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Medical Negligence under the Bharatiya Nyaya Sanhita (Section 106(1)): Balancing Professional Immunity with Criminal Accountability

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Abstract

There has been a paradigm shift in the adjudication of medical negligence with the transition from the Indian Penal Code, 1860 (IPC) to the Bharatiya Nyaya Sanhita, 2023 (BNS). IPC section 304A in the past treated catastrophic medical errors as car accidents which made medical personnel subject to arbitrary detentions. It encouraged a defensive medicine mentality resulting in jeopardizing patient care.

Section 106(1) of the BNS introduces a split punitive scheme in this regard. The proposed law contains a provision specifically for registered medical practitioners (RMP). An increase in general penalty for causing death due to carelessness from two years to five years. By law, the sentencing limits on the RMPs (registered medical practitioners) who cause death due to negligence in a medical operation is two years.

The doctrinal, constitutional, and practical implications of this new law are examined. The evolution of medical liability is traced in the paper, namely Bolam standard to the Jacob Mathew ruling of the Supreme Court wherein the apex court laid down the “gross negligence” threshold. It looks at the constitutionality of the dual-sentencing structure under Article 14. The life and death hazards of the medicine per se create an intelligible differentia which justifies this protection.

Ultimately, the study will assess whether Section 106(1) has successfully achieved a balance that protects the physician from false claims while assuring the victim of medical negligence. Consequently, it is concluded that while BNS offers practical substantive protection, strong procedural safeguards, especially the statutory codification of pre-FIR independent medical screening boards, are essential for the success of BNS to prevent professional protection from unintentionally becoming institutional impunity.

Keywords: Medical Negligence; Bharatiya Nyaya Sanhita; Section 106(1); Gross Negligence; Criminal Accountability; Article 14.

I. Introduction: The Intersection of Medical Science and Criminal Jurisprudence

An interaction between the medical community and the state's criminal justice system is one of the most difficult, most controversial and most philosophically problematic areas of contemporary legal theory. Previously, the doctor-patient relationship was paternalistic, fiduciary, and covenanted based on the Hippocratic Oath. The doctor's clinical judgment was unrestricted and generally protected from systemic legal challenge.¹ However, because of the rapid commercialization of the healthcare industry and the legal recognition of patients as "consumers" under the Consumer Protection Act, this sacred covenant has been converted into a contractual and service-oriented one.² The revised crime science paradigm generates a violent clash between the outcome-oriented and strict yardsticks of criminal law, on the one hand; and the biologically and systemically dangerous character of medicine, on the other. Even while the treatment was performed with utmost care, due to the physiological peculiarities of the patient and unexpected clinical outcomes, a fatal outcome may occur. Also, even the assessment of contemporary medical research has limitations.³

It has forever been the dilemma of criminal law to delineate between acts which are so grossly irresponsible, and indefensible, that a criminal charge can be laid; an act which constitutes a civil error of judgment, in respect of which a tort will lie, so as to warrant financial compensation; and a clinical misadventure, in respect of which there was no reasonable prospect of avoiding the accident.⁴ It is important to strike this balance because an excessively lenient legal regime generates institutional impunity and endangers the right to life, while an extremely heavy-handed punitive regime paralyses the healthcare delivery system and ultimately deprives the most disadvantaged people of essential medical services.

The only legal framework available for the resolution of medical negligence resulting in death in India was the Indian Penal Code, 1860 (IPC), developed during the colonial period, for over 150 years. The IPC's section 304A, which prohibits causing death by a "rash or negligent act not amounting to culpable homicide", in particular, was a broad yet harsh piece of legislation.⁵ The act's definitions for clinical negligence were not precise because of the mid-19th century drafting, which preceded sophisticated modern medical procedures. It was consistently applied in all fields, forcing the Indian judiciary and local police to apply the same penal standards to a specialist neurosurgeon whose patient died on the operating table, a careless engineer who caused a structural collapse, and a drunk driver who caused a death on the highway.⁶

In the absence of a specified statutory distinction for clinical conduct, medical personnel were extremely vulnerable to arbitrary arrests, harassment in custody and malicious prosecutions. Police FIRs against doctors are often registered in response to public pressure by local police officials rather than based on any objective medical facts.⁷ A rise in mob violence against medical professionals and a toxic mainstay of "defensive medicine" were two catastrophic socio-medical phenomena in India triggered by this systemic legal vulnerability.⁸ Medical professionals began altering their clinical practices systematically for self-preservation and fear of criminal incarceration.

They denied entry to critically ill or high-risk patients; often delayed complex surgical emergencies to already overworked tertiary government hospitals; and prescribed costly, elaborate, and time-consuming battery of diagnostic tests to create a legally defensible paper trail.⁹ In landmark judgments like *Jacob Mathew and Kusum Sharma*, the Supreme Court of India recognized this systemic threat on several occasions and cautioned that society would pay the price if doctors are forced to practise their lifesaving

¹ Tom L. Beauchamp & James F. Childress, *Principles of Biomedical Ethics* 30–35 (7th ed. 2013)

² *Indian Med. Ass'n v. V.P. Shantha*, (1995) 6 S.C.C. 651 (India)

³ Michael A. Jones, *Medical Negligence* 12–15 (5th ed. 2017)

⁴ Michael A. Jones, *Medical Negligence* 12–15 (5th ed. 2017)

⁵ Indian Penal Code, 1860, § 304A, No. 45, Acts of Parliament, 1860 (India) (repealed 2023).

⁶ *Dr. Suresh Gupta v. Govt. of N.C.T. of Delhi*, (2004) 6 S.C.C. 422, ¶ 21 (India)

⁷ *Jacob Mathew v. State of Punjab*, (2005) 6 S.C.C. 1, ¶ 28 (India).

⁸ Amrita Ghosh & T.K. Ghosh, *Violence Against Doctors: A Wake-Up Call*, Indian J. Med. Rsch., Apr. 2018, at 331, 332

⁹ B. Sonny Bal, *An Introduction to Medical Malpractice in the United States*, 46 Clinical Orthopaedics & Related Rsch. 2397, 2398 (2008)

profession with a “sword of Damocles” hanging over their heads.¹⁰

The government of India has passed the Bharatiya Nyaya Sanhita, 2023 (BNS). The bill aims to be a radical and paradigm-shifting departure from colonial penal philosophy in recognition of this crippling systemic friction, the urgent inadequacy of reliance on sole judicial guidelines, and the need to denormalise intricate medical misadventures from simple criminal recklessness.¹¹ Section 106(1) of the BNS repeals IPC Section 304A and introduces a highly specialized bifurcated penal provision. In an effort to address persistent demands for enhanced deterrence against deadly accidents, the BNS plans to progressively raise the general penal penalty for causing death by negligence for ordinary citizens from a maximum of two years to five years. Simultaneously, it formulates a distinct protective legislative provision which is applicable exclusively to registered medical practitioners (RMPs).¹² As per this clause, the cap on the punitive sentence shall be two years as per law if an RMP while performing a medical procedure ends up causing death and the offence is also still bailable.¹³

Nonetheless, this unconventionally large split in parliament sparks a major constitutional, ethical, and socio-legal debate. The law legally pits the patient’s fundamental right to life, health and bodily integrity, guaranteed under Article 21 of the Indian Constitution, and the doctor’s fundamental right to practice his profession freely (Article 19(1)(g)), without fear of arbitrary incarceration.¹⁴ Patient advocacy groups and legal scholars have voiced strong concerns over the clause. In contrast, the Indian Medical Association (IMA) and the broader medical fraternity have lauded it as an essential statutory safeguard against frivolous or vexatious harassment and media trials. Rivals are arguing about lowering the penalty for doctors while increasing such for the rest of the population may inadvertently reduce the deterrence that is required to curb serious medical misconduct. This may violate the Article 14 guarantee of equality before law.¹⁵ Moreover, questions remain as to how the text of the statute will interact with the long-standing common law requirement to show “gross negligence” to found a criminal conviction.

II. Jurisprudential Evolution: From Civil Torts to the Criminal Threshold of "Gross Negligence"

To thoroughly understand the legislative intent of the special medical provision incorporated in section 106(1) of the Bharatiya Nyaya Sanhita (BNS), the first step is to look into the judicial evolution of the standard of care needed to apply by medical practitioners. The BNS's statutory text is the legislative outcome of a long struggle in which Indian constitutional courts have had to find a balance between the tough penal provisions in the Indian criminal justice system on the one hand and, on the other, the rigid delineation of the boundaries of English tort law. It does not exist in a unique context.

A. The Civil Standard and the Duty of Care: Bolam to Bolitho

The roots of the essential structure that regulate medical liability in India can be traced back to English common law. The first step in any medical negligence case is to establish that there existed a “duty of care” and which was breached. In the landmark Indian case of *Dr. Laxman Balkrishna Joshi v. Dr. Trimbak Bapu Godbole*, the Supreme Court of India held that when a physician takes on a patient, he implicitly assumes three separate legal obligations.

- It is the responsibility of a care to ascertain whether the case is taken or not.
- A responsibility to choose the right treatment option for the patient.
- A responsibility to execute the treatment with care.¹⁶

Any breach of duty mentioned above results in actionable negligence.

However, an objective criterion would help define what a “breach” is. To do this, Indian courts adopted the well-accepted test based on the *Bolam v. Friern Hospital Management Committee* ruling of the English Queen’s Bench, known as the “Bolam Test.”¹⁷ As per Bolam standard, a physician is not negligent if he follows the procedure which is accepted as proper by a responsible body of medical men skilled in that

¹⁰ *Kusum Sharma v. Batra Hosp. & Med. Rsch. Ctr.*, (2010) 3 S.C.C. 480, ¶ 90 (India)

¹¹ Bharatiya Nyaya Sanhita, 2023, No. 45, Acts of Parliament, 2023 (India)

¹² *Id.* at § 106(1).

¹³ *Id.* at § 106(1) proviso

¹⁴ India Const. art. 19(1)(g)

¹⁵ India Const. art. 14

¹⁶ *Dr. Laxman Balkrishna Joshi v. Dr. Trimbak Bapu Godbole*, A.I.R. 1969 S.C. 128, ¶ 11 (India).

¹⁷ *Bolam v. Friern Hosp. Mgmt. Comm.*, [1957] 1 W.L.R. 582 (Q.B.).

particular art.¹⁸ Importantly, Bolam ruled that a practitioner is not irresponsible merely because there is a body of medical opinion which would have adopted a different clinical approach.¹⁹ Doctors were able to set their own legal standards thanks to this very doctor-friendly standard, making it easier and more free for doctors to operate.

It became clear to the House of Lords that this rule would shield outmoded or illogical medical practices, so they improved it in *Bolitho v. City and Hackney Health Authority*.²⁰

Under the Bolitho adjustment, the court should not simply accept the medical opinion proffered on behalf of the defendant but should instead show that it is responsible, reasonable and able to withstand a full, independent logical scrutiny by the trial judge.²¹ Bolitho refinement was incorporated into Indian jurisprudence by the Supreme Court Of India returning the final authority to determine negligence from the medical profession to the constitutional courts.

B. The Criminal Threshold: The Genesis of the "Gross Negligence" Requirement

Applying the same standard to criminal proceedings under Section 304A IPC gives rise to a serious jurisprudential problem though the Bolam and Bolitho standards are sufficiently governing civil suits for damages under the Law of Torts and the Consumer Protection Act. Liability or culpability in criminal law is based on the extent of negligence and mens rea or guilty mind. On the other side, in civil law, liability is the extent of harm caused.²²

In *Dr. Suresh Gupta v. Govt. of N.C.T. of Delhi*, the Supreme Court made its first attempt to clearly draw a line between criminal and civil medical malpractice.²³ In this case, a routine nose operation caused a patient's death from lack of oxygen. The criminal proceedings against the surgeon have been quashed by the Court. A civil claim can be supported simply based on the absence of necessary care, attention and skill. However, to get the surgeon convicted under Section 304A of IPC, it must be proven that the negligence of the doctor was gross or

highly reckless.²⁴ The Court was of the opinion that the medical system would collapse catastrophically if there was prosecution for every surgical failure. Nonetheless, following the *Suresh Gupta* judgment, there was a considerable public outcry. The critics alleged that the addition of the word "gross" in Section 304A (notably absent in the text of the statute) was judicial overreach and a violation of Article 14 which created an unlawful privileged class of citizens, namely physicians. With respect to this view, a larger Bench was required thus.

C. The Jacob Mathew Paradigm: The Definitive Judicial Guideline

A three-judge Supreme Court bench led by Chief Justice R.C. Lahoti resolved the doctrinal dispute in the case *Jacob Mathew v. State of Punjab*.²⁵ Due to reportedly empty oxygen cylinders and delays in emergency planning, the patient died in this case of respiratory issues.

On the basis of the *Suresh Gupta* ratio, the Supreme Court differentiated between criminal recklessness and occupational carelessness. The legal principle of negligence varies in its operation in the criminal and civil law sphere. Criminal law necessarily includes mens rea as an element.²⁶ Court rulings which must mandatorily be complied with for twenty years from now on by Indian medical jurisprudence are the following.

- In order for a medical professional to be convicted under criminal law, the negligence must be strictly gross. Errors in clinical judgment, a surgical error or a failure to cure does not amount to criminal negligence. To show malpractice, they must either show a blatant, careless failure to use that competence (eg cutting off the wrong leg) or lack the skill claimed (eg a homeopath trying to do neurosurgery).²⁷
- The Court clarified that doctors who are named in FIRs shouldn't be arrested regularly. Since the Damocles sword can impair clinical judgment, an arrest can only be done when the arrest is necessary

¹⁸ *Id.* at 587 (per McNair, J.)

¹⁹ Michael A. Jones, *Medical Negligence* 210–215 (5th ed. 2017)

²⁰ *Bolitho v. City and Hackney Health Auth.*, [1997] 4 All E.R. 771 (H.L.).

²¹ *Id.* at 778

²² *Syed Akbar v. State of Karnataka*, (1980) 1 S.C.C. 30 (India)

²³ *Dr. Suresh Gupta v. Govt. of N.C.T. of Delhi*, (2004) 6 S.C.C. 422 (India).

²⁴ *Id.* at ¶ 21.

²⁵ *Jacob Mathew v. State of Punjab*, (2005) 6 S.C.C. 1 (India).

²⁶ *Id.* at ¶ 13–17

²⁷ *Id.* at ¶ 48(5)

to further the investigation, or when there is a risk of flight.²⁸

- Legal principles of regulatory enforceability for procedural safeguards as is, were considered necessary by the Jacob Mathew case, realizing the prevalence of frivolous litigations. The Court directed that a magistrate shall not entertain a private criminal complaint against a doctor unless it is supported with reliable expert medical opinion. Moreover, for the officer in charge to demonstrate that the accused doctor was guilty of gross negligence in order to file an FIR for 304A, they must get an independent opinion from a medical expert employed by the government.²⁹

D. Subsequent Affirmations and the Path to the BNS

Following the case of Jacob Mathew, the Supreme Court intensified the enforcement of these procedural safeguards to deter unnecessary lawsuits. In *Martin F. D'Souza v. Mohd. Ishfaq*, police officers across India were directed not to detain medical professionals without getting the complaint referred to a proper medical board.³⁰ Through like process, the Court clubbed these ideas into exhaustive rules in *Kusum Sharma v. Batra Hospital*, and re-iterated that the medical practitioners enjoy a right to a high level of protection, so that they can provide treatment without fear of criminal prosecution paralyzing their practice.³¹

The rich tapestry of legal precedent illustrates the intense battle Indian courts have to defend physicians who practice in high-stress, high-risk environments, while being constrained by the outdated, inflexible language of Section 304A of the IPC. The failure of the legislature to recognize the special status of medical science made it necessary for the judiciary to create procedural safeguards and artificially insert the word “gross” into the act. The Bharatiya Nyaya Sanhita has been written in this context. The legislature in passing Section 106(1) and by adding a proviso limiting punishment to registered medical practitioners has, thus, recognized and codified the essential of the Jacob Mathew doctrine. This has changed medical immunity from a flimsy judicial idea to a firm statutory guarantee.

III. Anatomy and Statutory Interpretation of Section 106(1) of the BNS

The Bharatiya Nyaya Sanhita, 2023, consciously deviates from the uniform conception of punishment rooted in colonial origins. The BNS reorganizing the criminal rules for deadly negligence taking into account complex environment of contemporary socio-economic and professional life. Though section 106 of the BNS serves as the immediate legislative successor to section 304A, its structure is far more complex. It is a product of a deliberate legislative attempt to strike a balance between conflict between dangers to professions and public safety.

A. Legislative History and Parliamentary Intent

To appreciate 106(1), it is essential to examine its immediate legislative history. The first draft of the Bharatiya Nyaya Sanhita Bill's Clause 106(1) given to the Lok Sabha in August 2023 proposed a general increase in penalty for causing death by negligence from two years (under earlier IPC 304A) to seven years, without any specific exemption for the medical profession.³² The Indian healthcare sector experienced a great deal of worry due to this. In an emergency representation made to the Parliamentary Standing Committee on Home Affairs, the IMA argued that seven years in prison for doctors for clinical failures would lead to a huge rise in the practice of defensive medicine and resignation from the field by doctors from high-risk specialties.³³

Thanks to institutional lobbying and acceptance of the Jacob Mathew judicial paradigm, the Union Government introduced a revised version, the Bharatiya Nyaya Sanhita (Second) Bill, 2023. During the parliamentary debate held in December 2023, the Hon'ble Home Minister stated the legislative intent behind the amendment. He said the doctor operating on the patient does not do so out of malice or mens rea to kill, but to save life.³⁴ Accordingly, the law-makers introduced a distinct statutory clause wherein the maximum sentence of medical personnel ought to be limited to two years and reduced the general punishment for negligence to a maximum of five years.

²⁸ *Id.* at ¶ 52.

²⁹ *Id.* at ¶ 51–53

³⁰ *Martin F. D'Souza v. Mohd. Ishfaq*, (2009) 3 S.C.C. 1, ¶ 106 (India).

³¹ *Kusum Sharma v. Batra Hosp. & Med. Rsch. Ctr.*, (2010) 3 S.C.C. 480, ¶ 89–90 (India)

³² The Bharatiya Nyaya Sanhita Bill, 2023, Bill No. 121 of 2023, cl. 106(1) (India)

³³ *IMA Urges Amit Shah to Reconsider Stringent Provisions Against Doctors in BNS Bill*, Medical Dialogues (Aug. 24, 2023),

³⁴ Parliamentary Debates, Lok Sabha, Dec. 20, 2023

B. Deconstructing the General Penal Provision

The Principal Provision of Section 106 (1) states:

"Whoever causes the death of any person by doing any rash or negligent act not amounting to culpable homicide, shall be punished with imprisonment of either description for a term which may extend to five years, and shall also be liable to fine.³⁵."

The maximum penalty under IPC has been raised from two years for the general public, which is a historical shortcoming to five years. For several years, the constitutional courts and the Law Commission of India (notably in its 42nd and 156th Reports) criticized Section 304A IPC for being too lenient on deaths due to negligence, especially cases of negligent driving and corporate negligence.³⁶

The BNS increases the maximum penalty to five years, making a stronger deterrence for typical civilian negligence.

C. The Medical Proviso: Scope, Boundaries, and Limitations

This better general provision is subject to the vital legislative carve-out.

"...and if such act is done by a registered medical practitioner while performing medical procedure, he shall be punished with imprisonment of either description for a term which may extend to two years, and shall also be liable to fine.³⁷"

While this clause is described as a protection, a proper reading of the statute shows that it is fettered by legal requirements. The protection is based on three strict requirements, not a blanket immunity, so is a conditional privilege.

- The BNS defines an RMP as a medical professional, holding any recognized medical qualification under the National Medical Commission Act, 2019, whose name has been entered in the National Medical Register or a State Medical Register. The law makes it clear that only registered medical practitioners will receive leniency under it.³⁸ Due to this definitional rigidity, quacks, unregistered practitioners and

compounders are wholly barred from laying claim to two-year sentencing cap, which fulfills an important public policy purpose. Moreover, as per the decision of the Supreme Court in *Poonam Verma v. Ashwin Patel*, practitioners of alternative medicine (AYUSH) who casually prescribe allopathic drugs without any knowledge of pharmacology resulting in the death of a patient are negligent per se.³⁹ As their actions fall outside the legal parameters of their specific registration, those cross-pathway practitioners who practice outside their permitted jurisdiction would likely lose the immunity of the proviso and attract the harsher five-year punishment.

- The second statutory limitation is the negligent act must occur, when performing a medical procedure. The wording links the practitioner's shield with the direct clinical activity.
- The following are included acts: surgery, anesthesia, diagnostic procedures (such as endoscopies or biopsies), medicine prescriptions, and immediate post-operative clinical care.⁴⁰
- The excluded acts clause does not protect a doctor for administrative carelessness. An example would be refusing to admit a critically ill patient for no reason, failure to ensure that life-support equipment in the ICU is in working order, or delaying an ambulance for billing reasons. The Supreme Court in the case of *P.B. Desai v. State of Maharashtra* drew a clear line between a gross violation of the fundamental duty to care and an error in judgment in a clinical setting.⁴¹ When a doctor entirely abandons a patient, this does not qualify as a "treatment." Hence the physician will be held liable under the extensive and stringent requirements of the BNS.
- The legislature successfully maintained the amount of penalty that existed under the earlier IPC 304A by capping the maximum sentence to two years in particular for RMPs. Thus, it protects doctors from the newly extended threat of five years. Crucially, however, it is clear that offences in terms of section 106(1) are bailable under the First Schedule

³⁵ Bharatiya Nyaya Sanhita, 2023, § 106(1), No. 45, Acts of Parliament, 2023 (India)

³⁶ Law Comm'n of India, 156th Report on the Indian Penal Code, at 55–58 (1997)

³⁷ BNS, *supra* note 35, § 106(1).

³⁸ *Id.* at § 106(1) Explanation

³⁹ *Poonam Verma v. Ashwin Patel*, (1996) 4 S.C.C. 332, ¶ 40 (India)

⁴⁰ *Malay Kumar Ganguly v. Dr. Sukumar Mukherjee*, (2009) 9 S.C.C. 221 (India)

⁴¹ *P.B. Desai v. State of Maharashtra*, (2013) 15 S.C.C. 481, ¶ 42 (India)

of the associated procedural law, the BNSS 2023.⁴² The law protects the fundamental right of the accused doctor to personal liberty under Article 21. Moreover, it stops untold disruption of the doctor's continuing medical practice by ensuring that the Police cannot arbitrarily put him/her under punitive pre-trial custody even when the FIR filed and charge sheet filed for a fatal medical mistake.⁴³

In conclusion, Section 106(1) is revealing of a calibrated legislative mechanism. In the face of stringent regulatory demands, a "proviso" as a statutory instrument is used as an independent substantive classification to very sharply distinguish clinical medical errors from pervasive criminal negligence.

IV. Mens Rea in Medical Offenses: The Dichotomy of Rashness, Negligence, and Knowledge

The absence of a purpose is criminalized under Section 106(1) of the Bharatiya Nyaya Sanhita (BNS), which is a very complex and often contradictory area of criminal law. The principle of *actus non facit reum nisi mens sit rea* which means "an act does not make a person guilty unless the mind is also guilty" is at the heart of traditional criminal law.⁴⁴ Conversely, negligence charges differ fundamentally from this principle because the accused lacks the clear perception that death is a certainty that cannot be avoided or that there is a deliberate intention to inflict injury.

Because the BNS keeps the same wording from the previous IPC Section 304A, the implementation of Section 106(1) is directly governed by a long-standing interpretation in accordance with the common law. In order to secure a conviction of a medical practitioner criminally, the prosecution must establish a certain state of mind which is grossly negligent. It refers to the fine but important nuances of the differences between "willfulness" "negligence" and knowledge".

A. Distinguishing Criminal Rashness (Advertent Risk) and Negligence (Inadvertent Omission)

The Supreme Court of India has made a clear distinction between "rash" act and "negligent" act

based on the basic concepts of criminal law. The court clarified in the case of *S.N. Hussain against state of A.P* It was later reemphasised in medical contexts that criminal negligence and criminal recklessness denote different mental states.⁴⁵

- Rashness is described as conduct typified by advertent carelessness or deliberate risk-taking.

The medical practitioner is aware that a certain clinical intervention carries a very high risk of catastrophic failure or death. He does that anyway with outlandish optimism that there won't be any harm.⁴⁶ The criminality is determined by the audacity of the risk taken relative to the expertise of the practitioner.

- Criminal negligence refers to omission that is unintentional in nature. Negligence or medical malpractice refers to failure to use the reasonable and appropriate care that the practitioner was required to use.⁴⁷ The physician in this situation did not revel in resulting harm with intent, but the failure to foretell the injury and prevent it is such an outrageous violation of accepted medical norms, that it is punishable by law.

B. The Borderline of Culpable Homicide: Section 106(1) vs. Section 105 BNS

Understanding if a medical negligence goes beyond the bounds of Section 106(1) (negligence) and starts touching Section 105 BNS (culpable homicide not amounting to murder) is an interesting statutory interpretation exercise.

If the prosecution can prove the practitioner knew their act would surely lead to death, the two-year punishment cap in section 106(1) is rebutted immediately.⁴⁸ The difference between culpable homicide and gross negligence is significant from the legal perspective. The Supreme Court of India, in the case of *Alister Anthony Pareira v. State of Maharashtra* observed that, a person cannot claim the defence of negligence when he does a very dangerous act knowing that it will result in death.⁴⁹

⁴² Bharatiya Nagarik Suraksha Sanhita, 2023, First Schedule, No. 46, Acts of Parliament, 2023

⁴³ *Arnesh Kumar v. State of Bihar*, (2014) 8 S.C.C. 273 (India)

⁴⁴ Glanville Williams, *Criminal Law: The General Part* 30–32 (2d ed. 1961)

⁴⁵ *S.N. Hussain v. State of A.P.*, (1972) 3 S.C.C. 18, ¶ 11 (India).

⁴⁶ *Bhalchandra Waman Pathe v. State of Maharashtra*, 1968 Mah. L.J. 423 (India)

⁴⁷ *S.N. Hussain*, (1972) 3 S.C.C. at ¶ 11.

⁴⁸ Bharatiya Nyaya Sanhita, 2023, § 105, No. 45, Acts of Parliament, 2023 (India)

⁴⁹ *Alister Anthony Pareira v. State of Maharashtra*, (2012) 2 S.C.C. 648 (India)

This spike is in cases of grave unconscionable recklessness that impute knowledge in the medical context. To illustrate.

- An intoxicated surgeon performing a complicated surgery is engaged in perform under the influence of drugs or alcohol. The charge is moved from Section 106 to Section 105 BNS as the voluntary incapacitation provides a notification of legal knowledge and happen that the surgical conduct may result in death.⁵⁰
- A doctor who performs illegal, late sex-selective abortion under clandestine, unsterilised conditions causing mother death is an allopathic doctor. According to the judgment of courts, the practitioner knows that the act is illegal and dangerous and can cause death, which disproves the defence that it was a mere case of carelessness.⁵¹

When faced with such extremes, the practitioner faces the severe penalty of culpable homicide and loses the status of performing a valid medical procedure as per the provision of section 106(1).

C. Evidentiary Challenges and Res Ipsa Loquitur in Criminal Trials

The prosecution has a high burden of proof to establish the necessary mens rea for gross negligence. According to the legal maxim in civil tort law res ipsa loquitur (“the thing speaks for itself”), the plaintiff must show that the doctor has to show that he was not negligent because the medical mishap was utter nonsensical.⁵²

The applicability of this principle in criminal cases is severely confined by Section 106(1). In *Syed Akbar v. State of Karnataka* (1980), the Supreme Court held that the doctrine of res ipsa loquitur does not have much significance in a criminal trial, and the burden of proving guilt “beyond reasonable doubt” is always on the prosecution.⁵³

Nonetheless, the courts recognize an exception in medical malpractice cases that are so egregious that they offend the judicial conscience. The Court in *V. Kishan Rao v. Nikhil Super Specialty Hospital* held that although expert evidence is generally required to establish criminal negligence, this is not essential in

cases which are very simple and clear involving simplicity and high degree of negligence (for example, taking away the other kidney).⁵⁴ In such extreme situations, the physical proof of actus reus is so powerful that the law infers the presence of criminal mens rea and satisfies the requirements of section 106(1) without the need for elaborate circumstantial reasoning.

So, while the provision of Section 106(1) gives substantive leeway in relation to sentence, nonetheless, the jurisprudence governing the mental element is still strict, ensuring, that criminal liability does not arise from clinical mishaps completely free of gross negligence.

V. Constitutional Validity: Article 14, Equality, and the Test of Intelligible Differentia

The most hotly contended jurisprudential feature of the Bharatiya Nyaya Sanhita (BNS) may be the constitutionality of Section 106(1). The lawmaker introduces a bifurcated sentencing framework that causes intense constitutional scrutiny. This is so, as it provides RMPs with a maximum cap of two years for the same offence ie causing death by negligence. For the general public, there is a five-year maximum imprisonment. Does the medical community receive an unlawful, protected status due to this legal provision? This part discusses the contested clause with reference to Article 14 of the Indian Constitution, which states that all persons are equal before the law and entitled to equal protection of the laws.⁵⁵

A. The Article 14 Conundrum and the Presumption of Constitutionality

The constitutional democracy of India stands on the great principle of Article 14, which specifically forbids the State from denying equality before the law to anybody. A preliminary probe of the Section 106(1) shows great disparity in the treatment meted out to the victim depending on the work of the accused. If a doctor makes a lethal mistake in the operating room, he can be sentenced to a maximum of two years in jail. In contrast, if a civil engineer makes a mistake that causes a building to collapse, he can be sentenced to a maximum of five years in jail. Critics argue that this violates the basic tenets of formal equality and

⁵⁰ *Juggan Khan v. State of M.P.*, A.I.R. 1965 S.C. 831 (India)

⁵¹ *Dr. Anoop Jaiswal v. State*, 2018 Cri. L.J. 1944 (Madras H.C.) (India)

⁵² *Meadows Hosp. v. Harjol Ahluwalia*, (1998) 4 S.C.C. 39 (India)

⁵³ *Syed Akbar v. State of Karnataka*, (1980) 1 S.C.C. 30, ¶ 28–30 (India)

⁵⁴ *V. Kishan Rao v. Nikhil Super Speciality Hosp.*, (2010) 5 S.C.C. 513, ¶ 47–50 (India)

⁵⁵ India Const. art. 14

amounts to arbitrary class legislation that prioritises the doctor's freedom over the patient's life.

An essential presumption in favour of a statute's validity is required by the constitution, and it is assumed that the government is aware of the needs of its own people and appropriately values them.⁵⁶ Also, the Supreme Court has repeatedly held that class legislation is forbidden by Article 14 but not a reasonable classification for legislative purpose⁵⁷

B. The Twin Test of Reasonable Classification

According to the Supreme Court's leading judgment in *State of W.B.*, the legislative classification specified in clause (1) of section 106 must pass the traditional twin test. v. In order to withstand an Article 14 challenge the case of *Anwar Ali Sarkar*⁵⁸ and *Ram Krishna Dalmia v. Justice S.R. Tendolkar*⁵⁹ is very noteworthy.

- The basis of the classification must be an intelligible differentia which distinguishes the persons or things grouped together from others that are left out.
- The differentia should have a rational relation to the object of the statute in question.

C. Satisfying the 'Intelligible Differentia': The Unique Ontology of Medicine

No doubt the medical field has an obvious difference which is legally and practically distinct from other dangerous professions.

The first thing to note the act is essentially different in nature. A commercial truck driver's goal is to transport goods; a car accident is far from that goal. By contrast, in the surgeon's everyday work, it entails physically, legally and intentionally violating the human body, cutting tissue, stopping hearts and altering neurochemistry.⁶⁰ It is not a failure in their responsibility but the whole point of it to work on the razor edge between life and death.

Physicians have a special legislative and constitutional duty to save lives. The Supreme Court

stated in *Pt. Doctors*, whether they work in Government Hospitals or otherwise, have a professional obligation to furnish emergency life-saving treatment. Furthermore, this shall be done without waiting for outcome of the judicial proceeding: *Parmanand Katara v. Union of India*⁶¹ (1989). It is an absurdity to equate a profession mandated by the Constitution to intervene at risk of life to save lives to regular people who perform high-risk activities causing death and injury to others. In the case of *Jacob Mathew*, the Supreme Court has rightly identified this distinction as a specialist entering a complicated clinical setting inherently takes risks which a lay person does not.⁶²

The exception under Section 106(1) of the BNS is confined to "registered medical practitioners" only.⁶³ A formally controlled, statutory licensing system regulate classification and are therefore unambiguous, precise and clear. Consequently, RMPs form a clear and distinct category.

D. The 'Rational Nexus' to the Legislative Object: Securing Article 21

The legislative intent of the BNS proviso must be examined after a finding of differentia. The primary aim of the Criminal Justice System is Deterrence. Yet, the application of a harsh punitive deterrence/measure- a five-year sentence, in the medical field has social repercussions that are contradictory and disastrous.

The two-year limit was legislated to protect the wider public health system and was not intended to give doctors immunity. Parliament of BNS adopted that defensive medicine has a chilling effect in cases where there are severe criminal penalties against the doctor.⁶⁴ Surgeons will regularly refuse to treat critically ill patients and will refer them elsewhere to escape liability if faced with a five-year prison for surgical deaths in high-risk cases.

The Supreme Court has broadly interpreted the public's fundamental right to health as the right to life under Article 21 of the Constitution and this is being

⁵⁶ *Charanjit Lal Chowdhury v. Union of India*, A.I.R. 1951 S.C. 41, ¶ 10 (India)

⁵⁷ *Kedar Nath Bajoria v. State of W.B.*, A.I.R. 1953 S.C. 404 (India)

⁵⁸ *State of W.B. v. Anwar Ali Sarkar*, A.I.R. 1952 S.C. 75, ¶ 54 (India);

⁵⁹ *Ram Krishna Dalmia v. Justice S.R. Tendolkar*, A.I.R. 1958 S.C. 538, ¶ 11 (India)

⁶⁰ V.N. Sehgal et al., *Medical Negligence and the Law in India*, 71 Med. & L. 129 (2002)

⁶¹ *Pt. Parmanand Katara v. Union of India*, (1989) 4 S.C.C. 286, ¶ 7–8 (India)

⁶² *Jacob Mathew v. State of Punjab*, (2005) 6 S.C.C. 1, ¶ 19 (India)

⁶³ Bharatiya Nyaya Sanhita, 2023, § 106(1) Explanation, No. 45, Acts of Parliament, 2023 (India)

⁶⁴ Parliamentary Debates, Lok Sabha, Dec. 20, 2023

threatened.⁶⁵ As a result, there is a logical connection: the limitation of doctors' criminal responsibility to two years (given that bail is preserved) gives them the assurance that they can take high-risk, split-second therapeutic decisions without the fear of being locked up for a long time. The lesser sentence is a legislative measure aimed at ensuring that the right guaranteed under article 21 to receive emergency medical help continues without interruption.

E. Substantive Equality vs. Formal Equality and the Royappa Standard

According to Justice P.N. Bhagwati in *E.P. Royappa v. State of T.N.*,⁶⁶ Modern Article 14 jurisprudence does not strictly remain confined to the classification test but now also extends to arbitrariness which entails that any arbitrary action of the government is unfair.

If medical professionals were treated equally with the public, then ironically the theory of substantive equality would get violated. Substantive equality implies that equal treatment of fundamentally different situations leads to gross injustice.⁶⁷ Comparing a well-meaning physician, who loses a patient during a very complicated, haemorrhagic emergency C-section, with a drunk driver who runs over a pedestrian is an unreasonable and arbitrary analogy from an important jurisprudential point of view.

This historical arbitrariness is addressed by Section 106(1) of the BNS. The law ensures substantive equality taking into account the special occupational hazards, high educational demands and essential utility to society which characterises the profession of medicine. The statutory carve-out is a legitimate legislation weapon that balances the essential need for a functional, brave healthcare system against the retributive force of criminal law. It is not a privilege for the elite.

VI. Evaluating the Socio-Legal Impact: Professional Protection vs. Victim Accountability

The implementation of Section 106(1) of the Bharatiya Nyaya Sanhita (BNS) will have substantial

implications for the Indian healthcare system. The legislature has made a public policy decision to statutorily restrict the maximum penalty applicable to registered medical practitioners to two years while enhancing the overall penalty for negligence to five years. This section critically evaluates the practical implications of this legislative divide, weighing the potential dilution of victim rights and access to justice against a decrease in defensive medicine.

A. Mitigating the Crisis of Defensive Medicine and Healthcare Inflation

The primary societal argument of the Section 106(1) proviso is the urgent need to halt the unrestrained growth of "defensive medicine". The legal regime imposes very harsh penalties for clinical errors including criminal sanctions that will inevitably lead healthcare professionals to take a hyper-cautious self-preserving approach to patient care.⁶⁸ This comes in two harmful forms.

- Doctors often suggest unnecessary diagnostic tests in order to build a legally airtight paper trail to protect themselves against lawsuits. Oftentimes, they order medically unnecessary, expensive, and damaging tests (like unjustified MRI scans or biopsies) for the sake of a defensive strategy. In this way, they're artificially increasing the out-of-pocket medical costs of the average citizen.⁶⁹
- Expert surgeons deliberately refuse to admit moribund or at-risk patients for fear that a death that occurs on their table will lead to a complaint on the criminal and public trial side.⁷⁰

Section 106(1), by law maintaining the two-year sentencing cap and guaranteeing that the charge remains expressly bailable under the BNSS, provides essential psychological security. The State legally recognizes that medical science contains inherent and unavoidable risks, which comforts doctors not to worry about prolonged pre-trial detention if they perform complex and life-saving procedures.⁷¹

⁶⁵ *Paschim Banga Khet Mazdoor Samity v. State of W.B.*, (1996) 4 S.C.C. 37, ¶ 9 (India)

⁶⁶ *E.P. Royappa v. State of T.N.*, (1974) 4 S.C.C. 3, ¶ 85 (India)

⁶⁷ *St. Stephen's Coll. v. Univ. of Delhi*, (1992) 1 S.C.C. 558, ¶ 96 (India)

⁶⁸ B. Sonny Bal, *An Introduction to Medical Malpractice in the United States*, 46 *Clinical Orthopaedics & Related Rsch.* 2397 (2008)

⁶⁹ *Kusum Sharma v. Batra Hosp. & Med. Rsch. Ctr.*, (2010) 3 S.C.C. 480, ¶ 90 (India)

⁷⁰ *Martin F. D'Souza v. Mohd. Ishfaq*, (2009) 3 S.C.C. 1, ¶ 41 (India)

⁷¹ Bharatiya Nagarik Suraksha Sanhita, 2023, First Schedule, No. 46, Acts of Parliament, 2023 (India)

B. The Victim's Plight and the Evidentiary "Conspiracy of Silence"

Conversely, from the standpoint of patient advocacy groups and those who have been victims of terrible medical mistakes, the BNS proviso is often interpreted as an undue state-facilitated leeway. The loss of life is permanent. The most that a person can get is a maximum sentence of two years. For example, a patient dies due to unquestionable clinical incompetence.⁷²

Moreover, when going through the criminal justice system, the victim's family has an especially high burden of proof.

In every criminal case, guilt must be proved "beyond a reasonable doubt". In the case of a corporate hospital which has plentiful resources at its behest and on the other hand, the victim being a poor patient, it may be particularly difficult to establish gross medical negligence.⁷³

This problem is greatly aggravated by a sociological phenomenon named as conspiracy of silence (white wall of silence).⁷⁴ The victims must find a doctor who is willing to testify against his colleague as under Jacob Mathew standards and BNSS, independent medical assessment is mandatory for validating a criminal FIR. In reality, medical personnel tend to be quite hesitant to testify against peers due to fear of institutional rejection and professional solidarity.⁷⁵ The legitimate criminal complaints often get dismissed at the preliminary screening stage, which denies victims any closure and gives an impression of institutional immunity.

C. The Paradigm Shift: From Retributive to Restorative Justice

To solve the conflict between protection of professional and accountability of victim, Indian medical jurisprudence is showing a shift in its philosophy from retributive justice (imprisonment) to restorative justice (compensation and disciplinary action). The leniency granted by Section 106(1)

merely restricts the ambit of criminal detention; doctors are not completely freed from the sovereign act. Those who have been wronged have access to powerful alternative legal remedies that often prove more effective than a criminal trial.

- As a result of the historic decision in *Indian Medical Association v. V.P. Shantha*, medical services rendered against payment came within the ambit of the Consumer Protection Act by the Supreme Court.⁷⁶ The deceased's relatives can file for substantial compensation claims at Consumer Disputes Redressal Commissions. Crucially, these civil forums require proof of only simple negligence. This is in contrast to the gross negligence required by the BNS. Furthermore, the standard of proof is on a lesser scale. This standard operates on the scale of preponderance of probabilities.⁷⁷ Substantial financial compensation can often provide the bereaved family with far greater compensation than sending the doctor to a short bailable jail term.
- The most effective deterrent against medical malpractice is the regulatory and disciplinary sanctions of the National Medical Commission (NMC) and the corresponding State Medical Councils. Not the BNS.⁷⁸ Disciplinary committees exercise legislative powers to suspend the name of a practitioner from the medical register or permanently erase it, as per the professional conduct laws of NMC.⁷⁹ Medical professionals are almost unified in believing that a two-year conviction under Section 106(1) is a less severe and less effective punishment than an irreversible curtailment of a doctor's medical licence which takes away the doctor's livelihood, professional identity and social standing.⁸⁰

D. Concluding Assessment of the Impact

Section 106(1) of the BNS- Socio-legal impact is fundamentally a compromise. Legal discourse recognizes that locking up surgeons of good character who make mistakes is not in the general public interest

⁷² V.N. Sehgal et al., *Medical Negligence and the Law in India*, 71 Med. & L. 129, 132 (2002)

⁷³ *P.B. Desai v. State of Maharashtra*, (2013) 15 S.C.C. 481 (India)

⁷⁴ *Malay Kumar Ganguly v. Dr. Sukumar Mukherjee*, (2009) 9 S.C.C. 221

⁷⁵ *V. Kishan Rao v. Nikhil Super Speciality Hosp.*, (2010) 5 S.C.C. 513, ¶ 46 (India)

⁷⁶ *Indian Med. Ass'n v. V.P. Shantha*, (1995) 6 S.C.C. 651 (India)

⁷⁷ *Nizam's Inst. of Med. Scis. v. Prasanth S. Dhananka*, (2009) 6 S.C.C. 1

⁷⁸ The National Medical Commission Act, 2019, § 30, No. 30, Acts of Parliament, 2019 (India)

⁷⁹ Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, Gazette of India, pt. III sec. 4, reg. 8.2 (Apr. 6, 2002)

⁸⁰ Anurag Bhargava et al., *Medical Negligence in India: A Review of the Disciplinary Mechanisms*, 21 Indian J. Med. Ethics 15 (2020)

because it reduces the health system's capacity and willingness to further attempt high-risk cases. Still, the State must proactively fortify alternative remedial paths so that this protective layer does not become a shield against corporate hospitals' negligence. The State can really assist its providers all the while compensating its consumers only by making consumer courts more efficient for expedient monetary compensation and by endowing with the National Medical Commission the power to remove incompetent practitioners.

VII. Conclusion and Procedural

Recommendations: Achieving the Delicate Equilibrium

Section 106(1) of *bharatiya nyaya sanhita* BNS which replaces IPC, section 304A, is a mature and significant development in Indian criminal law. The colonial criminal system imposed a uniform standard of carelessness for over a century, without taking into account the complexities, hazards, and life-saving needs of present-day medical science. The State inadvertently encouraged a debilitating culture of "defensive medicine" that endangered and obstructed the public with Article 21 and the Constitution's Right to Health, by subjecting complicated clinical mishaps to the same penal metrics as any private civilian recklessness.⁸¹

Section 106(1) rectifies this historical incongruity. The BNS does codify the judicial wisdom painstakingly built up by the Supreme Court from *Dr. Suresh Gupta* to *Jacob Mathew* by statutorily capping punishment of incarceration for registered medical practitioners (RMPs) at two years and enhancing the general penalty of negligence to five years.⁸² According to a structural and constitutional analysis, this distinction is a reasonable classification based on intelligible differentia and not an unconstitutional privilege violating Article 14. In light of the peculiar ontology of the physician, who is legally required to enter the human body for the purpose of preserving life, it is necessary to set a particular threshold in order to ensure that physicians can safely exercise their profession without being subjected to the sword of Damocles of arbitrary pre-trial detention.⁸³

However, a progressive substantive law cannot operate in procedural isolation. Through S 106(1), the medical system is successfully shielded from unjustified criminal prosecution. However, it should not turn into a wall of institutional impunity unmindfully created by the State. If the criminal justice system is to properly withdraw from the operating theatre, alternative accountability systems must actively move forward to protect the victims of clear medical negligence.

To make sure that the BNS achieves its intended balance of guarding the fearless practice of medicine while securing justice for victims, the following systemic and procedural reforms must be implemented scrupulously:

- **Statutory Codification of Pre-FIR Medical Screening Boards:** The greatest flaw in the current legal system is its extreme dependence on judicial criteria. *Jacob Mathew* needs independent medical assessment before filing a complaint against a doctor. However, public pressure often leads to bypassing this requirement for street-level enforcement.⁸⁴ This protection must be incorporated into the *Bharatiya Nagarik Suraksha Sanhita, 2023 (BNSS)* by the legislature. State governments will have to set up independent, standing "District Medical Negligence Screening Boards" with an exclusive statutory jurisdiction for screening allegations. The proposals on the boards will consist of government doctors, lawyers and civil society members. The police can only file a FIR under Section 106(1) against an RMP if this Board gives prior affirmative report.⁸⁵
- **Law enforcement must be strictly instructed to differentiate between Section 105 BNS (culpable homicide) and Section 106(1) (negligence), in clear terms for investigation agencies.** Practitioners found to have operated outside their jurisdiction (eg, cross-pathy quackery), performed illegal treatment, or performed the surgery while intoxicated must be denied the two years protection cap.⁸⁶ In these cases, the act will not amount to a valid medical procedure and for ensuring a strict deterrent against unconscionable carelessness, the

⁸¹ *Paschim Banga Khet Mazdoor Samity v. State of W.B.*, (1996) 4 S.C.C. 37 (India)

⁸² *Jacob Mathew v. State of Punjab*, (2005) 6 S.C.C. 1, ¶ 48 (India)

⁸³ *State of W.B. v. Anwar Ali Sarkar*, A.I.R. 1952 S.C. 75 (India)

⁸⁴ *Amrita Ghosh & T.K. Ghosh, Violence Against Doctors: A Wake-Up Call*, Indian J. Med. Rsch., Apr. 2018, at 331

⁸⁵ *Martin F. D'Souza v. Mohd. Ishfaq*, (2009) 3 S.C.C. 1, ¶ 106 (India)

⁸⁶ *Poonam Verma v. Ashwin Patel*, (1996) 4 S.C.C. 332 (India)

State must promptly invoke the stringent provisions of the BNS.

- The National Medical Commission is proposed to have its regulatory teeth strengthened. The self-regulation by profession is set to become exponentially tougher as the risk of criminal imprisonment decreases. State Medical Councils and the National Medical Commission (NMC) can no longer afford to act just like guilds for fraternal protection. Disciplinary actions for gross negligence need to be completed within strict legal timelines. The permanent revocation of a medical licensing can provide professional deterrence in lieu of jail. It should be used more often and with greater openness in catastrophic incompetence cases.⁸⁷
- Speedy restorative justice via consumer redressal: due to horrific delays in the civil court system, victims of medical negligence often resort to criminal prosecution. In order to transform the consumer dispute redressal commissions and their framework from retributive justice to restorative justice, a vigorous upgradation is required. To prevent bereaved families from undergoing decades-long litigation for compensation based on the threshold of simple negligence, tribunals must be formed on a fast-track basis that will exclusively deal with medical negligence claims.⁸⁸

Ultimately, Section 106(1) of the Bharatiya Nyaya Sanhita accomplishes a very calibrated, philosophically robust balance on paper. From a legal point of view, treating a well-intentioned but error-prone doctor as if they were a negligent motorist serves neither justice nor the health of the nation. Nonetheless, the actual legacy of the Act will depend on its implementation. In a civilized society, there must be fearless practitioners who take calculated risks to save lives. There must also be institutions that are strong and uncorruptible so they can hold those healers accountable in case of a catastrophic failure.

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⁸⁷ The National Medical Commission Act, 2019, No. 30, Acts of Parliament, 2019 (India)

⁸⁸ *Indian Med. Ass'n v. V.P. Shantha*, (1995) 6 S.C.C. 651 (India)