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AN EMPIRICAL RESEARCH ON ATTACKS ON DOCTORS.

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Abstract

Violence against doctors has led many people including healthcare workers like registered medical practitioners and legal jurists to author articles or books about the legal defense and physical protection of doctors in the field of medicine and law. The doctors are well aware about their rights and duties and in the past they struggled with inadequate protections under Indian Penal Code while earlier iterations of National Medical Commission and Medical Council Of India regulations fell short in providing clear defense against frivolous criminal complaints or patients violence. They were vague, unclear and ambiguous in nature. But after 2020, the existing laws have been amended and numerous state laws about doctors safety have been created. The BNS of 2023 and the newer NMC has given the clear criteria about when and under what criteria should doctors be prosecuted for. Also, they have given ironclad protection and defense for doctors from the patients' violence and baseless faultless allegations. Laws were passed in recent times to allow patients to redress their grievances against doctors, yet the patients take matters into their own hands illegally and unlawfully without giving doctors their side of story to be heard regardless of whether the doctors are innocent or guilty. A one-week cross-sectional study of 47 medical practitioners revealed high vulnerability and a severe reporting paradox:

- High Abuse Rates: 55.3% faced verbal abuse, 23.4% experienced stalking or threats, 10.6% encountered public accusations/demonstrations, and 4.3% suffered physical assaults or property damage.
- Reporting Paradox: 93.6% of victimized practitioners did not file official complaints. Primary deterrents included reliance on informal mediation (29.8%), fear of retaliation (21.3%), and a lack of institutional support or channel awareness (10.6%).

- Intervention Outcomes: Out of 24 practitioners who intervened, 58.3% succeeded via informal mediation, 33.3% failed completely due to institutional inaction, and 8.4% remain partially resolved or under investigation.

Despite making prevention to curb the cause for violence against doctors, it is still prevailing.

Chapter 1: Introduction

While society relies on doctors, nurses, surgeons, paramedics, and pharmacists to diagnose illness, administer treatment, manage patient care, and perform life-saving interventions, many fail to recognize their fundamental humanity. Healthcare workers are human beings who operate within the limits of medical science, doing everything within their power to meet patient demands and execute their duties with professional excellence. Despite their rigorous training, they remain imperfect and capable of making mistakes.

Regrettably, their exhausting sacrifices are frequently overlooked or exploited. In a vast majority of cases, patient fatalities or prolonged suffering stem from complex injuries, advanced infections, severe fractures, or deep-seated deformities that are simply beyond the reach of modern medicine. Medical professionals cannot be held accountable for the natural limitations of biology. However, clear boundaries exist: in genuine cases of medical malpractice, criminal negligence, or systemic patient abuse, healthcare providers must be held legally responsible for safeguarding patient health, safety, and life.

Crucially, regardless of whether a medical professional is guilty or innocent, private citizens have absolutely no right to act as judge, jury, and executioner. The law does not permit individuals to take matters into their own hands. Any legitimate grievances must be channeled through law enforcement agencies and judicial systems to ensure suspects are fairly investigated and, if proven guilty, legally penalized.

The current wave of vigilantism and violence yields devastating consequences. Fearing for their own safety, their families, and their property, many clinicians are becoming deeply hesitant to take on high-risk, critically ill patients, while others are abandoning the profession entirely. This environment leaves medical staff emotionally traumatized and psychologically distressed. Ultimately, a profound irony defines this crisis: a patient's relatives will passionately pray to doctors as heaven-sent saviours, only to instantly reframe them as heartless killers the exact moment a patient loses their battle for survival.

Chapter 2: Causes for Violence Against Registered Medical Practitioners

1. Physician-Centric Factors

- **Communication Breakdown:** Assaults frequently stem from a failure to clearly explain medical concepts, including the root cause of an illness, its expected trajectory, diagnostic necessities, and therapeutic pathways.
- **Mismanaged Expectations during Crises:** If a patient's prognosis is not transparently shared from the outset, any subsequent clinical deterioration or sudden complication is easily misinterpreted by grieving families as medical apathy or callousness.
- **Therapeutic Disagreements:** Hostility can arise when patients or their families are dissatisfied with clinical outcomes or actively disagree with the physician's chosen treatment modalities.
- **Malpractice:** Actual instances of clinical negligence or medical errors naturally spark intense anger and retaliatory behavior.
- **Suspected Financial Corruption:** A deep-seated public suspicion exists that physicians routinely prescribe redundant diagnostic tests and expensive medications to secure illicit kickbacks from pharmaceutical and medical industries.
- **Absence of Collaborative Decision-Making:** Patients often feel alienated when doctors fail to adopt a cooperative approach or refuse to openly share vital health data.
- **Provocation by Peer Criticism:** Casual, negative remarks or critical second opinions voiced by other medical professionals regarding a colleague's treatment plan can instantly trigger family aggression against the primary doctor.

2. Patient and Attendant-Centric Factors

- **Emotional Vulnerability:** Families entering hospitals are often facing severe trauma, impending disability, or death. This state of profound fear and panic requires deep empathy from medical staff; any perceived arrogance or challenge from the hospital team can cause an emotional explosion.
- **Public Sector Infrastructure Deprivation:** Government facilities face extreme overcrowding, agonizingly long wait times, unhygienic environments, and repetitive visits just to complete basic lab work. The systemic practice of assigning two to three patients per bed, utilizing floor bedding, and operating in unsanitary conditions creates a naturally volatile environment.
- **Private Sector Operational Delays:** Even in private setups, prolonged waiting intervals, delays in admitting critically ill individuals, or perceived stagnation in

initiating diagnostics provoke intense frustration.

- **Severe Specialist Deficit:** There is a critical shortage of trained medical specialists, compounded by a heavy geographic imbalance favoring urban centers. This leaves rural and low-resource regions completely underserved, opening the door for unqualified quacks to exploit the population.
- **Overburdened Staff Apathy:** Public sector clinicians are crushed under massive patient loads because the system is understaffed and the private sector remains financially inaccessible to low-income families. Heavily congested outpatient departments (OPDs) and emergency wards overstretch both infrastructure and human endurance, manifesting as a perceived lack of compassion.
- **Altered Mental States:** Aggression is frequently amplified when patient attendants are under the influence of alcohol or drugs, suffering from unmanaged psychiatric conditions, or experiencing extreme acute stress.
- **Dysfunctional Public Infrastructure:** Paramedical and auxiliary support staff in public hospitals are often poorly trained or insufficient in number, and equipment failures are common. Because doctors sit at the apex of the clinical hierarchy, they ultimately absorb the blame for these structural breakdowns.
- **The Financial Crisis of Medical Billing:** With minimal health insurance penetration, a single medical emergency can plunge a middle-class family into systemic poverty. Consequently, a vast majority of violent outbreaks are directly triggered during the finalization and presentation of the medical bill.
- **Low Health Literacy:** While basic literacy may be rising, public understanding of complex medical processes remains dangerously low. Families regularly fail to grasp the naturally degenerative course of certain diseases or the realistic limitations of available therapies.

3. Hospital-Centric Factors

- **Deficient Security Infrastructure:** While hospitals are highly optimized for clinical technology, physical security is routinely neglected. Most public hospitals completely lack security guards in high-risk zones like emergency rooms and Intensive Care Units (ICUs). Nearby police posts are either non-existent or completely indifferent during active crises.
- **Lack of Deterrent Technology:** Basic security checkpoints, such as functional metal detectors and baggage scanning devices, are missing from hospital entrances.

- **Absence of Emergency Protocols:** Institutions rarely maintain structured rapid-response protocols outlining exactly who should intervene and what actions to take when an administrator or clinician is threatened.
- **Socioeconomic Privatization Traps:** National budgetary spending on healthcare is among the lowest globally, meaning state infrastructure accommodates less than 20% of public medical needs. Forced into the private sector, the majority of the population relies on small-to-medium private clinics (which constitute nearly 85% of private institutions). These smaller establishments are highly fragmented, isolated, and completely unprotected by professional security setups.

4. Community and Societal Factors

- **Toothless Legal Enforcement:** Although legislative acts exist on paper to protect medical workers, they are rarely enforced effectively for private practitioners. In the public sector, assaulting an on-duty government doctor is legally a non-bailable offense, yet weak implementation means mobs face zero legal consequences. This systemic impunity actively encourages cyclical, copycat violence.
- **Exploitation by Local Political Elements:** Small-time community agitators and self-proclaimed leaders frequently exploit medical crises in public or employee-state insurance (ESI) hospitals to display their influence. Driven by resentment toward the perceived authority of physicians, these individuals deliberately incite patient relatives into a mob format. When intellectual clinicians respond defensively to protect their dignity, it triggers a destructive, escalatory loop.
- **Erosion of Trust in the Judiciary:** A widespread public belief persists that the legal system is sluggish, and that wealthy or well-connected doctors can easily evade accountability for malpractice. This deep skepticism drives ordinary citizens to bypass the law and seek immediate vigilante justice.

5. Media-Centric Factors

- **Sensationalism and the "Underdog" Narrative:** Media outlets frequently prioritize high-engagement sensationalism over objective truth. Journalism routinely frames medical crises as a battle between a defenseless, impoverished patient (the underdog) and a massive, predatory healthcare industry led by elite, cold-hearted physicians. By twisting complex clinical outcomes into black-and-white stories of corruption, the press severely damages the public image of ordinary doctors and fuels societal hostility.

Chapter 3: Prevention of Violence against Registered Medical Practitioners

1. Doctors should ideally aim to increase patient interaction and minimize lengthy waiting times for patients in the waiting rooms as much as possible. To achieve this, it may be useful to use digital technologies, mobiles. For example, long in-hospital queues, a lack of doctor communication, and opaque billing systems have been seen time and time again as important predictors of violence in India. Digital and mobile technology can make a significant contribution to this field.
2. There can be a lot of help in hospitals to reduce violence. In government hospitals, this can be done as part of a general reform of hospital services in the form of, (i) improving services on a global scale; (ii) employing a sufficient number of physicians and other steps to ease patient rushes and long waiting hours; (iii) using computer and internet technology; (iv) strengthening hospital safety and the need to be properly informed, etc.
3. Patients, their families, and society as a whole have an enormous duty to discourage such abuse. Disputes between patients and hospitals or physicians should not be resolved by violent means, but disputes should be resolved through civilized means. It should be understood that vandalism and violence in a hospital or clinic is a criminal offence, and any civilized society should have a low tolerance for such heinous acts.
4. Both print and electronic media have a duty not to sensationalize the news. Medicine is not a black and white subject, and so is its management. Patient diagnosis is essentially hypothetical and detractive and the diagnosis of several cases continues to be refined with new evidence through investigation and knowledge.
5. In India, there is a multi-layered cause of violence against doctors. Government spending about **1 percent of GDP** in a population that has grown five times since independence is not enough. Modern medicine is progressing by leaps and bounds, but most of the country's medical colleges and hospitals have struggled to keep up with the growth. The government needs to put the effort into seeing how to avoid overcrowding in the hospitals. No nation can build hospitals for 1300 million patients, but it is possible to create hospitals for a relatively healthy 1300 million people. In a country like India keeping 1300 million people healthy is a humongous task.
6. The fundamental requirements are nutrition, immunization, health education, pollution control, personal hygiene, clean water access, unadulterated milk, unadulterated food, exercise facilities, playground, etc. Preventive medicine should be the focus of its

activities. The government will punish someone who hurts the doctor and vandalises the hospital with illegal behaviour.¹

Chapter 4: The Rights of a Registered Medical Practitioner (RMP)

1. Professional & Statutory Privileges

- **Right to Use Titles or Degrees:** A registered doctor holds the exclusive legal right to use the prefix "Doctor" or "Dr." before their name. They are fully authorized to display their valid academic degrees, diplomas, and state registration details on prescription sheets, letterheads, and clinical signboards.
- **Appointment in Public, Private, and Government Sectors:** Official state registration legally qualifies a practitioner to apply for and hold medical offices. They have the right to be employed as medical officers or consultants across public sector undertakings, private corporate hospitals, and government health departments.
- **Right to Issue Medical Certificates:** RMPs possess the sole legal authority to sign, validate, and issue official medical documents. This includes medical fitness certificates, sick leave notifications, and legally mandated birth or death certificates required by employers, courts, or government bodies.
- **Right to Give Evidence in Court:** Under statutory evidentiary laws, an RMP has the right to testify in a court of law as an expert witness. They can present professional opinions, clarify forensic findings, and interpret clinical data regarding injuries, toxicological analysis, or post-mortem evaluations.

2. Clinical Autonomy & Patient Management

- **Right to Choose His Patient:** Except in life-threatening clinical emergencies, a doctor is never legally forced to treat every individual. They retain the professional freedom to refuse a new patient or terminate an active doctor-patient relationship due to non-cooperation, specialized resource limitations, or abusive behavior, provided they give adequate notice to ensure a safe transition of care.
- **Right to Prescribe Relevant and Existing Medicine:** Only a validated RMP holds the legal monopoly to prescribe modern allopathic medicines, therapeutic interventions, and controlled formulations. They have the right to select, stock, and administer appropriate scheduled drugs based entirely on their independent clinical diagnosis.

¹ Jaya Vats, *Zero Tolerance: Violence Towards Doctors and Healthcare Workers*, iPleaders Blog (Sept. 25, 2020), [ipleaders.in](https://www.ipleaders.in).

- **Clinical Autonomy & Independent Judgment:** Doctors have the absolute right to diagnostic and therapeutic freedom. They are entitled to decide the best course of medical treatment or diagnostic pathways for their patients based entirely on standard guidelines and medical ethics, completely free from external corporate, administrative, or non-medical interference.

3. Financial, Institutional, & Special Rights

- **Right to Realise Fees:** An RMP has a legally enforceable right to demand, receive, and recover fair remuneration for their diagnostic skills, time, and surgical operations. If a patient or their handlers default on payments, the doctor is legally entitled to file a civil suit to recover these dues.
- **Right to Remove Organs from a Dead Body:** Under regulated human organ transplantation statutes, a qualified medical practitioner is legally permitted to harvest organs and tissues from a deceased individual. This right applies strictly for legitimate anatomical donations, therapeutic transplants, or during authorized legal autopsies.
- **Right to Use Recognized Medical Symbols:** Allowed to display universally accepted medical symbols—such as the Staff of Asclepius or Caduceus—on their private vehicles, clinics, and prescription forms to identify their status as healthcare providers. (Note: Use of the official Red Cross emblem by private practitioners is prohibited under the Geneva Conventions Act).
- **Workplace Protection and Safety:** Doctors have the right to a secure and non-threatening professional environment. They are legally protected by specialized workplace statutes that penalize physical violence, verbal abuse, or property damage caused by patients or their relatives within clinical premises.

Chapter 5: The Duties of a Registered Medical Practitioner (RMP)

1. Primary Duties Towards the Patient

- **Adhering to the Standard of Care:** An RMP has a legal obligation to provide professional services with a reasonable degree of skill, knowledge, and clinical caution expected from a competent peer in the same specialty. Falling below this baseline constitutes actionable medical negligence.
- **Obligation to Provide Emergency Care:** While a doctor has the right to choose their regular patients, they are legally and ethically bound to provide immediate, life-saving emergency medical treatment on humanitarian grounds to any critical patient.

- **Securing Informed Consent:** Before performing any surgical operation, invasive diagnostic test, or high-risk therapy, a doctor must fully explain the nature of the condition, alternative treatment paths, and potential risks. They must obtain explicit, written informed consent from the patient or a legal guardian.
- **Maintenance of Medical Records:** A physician is legally mandated to properly maintain, update, and preserve detailed indoor and outdoor patient medical records for a minimum period of 3 years. Upon formal request by the patient, their authorized attendants, or legal authorities, the doctor must issue these records within 72 hours.
- **Ensuring Continuity of Care:** An RMP cannot abruptly abandon a patient mid-treatment without a valid reason. If a doctor-patient relationship must be terminated, the doctor must give sufficient advance notice to allow the patient to find alternative medical care safely.

2. Primary Duties Towards the Public

- **Public Health Safety and Awareness:** RMPs must prioritize public safety, offering their professional services to aid the community during health crises, natural disasters, or mass epidemics.
- **Ethical Dissemination of Knowledge:** When addressing the public, a doctor must share scientifically validated medical facts, avoid creating public panic, and refrain from endorsing commercial brands or secret remedies for financial gain.

3. Administrative & Professional Conduct Regulations

- **Display of Registration Number:** A physician must prominently display the official registration number accorded to them by the State or National Medical Council inside their clinic, as well as print it clearly on all prescriptions, certificates, and financial receipts given to patients.
- **Exposure of Unethical Conduct:** A practitioner has a strict duty to safeguard the integrity of the medical community. A physician should expose, without fear or favour, any incompetent, corrupt, dishonest, or unethical conduct observed on the part of any member of the medical profession.
- **Provision of Professional Services:** RMPs must render professional services with complete independence, avoiding commercial pacts (such as accepting kickbacks, rebates, or commissions for diagnostic and pharmaceutical referrals) that compromise patient care.

- **Supervision of Subordinates:** When delegating medical duties, a practitioner must adequately supervise all non-physician staff, interns, and nurses under their command to ensure strict adherence to safety protocols.

4. Legal Compliance & Forensic Obligations

- **Evasion of Legal Restrictions:** The physician must strictly observe the laws of the country. They must not attempt to bypass, circumvent, or evade established statutory mandates governing medical practice.
- **Duty to Avoid Illegal Activity:** A physician must never participate in, facilitate, or execute unlawful medical procedures. This includes a strict ban on illegal sex-determination tests (under the PCPNDT Act), performing unauthorized abortions (outside MTP Act limits), or engaging in commercial organ trading.
- **Duties to Law Enforcement:** A practitioner has a mandatory legal duty to immediately notify law enforcement authorities regarding any unnatural cases that cross into their clinic—such as poisoning, burns, gunshot wounds, stab injuries, or suspected sexual assault cases.
- **Patient Confidentiality & Legal Exceptions:** RMPs must protect a patient's private data, but they are legally required to breach confidentiality and share health disclosures under specific compulsory legal mechanisms:
 1. **Public Health Threats:** Reporting mandatory communicable diseases to government registries.
 2. **Vulnerable Protection:** Notifying police or social services about child abuse or neglect.
 3. **Judicial Subpoenas:** Disclosing clinical files under a direct court order or subpoena.
 4. **Duty to Warn:** Informing authorities if a patient explicitly threatens the life of a specific third party.

Chapter 6: Laws Protecting Doctors from Patients

A. Criminal & Physical Protection Counter-Measures

- **Cognizable & Non-Bailable Workplace Defenses:** Acts of violence, verbal abuse, intimidation, or infrastructure damage directed at an active practitioner within a medical center constitute a cognizable, non-bailable offense. The offender faces a prison term

of up to 3 to 5 years, alongside an obligation to pay double the market replacement value for any broken clinical property.²

- **Epidemic Action Penalties:** Any physical assault, systemic harassment, or dynamic injury inflicted upon medical personnel executing disease-control protocols or public health assignments during emergency periods triggers rigorous central prosecution, carrying prison terms ranging from 3 months to 7 years.³

B. Judicial Immunities & Practice Safeguards

- **Protection Against Malicious Criminal Arrests:** Law enforcement personnel are legally barred from registering a First Information Report (FIR) or executing an arrest against an RMP for criminal negligence unless a competent, independent medical panel comprising public sector practitioners explicitly reviews the medical file and issues a signed report verifying the commission of "gross negligence."⁴
- **Good Faith Clinical Safeguards:** An active physician is granted total immunity from standard criminal homicide or hurt charges if a patient encounters an unpredictable clinical complication, adverse outcome, or death during a bona fide medical procedure or surgery, provided the physician acted with absolute good faith, reasonable care, and devoid of criminal intent.⁵
- **Errors of Judgment Shield:** The law insulates practitioners from liability for errors of medical judgment, confirming that a standard diagnostic or therapeutic failure does not equate to actionable negligence as long as the physician's choices align with a logical course of care supported by a responsible body of medical opinion.⁴
- **Resource and Structural Infrastructure Limitations:** A physician cannot be sued for a deficiency of care or professional negligence if they refuse to admit or treat a non-emergency patient due to an actual lack of vacant beds, unequipped operating rooms, or saturated critical care infrastructure.

C. Civil & Autonomy Privileges

- **Remuneration and Fee Enforcement Recovery:** Medical practitioners hold a legally

² Hospital Protection Acts vary by state. E.g., The Maharashtra Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage to Property) Act, 2008, § 4.

³ The Epidemic Diseases Act, 1897, § 3 (amended by The Epidemic Diseases (Amendment) Act, 2020, No. 34 of 2020).

⁴ Jacob Mathew v. State of Punjab, (2005) 6 S.C.C. 1 (India).

⁵ The Bharatiya Nyaya Sanhita, 2023, No. 45 of 2023, § 26, § 88 (India).

enforceable contract right to demand and recover fair compensation for their diagnostic acumen, surgical time, and clinical treatments. If a recipient defaults on the billed charges, the RMP is fully entitled to initiate recovery proceedings.⁶

- **Right to Refuse/Terminate Non-Emergency Care:** RMPs maintain professional autonomy to refuse a prospective client or terminate a current relationship based on severe non-cooperation, specialized technical limitations, or toxic/abusive behavior, as long as the case is a non-emergency and advance notification is served to secure a safe transition of care.⁷

Chapter 7: Laws Punishing Doctors for Actions Towards Patients

A. Negligence & Civil Accountability

- **Deficiency of Care Compensation:** Patients or their legal heirs hold an unshakeable right to file civil compensation claims against private physicians or corporate clinics for "deficiency of service," misdiagnosis, or structural care errors before Consumer Dispute Forums.⁸
- **Unlawful Patient Retention / Holding Bodies Hostage:** Hospitals and physicians are strictly prohibited from holding a living patient hostage or refusing to release a deceased body over unpaid medical bills or financial disputes. Doing so triggers heavy civil compensation mandates and emergency regulatory crackdowns.
- **Vicarious Liability for Subordinates:** Medical institutions and hospital managements bear primary vicarious liability for the negligent acts of subordinate staff—including junior interns, operational nurses, or technicians—meaning the facility cannot escape financial liability by shifting blame to individual consultants or citing the independent status of its practitioners.⁹

B. Criminal Code & Forensic Offenses

- **Negligence Causing Death:** If a practitioner kills a patient through a reckless or severely rash clinical act, they face criminal prosecution. RMPs are subject to a targeted statutory classification that caps the maximum criminal imprisonment at 2 years

⁶ The Indian Contract Act, 1872, No. 9 of 1872, § 73 (India).

⁷ National Medical Commission (Registered Medical Practitioner) Professional Conduct Regulations, 2023, § 20.

⁸ Indian Medical Association v. V.P. Shantha, A.I.R. 1996 S.C. 550 (India).

⁹ Savita Garg v. Director, National Heart Institute, (2004) 8 S.C.C. 56 (India).

alongside a mandatory financial fine, provided the event arose during a bona fide medical procedure.¹⁰

- **Medical Misrepresentation & Cheating:** A person who treats patients using fake medical degrees, presents false specialist certifications, or intentionally misrepresents their diagnostic credentials faces severe criminal penalties of up to 7 years in prison¹¹.
- **Tampering and Destruction of Clinical Evidence:** Any medical professional who deliberately overwrites, falsely alters, backdates, or destroys medical charts, operation notes, or indoor case records to conceal a lethal clinical blunder or evade law enforcement verification faces independent criminal terms.¹²

C. Specialized Statutory Bans & Data Restrictions

- **Illegal Prenatal Sex Selection:** Medical professionals are strictly prohibited from conducting or facilitating prenatal sex-determination tests. Conviction triggers up to 3 to 5 years of rigorous imprisonment, significant fines, and the mandatory, permanent cancellation of the offender's medical license.¹³
- **Unlawful Terminations of Pregnancy:** Performing an abortion outside the specific clinical indicators, legal week limits, or registered facility approvals outlined by state law constitutes a major criminal offense carrying a prison sentence of up to 7 years.¹⁴
- **Commercial Organ Trading and Harvesting:** Manipulating transplant waitlists, buying or selling organs, or harvesting tissue from a living or deceased subject without verified statutory consents exposes the practicing doctor to up to 10 years of imprisonment and significant financial penalties.¹⁵
- **Electronic Health Record Violations & Data Leaks:** Clinics and hospital networks operate under a strict "Data Fiduciary" status. If a medical entity leaks, shares, or leaves a patient's personal electronic health records, diagnostic imaging, or prescriptions exposed without explicit user consent, the central board can impose massive financial penalties directly on the medical institution.¹⁶

¹⁰ The Bharatiya Nyaya Sanhita, 2023, No. 45 of 2023, § 106(1) (India).

¹¹ The Bharatiya Nyaya Sanhita, 2023, No. 45 of 2023, § 318 (India).

¹² The Bharatiya Nyaya Sanhita, 2023, No. 45 of 2023, § 238 (India).

¹³ The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994, No. 57 of 1994, § 23 (India).

¹⁴ The Medical Termination of Pregnancy Act, 1971, No. 34 of 1971, § 5 (India).

¹⁵ The Transplantation of Human Organs and Tissues Act, 1994, No. 42 of 1994, § 18 (India).

¹⁶ The Digital Personal Data Protection Act, 2023, No. 22 of 2023, § 33 (India).

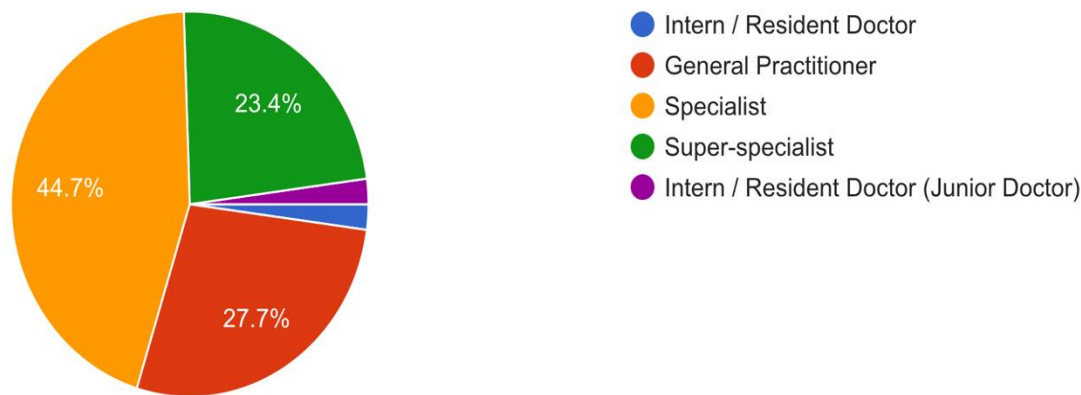
- **Deceptive Advertising and Mass Solicitation Mandates:** Registered practitioners face multi-level disciplinary enforcement action—ranging from formal ethics remediation to extended practitioner registration suspension (spanning up to 12 months) or multi-year complete removal from the national and state registers—for executing deceptive digital marketing campaigns or mass online solicitations.¹⁷

The laws protecting and defending as well as prosecuting and punishing doctors passed by the central government and state governments are already well established and the rights and duties of doctors are thoroughly grounded in statutory laws and medical ethics. Now the real question is about the safety of doctors' minds, bodies, reputations and properties when they are aggressively approached and threatened by the patients and their kith and kin. The patients and their friends or families can file the complaint against the doctors if they are not satisfied about the doctors' work and efforts but instead, they take matters into their own hands and sometime violently thus they are the ones who should be held responsible for causing harm to doctor. So, a survey was conducted to see if the doctors had faced these kinds of issues either in past or present and whether they had sought recourse and remedies to protect and defend themselves against the patients and if they did, were they successful in getting the justice they deserved or not.

Chapter 8: Survey on attacks on doctors.

What is your designation?

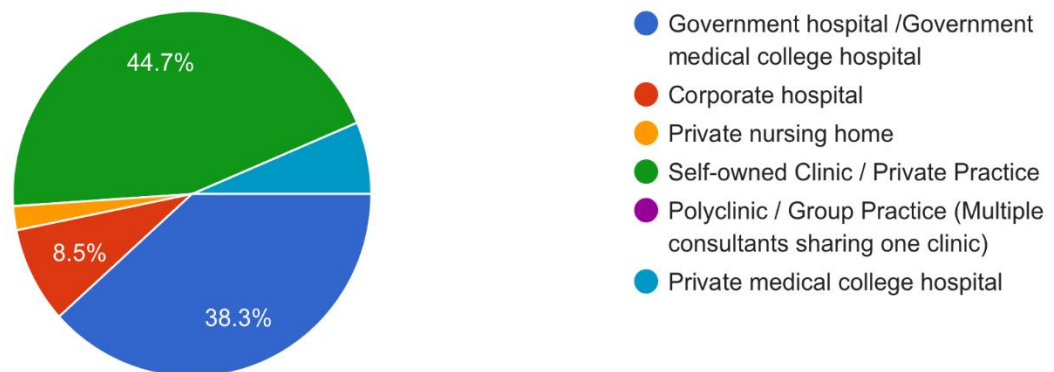
47 responses



¹⁷ National Medical Commission Guidelines on Ethical Advertising and Public Communication by Hospitals/Medical Institutions and Registered Medical Practitioners, 2026, ch. 5.

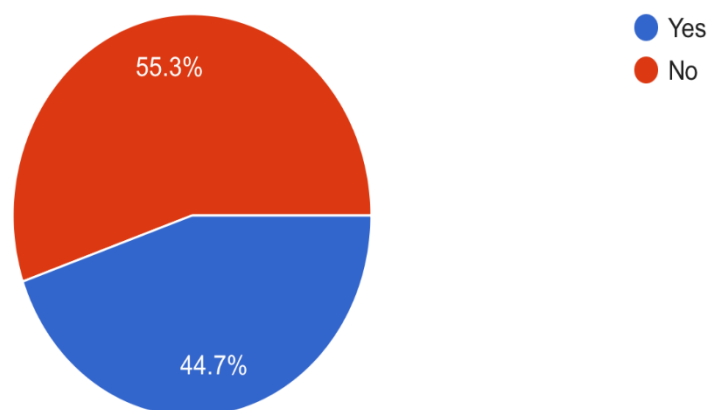
Which of the following healthcare settings do you work in ?

47 responses



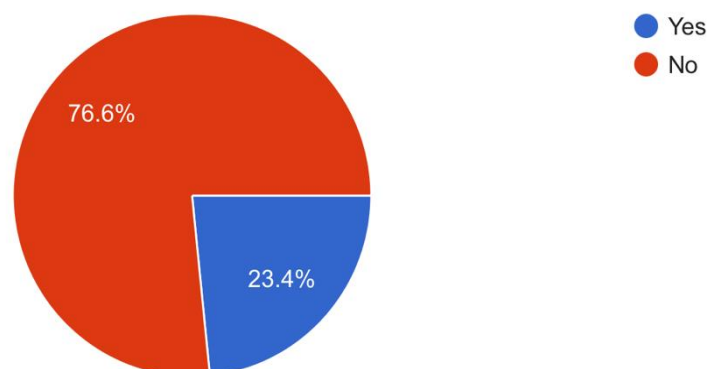
Have the patients or their accompanying visitors subjected you to verbal abuse (eg: yelling, shouting or foul language)?

47 responses



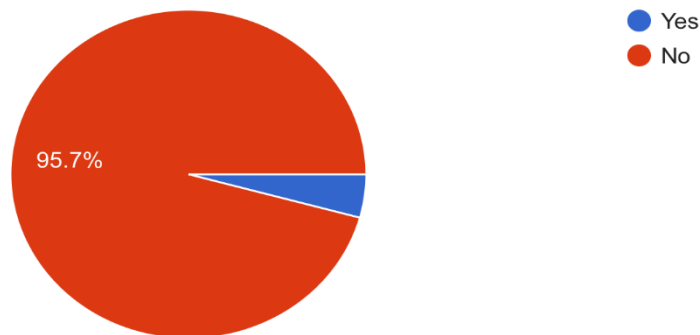
Have you experienced any stalking or threats from them?

47 responses



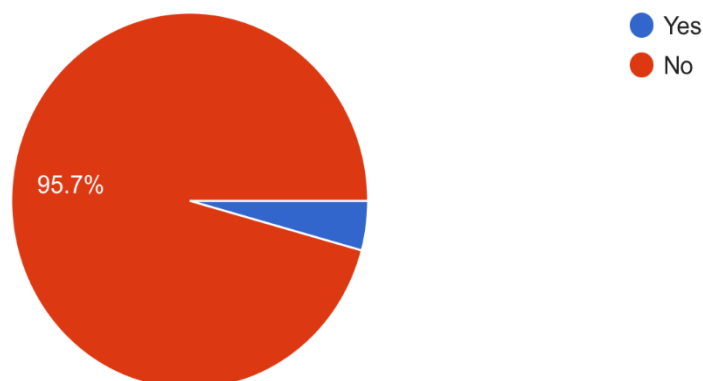
Have you experienced physical assault (like hitting, slapping, pushing, kicking or being stabbed) or direct threats of physical violence?

47 responses



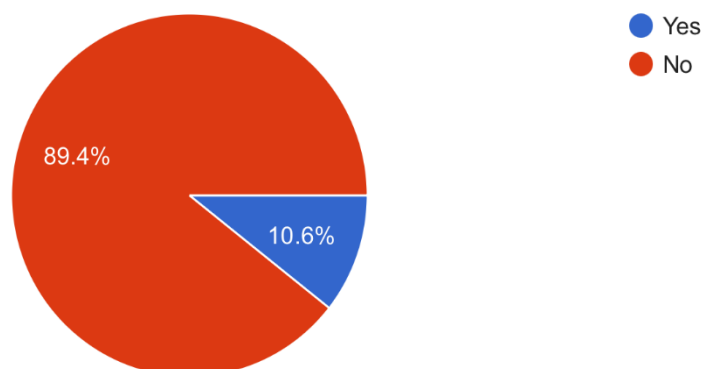
Have you experienced property damages (such as personal belongings, clinical equipments or facility structure) caused by them?

47 responses



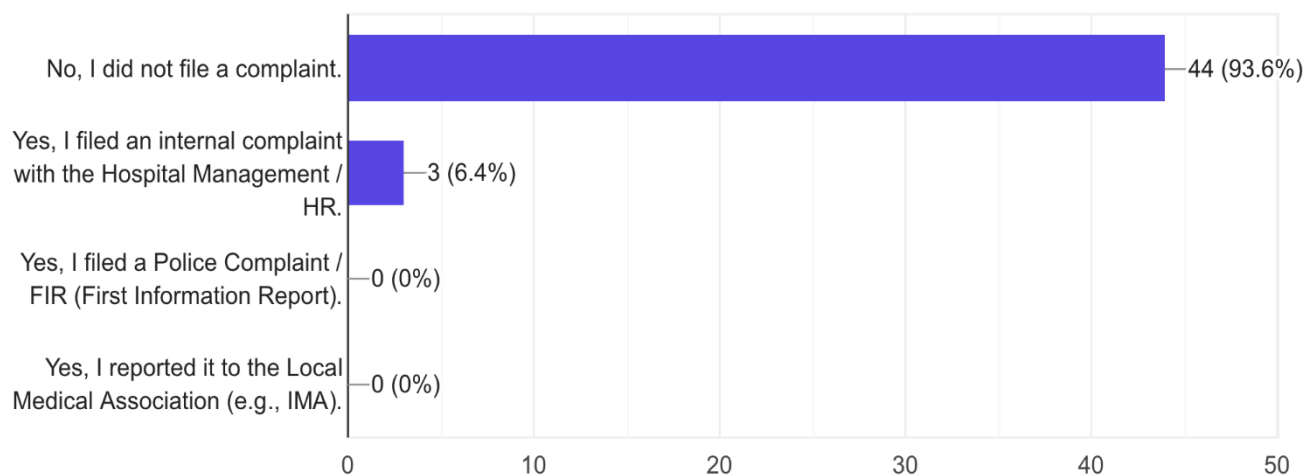
Have you faced unverified accusations or protests (such as social media defamation, character attacks or staged demonstrations/ dharnas) against you or your clinic?

47 responses



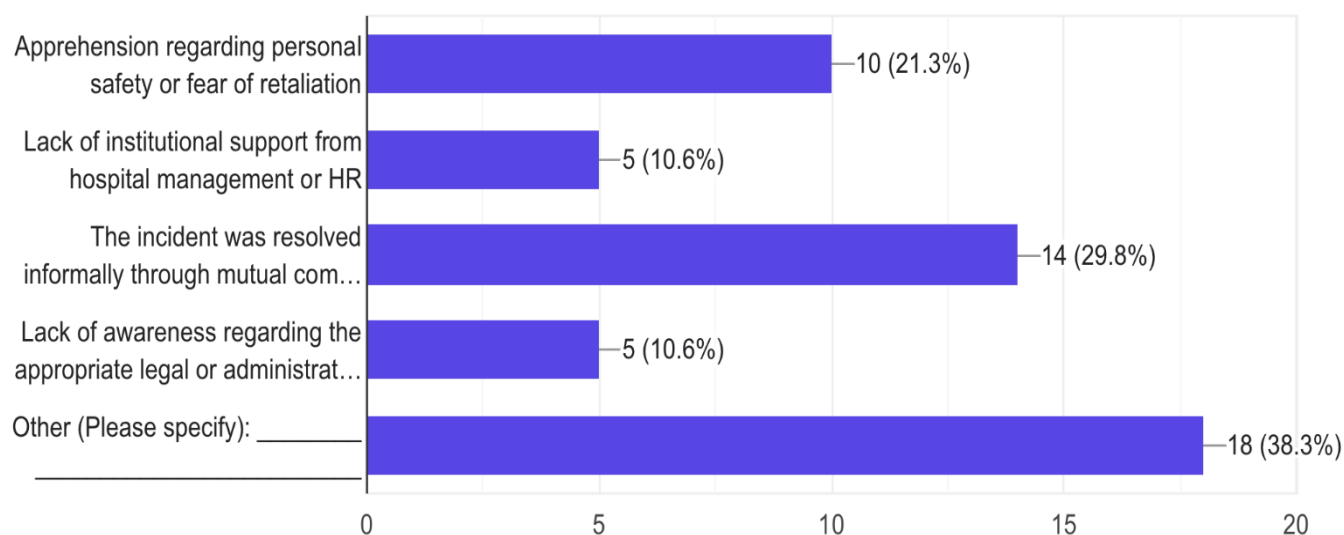
Have you filed an official complaint against them regarding any such incident(s)? (Select all that apply)

47 responses



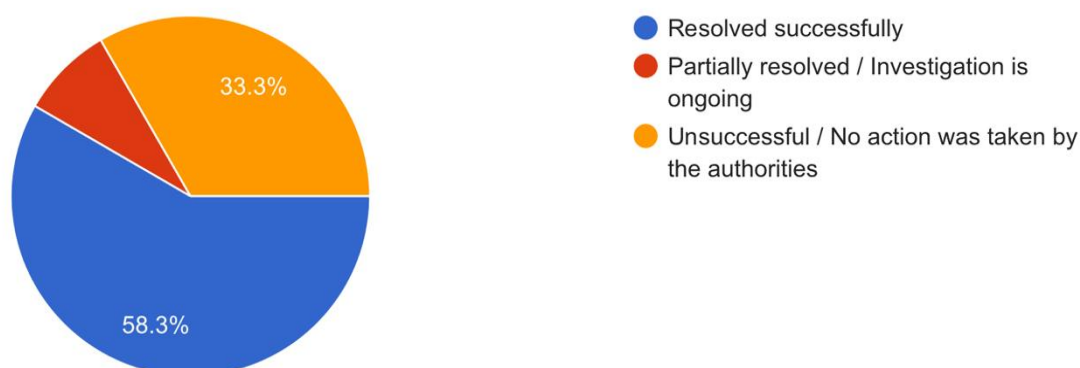
If no official complaint was filed, or if the filed complaint was unsuccessful, what were the reasons? (Select all that apply)

47 responses



If yes, has the action taken been successful so far?

24 responses



This survey evaluates the demographic profiles, professional environments, and direct experiences with workplace hostility among 47 medical practitioners. The sample features a slight male majority, consisting of 25 male doctors (53.2%) and 22 female doctors (46.8%). In terms of age distribution, the overwhelming majority belong to the 40 to 60 age bracket, comprising 39 respondents (83.0%), while the remaining cohorts are distributed between the 20 to 40 age bracket (5 respondents or 10.6%) and the 60 to 80 bracket (3 respondents or 6.4%); no respondents were aged 80 or above. Professionally, the cohort is highly senior, led by 21 Specialists (44.7%), followed by 13 General Practitioners (27.7%), 11 Super-specialists (23.4%), and a combined total of 2 Interns or Resident Junior Doctors. These practitioners predominantly operate out of Self-owned Clinics or Private Practices (21 doctors or 44.7%) and Government Hospitals or Government Medical College Hospitals (18 doctors or 38.3%), with minimal representation across Corporate Hospitals (4), Private Medical College Hospitals (3), and Private Nursing Homes (1), and absolute zero representation in Polyclinics or Group Practices.

Regarding exposure to patient- or visitor-initiated hostility, workplace violence primarily manifests through psychological and verbal channels rather than overt physical damage. Verbal abuse such as yelling, shouting, or foul language is the most widespread threat, experienced by 21 practitioners (44.7%), while 26 practitioners (55.3%) reported no such incidents. This is followed closely by stalking or direct threats, which targeted 11 practitioners (23.4%), while 36 practitioners (76.6%) remained unaffected. Additionally, 5 doctors (10.6%) faced unverified accusations or protests such as social media defamation, character attacks, or staged dharnas, whereas 42 doctors (89.4%) did not. Conversely, physical assault—including hitting, slapping,

pushing, kicking, or stabbing—and property damages to clinical equipment or facilities were much rarer, with both categories yielding identical figures of 2 positive responses (4.3%) against 45 negative responses (95.7%).

Despite this significant baseline of hostility, the data exposes a profound crisis of institutional and legal underreporting among victims. A staggering 44 out of 47 doctors (93.6%) did not file any official complaint following these encounters. A mere 3 practitioners (6.4%) filed an internal complaint with their hospital management or HR, while absolutely zero formal police complaints or FIRs were initiated, and zero incidents were reported to local medical bodies like the Indian Medical Association (IMA). When evaluating why these channels are avoided, the primary drivers for non-reporting or unsuccessful escalations include informal resolutions through mutual communication or mediation (14 counts or 29.8%) and deep-seated apprehensions regarding personal safety or fear of retaliation (10 counts or 21.3%). Institutional roadblocks are also prominent, with 5 counts (10.6%) attributing the barrier to a lack of institutional support from management or HR, and another 5 counts (10.6%) pointing to a distinct lack of awareness regarding appropriate legal or administrative reporting channels. Furthermore, a significant share of respondents chose "Other" reasons (18 counts or 38.3%), capturing systemic normalization or disillusionment with the efficacy of reporting pathways. Consequently, out of the 24 responses tracking the resolution status of actions taken, the overwhelming trend confirms that conflict mitigation relies primarily on non-legal avenues with mixed outcomes. Among the 24 practitioners who attempted some form of intervention, a majority of 58.3% (14 respondents) noted that the situation was resolved successfully, largely mirroring the subset of cases settled via informal bedside mediation and mutual communication. However, a significant 33.3% (8 respondents) reported that their efforts were completely unsuccessful with no action taken by the authorities, highlighting an institutional vacuum in addressing staff distress. The remaining 8.4% (2 respondents) indicated that the issue was only partially resolved or that an investigation remains ongoing. Given that zero formal police complaints or FIRs were filed across the entire sample, these success rates strictly gauge localized, internal dispute processing rather than standard legal enforcement under the central BNS framework, underscoring a critical need for structured administrative protections.

Criminal & Physical Protection Countermeasures For The Following Offences Mentioned In The Above Survey Are:

- **Verbal Abuse & Modesty Violations:** Using vulgar, abusive, or obscene language to intentionally insult a practitioner falls under **BNS Section 352** (intentional insult to

provoke a breach of peace), carrying up to **2 years imprisonment**, a fine, or both. If the verbal abuse or gesture specifically targets a female doctor with the intent to insult her modesty, **BNS Section 79** applies, which mandates a stricter prison term of up to **3 years** along with a fine.¹⁸

- **Gender-Specific Stalking Protections (Female Practitioners):** Repeatedly following, monitoring, or contacting a female practitioner against her will—physically or digitally via emails, social media, or electronic communication—constitutes stalking under **BNS Section 78**. As this provision is legally gendered, it applies strictly to offenses committed by a man against a woman, carrying up to **3 years imprisonment** and a fine for a first offense, and up to **5 years** for repeat offenses.²¹
- **Harassment Countermeasures (Male Practitioners):** Because BNS Section 78 does not apply if the victim is male, persistent tracking, digital harassment, or obsessive monitoring targeting a male practitioner is prosecuted under gender-neutral provisions. This includes **BNS Section 351** (Criminal Intimidation) if the harassment causes alarm or involves threats to person, property, or reputation,²¹ alongside **Section 66D of the IT Act, 2000** if the perpetrator uses a fake digital profile or computer resource to impersonate another individual to harass them.²²
- **Universal Cyber-Harassment & Digital Abuse:** If any doctor (regardless of gender) is targeted online via abusive, obscene, or threatening messages, specific sections of the **Information Technology (IT) Act, 2000** are invoked alongside the BNS. Sending or publishing obscene, defamatory, or vulgar material electronically is prosecuted under **IT Act Section 67** (punishable by up to **3 years imprisonment** and a fine up to ₹5 lakh). If the stalker or harasser creates fake social media accounts using the doctor's name, photos, or medical credentials to destroy their practice, it is prosecuted under **IT Act Section 66C** (Identity Theft).¹⁹
- **Criminal Intimidation:** Direct threats intended to alarm any practitioner (regardless of gender) or force them to perform or omit an act constitute criminal intimidation under **BNS Section 351**, carrying up to **2 years imprisonment**, a fine, or both. If the threat involves causing death or grievous hurt, the penalty scales up to **7 years**.²¹
- **Workplace Disturbance, Mobbing & Rioting:** Forming an aggressive crowd, mobbing clinical facilities, or engaging in rioting to disrupt hospital operations or intimidate staff is strictly prohibited. Under **BNS Section 189** (unlawful assembly)

¹⁸ The Bharatiya Nyaya Sanhita, 2023, No. 45 of 2023 (India).

¹⁹ The Information Technology Act, 2000, No. 21 of 2000 (India).

and **BNS Section 191** (rioting), offenders face rigorous prosecution with prison terms ranging from **2 to 5 years** alongside applicable fines.²¹

- **Obstruction of Clinical Duty:** Voluntarily obstructing, interrupting, or deterring a healthcare professional from discharging their official clinical duties triggers rapid prosecution under **BNS Section 221**, carrying a prison term of up to **3 months**, a fine, or both.²¹
- **Physical Assault & Criminal Force:** Making threatening gestures that cause a doctor to apprehend imminent violence constitutes assault under **BNS Section 130**, while the actual unauthorized use of physical force (striking or pushing) falls under **BNS Section 129**. Under **BNS Section 131**, basic assault or criminal force carries a penalty of up to **3 months imprisonment**, a **₹1,000 fine**, or both. Voluntarily causing bodily hurt or severe permanent injury falls under **BNS Sections 115 and 117**.²¹
- **Deterrence of Public Servants:** If the physical assault, obstruction, or criminal force is directed at a government doctor or medical public servant to deter them from executing their public duty, **BNS Section 132** applies directly, elevating the legal penalty to a maximum of **2 years imprisonment** and a fine.²¹
- **Clinical Property Damage & Mischief:** Vandalism, infrastructure destruction, or damaging clinical premises, medical devices, emergency vehicles, and pharmacy supplies is treated as criminal mischief under **BNS Section 324**. The punishment scales strictly based on the market value of the damage caused, escalating dramatically if fire, explosives, or public utility infrastructure are affected.²¹
- **Professional Defamation Countermeasures:** Making or publishing false, malicious, or unverified imputations against a doctor's professional capability or moral character—whether spoken, written, or distributed across digital media platforms—is prosecuted under **BNS Section 356**. Convicted offenders face simple imprisonment of up to **2 years**, a fine, both, or a mandatory sentence of **community service**.²¹

Chapter 9: What Were The Main Research Objective And The Specific Sub Objectives For Attacks On Doctors?

Main Research Objective

The primary objective of this study was to assess the prevalence, nature, and reporting patterns of workplace violence among medical practitioners across varied healthcare settings, while identifying the systemic barriers encountered when seeking legal or institutional redress.

Specific Sub-Objectives

- To profile the demographic and professional characteristics of the surveyed healthcare providers, including their age, gender, designation, and practice settings.
- To quantify and categorize the types of violence inflicted by patients or visitors, specifically comparing the prevalence of verbal abuse, stalking, physical assault, property damage, and unverified public accusations or defamation.
- To evaluate the reporting behaviors of the victimized doctors, specifically measuring their utilization of internal management reporting versus formal legal or association channels.
- To identify the primary barriers and deterrents that prevented the participants from filing official complaints, such as fear of retaliation, lack of institutional support, informal resolutions, or awareness gaps.

Chapter 10: What Kind of Research Methodology, Research Design And Research Methods Were Being Used For The Above Survey.

Having presented the empirical findings and percentage distributions of the collected data, it is necessary to outline the underlying structural framework that governed this study. The following sections detail the specific research methodology, design protocols, and practical data collection methods that were implemented to achieve these results.

Research Methodology

This study utilized a Quantitative Research Methodology to examine the prevalence of workplace violence and the corresponding reporting behaviors among medical practitioners. This methodology was selected because it allowed for the transformation of operational human experiences into empirical data, frequency counts, and percentage distributions. By quantifying these occurrences, the study provided measurable data regarding safety challenges within the medical sector and mapped them against the legal frameworks of the Bharatiya Nyaya Sanhita, 2023, and the Information Technology Act, 2000.

Research Design

- **Descriptive Research Design:** A descriptive research framework was implemented to systematically observe, document, and describe the current safety landscape, the specific typologies of hostility encountered by healthcare staff, and the structural

barriers preventing formal legal escalation. The primary purpose was to address the question of "what was happening" across active clinical settings without manipulating environmental variables.

- **Cross-Sectional Time Horizon:** The study adopted a cross-sectional time approach, collecting empirical data from the target population at a single, specific point in time **over a one-week duration**. This approach provided an objective operational snapshot of the sample group's working realities **during this designated timeframe** rather than tracking behavioral shifts over a longitudinal tracking period.

Research Methods

- **Data Collection Instrument:** Data collection was executed using a highly structured, self-administered digital questionnaire. The survey utilized closed-ended multiple-choice options, dichotomous (Yes/No) filtering logic, and multi-select checkboxes to gather standardized metrics from all participants.
- **Sampling Technique:** The study employed Purposive Non-Probability Sampling. Participants were deliberately selected based on strict professional inclusion criteria: they had to be active medical practitioners (ranging from interns and resident doctors to senior specialists and super-specialists) operating within recognized public or private healthcare delivery environments. This targeted approach ensured that the sample possessed the exact operational experience necessary to satisfy the research objectives.
- **Data Analysis:** The collected raw empirical data was processed using descriptive statistical analysis. This involved sorting the cumulative responses, calculating frequency distributions, converting raw counts into representative percentages, and utilizing visual data analysis tools, such as pie charts, to identify clear trends in conflict outcomes and reporting barriers.

Chapter 11: Conclusion

This shows that despite laws and guidelines have been provided to deal with any kind of problems arising between the patients and doctors where doctors are victims, the attacks on doctors are persisting and they are forever haunted by the harms caused on them. It is heartbreaking that doctors are still scared and stressed about the injury and the loss caused by the patients despite the fact they have the full backing of the laws. The patients have absolutely no right to decide whether doctors are guilty or innocent and there is no justification for the patients to be emotionally and psychologically act as judge, jury and executioner to doctors.

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