh prescribes imprisonment extending up to three months or a fine extending up to Rupees Ten Thousand (Rs. 10000), or both. Haryana provides for imprisonment extending up to three years and mandates compensation equivalent to the actual damage as determined by the court. This divergence in statutory penalties reflects the absence of uniformity across States in addressing violence against healthcare professionals.[20]

V. THE SEXUAL HARASSMENT OF WOMEN AT WORKPLACE (PREVENTION, PROHIBITION, AND REDRESSAL) ACT, 2013 :

In Vishaka v. State of Rajasthan[21], The Supreme Court recognised sexual harassment at the workplace as a violation of Articles 14, 19, and 21 of the Constitution, leading to the enactment of the Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013. Under this Act, women are protected against sexual harassment in hospitals, dwelling places, medical colleges etc., which are treated as workplaces under Section 2(o). Sexual harassment is defined in Section 2(n). Any aggrieved woman may file a written complaint before the Internal Committee or Local Committee under Section 9 within three months of the incident. The Committee must conduct a fair inquiry under Section 11 and complete it within ninety (90) days, submit its report within ten (10) days under Section 13, and the employer or District officer must act within sixty (60) days. During the inquiry, the complainant may seek interim relief, such as transfer or leave, under Section 12, while Section 16 ensures confidentiality and protection against retaliation, thereby upholding constitutional guarantees of equality and dignity in medical workplaces.[22]

VI.RIGHT TO PROFESSIONAL AUTONOMY:

The National Medical Commission Ethics and Medical Registration Board, vide Notification National Medical Commission registered Medical Practitioner (Professional Conduct) Regulations, 2023, outlines the scope of professional autonomy available to doctors.[23] Chapter II (Duties of Registered Medical Practitioners) provides that in instances of abusive, unruly, or violent conduct by patients or their relatives, a Registered Medical Practitioner (RMP) is entitled to document and report such behaviour and may refuse treatment, subject to appropriate referral to another medical facility. Further, Chapter I (Professional Conduct of RMP) permits an RMP to refuse or discontinue treatment where the indicated fees have not been paid, except in cases involving doctors in government service and in emergency situations. In all circumstances, the practitioner must ensure that the patient is not abandoned.

Additionally, Guideline 3 of the NMC Code of Medical Ethics recognises professional autonomy as a core principle of medical practice. It mandates that doctors provide care with compassion and respect, keeping the best interest of the patient in mind at all times. It recognises their inherent right to exercise independent clinical judgment solely for the patient's welfare, free from undue interference by hospital management, political influence (including VIP culture), or pharmaceutical inducements.[24]

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[20]Delhi Medical Association Petition, accessible at https://medicaldialogues.in/pdf_upload/delhi-medical-association-petition-156690.pdf (accessed 19 February 2026).

[21]*Vishaka&Ors. v. State of Rajasthan &Ors.*, AIR 1997 SC 3011; (1997) 6 SCC 241 (SC), accessible at https://indiankanoon.org/doc/1031794/?type=print (Accessed 19 February 2026)

[22]*The Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013*, No. 14 of 2013, Sec 1–30, accessible at https://www.indiacode.nic.in/bitstream/123456789/2104/1/A2013-14.pdf (accessed 19 February 2026)

[23]*Doctors can now refuse treatment of violent patients or relatives: NMC*, The Economic Times (10 August 2023) https://economictimes.indiatimes.com/industry/healthcare/biotech/healthcare/doctors-can-now-refuse-treatment-of-violent-patients-or-relatives-nmc/articleshow/102620225.cms?from=mdr (accessed 20 February 2026).

[24]*National Medical Commission Registered Medical Practitioner (Professional Conduct) Regulations, 2023*, **National Medical Commission** (2 August 2023) https://www.nmc.org.in/rules-regulations/national-medical-commission-registered-medical-practitioner-professional-conduct-regulations-2023-reg/ (accessed 20 February 2026)

VII.RIGHT TO STRIKE:

The issue of doctors' right to strike resurfaced following the brutal rape and murder of a postgraduate trainee doctor at R.G. Kar Medical College and Hospital in August 2024, which sparked nationwide protests demanding workplace safety and institutional accountability. The Madras High Court has held that doctors possess no fundamental or statutory right to strike, given their ethical duties and the impact on patients' rights under Article 21. Nevertheless, it has set aside punitive charge memos and transfer orders issued against protesting doctors as mala fide and disproportionate.[25]Similarly, in the R.G. Kar context, the Calcutta High Court quashed the transfer of a protesting doctor for being arbitrary and contrary to counselling-based posting norms.[26] The jurisprudence thus reflects a balance between safeguarding uninterrupted public healthcare and restraining vindictive administrative action.

VIII.RIGHT TO CLEAN WORKPLACE:

Government hospitals in India frequently suffer from infrastructural deficiencies, including overcrowded emergency wards, non-functional restrooms, and the absence of basic amenities for doctors performing prolonged or night duties.[27] During the COVID-19 Pandemic, there was severe shortage of personal protective equipment (PPE), including masks, respirators, gowns and shields, which forced many doctors and healthcare workers working without adequate protective gear or reuse disposable items, exposing them to infection.[28] Doctors have a fundamental right to a safe and clean working environment under Article 21 of the Indian Constitution. The right is further reinforced by Section 23 of the Occupational Safety, Health and Working Conditions Code, 2020, which obligates employers to ensure workplaces that are free from hazards, maintain hygiene and sanitation standards, and provide necessary protective equipment to employees[29]. Additionally, The National Accreditation Board for Hospitals and Healthcare Providers (NABH) grants accreditation to hospitals only upon compliance with comprehensive quality benchmarks, including stringent requirements relating to hygiene, sanitation, and infection control.[30] Thus, maintaining a clean and safe workplace is not merely an administrative goal but a constitutional, statutory, and professionally recognised right of doctors.

PROPOSED BILLS:

Key Provisions-

I. EVOLUTION OF LEGISLATIVE FRAMEWORK:

Although several States in India have enacted laws addressing violence against healthcare professionals, the increasing incidents of attacks on doctors and medical staff have highlighted the need for a uniform central legislation. In response, the Ministry of Health and Family Welfare, Govt. of India issued a draft legislation titled the Healthcare Service Personnel and

[25]**Dr. P. Balakrishnan v. Government of Tamil Nadu &Ors.,** W.P. No. 13584 of 2019 (Madras High Court, Single Bench of Justice N. AnandVenkatesh) : order dated 28 Feb. 2020, available at https://www.mhc.tn.gov.in/judis/index.php/casestatus/viewpdf/541443 (accessed 22 Feb. 2026).

[26]**Dr.AniketMahata v. State of West Bengal,** WPA 12496 of 2025 (Calcutta High Court), available at https://hcservices.ecourts.gov.in/hcservices/cases/display_pdf.php?filename=A9S7c5LDIsB6RXaCf816x5FTjrCg4jOmVXlkkZn9u2VyTxnB9xjRvCtQ6nRGBW4I&caseno=WPA/12496/2025&cCode=3&cino=WBCHCA0254382025&state_code=16&court_code=3&&appFlag= (accessed 22 Feb. 2026).

[27] India Today, *A reality check of top government hospitals in Delhi reveals a big rot: Reporter's Diary,* available at https://www.indiatoday.in/india/story/late-night-reality-check-of-delhi-top-government-hospitals-reveals-a-big-rot-reporter-diary-2583458-2024-08-16 (Accessed 23 February 2026)

[28]DeepanjaliBehera, Devarsetty Praveen &ManasRanjanBehera, *Protecting Indian health workforce during the COVID-19 pandemic*, available at https://pmc.ncbi.nlm.nih.gov/articles/PMC7652162/ (accessed 23 February 2026).

[29] Occupational Safety, Health and Working Conditions Code, 2020, available at https://www.indiacode.nic.in/bitstream/123456789/22041/1/a2020-37.pdf (accessed 23 February 2026).

[30] National Accreditation Board for Hospitals & Healthcare Providers, *NABH Hospital Accreditation Standard 6th Edition January 2025*, available at https://portal.nabh.co/images/Standards/NABH%20Hospital%20Accreditation%20Standard%206th%20Edition%20January%2025.pdf (accessed 23 February 2026).

Clinical Establishments (Prohibition of Violence and Damage to Property) Bill, 2019 through a notification dated 2nd September 2019.[31]

The Draft Bill sought to prohibit acts of violence against healthcare personnel and damage to the property of clinical establishments.[32] It proposed punishment of six months to five years of imprisonment with fines between Rs.50,000 and Rs.5,00,000, which could increase to three to ten years of imprisonment with fines between Rs.2,00,000 and Rs.10,00,000 where the act results in grievous hurt. The Bill also provided for compensation, including twice the market value of damaged property, Rs.1,00,000 for causing hurt, and Rs.5,00,000 for grievous hurt, and classified such offences as cognizable and non-bailable.[33] However, this draft Bill was never enacted into law.

During the COVID-19 pandemic, the Government further addressed this issue by promulgating an ordinance in 2020 amending the Epidemic Diseases Act, 1897. The amendment specifically criminalised acts of violence against healthcare workers and introduced stricter penalties, including imprisonment of up to seven years and fines up to Rs.5,00,000.

Subsequently, several Private Member Bills were introduced in Parliament in 2019, 2022, 2023, and 2025 proposing dedicated legislation to protect healthcare professionals and medical establishments, with variations mainly in the severity of punishment and scope of protection.[34]

II.COMPARATIVE ANALYSIS OF PENAL PROVISIONS:

All the proposed legislations classify offences against healthcare professionals as cognizable and non-bailable. However, they differ in terms of punishment and penalties.

Bill	Punishment prescribed	
	Act of violence	Causing Grievous Hurt as described under Section 116 of BNS, 2023 (Previously Section 320 of IPC)
The Prevention of Violence Against Doctors, Medical Professionals and Medical Institutions Bill, 2019 (Bill No. 151 of 2019)[35] Introduced By –	Imprisonment Min: 2 years Max: 5 years And Fine	Not specifically provided

[31]UtkarshBhatnagar and CAM Corporate Team, 'Healthcare Service Personnel and Clinical Establishments (Prohibition of Violence and Damage to Property) Bill, 2019' (Cyril AmarchandMangaldas Corporate Blog, 9 September 2019) https://corporate.cyrilamarchandblogs.com/2019/09/healthcare-service-personnel-and-clinical-establishments-prohibition-of-violence-and-damage-to-property-bill-2019/ (accessed 14 March 2026).

[32]Gayatri Mann, "Explaining the Draft Bill on Violence against Healthcare Professionals and Clinical Establishments", PRS Legislative Research (3 September 2019), available at: https://prsindia.org/theprsblog/explaining-draft-bill-violence-against-healthcare-professionals-and-clinical?page=42&per-page=1 (accessed 14 March 2026).

[33] Ministry of Health and Family Welfare, *The Healthcare Service Personnel and Clinical Establishments (Prohibition of Violence and Damage to Property) Bill, 2019 (Draft)* available at: https://prsindia.org/files/bills_acts/bills_parliament/1970/Draft-%20Healthcare%20Service%20Personnel%20and%20Clinical%20Establishments%20(Prohibition%20of%20violence%20and%20damage%20to%20property)%20Bill,%202019.pdf (accessed 14 March 2026).

[34] Live Law, "Prevention of Violence Against Healthcare Professionals Bill 2022 | Legal Analysis & Key Provisions," YouTube video, available at: https://www.youtube.com/watch?v=6JGQHnk6qS8 (accessed 14 March 2026).

[35]The Prevention of Violence Against Doctors, Medical Professionals and Medical Institutions Bill, 2019, Bill No. 151 of 2019, available at: https://sansad.in/getFile/BillsTexts/LSBillTexts/Asintroduced/1644LS%20As%20Int....pdf?source=legislation (accessed 14 March 2026).

ShrikantEknathShinde	Min: Rs. 5,000 Max: Rs. 5,00,000	
The Prevention of Violence Against Healthcare Professionals and Clinical Establishments Bill, 2022 (Bill No. 280 of 2022)[36] Introduced By – Dr. DNV Senthilkumar S.	Imprisonment Min: 6 months Max: 5 years And Fine Min: Rs. 5,000 Max: Rs. 5,00,000	Imprisonment Min: 3 years Max: 10 years And Fine Min: Rs. 2,00,000 Max: Rs. 10,00,000
The Healthcare Personnel and Healthcare Institutions (Prohibition of Violence and Damage to Property) Bill, 2023 (Bill No. 99 of 2023)[37] Introduced By – ShashiTharoor	Imprisonment Min: 6 months Max: 5 years And Fine Min: Rs. 50,000 Max: Rs. 5,00,000	Imprisonment Min: 3 years Max: 7 years And Fine Min: Rs. 2,00,000 Max: Rs. 10,00,000
The Healthcare Professionals and Clinical Establishments (Prevention of Violence) Bill, 2025 (Bill No. 78 of 2025)[38] Introduced By – Shobha Dinesh Bachhav	Imprisonment Min: 3 years Max: 10 years And Fine Min: Rs. 50,000 Max: Rs. 20,00,000	Imprisonment Min: 7 years Max: Life Imprisonment And Fine Min: Rs. 5,00,000 Max: Rs. 50,00,000
	Notably, the 2025 Bill significantly increases the penalties, and the fines are proposed in addition to the recovery of the full value of property damage. The Bill also incorporates several additional measures, including mandatory security	

[36] Prevention of Violence Against Healthcare Professionals and Clinical Establishments Bill, 2022, Bill No. 280 of 2022, available at: https://sansad.in/getFile/BillsTexts/LSBillTexts/Asintroduced/280%20of%202022%20(EV)%20As%20Introduced84202380720PM.pdf?source=legislation (accessed 14 March 2026).

[37] *The Healthcare Personnel and Healthcare Institutions (Prohibition of Violence and Damage to Property) Bill, 2023*, Bill No. 99 of 2023, available at: https://sansad.in/getFile/BillsTexts/LSBillTexts/Asintroduced/99%20of%202023%20AS84202371745PM.pdf?source=legislation (accessed 14 March 2026).

[38] The Healthcare Professionals and Clinical Establishments (Prevention of Violence) Bill, 2025, Bill No. 78 of 2025 (introduced in the LokSabha by Dr.Shobha Dinesh Bachhav), available at: https://sansad.in/getFile/BillsTexts/LSBillTexts/Asintroduced/78%20of%202025%20As125202593127PM.pdf?source=legislation (accessed 15 March 2026).

	infrastructure in medical establishments, broader definitions of violence covering physical and mental harm, intimidation, verbal abuse, obstruction of professional duties, property damage, and digital or online harassment. It further proposes institutional mechanisms for incident reporting, victim assistance, national mental-health helplines, awareness programmes, and counselling and peer-support systems for healthcare workers, in alignment with the objectives of the Mental Healthcare Act, 2017.

III. INSTITUTIONAL & PREVENTIVE MECHANISMS:

Amid the continuing demand for comprehensive legal protection for healthcare professionals, MP Fauzia Khan introduced a Bill in the RajyaSabha titled 'The Central Protection Of Healthcare Workers and Medical Establishments From Violence Bill, 2025' (Bill XLIV of 2025) aimed at establishing a uniform national framework for safeguarding healthcare workers and medical establishments.[39] The Bill represents a significant shift from purely punitive approaches to a preventive and institutional governance model by introduction of structured monitoring mechanisms.[40] The key provisions of this latest bill are as follows[41]:

a) Broader and inclusive definitions:

The Bill adopts an expansive approach by providing wider definitions of *medical establishment*, *healthcare professionals*, *healthcare services*, and *violence*, thereby extending the scope of legal protection to a broader category of healthcare personnel and institutions.

b) Punishment for offences and penalties:

Offence	Punishment	and fine	Additional compensation
Act of violence	Min:6 months Max: 5 years	Min: Rs. 50,000 Max: Rs. 5,00,000	Twice the fair market value of damaged property. For hurt: Rs. 1,00,000 For Grievous hurt: Rs. 5,00,000 If unpaid, it will be recoverable as arrears of land revenue.
Causing Grievous hurt (Sec 116 of BNS, 2023)	Min: 3 years Max: 10 years	Min: Rs. 2,00,000 Max: Rs. 10,00,000	

c) Action Against Incidents of Violence:

Upon receipt of a written complaint from the affected healthcare worker, the Head of the medical establishment must immediately inform the Officer-in-Charge of the concerned police station, and the police are required to register an FIR within one hour. In cases involving an on-duty healthcare professional, the FIR must be registered within six hours of the incident. The investigation must be completed within 30 days under the supervision of a Deputy Superintendent of Police (DSP), and the inquiry and trial are to be concluded within one to one and a half years from the filing of the charge-sheet.

[39] "Bill for Protection of Doctors Introduced in RajyaSabha: Check Out Key Points," *Medical Dialogues*, available at: https://medicaldialogues.in/news/health/bill-for-protection-of-doctors-introduced-in-rajya-sabha-check-out-key-points-160433 (accessed 15 March 2026).

[40] "Bills Introduced in RajyaSabha – Legal News," *SCC Online Blog*, available at: https://www.scconline.com/blog/post/2025/12/11/bills-introduced-in-rajya-sabha-legal-news/ (accessed 15 March 2026).

[41] *The Central Protection of Healthcare Workers and Medical Establishments from Violence Bill, 2025*, Bill No. XLIV of 2025, introduced in the RajyaSabha on 5 December 2025, available at: https://sansad.in/getFile/BillsTexts/RSBillTexts/Asintroduced/231211202550026PM.pdf?source=legislation (accessed 15 March 2026).

d) Safe Working Environment and Basic Safety Measures:

Medical establishments are required to ensure a safe working environment by formulating internal safety policies, promptly reporting incidents, and submitting a detailed Action Taken Report to the National Medical Commission within 48 hours. They must also implement basic security measures, including CCTV surveillance, improved lighting, trained security personnel, visitor management systems, safe transportation for healthcare workers (especially during night shifts), and deployment of Quick Response Teams.

e) Board and Committee Mechanism

The Bill provides for multi-tier monitoring structure, A State Healthcare Protection Board to be constituted in every State and Union Territory to monitor implementation of the Act, supervise compliance, and advise the Government. At the district level, District Healthcare Vigilance Committees will monitor safety compliance, review incidents, and coordinate with law enforcement agencies. The entire framework is subject to Central Government supervision, including periodic review of compliance reports submitted by the Boards and Committees.

POLICY GAPS:

Before examining the legal gaps in existing legislative proposals, it is necessary to understand the underlying factors contributing to violence against healthcare professionals. Such incidents often arise from systemic problems in the healthcare system, including inadequate infrastructure, shortage of hospital beds, lack of essential medicines and vaccines,[42] high treatment cost, poor insurance coverage, misinformation on social media[43] and weak doctor–patient relationships.[44] These factors indicate that the issue cannot be addressed solely through criminal penalties but requires a broader policy response.

I. ABSENCE OF A COMPREHENSIVE CENTRAL LAW:

The Indian Medical Association (IMA) has repeatedly urged the Central Government to enact a comprehensive central law, and amend the BharatiyaNyayaSanhita, 2023 and BharatiyaNagarikSurakshaSanhita, 2023, to specifically criminalise violence against medical personnel.[45] However, the Union Government has maintained that existing state laws and general criminal provisions under the BharatiyaNyayaSanhita, 2023 are sufficient to address such offences.[46]

Proposed legislations such as the 2019 *Healthcare Service Personnel and Clinical Establishments (Prohibition of Violence and Damage to Property) Bill* and the *Prevention of Violence Against Healthcare Professionals and Clinical Establishments Bill* introduced in 2022 were shelved. The government justified this by referring to protections provided under the Epidemic Diseases (Amendment) Ordinance, 2020. However, such reliance is inadequate because these provisions apply only during public health emergencies

[42]Avneesh Kumar and Saurav Gupta, 'Health Infrastructure in India: Critical Analysis of Policy Gaps in the Indian Healthcare Delivery' (Vivekananda International Foundation, 2012). Accessible at: https://www.vifindia.org/sites/default/files/health-infrastructure-in-india-critical-analysis-of-policy-gaps-in-the-indian-healthcare-delivery.pdf (accessed 15 March 2026).

[43]IndlaRamasubba Reddy, JateenUkrani, Vishal Indla and VarshaUkrani, 'Violence against Doctors: A Viral Epidemic?' (2019) 61 *Indian Journal of Psychiatry* (Suppl 4) S782. Accessible at: https://pmc.ncbi.nlm.nih.gov/articles/PMC6482703/ (accessed 15 March 2026).

[44]RavindraNath, Anuj Sharma, PrernaPrerna, VidushiRathi and PranavIsh, 'Violence against Doctors – Threat to Indian Health-care System' (2023) 3(3) *Journal of Advanced Lung Health* 87. Accessible at: https://journals.lww.com/jalh/fulltext/2023/03030/violence_against_doctors__threat_to_indian.1.aspx (accessed 15 March 2026).

[45]Babitha N S, 'Violence Against Doctors – A Zero Tolerance Approach' (Live Law, 10 September 2019) https://www.livelaw.in/columns/violence-against-doctors-a-zero-tolerance-approach-147937 (accessed 15 March 2026).

[46] The New Indian Express, *No Central Data on Violence Against Doctors: Government Tells LokSabha* (29 November 2024), available at: https://www.newindianexpress.com/nation/2024/Nov/29/no-central-data-on-violence-against-doctors-government-tells-lok-sabha (accessed 15 March 2026).

and contain a sunset clause.[47] Relying on laws specifically enacted for pandemic situations fails to address the routine violence faced by doctors on a regular basis.

II. FRAGMENTED STATE LAWS AND WEAK IMPLEMENTATION:

Although several states have enacted laws to protect healthcare professionals, their implementation remains inconsistent. Most state laws prescribe uniform punishments regardless of the severity of violence, which reduces their effectiveness.[48] Only a few states (such as Goa) have provisions for graded penalties based on the severity of the violence.[49] Another challenge is the lack of awareness among doctors and law enforcement authorities regarding these laws. Many incidents remain unreported or are informally resolved within hospitals due to fear of retaliation or administrative pressure. For example, between 2021 and 2025, government hospitals in Delhi recorded 149 incidents of violence against doctors and medical staff, but only 33 FIRs were registered.[50]

This highlights significant under-reporting and weak enforcement and calls for proper awareness programmes to doctors, law enforcement agencies and the general public. Fragmented state legislation has posed a serious threat to the implementation of law throughout the country. Hence, central legislation is the sine qua non. The effectiveness of a proposed framework would depend not only on the enactment of legislation but also on its practical implementation across different healthcare institutions. Implementation should be based on clearly defined minimum standards regarding workplace security, incident reporting, emergency response, institutional responsibility and protection of healthcare professionals. A phased implementation shall be adopted to enable healthcare institutions to develop the required infrastructure, personnel and reporting mechanisms. Special attention is given to hospitals with minimum resources and healthcare facilities in rural and remote areas.

III. COORDINATION BETWEEN CENTRAL AND STATE AUTHORITIES

A national framework should clearly divide the role and of responsibilities of Central and State authorities. The Central Government shall prescribe national standards for the protection of healthcare professionals; establish uniform reporting and monitoring system. The State Governments and their designated authorities should be responsible for implementing these standards according to local requirements, monitoring healthcare institutions within their jurisdiction and coordinating with police and other enforcement agencies. Such a coordinated model would preserve the role of States while ensuring a uniform minimum level of protection throughout the country.

IV. LACK OF RELIABLE DATA AND CENTRALISED MONITORING:

The Union Government has informed the LokSabha that it does not maintain centralised data on incidents of violence against healthcare professionals, as health and law and order fall under state jurisdiction. However, the absence of a national database makes it difficult to identify trends, high-risk areas, and recurring patterns of violence. Without reliable data, effective policy planning and preventive strategies remain limited.[51] A centralised reporting mechanism could significantly improve monitoring, transparency and policy intervention.

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[47] **Jehosh Paul**, 'Why India Urgently Needs a Union Law to Protect Healthcare Workers' (05 September 2024) *The Leaflet*, available at: https://theleaflet.in/explainer/why-india-urgently-needs-a-union-law-to-protect-healthcare-workers (accessed 15 March 2026).

[48] Ibid.

[49] Deccan Herald, *Rise in Violence Leaves Doctors Afraid, Vulnerable* (19 June 2021), available at: https://www.deccanherald.com/india/rise-in-violence-leaves-doctors-afraid-vulnerable-999380.html (accessed 15 March 2026).

[50] DurgeshNandanJha, "Violence Against Doctors in Delhi Govt Hospitals Rises, but Number of FIRs Remains Low," *The Times of India* (16 January 2026), available at: https://timesofindia.indiatimes.com/city/delhi/violence-against-doctors-in-delhi-govt-hospitals-rises-but-number-of-firs-remains-low/articleshow/126552024.cms (accessed 15 March 2026).

[51] The New Indian Express, *No Central Data on Violence Against Doctors: Government Tells LokSabha* (29 November 2024), available at: https://www.newindianexpress.com/nation/2024/Nov/29/no-central-data-on-violence-against-doctors-government-tells-lok-sabha (accessed 15 March 2026).

The absence of reliable and centralised data is still major obstacle to problem oriented policy-making. A central policy should therefore establish a standardised mechanism for recording and reporting incidents of violence against healthcare professionals. Healthcare institutions both public and private are required to submit periodic report regarding the incidents, location, affected party (medical professionals), institutional response, police action and outcome. The information should be compiled and stored at the State and national levels through a centralised reporting mechanism. Reliable data would enable authorities to identify high-risk locations, frequent patterns and deficiencies in institutional responses.

V. WEAK INSTITUTIONAL AND SECURITY INFRASTRUCTURE:

Inadequate security infrastructure in hospitals further contributes to the vulnerability of healthcare workers. The Clinical Establishments Act, 2010 does not currently mandate safety standards in medical establishments,[52] such as adequate security personnel, CCTV surveillance, emergency response systems, etc. Infrastructure deficiencies are particularly severe in rural areas where hospitals often face shortages of buildings, equipment, medicines, and staff.[53] Hence, it is necessary for the states to invest more in healthcare infrastructure, as recommended in the National Health Policy, 2017,[54] so that budget can be increased in deployment of Quick response team for emergency help-line numbers, better facilities such as well-lit premises, CCTV, trained security personnel etc. in hospital premises.

Proper protection requires institutional accountability within healthcare institutions. Every medical institution should appoint a specialised committee for workplace safety, incident reporting and coordination with law enforcement authorities. Institutions should also maintain internal grievance and reporting mechanisms through which healthcare professionals can report violence, intimidation, harassment or other safety concerns without fear of retaliation. Institutional responsibility should extend beyond responding to individual incidents and include preventive measures, periodic safety assessments and compliance with applicable national and State standards.

VI. FAILURE TO ADDRESS SYSTEMATIC DEFICIENCIES:

Existing policy frameworks do not adequately address systemic deficiencies in hospital working conditions that contribute to conflicts between doctors and patients. Issues such as excessive workload, long working hours, inadequate infrastructure, limited communication mechanisms, and lack of institutional support continue to persist. These gaps highlight the need for structured guidelines to improve workplace conditions and strengthen institutional support for healthcare professionals.[55]

The framework should recognise that healthcare professionals work in diverse institutional and professional settings and may face different forms and degrees of risk. Protection should extend to government hospitals, private hospitals, primary and community health centres, rural and remote healthcare facilities, Medical colleges, emergency departments, nursing homes and other recognised clinical institutions. Inter-alia safeguards may be necessary for healthcare workers performing night duties, working in emergency departments or serving in geographically isolated areas. While the framework should establish common minimum standards of protection, its implementation should remain sufficiently flexible to accommodate differences in institutional structure, resources and working conditions.

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[52]Babitha N S, 'Violence Against Doctors – A Zero Tolerance Approach' (Live Law, 10 September 2019) https://www.livelaw.in/columns/violence-against-doctors-a-zero-tolerance-approach-147937 (accessed 15 March 2026).

[53]Geetha JR, "Rural Health Infrastructure: A Study with Reference to India," (2021) 7(4) *International Journal of Applied Research* 348–353, available at: https://www.allresearchjournal.com/archives/2021/vol7issue4/PartE/8-10-71-212.pdf (accessed 15 March 2026).

[54] PRS Legislative Research, "Demand for Grants 2025-26 Analysis: Health and Family Welfare," PRS Legislative Research (1 March 2025), available at: https://prsindia.org/files/budget/budget_parliament/2025/DFG_Analysis_2025-26-Health.pdf (accessed 15 March 2026).

[55]Government of India, *Report of the National Task Force (NTF) Constituted by the Hon'ble Supreme Court of India on 20.08.2024 in SuoMotu Writ Petition (Criminal) No. 2/2024 for Formulating Recommendations to Remedy the Issues of Safety, Working Conditions and Well-being of Medical Professionals and Other Related Matters* (2025), available at: https://cdnbbsr.s3waas.gov.in/s31177967c7957072da3dc1db4ceb30e7a/uploads/2025/01/20250114182169320 0.pdf (accessed 15 February 2026).

VII. STRENGTHENING WOMEN'S SAFETY MECHANISMS:

Women healthcare professionals often face unique safety concerns, particularly during night shifts and in emergency departments. However, existing policy frameworks addressing violence against medical professionals do not sufficiently incorporate gender-specific safety mechanisms. Measures should include effective implementation of laws related to workplace sexual harassment, establishment of women help desks in police stations, timely disposal of complaints under the Prevention of Sexual Harassment (POSH) framework, and deployment of emergency response mechanisms. Furthermore, awareness programmes should be conducted on cybercrime prevention and legal remedies available to healthcare professionals, including the right to seek legal action in cases of online harassment, defamation, or media trials.[56]

VIII. LACK OF COMPREHENSIVE REGULATION OF TELEMEDICINE:

The rapid expansion of telemedicine, particularly during the COVID-19 pandemic, has exposed regulatory gaps in the legal framework governing digital healthcare services. On 25 March 2020, the Board of Governors (in supersession of the Medical Council of India) issued the *Telemedicine Practice Guidelines*, which were to be incorporated as Appendix 5 to the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002. However, the main body of the Ethics Regulations has not been formally amended to incorporate these provisions, leaving telemedicine largely governed by guidelines rather than a comprehensive statutory framework,[57] which creates ambiguity regarding the extent of the patient's consent and the doctor's professional accountability. Consequently, there is a need for a dedicated legislative framework that clearly defines the rights, responsibilities, and liabilities of both patients and healthcare professionals in telemedicine practice.

The above gaps demonstrate that violence against healthcare professionals cannot be addressed solely through fragmented legislative responses and a model central legislation should be formulated that combines criminal protection with institutional safeguards and preventive mechanisms.

ANALYSIS OF EMPIRICAL DATA:

This section of the paper presents the findings of an empirical study. To understand the experiences and perceptions of health care practitioners regarding workplace violence and the protection of their human rights and dignity in India. The survey examined issues such as the safety and dignity of the working environment, experiences of verbal and physical violence, reporting of violent incidents, awareness of legal protections, confidence in existing legal provisions, institutional support and security measures. It also considered the wider impact of workplace violence on doctor's mental health, clinical decision-making and willingness to continue in the profession.

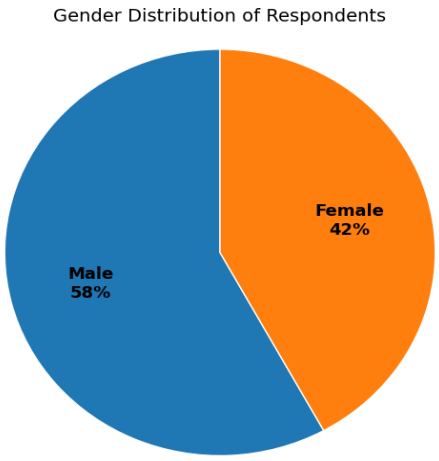


Figure-1

[56] Ibid.

[57] Satvik N Pai, MadhanJeyaraman, Naveen Jeyaraman and SankalpYadav, 'Understanding the Medico-Legal Aspects of Telemedicine in India' (2023) 15(7) *Cureus* e42431, available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC10448835/ (accessed 15 February 2026).

In this research 58% of the respondents were male and 42% were female. This indicates a relatively balanced representation of both genders, with male respondents forming a slightly larger proportion of the survey participants.

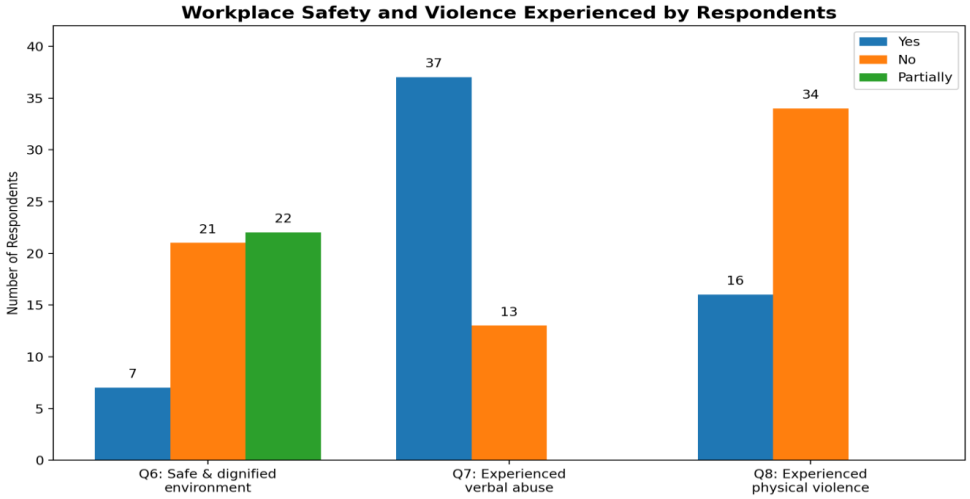


Figure-2

The fig.2 shows that 74% of respondents experienced verbal abuse, while 32% experienced physical violence at the workplace. Only 14% considered the working environment fully safe and dignified, whereas 44% considered it only partially safe, indicating substantial concerns regarding workplace safety and dignity among the respondents. Out of 50 respondents, 13 (26%) reported that they had never experienced either verbal abuse or physical violence, whereas 37 (74%) had experienced at least one form of workplace violence. Among the 37 respondents who had experienced at least one form of workplace violence only 15(40%) cases were reported to authorities. 59 % of people who experienced violence did not reported the case. Victims often refrain from reporting incidents because legal proceedings are prolonged and violence has become normalised.



Figure-3

The fig.3 shows that 11 respondents (50%) identified the lengthy legal process as the main reason for not reporting workplace violence. Seven respondents (31.8%) stated that violence had become normalised, while 3 (13.6%) cited lack of institutional support and 1 (4.5%) cited fear of retaliation.

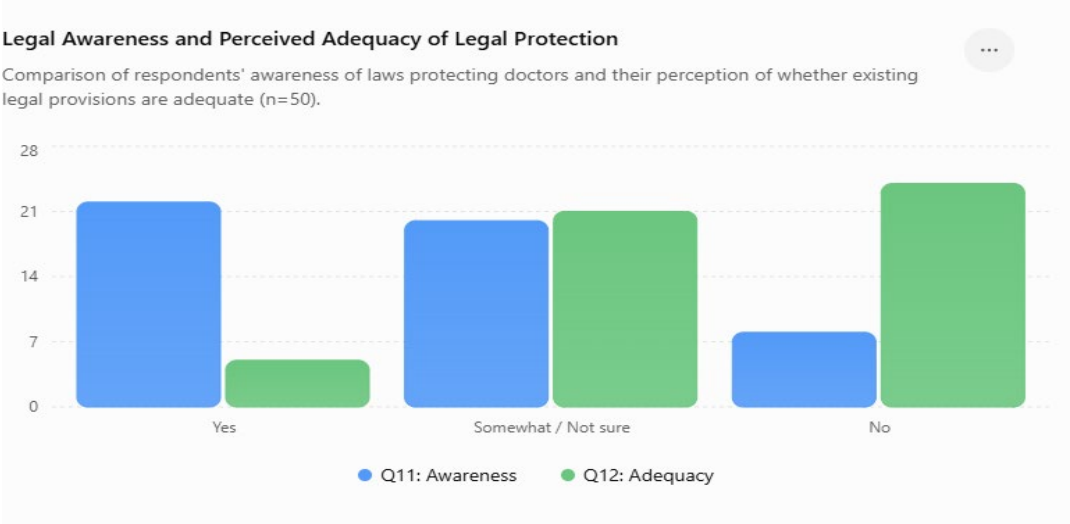


Figure-4

The fig.4 reveals a significant gap between doctor's awareness of legal protections and their confidence in the effectiveness of those protections. Although 44% of respondents were aware of laws intended to protect doctors from workplace violence, only 10% considered the existing legal provisions adequate. In contrast, 48% regarded them as inadequate, while 42% remained uncertain about their adequacy. These findings indicate that mere awareness of legal provisions does not necessarily generate confidence in their practical effectiveness.

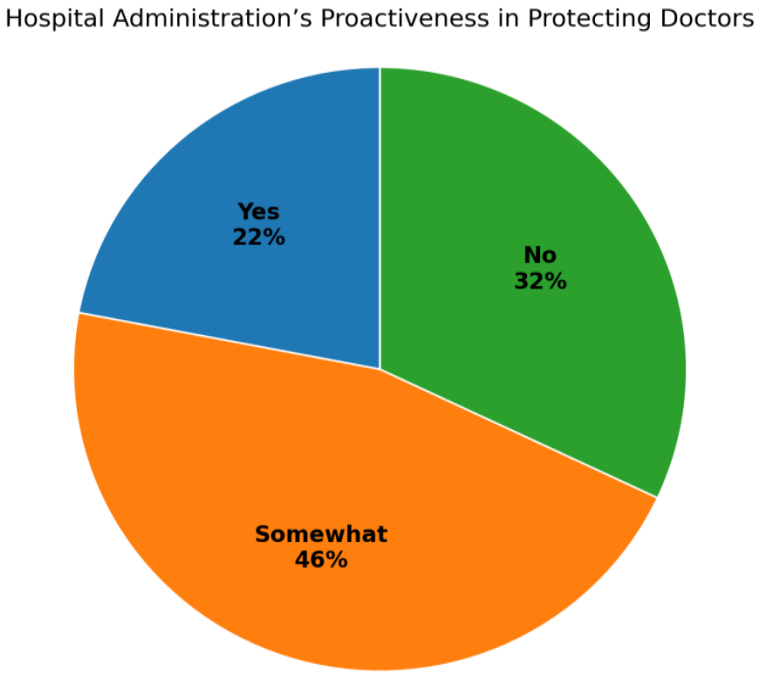


Figure-5

The fig.5 show that 46% of respondents considered hospital administrations somewhat proactive, while 32% felt they were not proactive. Only 22% viewed hospital administrations as proactive in protecting doctor's human rights.

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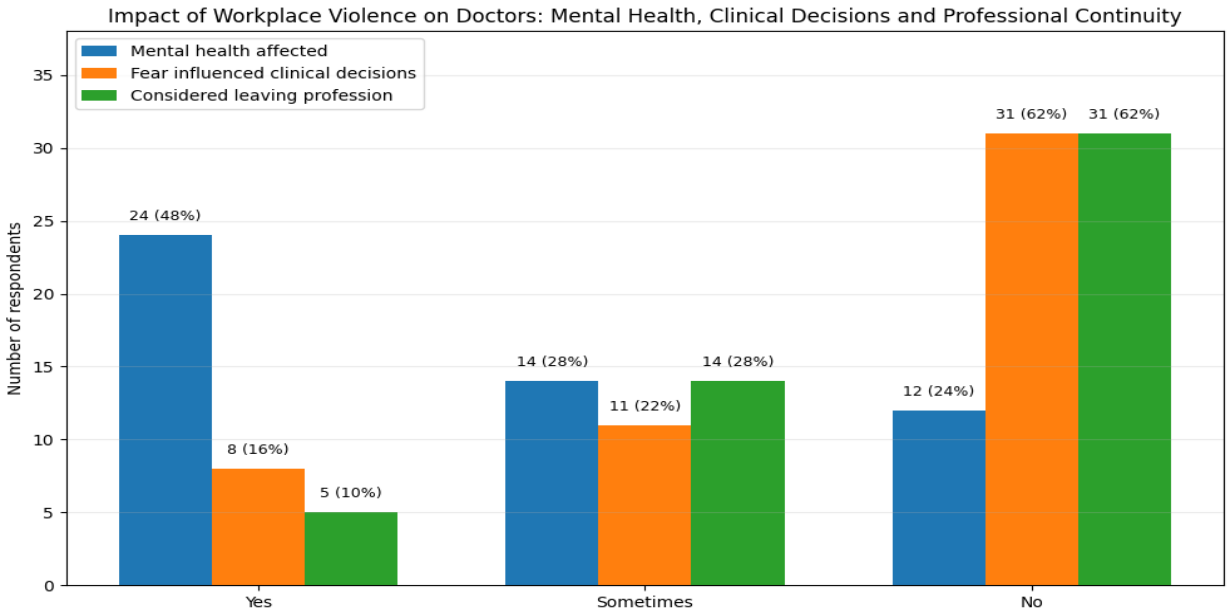


Figure-6

The fig.6 indicate that workplace violence has a noticeable impact on doctors' well-being and professional behaviour. 76% of respondents reported that workplace violence affected their mental health either directly or sometimes. Further, 38% reported that fear of violence influenced their clinical decision-making either directly or sometimes, while 38% had considered leaving the profession either directly or occasionally due to safety concerns. Overall, the findings show that workplace violence can affect doctors' psychological well-being, professional decisions and continuity in the medical profession.

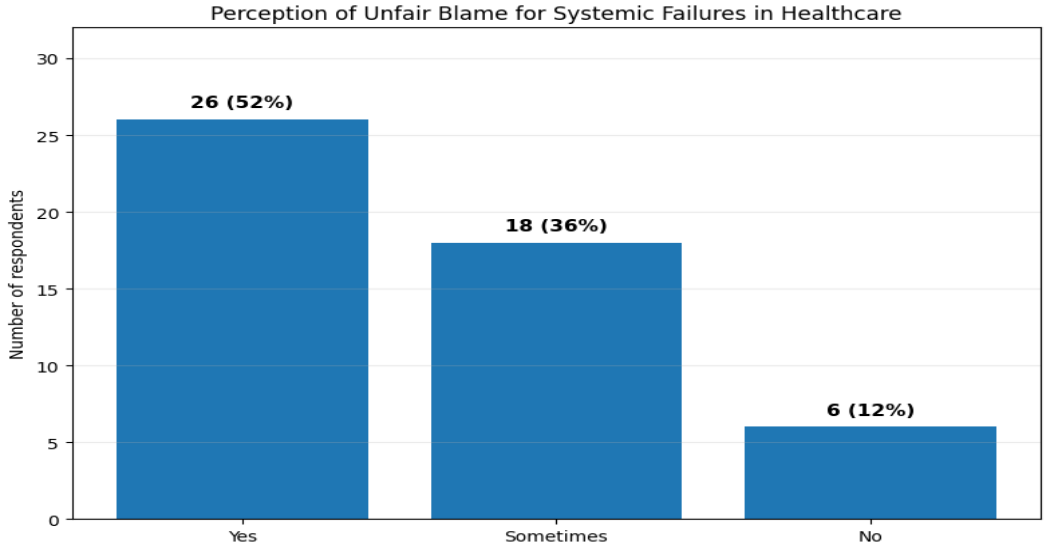


Figure-7

The fig.7 shows that 52% of respondents believed that doctors are unfairly blamed for systemic failures in healthcare, while 36% felt this happens sometimes. Only 12% disagreed. Overall, the findings indicate that a large majority of respondents perceive that doctors are often held responsible for broader systemic problems within the healthcare system.

The empirical findings demonstrate that workplace violence constitutes a significant challenge to the safety, dignity and professional well-being of doctors in India. The study identifies important gaps in legal awareness, reporting mechanisms, institutional support and workplace security, while also highlighting the adverse effects of violence on doctors' mental health

and professional decision-making. These findings underscore the need for effective implementation of existing legal safeguards, stronger institutional mechanisms and accessible reporting procedures to ensure meaningful protection of doctors' rights and dignity.

SUGGESTIONS:

To effectively address the rising violence against healthcare professionals and restore trust in the healthcare system, a comprehensive reform strategy involving the Government, medical institutions, regulatory bodies, media, and doctors themselves is essential.

I. Strengthening the Patient–Doctor Relationship:

The declining trust between patients and doctors, due to perceptions of negligence, long waiting times, overcrowding, and poor communication, must be urgently addressed. In high-stress environments, such distrust can quickly escalate into conflict and violence. Doctors should be trained in effective, empathetic communication andmust provide clear explanations regarding diagnosis, treatment options, risks, costs, and prognosis in simple language to build transparency and trust.[58]

II. Better Infrastructure at Hospital Premises:

Hospitals must implement strict security measures, including regulated entry through visitor passes, deployment of trained security personnel (preferably ex-army staff), installation of CCTV cameras, secure duty rooms with proper restroom facilities, and enhanced protection in sensitive areas such as ICUs, OTs, and emergency departments.[59]

III. Reducing Gender Disparities in Safety Perception:

Female doctors, particularly during night shifts, should be provided with adequate security support. Separate and secure duty rooms must be ensured. Hospitals should also promote awareness among the public to create a safe and gender-inclusive working environment.[60]

IV. Mental Health Programmes for Doctors:

Special attention must be given to young doctors and interns who face long working hours and high-pressure situations. Institutional mental health support systems, counselling services, and stress-management programmes should be established.

V. Role of the Government:

The Government should enact a comprehensive central law protecting healthcare professionals, increase healthcare budget allocation, improve infrastructure, expand hospital capacity, and strengthen public institutions. Special fast-track courts may be established for expeditious disposal of violence cases. Regulatory reforms should include preventing spurious drugs, strengthening the drug regulatory system through a National Drug Authority, and ensuring rational drug formulations. Continuous professional development mechanisms must be reinforced to promote safe and rational prescribing practices.[61]

VI. Role of Law Enforcement Agencies:

Police authorities must ensure proper registration and timely investigation of FIRs and maintain law and order. They should also facilitate safe and immediate transport of patients to appropriate healthcare facilities.

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[58]Mahani, A. and Zadu, R., 'Ensuring the safety of healthcare professionals: A review of current challenges and legal frameworks in India', *International Journal of Forensic and Clinical Medicine*, 11(4), Article 14721, available at: https://ijfcm.org/archive/volume/11/issue/4/article/14721/pdf (accessed 15 March 2026).

[59] Ibid.

[60]Ibid, at P. 19.

[61]**Ministry of Health and Family Welfare, Government of India,***Report of the Expert Committee on a Comprehensive Examination of Drug Regulatory Issues, Including the Problem of Spurious Drugs*, Government of India, available at: https://ijfcm.org/archive/volume/11/issue/4/article/14721/pdf (accessed 15 March 2026).

VII. Role of Regulatory Authorities:

Bodies such as the NMC and medical associations must remain vigilant, support victim doctors, ensure professional accountability, and integrate medical ethics, medico-legal education, and situation-management training into the curriculum, along with regular workshops.

VIII. Role of Media:

Media must report incidents responsibly, avoiding sensationalism, and promote factual awareness. Social media can also be used constructively for public education and legal awareness.

CONCLUSION:

"Wherever the art of medicine is loved, there is also a love of humanity." — Hippocrates

Human beings are often seen as the most important creation, and doctors, who reduce human pain and suffering, are therefore highly respected in society. However, violence against healthcare professionals in India is not just a law-and-order problem; it affects human dignity, constitutional values, and the proper functioning of the healthcare system. This study shows that the lack of a clear and uniform central law, along with poor implementation and weak enforcement, makes the existing fragmented legal system less effective.

The analysis also shows that punishment alone cannot solve the growing mistrust between doctors and patients. Problems like poor hospital infrastructure, shortage of doctors, lack of proper communication, and limited institutional support often lead to conflicts in healthcare settings. New issues, such as safety concerns for women doctors and unclear rules for telemedicine, further highlight the gaps in the current system. As William Osler said, *"Medicine is a science of uncertainty and an art of probability,"* yet doctors today are often expected to give perfect and certain results, which is unrealistic.

Therefore, a long-term solution needs a balanced and practical approach. This includes creating a uniform central law, improving monitoring through centralized data systems, and strengthening hospital infrastructure and workplace safety. At the same time, rebuilding trust is equally important and can be done through better communication between doctors and patients, ethical medical practices, and responsible media reporting.

In the end, protecting doctors is not just about protecting a profession; it is necessary for maintaining the entire healthcare system. Ensuring their safety, dignity, and independence is essential for protecting the right to health and building a fair and effective healthcare system.

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[2] *Constitution of India*, art. 246 read with Seventh Schedule, List II, entries 1, 2 & 6, available at: https://www.indiacode.nic.in/bitstream/123456789/19150/1/constitution_of_india.pdf (accessed 19 February 2026).

[3] *Epidemic Diseases (Amendment) Act*, 2020 (No. 17 of 2020), available at: https://prsindia.org/files/bills_acts/acts_parliament/2020/Epidemic%20Diseases%20(Amendment)%20Act,%202020.pdf (accessed 19 February 2026).

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