WEAVE SPRINT . PAPER III

Forensic ethics, consent and legal procedure

The ethics a psychiatrist is held to, and the legal machinery around the work. The four principles and the current professional-conduct code; informed consent and the limits of confidentiality; negligence and the Consumer Protection Act; and the psychiatrist as an expert witness. Then the criminal interface, where the substantive law changed on the first of July 2024, and the Bharatiya Nyaya Sanhita, Nagarik Suraksha Sanhita and Sakshya Adhiniyam now govern the offence, the procedure and the evidence. Closing on disaster, prisoners and custodial care.

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WEAVE . CENTRE FOR INTEGRATIVE PSYCHIATRY

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Concept / rule Key number Trap

PAPER III

Forensic ethics, consent and legal procedure

Five bands . one complete notes document

Orientation: forensic ethics and the legal interface

1 · Orientation: forensic ethics and the legal interface

Why this chapter earns its marks. Almost every question in forensic and ethical psychiatry is, underneath, a question about a single person standing in two places at once. The same clinician who sits with a patient in the consulting room may later sit in a witness box and be asked to give an opinion that helps convict that patient, or a different one. These two positions do not merely differ in setting; they impose opposing duties, answer to different masters, and are governed by different rules about what may be said and to whom. The candidate who holds that tension steadily can reason their way through unfamiliar vignettes; the candidate who has only memorised isolated rules cannot.

This opening section is the chapter's **advance organizer**: the map you should carry in your head while you read everything that follows. It asserts nothing new of its own and teaches no section numbers. Its whole job is to give the later material a shape, so that each rule you meet later has a place to sit rather than floating free. The accompanying figure sets out the same structure visually; read it alongside this text.

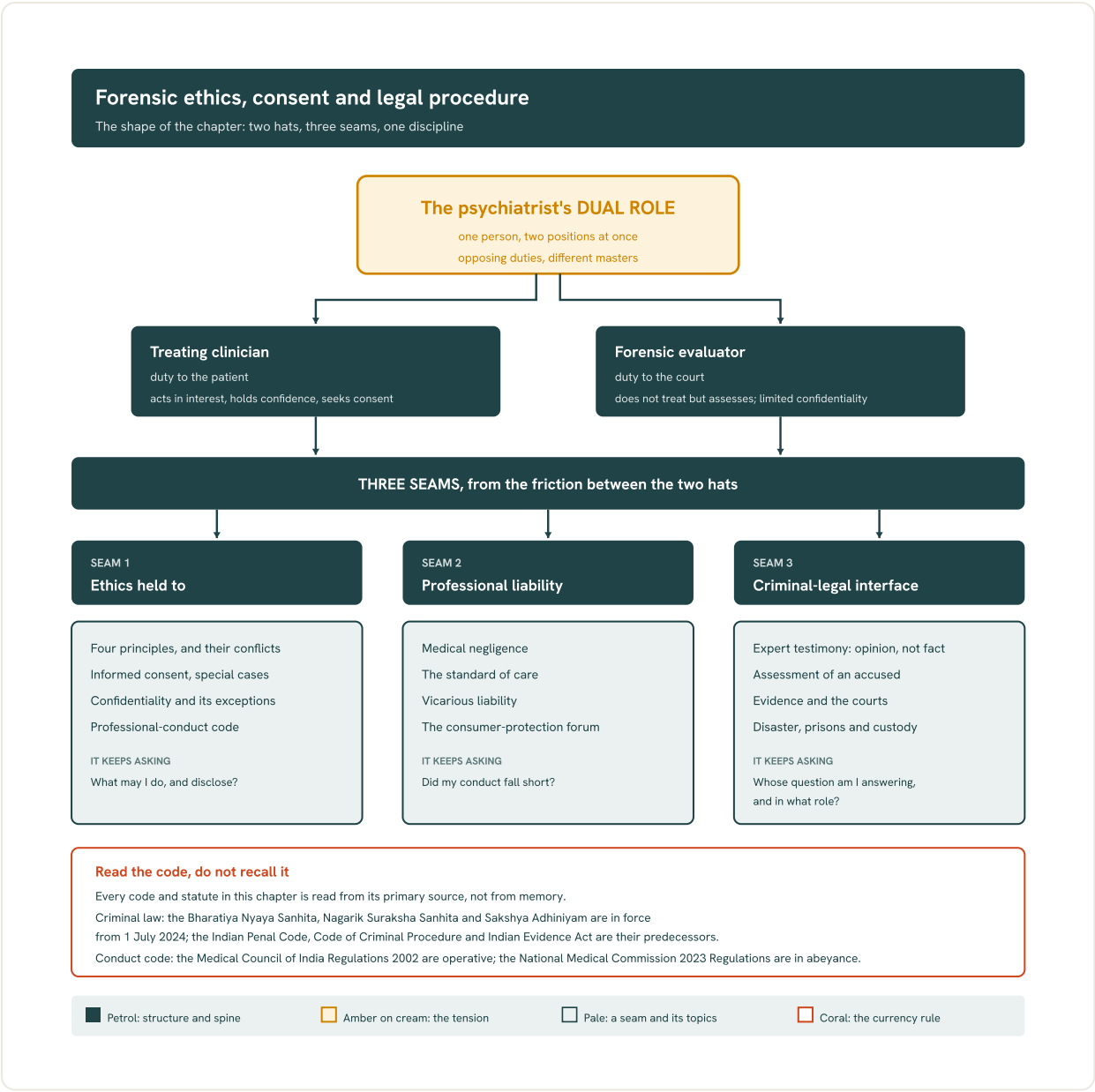

Fig 26.1. The chapter's architecture: one psychiatrist in a dual role, treating clinician on one side and forensic evaluator on the other, and from that friction three seams - the ethics held to, professional liability, and the criminal-legal interface - each read from its primary source with the law current as of 1 July 2024.

1.1 The two hats: the psychiatrist's dual role

The organising tension of this whole chapter is a **dual role**. In one role the psychiatrist is the **treating clinician**, who owes a set of duties to the patient in front of them: to act in that patient's interest, to hold their disclosures in confidence, to obtain their consent before acting. In the other role the psychiatrist is a **forensic evaluator**, who does not treat but assesses, and whose duty runs not to the person being examined but to the court that has asked the question. The forensic evaluator is not the person's doctor, owes them no therapeutic loyalty, and must say plainly, before beginning, that the ordinary clinical duty of confidentiality does not apply and that what is said may be set down in a report for whoever asked for the assessment.

Almost every controversy in the chapter is a friction between these two roles. The obligations that protect a patient in the first role become the very things a court needs the evaluator to set aside in the second. When a treating psychiatrist is dragged into a case about their own patient,

the two hats collide directly, and knowing which hat is being worn at a given moment is what tells you which duty controls.

MNEMONIC

Two Hats, Three Seams

The **two hats** are the treating clinician and the forensic evaluator. From that one tension follow the **three seams** the chapter is stitched along: the ethics a psychiatrist is held to, professional liability, and the criminal-legal interface. Hold the two hats and you can reconstruct the three seams; hold the three seams and you can place any rule the chapter teaches.

1.2 The first seam: the ethics a psychiatrist is held to

The first seam is the ordinary ethical scaffolding of practice, examined more strictly here because the forensic setting stresses it. It runs through the four principles of biomedical ethics and how they conflict; through informed consent and the special situations that complicate it; through confidentiality and, more importantly, the recognised grounds on which confidentiality may be broken; and through professional conduct under the statutory code and the profession's own code of ethics. The recurring exam move in this seam is to take a duty you think is absolute and show you its edge - the point at which a competing duty, or a statutory permission, lets it give way.

1.3 The second seam: professional liability

The second seam is what happens when practice is alleged to have fallen short. This is **professional liability**: the law of medical negligence, the standard of care against which a doctor is judged, the idea of vicarious liability for the acts of others, and the consumer-protection forum through which a patient can pursue a claim for a deficiency in medical service. The seam matters because it converts abstract ethical duty into concrete, enforceable consequence, and because candidates routinely underestimate how far the consumer-protection route reaches into medical practice.

1.4 The third seam: the criminal-legal interface

The third seam is where the psychiatrist meets the criminal justice system: as an expert witness whose opinion evidence must be kept distinct from fact evidence, in the assessment of an accused person, in the rules of evidence and the structure of the courts, and in the special settings of disaster, prisons and custody where a vulnerable population meets a coercive institution. This is the seam where the second hat is worn most consciously, and where the difference between treating and evaluating is not a nicety but the whole point.

SEAM	WHAT IT GOVERNS	THE QUESTION IT KEEPS ASKING
Ethics	Principles, consent, confidentiality, professional conduct	What am I permitted to do, and to disclose?
Professional liability	Negligence, standard of care, the consumer forum	Did my conduct fall below what was owed?
Criminal-legal interface	Expert testimony, assessment of the accused, evidence, custody	Whose question am I answering, and in what role?

1.5 One discipline throughout: the primary source and the currency problem

One habit binds the three seams together. Every code and statute in this chapter is read from its **primary source**, not from a summary or a remembered lecture, because this is precisely the ground that has been shifting under the profession's feet. Two live currency problems run across the whole chapter. The substantive criminal law has been recodified wholesale, so that the older penal, procedural and evidence statutes have given way to their successors, with a savings rule that decides which regime applies to a given case. And the professional-conduct code has its own complication: the long-standing Medical Council of India conduct regulations remain the operative code, while the successor National Medical Commission regulations, though formally notified, have been held in abeyance and are not operative pending a further notification. An answer written from memory of the old law, or from the assumption that the newest notified rule must be the live one, will be confidently wrong.

RULE **Read the code, do not recall it.** On this chapter the currency of the source is itself the examinable content. Name the statute you are relying on, confirm it is the version in force, and check the savings position before you apply it. The forensic seam punishes stale knowledge more than any other part of the syllabus.

TRAP **Citing the superseded criminal statutes as current law.** The Indian Penal Code, the Code of Criminal Procedure and the Indian Evidence Act read as the natural answers because they were the answers for a generation. After the recodification they are historical; the successor codes govern, subject to the savings rule. Candidates lose easy marks by naming the old statute by reflex.

PITFALL

The mirror-image real-world error is to treat the newest *notified* professional-conduct regulations as the live code. The newest notified regulations were themselves held in abeyance by a later amendment, which restored the earlier Medical Council of India code as the operative one, so that is the code a disciplinary body actually applies. Acting on the wrong code is a governance error, not merely an exam slip.

IN INDIA

This is an Indian statutory chapter, and its answers are Indian primary sources that differ from the Western textbook defaults: an Indian criminal law recently recodified, an Indian professional-conduct code with a live-versus-notified split, an Indian consumer-protection route into medical liability, and an Indian confidentiality regime that *permits* proportionate disclosure rather than importing a foreign duty to warn. Where a chapter topic has an Indian answer, that is the answer the examiner wants.

1.6 The edges of the map: what is named here and taught elsewhere

An advance organizer is as much about what lies outside the frame as inside it. Several bodies of law are touched by this chapter but owned by others, and are named here only so you know where they live:

- The Mental Healthcare Act machinery, the criminal-responsibility doctrine with its insanity-defence test and its burden of proof, the disability-rights and narcotics statutes, and the violence-risk instruments belong to the Mental health legislation and forensic psychiatry notes.
- The child-sexual-offences framework, the juvenile justice law and child custody belong to the Child psychiatry: assessment, treatment, services and protection notes.
- The clinical management of substance use in custodial and de-addiction settings belongs to the Substance use disorders notes.

Within this chapter, the material moves from the ethical foundations, through consent and confidentiality, into liability, and out to the criminal-legal interface and its special settings, before drawing the seams back together. Keep the two hats and the three seams in view and the sequence will read as one argument rather than a list.

Every duty in this chapter resolves to one question - what may be disclosed, to whom, and on whose authority - and the answer changes depending on which hat the psychiatrist is wearing.

Professional ethics, consent and confidentiality

2 · Principles of medical ethics (autonomy, beneficence, non-maleficence, justice)

The four principles are the grammar every ethical argument in medicine is written in. When a psychiatrist has to defend a decision - to admit a refusing patient, to withhold a diagnosis a family demands, to ration a scarce bed - the reasons that carry weight almost always reduce to four familiar considerations: the patient's right to decide for themselves, the duty to do them good, the duty not to harm them, and the duty to treat people fairly. These are not rules that dictate answers. They are the standing obligations a clinician must be able to name and weigh,

and an examiner who asks about medical ethics is asking whether the candidate can do that weighing out loud.

The marks here are for precision and for the hard part, which is conflict. Any candidate can list the four principles; the discriminating answer shows that they are separate obligations that routinely pull against one another, that none automatically defeats the others, and that resolving a real case is a matter of judged balance rather than a lookup. This account defines each principle at the depth the exam expects, then shows how they collide inside an ordinary psychiatric decision and how a defensible clinician reasons through the collision. The professional codes that translate these principles into enforceable conduct rules, and the specific law on consent, confidentiality and negligence, are each owned elsewhere in this chapter and are named here, not re-taught.

4

PRINCIPLES OF BIOMEDICAL ETHICS

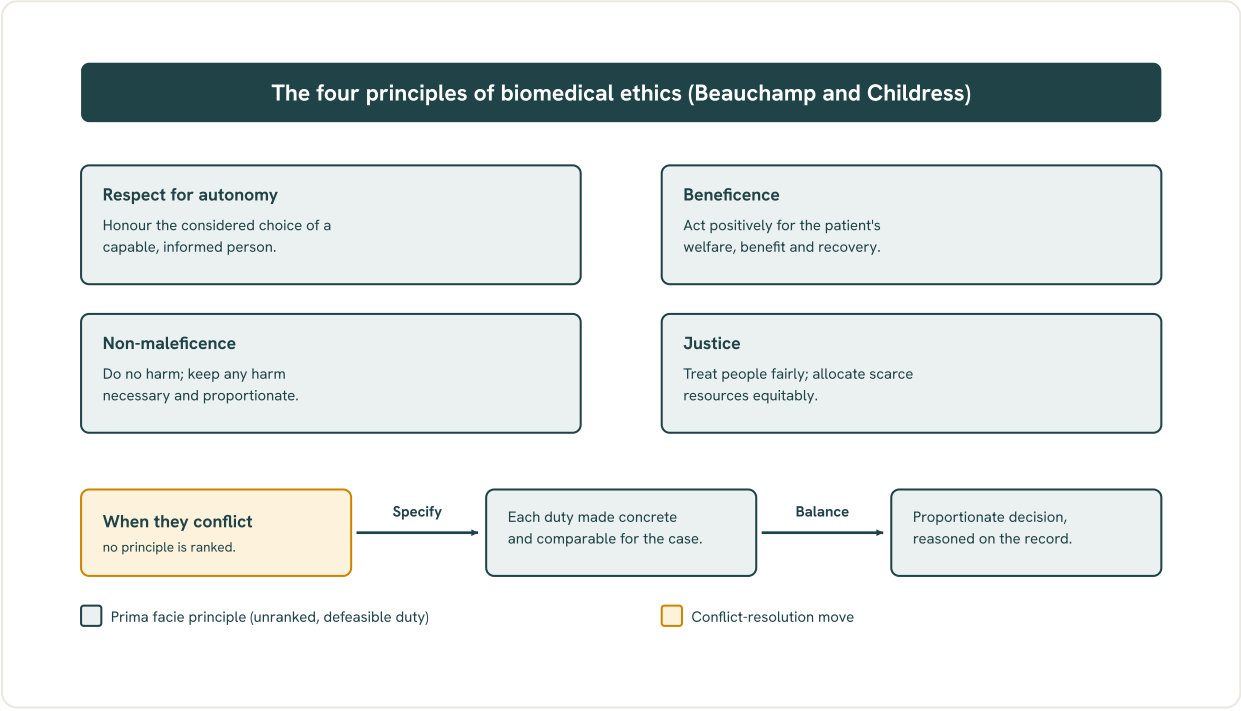

Fig 26.2. The four principles of biomedical ethics (Beauchamp and Childress) as unranked prima facie duties; at conflict, specify each then balance them into a proportionate, recorded decision.

2.1 The framework: four prima facie principles

The dominant framework in medical ethics is the four-principles approach set out by **Beauchamp and Childress**, who argued that a small set of general obligations, drawn from the morality that thoughtful people across traditions already share, can organise almost any clinical ethical problem. On this account there are **four** such obligations: respect for autonomy, beneficence, non-maleficence and justice. Their appeal is practical. They are neutral between the deeper moral theories a clinician may privately hold, so a consequentialist and a duty-based colleague can reason together in the same terms.

The single most important structural fact about the framework is that each principle is a **prima facie** obligation: it binds absolutely unless, in the particular case, it is outweighed by a competing obligation of equal or greater force. A prima facie duty is real and demanding, but it is defeasible. This is what separates the four principles from a code of commandments. There is no fixed ranking in which autonomy always beats beneficence, or non-maleficence always beats justice; the weight each carries is settled case by case. A candidate who writes that "autonomy is the highest principle" has misunderstood the model at its root, because a framework of prima facie obligations has no permanent highest.

MNEMONIC

A Bee Never Judges

The four principles of biomedical ethics: **A**utonomy (respect the capable patient's own choice), **Be**neficence (act for their good), **N**on-maleficence (do not harm), **J**ustice (treat people fairly and distribute resources justly). The phrase fixes the list; it deliberately encodes no ranking, because the framework sets none.

RULE **Each principle is a prima facie obligation with no fixed priority, so ethical reasoning is balancing, not ranking.** A principle can only be overridden by a competing principle that carries greater weight in the specific circumstances, and the clinician must be able to state which principle yielded to which, and why. An answer that resolves a dilemma by declaring one principle supreme has replaced the framework with a hierarchy the framework rejects.

2.2 Respect for autonomy

Respect for **autonomy** is the obligation to honour the considered choices of a person who is competent to make them. Its positive content is not merely leaving the patient alone; it is the duty to enable genuine self-determination - to tell the truth, to disclose what a reasonable patient needs in order to decide, to protect against coercion, and then to abide by the decision a capable person reaches, including a decision the clinician thinks unwise. Autonomy is the ethical engine behind the law of informed consent, whose elements, the assessment of decision-making capacity, and the special situations in which consent is complicated are set out in this chapter's account of informed consent and are not restated here.

Two clarifications earn marks. First, respect for autonomy presupposes capacity; it is a duty owed to a person who has the capacity to make the particular choice, so a decision made without that capacity is not an exercise of autonomy to be respected but an absence of it to be managed. The functional test for that capacity, and its statutory form under the Mental Healthcare Act, belong to this chapter's account of informed consent and to the Mental health legislation and forensic psychiatry notes, and are named here rather than stated. Where a patient lacks capacity, the clinician does not abandon autonomy but shifts to protecting the person's known will and preferences, a reframing the Mental Healthcare Act makes central and whose machinery belongs to the Mental health legislation and forensic psychiatry notes. Second, autonomy is not the same as getting whatever one asks for: a patient may refuse an offered treatment, but the right to

demand a treatment that is not indicated is not part of the principle, because the clinician's own duties of beneficence and non-maleficence remain in force.

2.3 Beneficence

Beneficence is the positive obligation to act for the patient's benefit - to prevent and remove harm, and to promote the patient's welfare and interests. It is the principle that makes medicine a helping profession rather than a merely technical one. In psychiatry beneficence is unusually demanding because the conditions treated can themselves impair the patient's ability to seek or accept help, so acting for the patient's good sometimes means acting before, or even against, what the patient currently says they want.

That is precisely where beneficence becomes dangerous, and the discrimination the exam wants is between beneficence and **paternalism**. Beneficence exercised over a capable patient's contrary wishes is paternalism, and paternalism is defensible only in narrow circumstances - broadly, where the patient's capacity for the decision is genuinely absent or compromised, and the benefit at stake is significant. When a clinician overrides a capable refusal in the name of the patient's own good, they have not applied beneficence cleanly; they have set beneficence against autonomy and must justify the trade. The habit of reaching for "it was in the patient's best interests" as though beneficence settled the matter is the commonest way this principle is abused.

> **PITFALL**
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> Invoking beneficence to override a capable patient's refusal without ever naming the conflict. In real wards, "it is for their own good" is used to close a decision that the four-principles framework says is still open: acting for the patient's good against their competent choice is not beneficence operating alone, it is beneficence defeating autonomy, and it needs the higher justification that overriding a capable choice always demands. Clinicians who never notice they have made that trade drift into routine paternalism and cannot defend the individual decision when it is later questioned.

2.4 Non-maleficence

Non-maleficence is the obligation not to inflict harm, the principle behind the old maxim primum non nocere, first do no harm. It is often paired with beneficence, and in Beauchamp and Childress's own account the two are distinct obligations rather than two faces of one: beneficence requires positive acts to help, while non-maleficence sets a floor by forbidding acts that harm. The distinction matters because the two carry different stringency. The duty not to harm is generally the more stringent - a clinician is expected to refrain from harming everyone, always, whereas the duty to actively benefit is owed within the specific therapeutic relationship and is bounded by what is feasible and proportionate.

Non-maleficence has sharp teeth in psychiatry, where the treatments themselves carry real burdens: the metabolic and neurological costs of medication, the harms of seclusion and restraint, the stigma that a careless disclosure can cause. Because almost every effective intervention carries some risk of harm, the principle is not a prohibition on all risk but a demand that harm be necessary, proportionate to the expected benefit, and reduced to the least that

achieves the aim - the ethical root of the least-restrictive-option requirement that runs through mental health law. The professional liability that follows when a clinician causes harm by falling below the standard of care - the law of negligence - is the subject of this chapter's account of professional negligence and is named, not developed, here.

The framework also supplies the tool for the case where doing good and doing harm are inseparable: the doctrine of **double effect**, by which an action with both a good intended effect and a harmful foreseen one may be permissible only when strict conditions hold together:

- the act itself is good, or at least morally neutral, and not wrong in its own right;
- the harmful effect is genuinely not the aim but a tolerated side effect;
- the good effect is not achieved by means of the harm; and
- the good is proportionate to the harm risked.

It is the reasoning that lets a clinician offer a treatment whose necessary benefit comes with a foreseen burden, without thereby intending the burden.

2.5 Justice

Justice is the obligation to treat people fairly - to give each their due, to treat like cases alike, and to distribute the benefits and burdens of care equitably. It is the principle that looks beyond the individual consultation to the patient's standing relative to others, and it is the one clinicians are least trained to reason about, which is exactly why it is examined. In its distributive form, **distributive justice** governs how a genuinely scarce resource - an inpatient bed, a slot in a specialist clinic, staff time, a costly medication in a public system - is allocated when not everyone who could benefit can be served.

Justice in psychiatry carries an added weight because of the population served. People with mental illness are among the most likely to face discrimination, to be denied parity with physical health in funding and access, and to have their preferences discounted; a serious commitment to justice therefore includes non-discrimination and the protection of a vulnerable group's fair claim on care, not merely the arithmetic of dividing a resource. Fairness also has a procedural dimension: an allocation decision is more defensible when the criteria are explicit, consistent and applied without regard to a patient's social worth.

PRINCIPLE	CORE OBLIGATION	WHAT IT PROTECTS	SIGNATURE TENSION	PSYCHIATRIC APPLICATION
RESPECT FOR AUTONOMY	Honour the considered choice of a capable person	Self-determination, truth, freedom from coercion	Against beneficence when a capable patient refuses help	Consent to and refusal of treatment; enabling choice where capacity is intact
BENEFICENCE	Act positively for the patient's welfare	The patient's interests and recovery	Against autonomy; slides into paternalism if it overrides a capable choice	Treating a disorder that impairs the will to be treated
NON-MALEFICENCE	Do not inflict harm; keep harm necessary and proportionate	The patient's safety from iatrogenic harm	Against beneficence when the helpful act also burdens	Medication burden, seclusion and restraint, least restriction
JUSTICE	Treat people fairly and allocate resources equitably	Equity, non-discrimination, parity of the vulnerable	Against beneficence to the individual when the resource is shared	Bed and clinic rationing; parity for mental illness

2.6 How the principles conflict, and how a clinician resolves it

The framework earns its keep at the point of conflict, not in the list. Because each principle is prima facie and none is ranked above the rest, a real case can present two or more principles that cannot all be satisfied, and the framework does not resolve this by producing a winner from a formula. It resolves it by two disciplined moves. The first is **specification**: taking an abstract principle and making it concrete for the situation, so that "respect autonomy" becomes "abide by this patient's refusal of this medication given their intact capacity to make it", narrowing a vague obligation into one that can actually be acted on and compared. The second is **balancing**: weighing the specified obligations against each other in the particular circumstances to decide which should prevail here.

Balancing is not licence to prefer whichever principle the clinician favours. A defensible override of one principle by another should meet recognisable conditions: the overriding principle must have a realistic prospect of achieving its aim, no less restrictive action would achieve it, the harm to the overridden principle is the least necessary, and the balance of benefit over harm is proportionate. Set out this way, "I decided on balance" becomes an argument that can be examined and defended.

- **Specify each principle** for the actual patient and decision, so the obligations are concrete enough to compare rather than slogans.
- **Identify the genuine conflict** - which specified obligations cannot both be honoured - rather than pretending one principle simply does not apply.
- **Weigh them** against the conditions above: prospect of success, necessity, least infringement, proportionality.

- **Record the reasoning**, naming which principle yielded to which and why, because a balancing judgement is only as defensible as the account that can be given of it.

TRAP **Treating the four principles as a fixed hierarchy, usually with autonomy on top.** Candidates resolve a dilemma by asserting that autonomy always prevails, or that beneficence does, and stop. The framework is explicit that the principles are prima facie and unranked; the whole task is to show the specification and the balance, not to crown a winner. An answer that names a permanent top principle scores below one that shows two principles in genuine tension and reasons to a proportionate resolution.

2.7 The conflicts in a psychiatric decision

Psychiatry concentrates the classic conflict of medical ethics into its sharpest form, because the disorders it treats can impair the very capacity on which respect for autonomy depends. The signature tension is autonomy against the paired duties of beneficence and non-maleficence: a patient whose illness drives a refusal that threatens their health or safety. The clinician who simply defers to the stated wish may abandon a patient who cannot, in this moment, choose freely; the one who simply overrides it may trample a capable person's right to decide. The framework insists that the decision turns first on capacity - the hinge that determines whether there is an autonomous choice to respect at all - and that assessment, together with the legal thresholds for acting without consent, belongs to this chapter's account of informed consent and to the Mental health legislation and forensic psychiatry notes, and is applied here rather than re-derived.

The conflict rarely stays a clean two-way contest. Non-maleficence enters through the harms of the very interventions that beneficence recommends, so that admitting or medicating a refusing patient to do them good also imposes the burdens of coercion and side effect that the duty not to harm requires be minimised - which is the ethical source of the demand that the least restrictive effective option be used. Justice enters whenever the resource is shared: the bed given to one acutely unwell patient is a bed denied another, so beneficence to the individual is checked by fairness to the population. A mature answer to a psychiatric ethics question therefore does not pick a principle; it maps which principles are engaged, shows where they conflict, and reasons to a proportionate resolution that respects capacity, uses the least restriction, minimises harm and remains fair.

IN INDIA

Indian mental health law has taken a deliberately autonomy-forward turn, and the four principles have to be read in that light. The Mental Healthcare Act reframes the autonomy of a person with mental illness around their will and preferences and supported decision-making rather than around substitute judgement made over their head, and it embeds least restriction and non-discrimination as legal duties, not merely ethical aspirations - the statutory machinery for all of which belongs to the Mental health legislation and forensic psychiatry notes. Justice also bites harder in the Indian setting, where a public system serves large numbers with scarce inpatient and specialist resources and where parity for mental illness against physical illness is still being won, so distributive fairness is a live daily judgement and not a seminar abstraction. The principles are universal; their weighting in Indian practice is shaped by a statute that puts the patient's own will near the centre and by a resource reality that keeps justice in the room.

GOOD TO REMEMBER

When a case feels like an ethical knot, name the four principles for that specific patient before reaching for a conclusion: what does respecting this person's choice require, what would do them good, what would harm them, and what does fairness to others demand. The knot almost always turns out to be two of the four in genuine tension, most often autonomy against beneficence, with capacity as the hinge. Decide which principle should yield, choose the least restrictive way to honour the one that prevails, and write down the reasoning. A decision reasoned that way is far easier to defend than one reached by instinct and dressed up afterwards.

The four principles - respect for autonomy, beneficence, non-maleficence and justice - are prima facie obligations with no fixed ranking, so medical ethics is the balancing of principles that conflict, not the application of one that wins; in psychiatry the signature conflict is autonomy against beneficence and non-maleficence, turning on the patient's capacity, and the defensible decision is the one that respects a capable choice, does good, minimises harm, stays fair, and is reasoned on the record.

3 · Informed consent in psychiatry (elements, capacity, special situations)

Consent is where the patient's autonomy stops being an abstraction and starts governing what a doctor may lawfully do. Nothing a psychiatrist proposes, from a first prescription to admission to electroconvulsive therapy, is lawful merely because it is clinically indicated; it is lawful because the person it is done to has agreed, or because a specific legal exception has displaced the need for agreement. Informed consent is how that agreement is made real, and the examinable weight of the topic sits in its structure: what makes a consent valid rather than a formality, how the capacity to give it is judged, how much the patient must be told, and what happens where the ordinary rule cannot apply.

Marks are lost when a candidate treats consent as a signature on a form. The signed form is evidence that a conversation happened; it is not the consent, and a form signed by a patient who did not understand, was not free, or was not told what mattered is worth nothing in law. This

account sets out the three elements of a valid consent as the Indian courts define them, the standard of disclosure, the scope to which a consent is confined, the documentation the conduct code requires, and the special situations where consent is modified or displaced. Where the Mental Healthcare Act's own machinery governs, this account names the provision and points to the Mental health legislation and forensic psychiatry notes for its full working.

2008	3	19	4
SAMIRA KOHLI, THE INDIAN AUTHORITY ON REAL AND VALID CONSENT	ELEMENTS OF A VALID CONSENT: CAPACITY, VOLUNTARINESS, ADEQUATE INFORMATION	INFORMED-CONSENT REGULATION IN THE MOST RECENTLY NOTIFIED CONDUCT CODE	MENTAL HEALTHCARE ACT SECTION STATING THE STATUTORY CAPACITY TEST

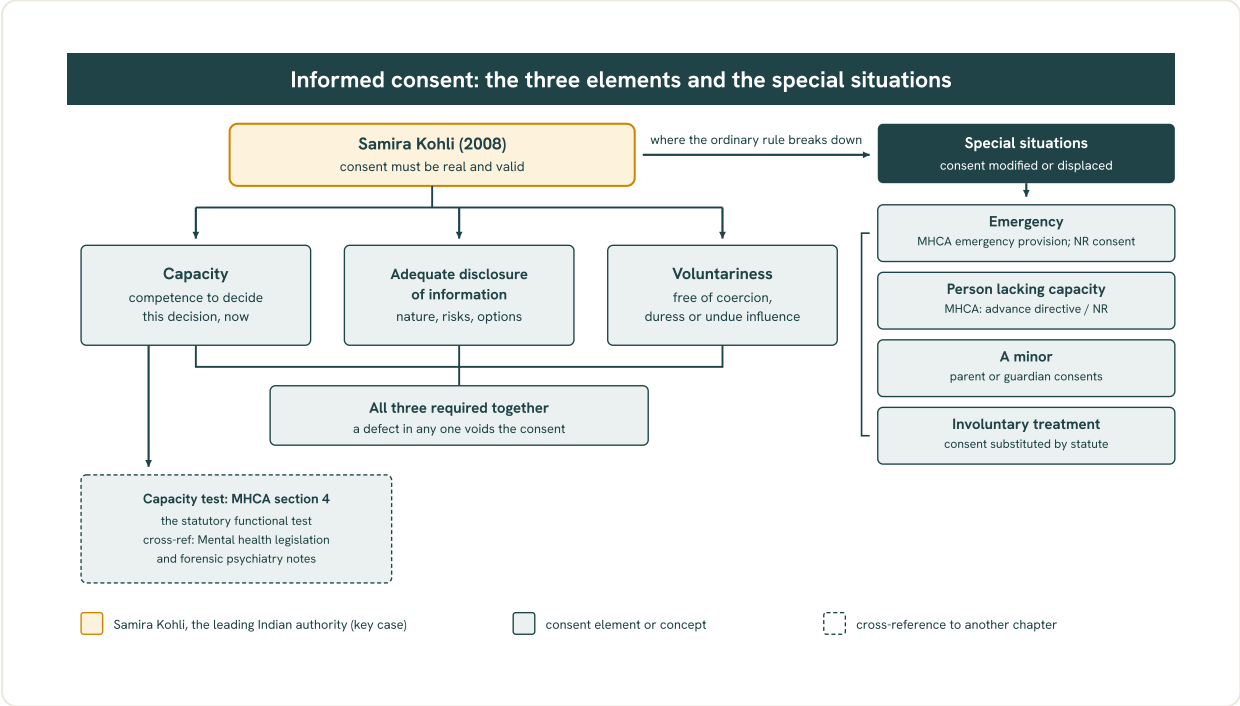

Fig 26.3. Informed consent has three cumulative elements - capacity, adequate disclosure of information and voluntariness - all required together for a valid consent (Samira Kohli, 2008), with a defined alternative for each special situation where consent is modified or displaced.

3.1 What informed consent is, and why the form is not the consent

Informed consent is a patient's voluntary, competent and informed agreement to a proposed procedure, given before it is begun. It rests on two footings that reinforce each other. Ethically it is the operational expression of respect for autonomy, the principle whose full treatment belongs to this chapter's account of the principles of medical ethics: a person has the right to decide what is done to their own body, and consent is how that right is exercised. Legally, treating a competent adult without valid consent is not merely poor practice but a wrong: it can found a claim in negligence where the failure lies in inadequate disclosure, and can amount to assault and battery where there was no agreement to the touching at all.

The conceptual correction to make early is that consent is a process, not a document. The conversation in which the clinician explains and the patient asks, weighs and decides is the consent; the signature merely records that it took place. A form can be exhaustive and the consent still invalid where the patient lacked capacity, was pressured, or was told nothing that

mattered, and a consent can be valid though its record is thin. The document protects the clinician evidentially but neither creates nor cures the underlying agreement, which is why the elements below attach to the patient's actual state of mind and freedom, not to the paperwork.

RULE **A consent is lawful only if it is real and valid, which means the patient had the capacity to decide, decided voluntarily, and decided on adequate information.** All three must be present together; a defect in any one voids the consent however well the other two are satisfied. The signature is evidence that consent was sought, not proof that it was valid.

3.2 The three elements: Samira Kohli

The Indian leading authority on what makes a treatment consent valid is **Samira Kohli**, decided in **2008**. The court held that a doctor must seek and secure the patient's consent before commencing treatment, and that the consent obtained must be real and valid. It then unpacked that phrase into **three** requirements that every candidate should be able to state and defend: the patient must have the capacity and competence to consent; the consent must be voluntary; and it must rest on adequate information about the nature of the treatment, so that the patient knows what they are agreeing to.

The value of the case is that it converts a vague ideal into a checklist that can be tested against the facts, with each element answering a different question. **Capacity** asks whether this patient, at this moment, can make this decision at all. **Voluntariness** asks whether the decision was the patient's own or the product of pressure. **Adequate disclosure** asks whether the patient was given enough to decide on. The three are cumulative and independent, and the following subtopics take each in turn.

MNEMONIC

Capable, Free, Informed, and Specific

A consent is valid only if the patient is **Capable** of deciding, decides **Free** of coercion, decides **Informed** by adequate disclosure, and the agreement is **Specific** to the procedure actually done. The first three are the elements of validity; the fourth is the limit on its scope, taken up below.

3.3 The first element: capacity to decide

Capacity is the ability to make a particular decision at the time it must be made, and three properties of it are examinable. It is **functional**: judged by the patient's actual reasoning about the decision in front of them, not by their diagnosis, their age, or how others rate the wisdom of the outcome. It is **decision-specific and time-specific**: a person may have capacity for a simple choice and lack it for a complex one, and may lack it in the morning and regain it by evening, so capacity is assessed for this decision now, never certified once for all purposes. And it is **presumed**: every adult is taken to have capacity unless the contrary is shown, so the burden lies on whoever asserts incapacity, and mental illness never by itself removes it.

The Mental Healthcare Act gives this a statutory form. At section **4** it provides that every person, including a person with mental illness, shall be deemed to have the capacity to make treatment decisions if they can understand the information relevant to the decision, appreciate the

reasonably foreseeable consequences of deciding or of not deciding, or communicate the decision, which is the Act's own disjunctive formulation. Two features of the statutory test are the ones candidates get wrong, and both matter directly to consent. The full working of the section, and how capacity interacts with advance directives, nominated representatives, admission and the review boards, belongs to the Mental health legislation and forensic psychiatry notes; what the consent doctrine needs from it is the functional standard and the discriminations below.

TRAP **A decision that looks wrong does not prove incapacity, and the statutory abilities are read disjunctively, not as a set all of which must be present.** Candidates infer incapacity from an unwise refusal, but a competent patient is entitled to make a decision others consider mistaken, and a choice perceived as inappropriate does not by itself negate capacity. The second error is to treat the statutory abilities as a conjunctive checklist; in the bare text of the Act they are joined by "or", and capacity is a rebuttable deeming rather than a hurdle the patient must clear.

3.4 The second element: voluntariness

Voluntariness means the decision was the patient's own, made free of coercion, duress and undue influence. It is the element most easily overlooked because it leaves no trace on a form, yet it is the one most often compromised in psychiatric settings, where the pressures are structural rather than crude. The test is whether the patient's choice was improperly controlled, not whether a consequence was mentioned: a patient pressured by a threat that refusal will be punished, or by a controlling inducement, may not be deciding freely even where no crude threat is spoken, whereas explaining a genuine clinical consequence of refusal, or offering a proportionate incentive, does not by itself negate voluntariness. Family pressure is a particular hazard in Indian practice, where treatment decisions are frequently made collectively and the identified patient may have the least voice in the room.

The clinician's task is not only to avoid applying pressure but to notice and, where possible, neutralise it: separating the consent conversation from any implied consequence, giving the patient a genuine and unpenalised option to decline, and staying alert to the difference between a family reaching a shared decision and a family overriding the patient's own. The distinction between a voluntary agreement and a merely compliant one is the distinction the law draws between a valid consent and an invalid one.

3.5 The third element: adequate disclosure and its standard

The third element asks how much the clinician must tell the patient, and here the Indian courts made a deliberate choice between two rival standards. One is the professional or **Bolam** standard, which measures disclosure against what a responsible body of skilled practitioners in the field would regard as normal and proper. The other is the patient-centred **Canterbury** standard, which measures it against what a reasonably prudent patient would want to know. In Samira Kohli the court adopted the former: the information a doctor must furnish to secure consent need not reach the more stringent degree required by the patient-centred approach, but should be of the extent accepted as normal and proper by a responsible body of skilled and experienced practitioners in that field, adjusted to the patient's condition and the treatment's risks.

The practical content of adequate disclosure follows from this: the nature and purpose of the proposed treatment, its risks and likely consequences, the reasonable alternatives including doing nothing, and enough about the illness for the choice to make sense. Two points sharpen it. The standard is not a licence to tell the patient as little as the profession can get away with; it sets a floor of what a responsible practitioner would disclose, and defensive minimalism does not meet it. And the measure is relevance to the decision, not exhaustiveness; a patient buried in every conceivable rare risk is no better placed to decide than one told too little.

AXIS	PROFESSIONAL STANDARD (BOLAM, REAL CONSENT)	PATIENT-CENTRED STANDARD (CANTERBURY)
THE QUESTION ASKED	What would a responsible body of practitioners disclose?	What would a reasonably prudent patient want to know?
WHOSE VIEWPOINT SETS THE MEASURE	The profession's accepted practice	The reasonable patient's information needs
RELATIVE DEMAND ON THE DOCTOR	Lower; the accepted and proper extent for the field	Higher; a more stringent degree of disclosure
POSITION ADOPTED IN INDIAN LAW	Adopted in Samira Kohli as the governing standard	Expressly not required to the stringent degree it sets

3.6 The scope of consent: specific, not general

A valid consent authorises only what it was given for. This is **specific consent**, and Samira Kohli states it with unusual clarity: consent given for a diagnostic procedure cannot be treated as consent for therapeutic treatment, and consent given for one specified treatment procedure will not be valid for conducting some other procedure. A patient who agreed to an assessment has not agreed to whatever the assessment reveals may be needed.

The court closed the obvious escape route as well. The fact that an unauthorised additional procedure turned out to benefit the patient, saved time or expense, or spared future suffering is no defence to an action in negligence or in assault and battery. Benefit does not backfill absent consent. For psychiatry the point bites wherever one intervention opens onto another; each step requires its own agreement, and the reasoning that "it was for the patient's good" is precisely the reasoning the court rejected.

GOOD TO REMEMBER

Treat consent as reopened whenever the plan moves beyond what the patient actually agreed to. If the working diagnosis, the drug class, the route, or the setting of care changes materially, consent afresh for the new proposal rather than reading the old agreement forward: a short documented second conversation is cheaper than defending an intervention the patient never agreed to.

3.7 Documentation and the conduct code

The professional-conduct code turns the doctrine into a documentation duty. The most recently notified conduct regulations set out informed consent at regulation **19**: before any diagnostic or therapeutic procedure or operation the registered medical practitioner should obtain the patient's

signed documented informed consent; where the patient is unable to consent, the consent of the legal guardian or a family member must be taken; an operation that may result in sterility requires the consent of both spouses; and assisted-reproduction procedures require the written consent of the female patient, the spouse and the donor. The modal verbs are not interchangeable and carry the marks: the practitioner should obtain the patient's consent, the guardian's consent must be taken where the patient cannot, and both spouses' consent is required for a sterilising operation.

A currency caution attaches to this. Whether the most recently notified regulations are the edition currently in force is a separate question, settled in this chapter's account of the professional-conduct codes; the operative professional-conduct code remains the earlier one, and the most recent regulations, though notified, were held in abeyance and are not yet in force. Both editions impose a documented consent duty, but the precise scope and wording of each edition's consent provision belong to this chapter's account of the professional-conduct codes; what matters here is that an answer presenting the most recent regulations as the live code states a currency that does not hold.

PITFALL

Citing the most recently notified professional-conduct regulations as the operative code. They were notified and then held in abeyance, and the earlier professional-conduct code remains the one in force; naming the newer set as live misstates the governing law even though the substance of the consent duty is largely unchanged. Name the provision actually in force, and defer any contested currency to this chapter's account of the professional-conduct codes rather than asserting it in passing.

3.8 The special situations

The elements describe the ordinary case; the marks cluster in the situations where the ordinary case breaks down. Four recur, and each modifies or displaces one element of consent rather than abolishing the requirement.

- **Emergency.** Where a patient needs immediate treatment to avert death or serious harm and cannot give consent, the practitioner should still try to obtain it, and if that is not possible must act in the patient's best interest and record the basis for doing so. Where the Mental Healthcare Act governs an emergency in a person with mental illness, the Act's own emergency-treatment provision supplies the rule rather than the general one: it requires the informed consent of the nominated representative where one is available, and attaches its own indications, time limit and excluded treatments; the full working of that provision belongs to the Mental health legislation and forensic psychiatry notes. The exception is necessity and is bounded by it: it authorises only what the emergency requires, not a general power to treat without agreement.
- **The person who lacks capacity.** Where an adult cannot give a valid consent, the most recently notified conduct regulations direct that the consent of the legal guardian or a family member be taken, subject to the currency caution above, and the decision must serve the

patient's interests rather than the convenience of others. Where the Mental Healthcare Act governs, a family member is not a generic substitute decision-maker: the advance directive carries the person's own earlier choice forward, and the nominated representative supports the person's decision-making and gives consent in their place only where a provision of the Act expressly says so; the full working of both belongs to the Mental health legislation and forensic psychiatry notes. Capacity being decision-specific and often fluctuating, the clinician should reassess it and return the decision to the patient once it is regained.

- **Minors.** A child below the age at which the law recognises a valid consent cannot give one, and consent is taken from the parent or legal guardian on the child's behalf, again in the child's interest. The statutory age thresholds and the child-protection framework, including the law on child sexual offences and juvenile justice, belong to the Child psychiatry: assessment, treatment, services and protection notes.
- **Consent under involuntary treatment.** Involuntary admission and treatment are precisely the situation in which ordinary consent has been lawfully displaced by a statutory framework, which substitutes its own safeguards, the nominated representative and independent review, for the patient's contemporaneous agreement, while the advance directive preserves the person's own earlier choice rather than replacing it. The mechanics of that framework belong to the Mental health legislation and forensic psychiatry notes, and its ethical frame to this chapter's account of the ethics of involuntary treatment and restraint; the consent point is that involuntary treatment is not consent-free but consent-substituted, and the safeguards are what police the substitution.

Consent to research, and the distinct criminal-law meaning of consent in sexual-offences law, are separate constructs treated in this chapter's accounts of the ethics of research and of sexual-offences law; each invokes the clinical elements set out here but adds rules of its own.

IN INDIA

The Indian consent doctrine is anchored in a single case and a statute a candidate should be able to pair. Samira Kohli supplies the three elements and the choice of the professional standard of disclosure over the more demanding patient-centred one, so an Indian answer asserting a Canterbury-level duty overstates the law. The Mental Healthcare Act supplies the statutory, functional capacity test and the framework under which consent is displaced in involuntary care, and the conduct code supplies the documentation duty. Together they make consent in Indian psychiatry a valid agreement properly recorded, with the statute governing the situations where agreement cannot be obtained.

TRAP **Reciting the three elements while omitting the special situations, or treating a signed form as conclusive proof of a valid consent.** The question on consent almost always turns on the hard case, the emergency, the incapacitated adult, the minor, the involuntary patient, so an answer that stops at capacity, voluntariness and disclosure has answered half the question. The paired error is evidential: producing a signed form as if it settled validity, when a form signed without capacity, freedom or adequate information is no consent at all.

A consent is lawful only if it is real and valid, meaning the patient had the capacity to make this decision, decided voluntarily, and decided on adequate information, and it authorises only the specific procedure agreed to; where the patient cannot give it, the emergency, the incapacitated adult, the minor and the patient under involuntary treatment each substitute a defined alternative rather than dispensing with the requirement.

4 · Confidentiality and its limits (duty to warn, Tarasoff)

Confidentiality is the promise that makes psychiatry possible. A patient tells a psychiatrist things they may never have said aloud, and does so only because they trust that what is spoken in the consulting room stays there. That trust is the working condition of honest disclosure, which is the raw material of every assessment and treatment decision, so the law and the professional codes treat confidentiality as a default duty the clinician owes, not a favour the clinician grants. The duty is not absolute, however, and the examinable heart of this topic is the exact shape of its limits: when the clinician may lift the veil, on whose authority, and how far.

Marks are lost in two opposite directions: one candidate treats confidentiality as sacrosanct and freezes when a patient names a person they mean to harm, another treats any hint of risk as a licence to broadcast the record. Both misread a rule that is conditional and whose conditions are specific. This account sets out the default duty, the principal grounds on which a disclosure is permitted, the American case that gave the world the language of a duty to warn, and the very different Indian position, in which a protective disclosure to an endangered other is permitted rather than commanded, alongside the separate mandatory-reporting duties that particular statutes impose in their own defined situations. Where the Mental Healthcare Act's own internal machinery is concerned, this account names the provision and points to the Mental health legislation and forensic psychiatry notes for its full working.

1976	1998	23	24
TARASOFF, THE UNITED STATES ORIGIN OF THE DUTY TO PROTECT	MR X V HOSPITAL Z, THE INDIAN AUTHORITY ON PROTECTIVE DISCLOSURE	MENTAL HEALTHCARE ACT SECTION, THE STATUTORY RIGHT TO CONFIDENTIALITY	PROFESSIONAL-CONDUCT REGULATION ON CONFIDENTIALITY

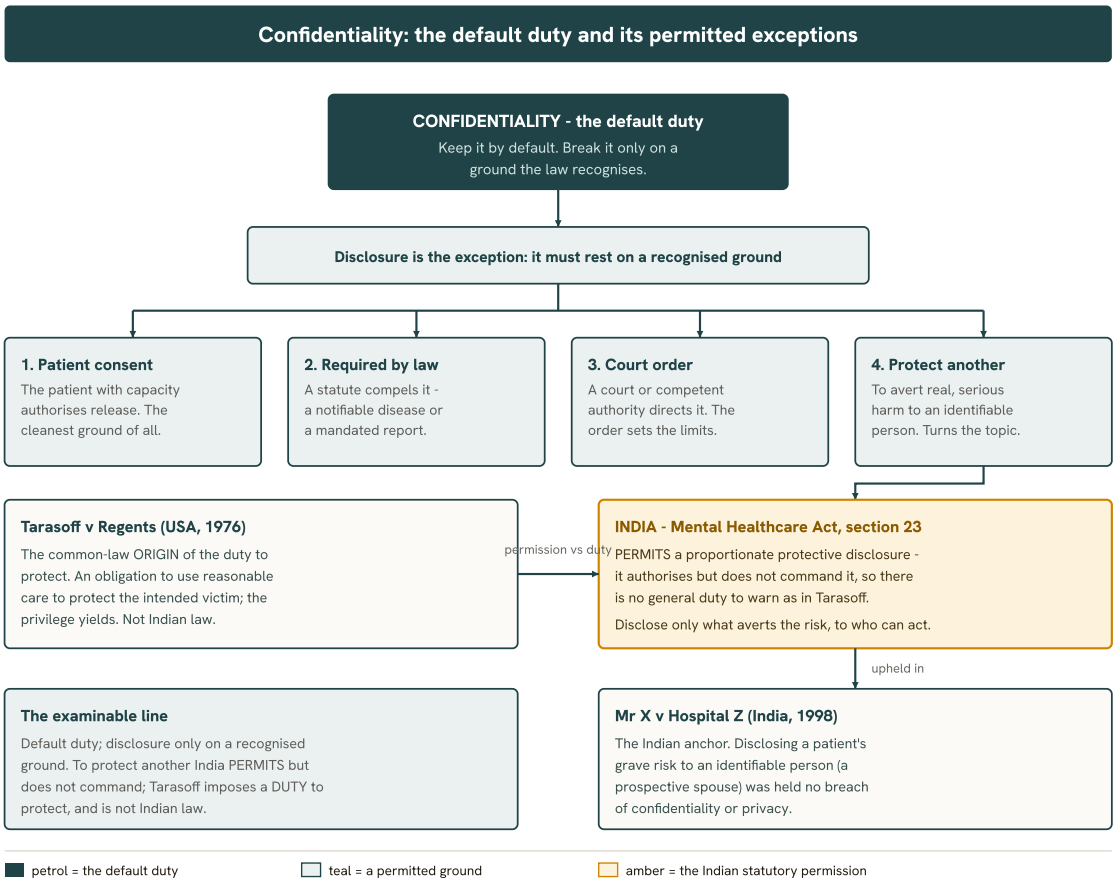

Fig 26.4. Confidentiality is a default duty that yields only on a recognised ground, principally consent, a requirement of law, a court order, or protecting an identifiable other, and for that last ground India permits but does not command disclosure, unlike the United States Tarasoff duty to protect the intended victim, with Mr X v Hospital Z holding a protective disclosure to a person at real risk no breach.

4.1 The default duty and where it comes from

At its core, **confidentiality** is the obligation not to disclose information a patient shares in the course of care to anyone outside that care without a justification the law recognises. It rests on more than one footing. Ethically it protects the patient's autonomy and privacy and secures the trust without which candour collapses; legally it is a duty imposed by both statute and the conduct code, and a serious breach can expose the clinician to complaint and to a civil claim.

Two sources give the duty its force in Indian practice. The statutory source is the Mental Healthcare Act, whose section **23** gives a person with mental illness a right to confidentiality over their mental health, mental healthcare and treatment, and places a corresponding duty on every health professional to keep that information confidential, subject to defined exceptions. The professional source is the medical conduct code. The most recently notified conduct regulations state the duty at regulation **24**: every communication between a practitioner and a patient shall be kept confidential and shall not be revealed except in stated circumstances. Whether that most recent edition is the one currently in force is a separate currency question, settled in this chapter's account of the codes of professional conduct; the duty is stated in the same mandatory terms across the editions and in the statute, so the doctrine does not turn on which edition governs.

One distinction should be fixed at the outset. Confidentiality is the clinician's ethical and statutory duty not to disclose. **Testimonial privilege** is a separate, courtroom creature: whether a clinician can be compelled to testify to what a patient said, and the rules that govern it. Both concern keeping a patient's words private, but they answer to different masters, confidentiality to the codes and the Act, privilege to the law of evidence. What the rules of evidence permit in the witness box is taken up in this chapter's treatment of the expert witness and the rules of evidence; the duty examined here is the clinical one.

RULE **Confidentiality is the default, and disclosure is the exception that must find a specific footing.** The clinician does not need a reason to keep a confidence; they need a reason the law recognises to break one. Every lawful disclosure must rest on a recognised ground, and a disclosure that cannot name its ground is a breach, however well meant.

4.2 When the veil may be lifted: the principal grounds

Because disclosure must justify itself, the circumstances that justify it form a defined set of recognised grounds, each carrying its own conditions. The conditions are where the marks sit, because collapsing a conditional rule to its headline is how a candidate loses the point. The principal grounds are these, and the Mental Healthcare Act's own statutory list of exceptions is fuller than this teaching set and is set out in the Mental health legislation and forensic psychiatry notes.

- **The patient's own consent.** A patient with capacity may authorise the release of their information, the first and cleanest ground of all. What consent requires, how capacity is judged and how special situations are handled are set out in this chapter's account of informed consent; here it is simply the ground needing no further justification once validly given.
- **Disclosure required by law.** Certain statutes compel a practitioner to disclose defined information, and where a law of the state requires the disclosure the duty of confidentiality gives way to it. The conduct code's own exception preserves exactly this, permitting a communication to be revealed where it is required by the laws of the state.
- **An order of a court or a competent authority.** A court or other authority empowered by law may direct the production of records or the giving of testimony, and confidentiality yields to a lawful order. The order defines and limits what must be produced; it is not a general waiver.
- **Protection of an identifiable other from serious harm.** Where withholding information would expose another person to a real risk to health or life, a proportionate disclosure to avert that risk is permitted. This is the ground the rest of the topic turns on.

MNEMONIC

Consent, Compulsion, Court, Caution

The principal grounds on which a confidence may lawfully be broken. **Consent** of the patient; **Compulsion** by a law of the state; a **Court** order or the direction of a competent authority; and **Caution** for an identifiable other in serious danger. A disclosure that fits no recognised ground has no footing and is a breach.

The last ground generates the hard cases and the examination questions, because it turns on judgement rather than on a document. It is available only when the danger is to an **identifiable other** and is serious, and even then it authorises only the disclosure necessary to avert the harm, made to the person who can act on it. It is a permission tightly bounded by proportionality, not a general waiver.

4.3 Tarasoff and the origin of the duty to warn

The vocabulary of a **duty to warn** entered clinical practice from a single American case. **Tarasoff**, decided by the California Supreme Court in **1976**, held that when a therapist determines, or under the standards of their profession should determine, that a patient presents a serious danger of violence to another, the therapist incurs an obligation to use reasonable care to protect the intended victim. The discharge of that obligation may require warning the intended victim, warning others likely to alert the victim, notifying the police, or taking whatever other steps are reasonably necessary in the circumstances. The confidentiality privilege yields to this duty: the protective purpose of the profession does not extend to guarding a patient's confidences at the cost of the intended victim's life.

The popular name understates the holding, and the discrimination is worth marking. The case did not create a narrow duty to send a warning; it created a broader **duty to protect**, of which warning is only one possible discharge. A therapist might protect the victim by warning them, by alerting someone able to warn them, by informing the police, or by intensifying treatment or arranging admission. Reducing the whole of it to a mechanical duty to warn shrinks a flexible standard of reasonable care into a single required act.

Two features of the case must travel with it into any Indian answer. First, it is United States common law, the decision of a state court, and it binds no Indian clinician; it is the origin of a concept, not a rule of practice here. Second, it frames a positive obligation, a duty the therapist incurs, which is a stronger thing than a permission to disclose, and it is on this second point that the Indian rule departs from it.

TRAP **Tarasoff is the United States origin of the duty to warn, not Indian law, and India permits protective disclosure without compelling it.** Candidates import Tarasoff wholesale and write that an Indian psychiatrist is under a legal duty to warn a third party. There is no such positive statutory duty in India. The Mental Healthcare Act's confidentiality section permits a proportionate disclosure to protect another; a permission is "may" and a duty is "shall", and the two are different laws. Answering with a duty where the statute gives only a permission loses the mark.

4.4 The Indian position: permission, not command

India has no case and no statute that imposes a Tarasoff-style positive duty to warn an endangered victim; what the law provides instead is a permission. That is a distinct question from the specific mandatory-reporting duties that particular statutes impose in defined situations, such as the reporting of child sexual abuse set out in the Child psychiatry: assessment, treatment, services and protection notes; those duties, where they apply, must be complied with on their own terms and are not displaced by anything said here. The Mental Healthcare Act's

confidentiality provision keeps confidentiality as the patient's right and the professional's duty, then lists the exceptions to it; among them is disclosure to protect any other person from harm or violence, releasing only the information necessary for that protection. The provision is permissive in character: it authorises the professional to make the protective disclosure and shields them when they do, but does not oblige them to make it. The full working of that section, its complete list of exceptions and the machinery around them, belongs to the Mental health legislation and forensic psychiatry notes and is named here rather than reworked; the point is the character of the provision, that it authorises and does not oblige.

The professional conduct code points the same way. Its confidentiality regulation allows a communication to be revealed where non-disclosure may itself be detrimental to the health of the patient or of another human being, again a permission to protect and not a duty to warn. Statute and code therefore converge on a single Indian rule: confidentiality yields to the protection of an identifiable other, but the yielding is discretionary and proportionate, exercised by a clinician who has judged the risk, not triggered automatically by the fact of a threat. A clinician who never discloses to protect an endangered third party may be criticised for poor judgement, but breaches no general duty to warn the victim, because Indian law imposes none; any separate mandatory-reporting duty a specific statute may create in a defined situation is a different matter and continues to apply on its own terms.

AXIS	TARASOFF (UNITED STATES)	MENTAL HEALTHCARE ACT CONFIDENTIALITY SECTION (INDIA)	MR X V HOSPITAL Z (INDIA)
SOURCE OF THE RULE	State supreme court, common law	Statute	Supreme Court judgment
LEGAL CHARACTER	A positive duty to protect	A permission to disclose	A holding that a protective disclosure was lawful
WHAT TRIGGERS IT	A serious danger of violence to another that the therapist determines or should determine	A need to protect any other person from harm or violence	A real risk to an identifiable person, a prospective spouse, from a life-threatening condition
EFFECT ON THE CLINICIAN	Must take reasonable steps to protect; the privilege yields	May disclose the information necessary to protect; the duty yields but is not compelled	The disclosure made was held not to breach confidentiality or privacy
WHAT IT DOES NOT DO	Does not fix one required act; warning is one option among several	Does not impose a duty to warn	Does not make privacy absolute, nor command disclosure in every case

4.5 Mr X v Hospital Z: the Indian judicial anchor

The Indian courts have addressed the limits of medical confidentiality directly, and the case every candidate should be able to name is **Mr X v Hospital Z**, decided in **1998**. A hospital disclosed a

patient's HIV-positive status to the woman he was about to marry. The court held that the disclosure violated neither the rule of confidentiality nor the patient's right to privacy, because the prospective spouse, an identifiable other, was thereby saved in time from a real risk to her health and life. The reasoning is the load-bearing part and repays exact memory: the right to privacy is not absolute and may be restricted to protect the rights, the health and the freedom of others.

Read carefully, the case supports the Indian permission and no more. It justified a disclosure that protected a specific person from a grave and avoidable harm; it did not announce a general duty on doctors to warn, nor make every disclosure lawful. Its principle is a limit on privacy, not an engine of disclosure: where a specific other faces a specific serious risk, protecting them is a legitimate reason to reveal what would otherwise be confidential. That is the same shape as the statutory permission and the protective ground in the general list.

IN INDIA

The Indian picture is coherent once its pieces are named: a statutory right to confidentiality with a protective exception in the Mental Healthcare Act, a professional conduct code that permits disclosure where silence would endanger the patient or another, and a Supreme Court holding that a protective disclosure to an identifiable person at real risk breaches neither confidentiality nor privacy. Nowhere in that picture is a positive duty to warn. The working rule for an Indian psychiatrist is therefore a permission exercised with judgement, not an American duty transplanted whole, and the difference between "may" and "shall" is what an answer must make explicit.

4.6 Making a protective disclosure well

Knowing that you may disclose is only the start; disclosing well is the harder part. Because the protective ground turns on judgement, the quality of the decision is what protects both the endangered third party and the clinician who acts. The organising idea is **proportionality**: the disclosure must be matched to the risk in its target, its content and its recipient, and no wider. The practical discipline runs as follows.

- Establish that the risk is to an identifiable person and is serious and real, not a vague unease that names no one.
- Prefer the least intrusive step that will actually avert the harm, whether intensifying treatment, arranging admission, or warning where a warning is what protects; escalation should track the danger.
- Disclose only the minimum necessary to the person able to act on it, not the whole clinical record and not to an audience wider than protection requires.
- Record the reasoning as it is made: the risk assessed, the options weighed, the ground relied on, and what was disclosed to whom. The contemporaneous note is what distinguishes a considered protective disclosure from a careless one.

GOOD TO REMEMBER

When a patient names a person they intend to harm, the move is neither silence nor a broadcast. Confirm that the threat is serious and the target identifiable, choose the least intrusive step that will actually protect them, disclose only what that step needs to whoever can act on it, and write down why. The defensible position is the proportionate one, and the record is what makes it defensible.

PITFALL

Treating a justified risk as a licence to empty the file. Once a clinician has decided that a protective disclosure is warranted, the temptation is to hand over the entire history to be safe, or to tell more people than need to know. The permission is to reveal what is necessary to avert the specific harm, to whoever can act on it, and no further; a disclosure wider than the risk requires is itself a breach, even where a narrower one would have been entirely lawful. Over-disclosure and non-disclosure are opposite failures of the same judgement.

4.7 The other direction of flow: the right to information

Confidentiality governs what leaves the consulting room about the patient, and it has a mirror-image companion governing what must reach the patient. The Mental Healthcare Act's section **22** gives a person with mental illness, together with their nominated representative, a right to information: about the provision under which they are admitted and its criteria, their right to seek review of that admission, and the nature of the illness and the proposed treatment plan with its known side effects, all in a language and form the person can understand. The complete machinery of this right, like that of the confidentiality right, belongs to the Mental health legislation and forensic psychiatry notes; it is named here to complete the picture.

The two rights are complementary rather than opposed. The patient is entitled to be told the truth about their own condition and care, and entitled to have what they disclose held in confidence. Confidentiality is not secrecy from the patient; it is the protection of the patient's information from the world outside the care they have entered, coupled with candour toward them within it.

Confidentiality is the default duty and disclosure the exception: it is lawful on a recognised ground, principally the patient's consent, a requirement of law, an order of a court or competent authority, or the protection of an identifiable other from serious harm, and even then only so far as the risk requires. Tarasoff is the United States origin of the duty to warn and does not bind Indian practice; in India the Mental Healthcare Act's confidentiality section permits, but does not command, a proportionate protective disclosure, and Mr X v Hospital Z holds that such a disclosure to an identifiable person at real risk is no breach.

5 · IPS code of ethics (Cuttack 1989)

A psychiatrist in India answers to two written standards of conduct at once, and they are not the same kind of thing. One is the profession's own **code of ethics**, drawn up by psychiatrists for

psychiatrists, which states the ideals the discipline holds itself to. The other is the statutory **professional-conduct code** made under the law that governs the medical register, which carries the disciplinary machinery and can end a career. The examiner who sets a question on the Indian Psychiatric Society code is really testing two things: whether the candidate knows the profession's own code and its history, and whether the candidate knows which statutory code is actually in force, because that second fact reversed itself recently and a great many textbooks now print the wrong answer.

This topic therefore has an unusually high yield relative to its size. The substance a candidate must carry is small and quotable, but it sits on a moving legal floor. The professional code is an ethical and professional standard; the statutory code is the enforceable one, and it has changed on paper without yet changing in force. Getting the currency right is the single discriminator between a safe answer and one that confidently states a regulation that does not operate. The underlying principles this code applies, the four principles of biomedical ethics, are set out in this chapter's account of the principles of medical ethics and are named here rather than relisted.

1989	2 Aug 2023	23 Aug 2023	2002
THE IPS CODE OF ETHICS APPROVED AT CUTTACK	THE 2023 REGULATIONS NOTIFIED	HELD IN ABEYANCE, DAYS LATER	THE MCI CODE THAT IS CURRENTLY OPERATIVE

5.1 Two codes, two kinds of force

The first discrimination to hold is between a professional code and a statutory code, because candidates blur them and the blur costs marks. A professional code of ethics is issued by a professional body to its own members; it articulates the standards the profession aspires to and expects, and it educates and guides more than it punishes. A statutory professional-conduct code is subordinate legislation made under the statute that regulates the medical profession; it defines misconduct and attaches consequences to it, and a breach can lead to erasure from the register. The two are not rivals. The professional code supplies the moral content and the statutory code supplies the enforceable floor, and in practice a serious breach of the profession's own ethics will usually also be a breach of the statutory conduct rules the regulator can act on.

For psychiatry the distinction has extra bite, because psychiatric practice raises ethical problems the general codes handle only thinly: consent where capacity is in question, confidentiality where a third party may be at risk, treatment that may be given against a patient's stated wishes. A discipline-specific code exists precisely to speak to these, which is why the Indian Psychiatric Society drew up its own rather than resting on the general medical code alone.

5.2 The Indian Psychiatric Society code and Cuttack, 1989

The Indian Psychiatric Society appointed a committee to prepare a code of ethics specifically for psychiatrists practising in India, and that code was approved at the Society's annual conference held in **Cuttack** in **1989**. This is the foundational Indian psychiatry-specific code of ethics, and its significance is as much symbolic as textual: it marked the point at which Indian psychiatry set down a written ethical standard of its own. For the examination the year and the place are the memorable pair, and they are the part most reliably asked.

The code is not a static document. What began at Cuttack has been revised and republished by the Society since, so the version a clinician reads today is the descendant of that original text rather than the original itself. The examinable spine is the lineage: a psychiatry-specific ethical code, originated by an IPS committee and adopted at Cuttack, which the profession has kept current. The content that follows is drawn from the Society's current published statement of that code.

IN INDIA

The IPS code sits alongside, not instead of, the statutory conduct rules that bind every registered medical practitioner. A psychiatrist is a doctor first, so the general professional-conduct code applies in full; the IPS code adds the discipline-specific ethical detail the general code cannot supply. Where the IPS code speaks of confidentiality, it is careful to tie the duty to the law of the land, which in Indian mental-health practice means the framework taught in the Mental health legislation and forensic psychiatry notes. The code guides the psychiatrist's conduct; the statute and the regulator supply the consequences.

5.3 What the code asks of the psychiatrist: the Fourteen Codes

The current published form of the code sets out the psychiatrist's duties as **fourteen** numbered codes. They do not need to be memorised verbatim, but a candidate should be able to reproduce their shape, because they map neatly onto the principles this chapter teaches elsewhere and onto the consent and confidentiality duties taught in their own fragments here. The core duties the code lays down are these:

- **The patient comes first.** The patient's care, well-being and best interests are the paramount consideration for the psychiatrist, which is the code's governing clause and the one everything else serves.
- **Competent, dignified care.** The psychiatrist provides competent care while respecting the humanity, dignity and autonomy of the person, so that skill and respect are held together rather than traded off.
- **Valid informed consent.** The psychiatrist acts to establish valid, informed consent with people living with mental illness; the elements of that consent and its special situations are taught in this chapter's account of informed consent in psychiatry and are not reworked here.
- **Professionalism and conflicts of interest.** The psychiatrist maintains professional standards, which includes recognising and managing conflicts of interest rather than pretending they do not arise.
- **Confidentiality within the law.** The psychiatrist upholds the patient's right to confidentiality, but expressly within the provisions the law of the land prescribes; the default duty and its permitted exceptions belong to this chapter's account of confidentiality and its limits.
- **Ethical research.** Research is conducted ethically and under the oversight of ethics committees or institutional review boards, a duty this chapter's account of the ethics of research develops in full.

- **No exploitation of the relationship.** The psychiatrist upholds the sanctity of the doctor-patient relationship and does not exploit it for personal, social, business or sexual gain, which is the code's firmest prohibition and the seam it shares with the topic of boundary violations.

Read together, the codes are less a checklist than a description of a trustworthy psychiatrist: one whose skill is placed at the patient's service, who seeks genuine agreement, who guards what is told in confidence, and who never turns the relationship to private advantage. That last duty, against **exploitation** of the relationship, is the one the code states most absolutely, and it is worth carrying as the code's moral centre.

5.4 The statutory code and the currency trap: 2002 operative, 2023 in abeyance

Here is the fact that decides the mark. The professional-conduct code currently operative for Indian doctors is the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, commonly abbreviated the MCI 2002 code after the Council that made it. It is tempting to assume the newer instrument has replaced it, and the newer instrument does exist: the National Medical Commission Registered Medical Practitioner (Professional Conduct) Regulations, 2023 were notified by the Commission on 2 August 2023 and were to come into force from the date of their publication in the Official Gazette. On the face of the notification, the 2023 Regulations looked like the new code.

They did not survive the month. On 23 August 2023 the Commission held the 2023 Regulations in **abeyance** with immediate effect, clarifying that they would not be operative or effective until a further Gazette notification, and in the same instrument it re-adopted and made effective the Indian Medical Council 2002 Regulations. The net position is precise and counter-intuitive: the 2023 code is notified but suspended, and the 2002 code is the one that governs conduct today. A candidate who writes that the NMC 2023 Regulations are the current professional-conduct code is stating a regulation that does not operate.

RULE **The operative statutory professional-conduct code is the MCI 2002 Regulations; the NMC RMP 2023 Regulations are notified but held in abeyance and are not in force.** The 2023 Regulations were notified and were to commence on Gazette publication, but the Commission suspended them within weeks and re-adopted the 2002 Regulations with immediate effect. Until a further Gazette notification revives the 2023 code, conduct is judged against the 2002 code. State the 2002 code as live and the 2023 code as notified-but-in-abeyance; do not present the 2023 Regulations as the current law.

TRAP **Naming the NMC 2023 Regulations as the code in force.** Because the 2023 Regulations were formally notified and are widely reported as the new ethics code, candidates and even recent textbooks cite them as operative. They are not: they were held in abeyance days after notification and remain suspended pending a further Gazette notification, while the 2002 MCI Regulations were re-adopted and are the code actually applied. The examinable point is not the content of either code but the currency: the newer, notified instrument is dormant and the older one governs.

5.5 Professional misconduct and graded discipline

Even though it does not currently operate, the suspended 2023 code repays study as a proposed framework, though its future operative form is uncertain: a further Gazette notification could revive, amend or replace it. Its treatment of misconduct is exam-friendly. In that code, professional misconduct is defined broadly at Regulation **37**: any violation of the Regulations, or of other applicable Acts relating to medical practice in force, shall constitute professional misconduct. The definition is deliberately open-ended, so that conduct need not be separately itemised to be actionable; a breach of the conduct rules is itself the misconduct.

The consequences are graded rather than binary. The 2023 code arranges disciplinary action across **five** levels, running from exoneration through a reformative warning and fixed periods of suspension of increasing length up to permanent debarment from practice. This graduated structure matters clinically: the regulator's response is meant to be proportionate to the gravity of the breach, so a first, minor lapse and a serious, repeated one do not attract the same sanction. A separate provision addresses criminal conviction: where a practitioner is convicted of a cognizable offence involving **moral turpitude**, that conviction may result in suspension of the licence to practise.

> **PITFALL**
>
> Reading conviction as automatic erasure. The provision on a cognizable offence involving moral turpitude says such a conviction may result in suspension, not that it must; the sanction is discretionary and sits within the graded scheme, not outside it. Telling a colleague that any conviction ends the registration overstates the rule and misreads the modal verb. A conviction opens the disciplinary process and permits suspension; it does not, of itself, strike the name off.

5.6 How the two codes bind together

The profession's code and the statute's code are two faces of one duty. The IPS code tells the psychiatrist what good practice looks like; the statutory conduct code is the instrument through which failures of that practice are called to account. A psychiatrist who exploits the therapeutic relationship, for instance, breaches the IPS code's firmest prohibition and, at the same time, commits professional misconduct the regulator can act on. The moral standard and the enforceable standard converge on the same conduct from different directions, which is why a candidate should be able to move between them: cite the IPS code for the ethical content and the statutory code for the consequence.

AXIS	IPS CODE OF ETHICS (CUTTACK LINEAGE)	STATUTORY PROFESSIONAL-CONDUCT CODE
WHO ISSUES IT	The Indian Psychiatric Society, for psychiatrists	The statutory medical regulator, for all registered practitioners
NATURE	Professional and aspirational; discipline-specific	Subordinate legislation; enforceable
PRIMARY FUNCTION	Guides and educates on ethical practice	Defines misconduct and attaches sanctions
CURRENCY	Originated at Cuttack, kept current by the Society	MCI 2002 Regulations operative; NMC 2023 Regulations in abeyance
CONSEQUENCE OF BREACH	Professional and reputational; feeds the statutory process	Graded action up to erasure from the register

GOOD TO REMEMBER

When a conduct question arises in real practice, ask two questions in order. First, what does good psychiatric ethics require here, for which the IPS code and the four principles are the guide. Second, which enforceable rule is engaged, and against which code, for which the answer today is the MCI 2002 Regulations and not the suspended 2023 code. Keeping the aspirational and the enforceable separate stops a clinician from either dismissing the profession's own code as toothless or mistaking the dormant statute for the live one.

The Indian Psychiatric Society's psychiatry-specific code of ethics was approved at Cuttack in 1989 and, in its current published form, states the psychiatrist's duties as fourteen codes centred on the patient's paramount interest, valid consent, confidentiality within the law and no exploitation of the relationship; the operative statutory conduct code is the MCI 2002 Regulations, while the NMC RMP 2023 Regulations, though notified, are held in abeyance and are not in force.

6 · Professional negligence and medical malpractice (four Ds, vicarious liability)

Every clinical act carries the standing risk that a bad outcome will be read as a wrong done. A patient who is harmed in the course of care may frame that harm as the doctor's fault, and the law of negligence is the machinery that decides whether the framing is right. For the psychiatrist the stakes are peculiar, because so much of the work is judgement exercised under uncertainty, with outcomes that are probabilistic and diagnoses that are contested; the discipline of this topic is learning exactly what turns an adverse outcome into an actionable wrong, and what does not. The examiner is testing whether a candidate can separate the two.

The account here is built around four questions that a negligence claim must answer in turn: was a duty owed, was it breached, did the breach cause harm, and was there harm to be caused. Those four questions are the "four Ds" that every candidate can recite, but the more precise formulation is what the Supreme Court of India actually said, and the discrimination between the mnemonic

and the holding is where marks are made and lost. On the standard against which a breach is judged, on the higher bar the criminal law sets, and on the liability an employer carries for its staff, the rules are settled and quotable. The forum in which a patient brings such a claim, chiefly the consumer forum, belongs to this chapter's account of the Consumer Protection Act and medical practice, and is named here rather than reworked.

1957	1997	1996	2005
BOLAM, THE ORIGIN OF THE PROFESSIONAL STANDARD OF CARE	BOLITHO, THE LOGICAL-BASIS GLOSS ON BOLAM	ACHUTRAO, THE INDIAN AUTHORITY ON HOSPITAL LIABILITY	JACOB MATHEW, THE INDIAN SETTLEMENT OF MEDICAL NEGLIGENCE

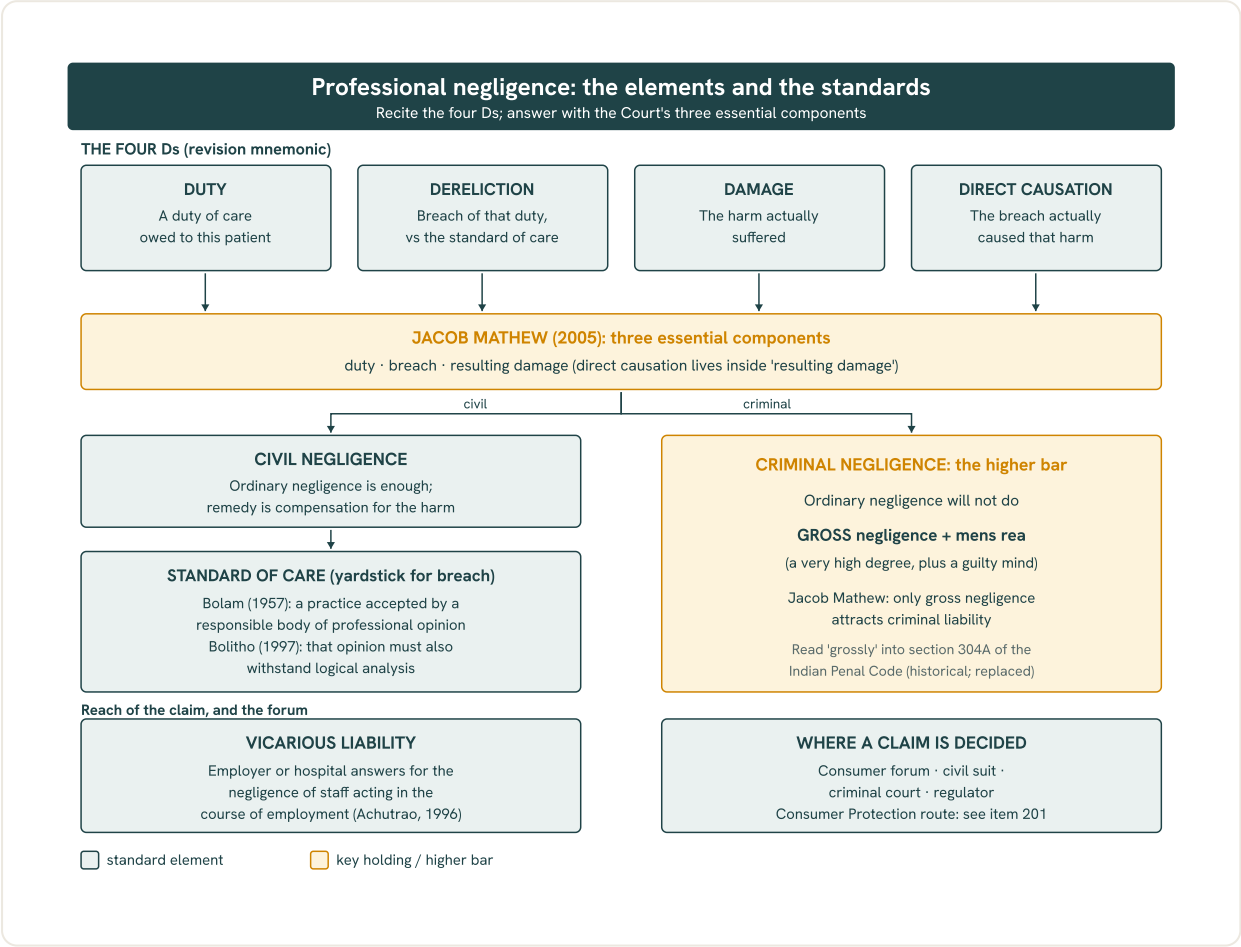

Fig 26.5. Professional negligence: the four Ds unpack the three essential components of Jacob Mathew (2005), breach is judged by Bolam as qualified by Bolitho, and criminal liability needs gross negligence plus mens rea.

6.1 What actionable negligence is: the four Ds and the three components

In ordinary language **negligence** is carelessness, but as a cause of action it is a structured thing with parts that must all be present. It is the breach of a duty caused by an omission to do what a reasonable person, guided by the considerations that ordinarily regulate human affairs, would do, or the doing of what a prudent and reasonable person would not do. A patient who alleges it must establish each of its elements; the absence of any one defeats the claim entirely, however grievous the outcome.

The revision mnemonic gathers those elements as the four Ds: a **Duty** of care owed to the patient, a **Dereliction** or breach of that duty, resulting **Damage**, and **Direct causation** linking the breach to the damage. The mnemonic is a useful scaffold and worth keeping, but it must be

married to what the Court actually held. In **Jacob Mathew** the Supreme Court of India stated that the essential components of negligence are **three**: duty, breach and resulting damage. Causation is not dropped; it lives inside "resulting damage", because damage that does not result from the breach is not the defendant's damage at all. The four Ds and the three components describe the same law: the mnemonic simply unfolds the causation that the holding keeps folded into its third element.

MNEMONIC

Duty, Dereliction, Damage, Direct causation

The four Ds of the negligence action: a **Duty** of care owed to this patient; a **Dereliction**, the breach of that duty measured against the standard of care; the **Damage** actually suffered; and the **Direct causation** that ties the breach to the harm. Recite the four for structure, but answer with the Court's three components, causation embedded in resulting damage, when asked for the authority.

TRAP **The Supreme Court states three essential components, not four Ds.** Candidates write that the Court laid down "four Ds" and lose the mark for putting a teaching mnemonic in the Court's mouth. The holding in Jacob Mathew names three components, duty, breach and resulting damage, with causation carried inside the third. State the three as the law, then offer the four Ds as the device that unpacks the causation requirement. Getting the direction of that relationship right, mnemonic derived from holding and not the reverse, is what a careful answer shows.

6.2 The standard of care: the Bolam test

The second element, breach, cannot be judged without a yardstick, and the yardstick is the heart of medical negligence law. A doctor is not measured against the ordinary reasonable person, because the ordinary person does not possess the special skill in question. This is the insight of the **standard of care** for skilled work, given its classical statement in **Bolam**. Where an act involves a special skill or competence, negligence is judged by the standard of the ordinary skilled person exercising and professing to have that skill, not by the standard of the ordinary person on the street. The practitioner need not possess the highest expert skill; it is enough that they exercise the ordinary skill of an ordinarily competent practitioner of that art.

The operative principle follows: a practitioner is not negligent if they have acted in accordance with a practice accepted as proper by a responsible body of professional opinion, even if other practitioners would have taken a different view. Medicine tolerates genuine differences of approach, and the law protects the doctor who has followed one recognised school of thought against the charge that a different school would have done otherwise. This is why a mere error of judgement, or the existence of a better alternative in hindsight, is not by itself negligence.

IN INDIA

The Bolam standard is not merely borrowed here; the Supreme Court in Jacob Mathew adopted it expressly, holding that the test for determining medical negligence laid down in Bolam holds good in its applicability in India. The practical consequence for civil liability is precise: so long as a doctor follows a practice acceptable to the medical profession of the day, they are not negligent merely because a better alternative existed, or because a more skilled doctor might have chosen differently. The Indian civil standard is therefore the accepted-practice standard, applied to Indian conditions and the resources actually available, not a counsel of perfection.

6.3 Bolam qualified: the Bolitho gloss

Bolam left an obvious gap. If any body of professional opinion could shelter a defendant, then a defendant needed only to find one supportive expert, and the profession, rather than the court, would decide what counted as reasonable care. The correction came in **Bolitho**, which glosses rather than overturns Bolam. A body of professional opinion protects a defendant only if that opinion can be shown to rest on a logical basis. The adjectives the law uses, that the body of opinion be responsible, reasonable and respectable, require the court to be satisfied that its exponents have actually weighed the comparative risks and benefits and reached a defensible conclusion. In the rare case where the opinion relied on is not capable of withstanding logical analysis, the judge is entitled to hold that it is not reasonable or responsible, and the shelter falls away.

The combined rule, Bolam as qualified by Bolitho, is the single most examinable proposition in this topic. The standard of care is set by a responsible body of professional opinion, but the court retains a residual power to reject that opinion when it cannot survive logical scrutiny. This keeps the final judgement of reasonableness with the court while giving proper weight to genuine professional practice, and it forecloses the defence built on an opinion that is merely asserted rather than reasoned.

RULE **The standard of care is Bolam as qualified by Bolitho: a responsible body of professional opinion sets the standard, but only where that opinion withstands logical analysis.** A doctor who acts in line with an accepted professional practice is not negligent, and this protects legitimate differences of clinical approach. Bolitho adds the safety catch: the practice relied on must have a logical basis, weighing risks against benefits, or the court may find it neither reasonable nor responsible. Both halves must appear in a full answer, because Bolam alone overstates the doctor's protection and misses where Indian and English law now stand.

GOOD TO REMEMBER

What protects the clinician is not a good outcome, which cannot be guaranteed, but a defensible process. Choose a management that a responsible body of your profession would accept, be able to say why the comparative risks and benefits pointed that way, and write that reasoning in the notes as it is made. A documented choice within accepted practice is answerable to Bolam and Bolitho even when the result is poor; an undocumented departure from it is exposed even when the result is good.

6.4 Causation: the fourth D and where the burden lies

Even a proven breach of duty does not by itself make a case, and this is the element candidates most often skate over. **Causation** is the requirement that the breach actually produced the injury complained of, and it is a distinct hurdle the claimant must clear. Bolitho is authority for the point as well as for the standard of care: where a breach of the duty of care is proved or even admitted, the burden still lies on the plaintiff to prove that the breach caused the injury suffered. A patient who was negligently managed but who would have come to the same harm regardless has suffered a breach without a remedy, because the breach caused nothing.

This is the "direct causation" the fourth D names, and it is why the mnemonic is a fair unpacking of the three components rather than an inflation of them. The link between breach and damage must be shown, not assumed from the coincidence of a lapse and a bad result. For the psychiatrist, where outcomes are multiply determined and the natural course of an illness may itself account for the harm, the causation question is frequently the strongest ground of defence: the illness, not the treatment, may be the operative cause.

6.5 Civil and criminal negligence: the higher bar

The same careless act can be met with a civil claim for compensation or, in a serious case, a criminal prosecution, and the two run on entirely different standards. The distinction is grounded and load-bearing. For civil liability the accepted-practice standard of Bolam and Bolitho governs, and ordinary negligence suffices. For criminal liability the bar is far higher: **mens rea** must be shown, and the degree of negligence must be **gross negligence**, or negligence of a very high degree. Negligence that is neither gross nor of a high degree may found a civil action but cannot form the basis of a prosecution. In Jacob Mathew the Court read the words "rash or negligent act" in the historical penal provision, Section **304A** of the Indian Penal Code, as qualified by "grossly", so that only gross negligence would attract criminal liability.

The rationale is protective. A doctor who acts in good faith and within accepted practice should not face the criminal law every time treatment fails, because that would make defensive medicine the rule and deter the very risk-taking that patients need. The criminal law is reserved for negligence so gross that it approaches recklessness, coupled with the guilty mind the offence requires. The insanity-defence doctrine and the burden of proof that attend criminal responsibility more generally belong to the Mental health legislation and forensic psychiatry notes and are not reworked here; the point retained is the standard specific to negligence.

AXIS	CIVIL MEDICAL NEGLIGENCE	CRIMINAL MEDICAL NEGLIGENCE
STANDARD APPLIED	Bolam, as qualified by Bolitho: departure from accepted responsible practice	Gross negligence, or negligence of a very high degree
MENTAL ELEMENT	None required; the act and its consequences are judged objectively	Mens rea must be shown to exist
DEGREE OF FAULT	Ordinary negligence is enough	Ordinary negligence will not do; the lapse must be gross
WHAT THE CLAIMANT SEEKS	Compensation for the damage caused	Punishment of the practitioner by the State
PURPOSE OF THE STANDARD	To make good the harm to the patient	To protect the good-faith doctor from prosecution for every failure

PITFALL

Citing the Indian Penal Code as the current source of the criminal-negligence provision. Jacob Mathew construed Section 304A of the Indian Penal Code, which was the operative penal code when the case was decided, but the substantive criminal law has since been replaced and the old codes are now historical. Quoting the Court on the qualifying word "grossly" is correct; presenting the Indian Penal Code as the code in force today is not. The current penal framework and the savings rule that decides which code applies to a given prosecution are set out in this chapter's account of the penal-code framework and its transition; name the new provision as current and the old as historical.

6.6 Vicarious liability: the employer answers for the servant

A negligence claim does not stop at the individual who erred. **Vicarious liability** is the principle that an employer, though personally without fault, is answerable for the harm done by the fault or negligence of a servant acting in the course of employment. The doctrine matters intensely in practice, because the individual clinician may be uninsured or of modest means while the hospital that employs them is not, and because the harm done by any of the doctors or other employees through whom a hospital delivers care is answered for by the hospital itself. The rule is stated authoritatively in **Achutrao**: an employer, though guilty of no fault himself, is liable for the damage done by the fault or negligence of his servant acting in the course of his employment.

The liability is not unlimited, and its boundaries are where the marks sit. Applied to the hospital, the Court held that running a hospital is a welfare activity and not a sovereign function, so the State or the hospital cannot claim sovereign immunity and is vicariously liable for the negligence of its doctors and other employees. The claimant may sue the individual, the institution, or both. The requirements that must hold, and the defence that fails, are these:

- **An employer-servant relationship.** The person who erred must be an employee, not an independent contractor beyond the employer's control; the closer the control over how the work is done, the firmer the liability.

- **Acting in the course of employment.** The negligent act must be part of, or reasonably incidental to, the work the servant is engaged to perform, not a personal venture unconnected with it.
- **A welfare, not a sovereign, function.** Because running a hospital is a welfare activity, the defence of sovereign immunity does not shield a public hospital from vicarious liability for its staff.

6.7 Where a negligence claim is decided

A patient harmed by alleged negligence is not confined to a single door, and the available tracks run on different standards and to different ends:

- **The consumer forum.** A dedicated statutory route treats a deficiency in a medical service as consumer redress; that forum, its remedy and the settled position that paid medical services fall within it belong to this chapter's account of the Consumer Protection Act and medical practice, and are named here without being reworked.
- **An ordinary civil suit.** A patient may sue for damages in the courts, where ordinary negligence against the accepted-practice standard suffices.
- **A criminal prosecution.** Available only where the negligence is gross and accompanied by the guilty mind the offence requires.
- **A complaint to the regulator.** Engaging the professional-conduct code, this track is concerned with fitness to practise rather than with compensation.

The tracks are independent and may run in parallel: a single episode of negligent care can generate a consumer complaint, a civil suit, a criminal case and a disciplinary inquiry at once, each on its own standard and to its own end. What travels across the civil and consumer forums is the substance taught in this fragment, the elements of the action and the standard of care: each asks whether a duty was breached against the Bolam-Bolitho yardstick and whether the breach caused the harm. The criminal court demands more, gross negligence and mens rea, and the regulator asks about fitness to practise rather than compensation, so the yardstick is not identical everywhere. The forum changes the procedure, the degree of fault required and the remedy; the underlying account of what negligent care is remains the reference point each forum starts from.

Actionable negligence has three essential components in Jacob Mathew, duty, breach and resulting damage, with causation embedded in the third and unpacked by the four-D mnemonic; the standard for breach is Bolam as qualified by Bolitho, an accepted responsible practice that must also withstand logical analysis; civil liability needs ordinary negligence while criminal liability needs gross negligence plus mens rea; and by vicarious liability the hospital, running a welfare and not a sovereign function, answers for the negligence of its servants acting in the course of employment.

7 · Consumer Protection Act and medical practice

A doctor who charges for care has, in the eye of the law, supplied a service, and a patient who feels short-changed by that service can come after the doctor not only as an injured plaintiff but as a dissatisfied consumer. That single move, treating the clinical encounter as a transaction in services, is what brought medical practice within consumer law and gave the aggrieved patient a forum that is faster and cheaper than an ordinary civil suit. The marks are for knowing which statute is actually in force, what the Act means by "service" and by "deficiency", and how the landmark judgment settled that a doctor's work is a service the Act can reach: each a discrete, quotable point, and each a place a hurried candidate goes wrong.

This fragment owns the consumer forum and its definitions, not the law of negligence itself. Whether a doctor was negligent, the elements of the action and the standard of care against which a breach is measured, belongs to this chapter's account of professional negligence and medical malpractice and is named here, not reworked. The Consumer Protection Act does not invent a new standard of care; it opens a door to a particular tribunal and calls the wrong a "deficiency in service". Keeping that boundary clear, forum here, standard there, is the discipline the examiner is testing.

2019	1986	1995
THE CONSUMER PROTECTION ACT NOW IN FORCE	THE EARLIER ACT, SINCE REPEALED	IMA V V.P. SHANTHA BROUGHT MEDICINE WITHIN THE ACT

7.1 The current statute and what it replaced

The first thing to fix is currency, because the obvious answer is now the wrong one. The operative law is the Consumer Protection Act, 2019, enacted as Act 35 of 2019, which received assent on 9 August 2019. By Section **107(1)** it repealed the earlier Consumer Protection Act, 1986. The older Act is historical, and a candidate who cites it as governing law is quoting a repealed statute.

The Act's commencement is itself a conditional worth stating precisely, because it is not a single switch. It comes into force on such date or dates as the Central Government appoints by notification, and different dates may be appointed for different provisions of the Act and for different States. That staggered commencement means the practical answer to "when did it apply" is a matter of notification rather than of the date of assent. What matters for medical practice is that the core concepts, service, deficiency and consumer, are carried forward from the old Act with their sense intact.

7.2 What the Act means by "service"

Everything turns first on whether the doctor supplies a **service** the Act recognises, because only then can the patient be a consumer of it. Section **2(42)** defines service expansively as service of any description made available to potential users, with an illustrative sweep from banking and insurance through transport and housing construction. The breadth is deliberate: the definition is inclusive, not a closed list, so a service is not excluded merely because it is unnamed.

Against that breadth the section sets two express exclusions, and stating the definition without them is how a candidate loses the mark:

- **Service rendered free of charge.** A service rendered free of charge is outside the definition, a carve-out decisive for camps, charitable care and government facilities; but as the discussion of free versus paid care below shows, whether care is "free" is read by how the facility is funded, not by what a given patient paid.
- **Service under a contract of personal service.** A master-and-servant employment relationship is excluded, so that the ordinary grievance of an employee against an employer does not become a consumer complaint.

The free-of-charge limb generates almost all the medical litigation, because it forces the question of exactly when treatment counts as free.

7.3 What the Act means by "deficiency"

If the encounter is a service, the actionable wrong is a **deficiency** in it. Section **2(11)** defines deficiency as any fault, imperfection, shortcoming or inadequacy in the quality, nature and manner of performance that is required to be maintained by law or has been undertaken by contract in relation to a service. Critically for medicine, the definition expressly includes any act of negligence, or omission or commission, by the provider that causes loss or injury to the consumer. This is the bridge that lets a negligence complaint be pursued as a consumer matter at all.

What the Act does not do is tell you when negligence exists. The **deficiency in service** is defined by reference to the performance "required to be maintained by law", and the content of that requirement, the four-part structure of the negligence action and the standard of care by which a breach is judged, is drawn from the general law set out in this chapter's account of professional negligence and medical malpractice. The consumer forum applies that standard; it does not lower it. A poor outcome is not a deficiency unless the care fell below the standard the law already demands, which is why the same fact may be a deficiency in one case and a non-negligent misadventure in another.

7.4 The landmark: medicine is a "service"

For years it was argued that a learned profession stood apart from consumer law, and that a doctor answerable to the medical regulator could not also be hauled before a consumer tribunal. That argument was settled by **IMA v V.P. Shantha**, which remains the governing precedent. The Court held that service rendered to a patient by a medical practitioner, by way of consultation, diagnosis and treatment, both medicinal and surgical, falls within the expression "service" as then defined in Section **2(1)(o)** of the 1986 Act, the historical predecessor of the current definition. Two exceptions were carried over from the statute itself: service rendered free of charge to every patient, and service under a contract of personal service.

The judgment also disposed of the profession's favourite escape route. The fact that a doctor is subject to the disciplinary control of the Medical Council does not take the doctor's service outside the Act. Regulatory oversight and consumer liability are parallel, not alternative; a clinician can face both a disciplinary inquiry into fitness to practise and a consumer complaint for compensation arising from the same episode. That the Court read a professional's work as a

marketed service, rather than as a calling immune from commercial law, is the conceptual core of the whole topic.

RULE **A doctor's diagnostic and therapeutic service is "service" under the Act, and a deficiency in it is actionable in the consumer forum, unless the service is rendered free of charge to everybody or under a contract of personal service.** The default is coverage; the exclusion is narrow and must be stated with its condition. Where a practitioner or facility charges no fee from any patient, the service is outside the Act, and the payment of a token amount for registration only does not change that position. The rule is not "free treatment is never covered" but "treatment free to everyone is not covered", and the difference between those two sentences is where the marks live.

7.5 The free-versus-paid distinction

The single most examined product of Shantha is the way it worked the free-of-charge exclusion out across the mixed economy of Indian hospitals, where paying and non-paying patients are treated side by side. Rather than a crude "did this patient pay" test, it asks how the facility is funded, so that a patient treated free at a hospital that charges others is still a **consumer**. The accompanying grid sets out the four situations the Court distinguished.

SITUATION	IS IT "SERVICE" UNDER THE ACT?	IS THE RECIPIENT A "CONSUMER"?
CHARGES ARE PAYABLE AND THE PATIENT PAYS	Yes; paid medical service falls squarely within the Act	Yes; may complain of a deficiency
CROSS-SUBSIDISED: THOSE WHO CAN PAY ARE CHARGED, THOSE WHO CANNOT ARE TREATED FREE	Yes; even the free treatment is "service"	Yes; the non-paying patient is also a consumer
FREE TO EVERYBODY, NO CHARGE TAKEN FROM ANY PATIENT	No; wholly free service is outside the Act	No
ONLY A TOKEN REGISTRATION FEE IS TAKEN, ALL ARE TREATED FREE	No; the token fee does not alter the free character	No

The organising idea is that the paying patients underwrite the free ones, so the institution supplies a service for consideration and the benefit of that service reaches the non-paying patient too. Coverage follows the economic character of the facility, not the receipt in a given patient's hand, and only where the service is free to all comers does the exclusion truly bite.

TRAP **Reading the free-of-charge exclusion too widely, so that any free treatment is treated as outside the Act.** Candidates state the exclusion correctly, then apply it as though a patient who paid nothing can never complain. Shantha holds the opposite for the cross-subsidised case: where a hospital charges paying patients and treats others free, the free treatment is still "service" and its recipient a consumer. The exclusion is confined to the facility that charges no one at all. Answer with the four situations, not with the headline, because the headline states a rule the judgment expressly rejected.

7.6 The forum, the remedy and the boundary with negligence

What the Act really gives the patient is a place to go. Beyond defining service and deficiency, it establishes a dedicated tier of consumer commissions, sitting at the district, State and national

levels, before which a consumer may bring a complaint of deficiency and seek redress, most commonly an award of compensation. The attraction over an ordinary civil suit is procedural: the consumer route offers a dedicated statutory forum and a compensation remedy, and it became a common route for medical grievances once Shantha confirmed doctors were within reach of it. The exact pecuniary jurisdiction of each tier, the limitation period for a complaint, and the statutory definitions of "consumer" and "complaint" are matters of the Act's machinery not reproduced here.

The boundary with the law of negligence is the point to carry away. The commission decides the forum question, is this a service, is the complainant a consumer, has there been a deficiency, but the deficiency question still turns on the ordinary negligence standard, the accepted-practice test qualified by the requirement of a logical basis, taught in this chapter's account of professional negligence and medical malpractice. The Consumer Protection Act is thus best understood as a remedy and a forum bolted onto the substantive law of negligence, not as a separate or stricter code of medical liability. A clinician who satisfies the standard of care has committed no clinical negligence, though the statutory definition reaches wider than negligence alone: a fault, imperfection, shortcoming or inadequacy in a performance the law requires or a contract undertook can still be a deficiency.

IN INDIA

Since IMA v V.P. Shantha the consumer commission has been the workhorse of medical-liability litigation in India, because it spares the patient the cost and delay of a regular civil action. For the practising psychiatrist the Act bites at the ordinary paid consultation: consultation, diagnosis and treatment given for a fee is service within the Act, so a dissatisfied patient may bring a complaint alleging a deficiency in it. The fee-paying private consultation is the paradigm covered service, so the everyday out-patient encounter falls squarely within the Act's reach.

GOOD TO REMEMBER

Do not treat a fee waiver as a shield. If your clinic charges other patients, the concession you extend to one does not put that patient's care outside the Act; a camp or charitable service is exempt only when nobody is charged at all. Because coverage follows how the service is funded rather than what this patient paid, hold every episode of care, subsidised, discounted or free within a paying practice, to the same documented standard, so that the deficiency question is answered by your notes whichever forum asks it.

PITFALL

Citing the Consumer Protection Act, 1986 as the statute in force. It was repealed by the 2019 Act, and quoting the old Act, or its old section for the definition of service, in a report, an opinion or an examination answer marks the writer as working from a superseded source. The case law decided under the 1986 Act, IMA v V.P. Shantha among it, remains good authority on the concepts, but the section it construed is historical. Name the 2019 Act as current and treat the 1986 provisions as the predecessor they now are.

The operative statute is the Consumer Protection Act, 2019, which repealed the 1986 Act; a doctor's paid diagnostic and therapeutic work is "service" and its negligent shortcoming a "deficiency", so IMA v V.P. Shantha lets a patient sue as a consumer, with only service that is free to everybody, unaltered by a token registration fee, falling outside the Act, while the standard of negligence itself is drawn from the account of professional negligence.

8 · Expert testimony and the psychiatrist as expert witness

Why the marks are here. Forensic work asks the psychiatrist to do something the rest of medicine never demands: to serve a master other than the patient. The clinician who, in the consulting room, owes undivided loyalty to the person in front of them may later be asked by a court to examine a litigant, an accused or a claimant and to report - not for that person's benefit, but for the administration of justice. The two examinations can look almost identical across the desk, yet they pull the clinician in different directions: to whom the duty is owed, and what confidentiality and stance the encounter carries, invert between them, even though duties of honesty, respect and competence hold in both. Evaluators who miss this produce reports that are partisan, poorly received, or quietly damaging to the very patient they meant to help; candidates who miss it lose an easy viva question that examiners return to year after year.

This section teaches the psychiatrist as an **expert witness**: how the treating role is held apart from the expert role, and how the law separates the opinion the expert is uniquely permitted to give from the facts to which an ordinary witness is confined. The rules of admissibility, the court hierarchy and the mechanics of how an opinion is received in evidence are set out elsewhere in this chapter and are only named here; the criteria of criminal responsibility and of fitness to stand trial belong to the Mental health legislation and forensic psychiatry notes.

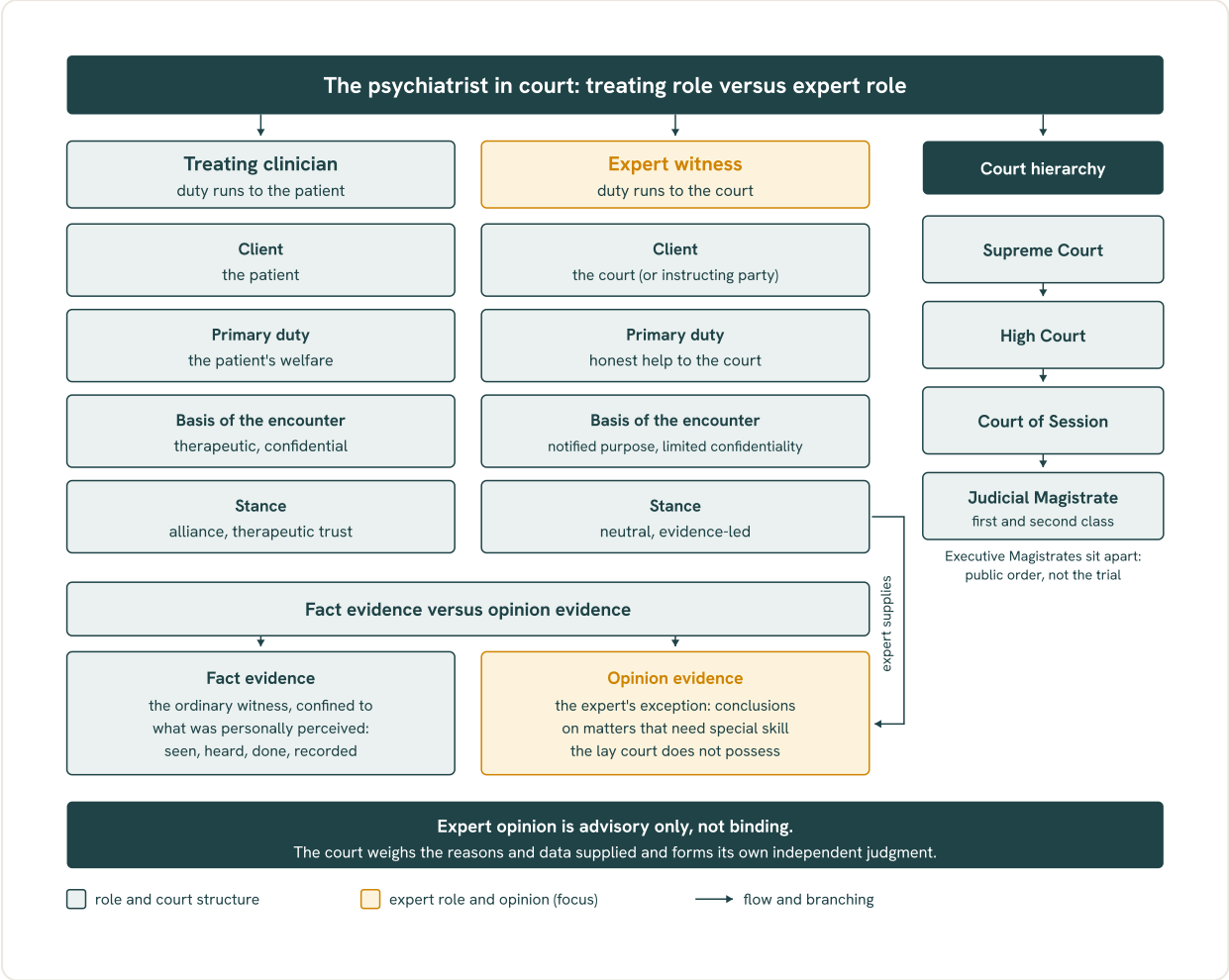

Fig 26.6. The treating role serves the patient and the expert role serves the court; the ordinary witness gives fact while the expert alone gives opinion on matters needing special skill, and that opinion is advisory only, the court never bound by it (Ramesh Chandra Agrawal, 2009).

8.1 Two roles, one clinician: treatment and evaluation

The confusion at the heart of forensic psychiatry is that one professional, with one set of skills, is asked to occupy two structurally different positions. In the **treating role** the client is the patient. The primary obligation is to that patient's welfare, resting on the principles of beneficence and non-maleficence (the four principles of biomedical ethics are set out elsewhere in this chapter and named here only). Consent is therapeutic consent to be helped; confidentiality is the default posture, breached only within the narrow permitted circumstances taught elsewhere in this chapter. The stance is one of alliance and therapeutic trust, because trust is itself part of the treatment, while clinical assessment stays objective.

In the **forensic evaluator** role almost every one of those settings inverts. The functional client is the court, or a retaining party whose instructions the evaluator accepts but whose interests do not command the opinion. There is no therapeutic purpose, and confidentiality is correspondingly limited rather than absent: before anything is said, the person examined must be told that the encounter is not treatment, that what they disclose is not held in the usual clinical confidence and may be set out in a report, and who will receive that report. The goal is not the person's welfare but an accurate answer to a legal question, and the stance is neutral and, where the data demand it, sceptical. When these two roles are forced into one person at one time - the treating

psychiatrist asked to be the court's expert on their own patient - a dual relationship forms that corrodes both the objectivity the court needs and the alliance the patient needs.

AXIS	TREATING ROLE	EXPERT ROLE
Who is the client	The patient	The court (or an instructing party)
Primary duty	The patient's welfare	Honest assistance to the court
Basis of the encounter	Therapeutic consent	Notified purpose, limited confidentiality
Confidentiality	Default, narrowly limited	Limited by the forensic purpose
Goal of the contact	To help the person	To answer a legal question accurately
Stance toward the person	Alliance, therapeutic trust	Neutral, evidence-led

8.2 Opinion and fact: why the expert is the courtroom's exception

A court is a machine for finding facts and drawing inferences from them, and it reserves the drawing of inferences to itself. The ordinary witness is therefore confined to **fact evidence**: what they personally perceived - saw, heard, did, recorded. They are not permitted to offer their conclusions, because inference is the court's own work. The expert is the deliberate exception to this rule. Where a question turns on specialised knowledge the lay judge does not possess, the law admits **opinion evidence** from a person qualified in that field, precisely so the court can reason about matters it could not otherwise understand.

The distinction has a direct and frequently examined consequence for the psychiatrist. A treating psychiatrist summoned to testify about a patient they have managed is, in that capacity, usually a witness of fact: they speak to their own observations, their records, the treatment given. That is fact evidence, even though the witness happens to be an expert by training. Giving an opinion on a legal question about someone the witness has not evaluated for that purpose is a different act, requiring the expert footing. The same psychiatrist may therefore be a witness of fact in one proceeding and an expert in another; the discipline is to know, at every moment, which capacity is being exercised, because the permissions and the duties differ.

8.3 The advisory character of the opinion

Because opinion is admitted only by way of exception, the law is careful to fix its weight. The governing Indian authority is **Ramesh Chandra Agrawal v. Regency Hospital Ltd.** (Supreme Court, **2009**), which states the principle plainly: an expert is not a witness of fact, and the evidence is really of an advisory character. The expert's duty is to furnish the judge with the necessary scientific criteria for testing the accuracy of the conclusions, so as to enable the judge to form an independent judgment by applying those criteria to the facts proved in the case. It is not the province of the expert to act as judge or jury; the court is not bound by the opinion, and weighs it against the reasons and the data the expert has actually supplied.

2009

RAMESH CHANDRA AGRAWAL: THE SUPREME COURT ON THE EXPERT'S ROLE

Two things follow, and both are examinable. First, the opinion is only ever an aid to the court's own reasoning, never a substitute for it, so a decision-maker who simply adopts an expert's conclusion has abdicated the very function the law reserves to it. Second, and more useful at the bedside of report-writing, an opinion carries weight in large part according to how far it exposes the criteria and data on which it rests. A bare conclusion, however eminent its author, gives the court nothing to test and therefore earns little. The reasoning is the evidence; the conclusion is merely its endpoint.

> An expert witness is not a witness of fact: the opinion is advisory only, and the court, never bound by it, forms its own independent judgment on the reasons and data supplied.

RULE **The expert advises; the court decides.** Expert evidence is of an advisory character. Its job is to hand the court the scientific criteria for testing a conclusion, not to deliver the conclusion the court is bound to accept. Weight tracks the transparency of the criteria and data offered.

8.4 Objectivity, and the partisan-expert trap

If the opinion is advice to the court, then the expert's overriding duty runs to the court and to the truth, not to whoever pays the fee. This is the ethical spine of the role and the point at which it most often fails in practice. The **partisan expert** - the hired opinion that shades every ambiguity in the instructing party's favour - is not merely distasteful; it is worthless in exactly the terms the governing authority sets out, because an opinion shaped to a conclusion cannot honestly furnish the criteria by which that conclusion could be falsified. Independence is not a courtesy the expert extends to the other side; it is the condition on which the evidence has any value at all.

Signs that an opinion has slipped from expert to advocate include:

- a conclusion stated with a confidence the underlying data cannot support;
- selective use of the record, with inconvenient findings omitted rather than addressed;
- straying beyond the witness's actual field of competence;
- answering the ultimate legal question directly instead of supplying the material the court needs to answer it.

TRAP **Deciding the ultimate legal issue.** The expert may give the clinical opinion, including whether the person was, by reason of unsoundness of mind, in a particular mental state, which the evidence code names as a paradigm expert question. What the expert must not do is announce the verdict: whether the statutory defence is made out, or whether the doctor is legally liable. That legal conclusion is the court's province. The expert furnishes the clinical criteria and findings; the judge, not bound by the opinion, applies the law.

IN INDIA

Indian courts treat expert medical and psychiatric opinion as advisory rather than conclusive, and the Supreme Court's statement of that position is the authority discussed above. A well-reasoned report that lays out its criteria and data will be given weight; an assertion offered on authority alone will not. The practical lesson for the Indian evaluator is to write for a reader who is entitled to disagree.

8.5 From consulting room to witness box

The expert's product is the written report, and it is prepared on the assumption that it will be read by an adversary and tested under cross-examination. A defensible report therefore does the opposite of what a clinical note does for a colleague: it spells out its own workings so that a hostile reader can retrace them. The psychiatrist states the instructions received and the question asked, records who was examined and on what material, distinguishes what was observed from what was inferred, and confines every opinion to matters within genuine competence. Where the data are thin or the literature divided, the honest report says so, because a candid limitation strengthens the parts that remain and a concealed one collapses the whole under cross-examination.

A defensible expert report characteristically:

- identifies the instructing party, the question, and the material relied on;
- separates facts observed from opinions drawn;
- gives the reasoning and criteria behind each opinion, not the conclusion alone;
- stays within the author's field and flags the limits of the data.

GOOD TO REMEMBER

Keep the two roles physically separate whenever you can: if you are the treating psychiatrist, resist accepting an expert brief on your own patient, and if you must give evidence about them, give it as a witness of fact - what you saw, recorded and did. Because those treating records can themselves be summoned as fact evidence, contemporaneous, legible and complete documentation is a medico-legal protection long before any court is involved.

PITFALL

A common and damaging real-world error is not a courtroom blunder but an acceptance made months earlier: agreeing to serve as the court's expert on a patient one is actively treating. The clinician believes they are best placed because they know the patient, but they arrive with a therapeutic loyalty and a prior belief that no amount of good faith can neutralise, and the resulting opinion is both ethically compromised and easily discredited. Decline the dual role at the outset, and refer the evaluation to an independent colleague.

8.6 Where the expert role meets the rest of forensic practice

The advisory posture set out above is not confined to one kind of case; it is the common footing on which the psychiatrist enters every legal forum. The psychiatric assessment of an accused,

whose procedural pathway of court referral and reporting is dealt with elsewhere in this chapter, is an application of exactly this role: the psychiatrist furnishes the court with clinical findings and criteria, while the substantive question of criminal responsibility, and the tests and burden of proof that govern it, belong to the Mental health legislation and forensic psychiatry notes. In a professional-negligence action the standard of care, taught elsewhere in this chapter, is itself proved through expert testimony about accepted practice, so the credibility of the whole claim can turn on how transparently that expert reasons. And the rules of evidence and the court structure that decide how an opinion is admitted and received, also treated elsewhere in this chapter, are the procedural frame within which the advisory character of the opinion actually operates.

The unifying idea. Across all of these settings the psychiatrist is doing one thing: translating clinical observation into criteria a court can test, while leaving the decision to the court. Hold the treating role and the expert role apart, remember that opinion is admitted only as an aid and never as a verdict, and the harder forensic tasks in this chapter become variations on a single, well-understood discipline.

9 · Boundary violations and ethics of the therapeutic relationship

The therapeutic relationship is the instrument of psychiatric treatment, and boundaries are what keep that instrument safe to use. Psychiatry works through a relationship in which a distressed person discloses the most private material of a life to a clinician trusted to hold it and to act only in that person's interest. That trust rests on an asymmetry of power, knowledge and dependence that does not reverse itself, and it is that asymmetry which makes the relationship both healing and dangerous. The ethics of the therapeutic relationship is the discipline of managing that danger, and its central examinable idea is the distinction between a departure from the frame that remains safe and one that has become harmful. A candidate who can define a boundary crossing and a boundary violation, hold the two apart on stated grounds, and trace the progression that carries one into the other has this topic; one who treats every deviation as misconduct, or reserves the word violation for sexual contact alone, has misunderstood it.

What is owned here is the doctrine of the relationship itself. The four principles of biomedical ethics, informed consent, confidentiality and its limits, and the professional-conduct codes each have their own treatment in this chapter and are named here, not re-derived; so too the disciplinary, civil and consumer-forum consequences of a breach.

Fiduciary	Clinician	Absolute
THE NATURE OF THE DUTY THE RELATIONSHIP IMPOSES	WHO OWNS THE BOUNDARY, IN EVERY CASE	THE PROHIBITION ON SEXUAL CONTACT WITH A CURRENT PATIENT

9.1 The therapeutic frame and the fiduciary duty

Every treatment proceeds inside a set of expectations about how the clinician and patient will relate: the length, time and place of appointments, what is discussed, the handling of money, touch and personal information, and the understanding that the encounter exists for the patient's benefit alone. This set of expectations is the **therapeutic frame**, and boundaries are its edges.

They are not coldness or rigidity but the conditions under which a patient can safely regress, disclose and depend, knowing the clinician will not exploit the openness that treatment requires.

The frame is necessary because the relationship is a **fiduciary** one: the patient entrusts their welfare to a clinician who holds greater power and knowledge and is bound, in return, to place the patient's interests first, subject to the law and to the narrowly defined duties owed to others, and never to convert the relationship to their own advantage. Two features of psychiatric treatment sharpen this duty beyond that of most specialties. The first is **transference**, in which the patient unconsciously experiences the clinician through the template of earlier significant relationships, investing them with an authority, intimacy or idealisation carried from those earlier relationships rather than earned by the real person; realistic reactions to what the clinician actually says and does run alongside it, and the two are not always easy to separate. The second is **countertransference**, the clinician's own emotional responses to the patient, ordinary and useful in the work but which, unexamined, can pull the clinician toward gratifying their own needs under the guise of helping. Because transference makes the patient especially susceptible and countertransference makes the clinician especially fallible, responsibility for the boundary can never be shared with the patient; it rests wholly and permanently with the clinician.

RULE **The relationship is fiduciary, and the duty to maintain its boundaries rests entirely with the clinician, never with the patient.** Because transference and the power asymmetry leave the patient unable to protect themselves within the relationship, the patient's apparent willingness, invitation or even initiation never transfers responsibility: whatever the patient does, the clinician is answerable for the boundary, at every stage.

9.2 Boundary crossing versus boundary violation

The pivotal distinction of this topic is between two kinds of departure from the frame. A **boundary crossing** is a deviation from usual practice that is minor, non-exploitative and potentially benign or even helpful, and that can be openly acknowledged and discussed. Offering a distressed patient a tissue, briefly extending a session at a moment of crisis, or a small self-disclosure that normalises a fear may all be crossings: they step outside the frame, but they serve the patient, are reversible, and survive being talked about in supervision or written in the notes.

A **boundary violation** is a departure that is exploitative and harmful, that serves the clinician's needs rather than the patient's, and that damages the treatment. The difference is not the size of the step but its direction and effect: whose need it meets, whether it can be reversed, whether it can be discussed honestly, and whether it stands alone or forms part of a drift away from the patient's interest. A crossing that recurs, escalates, is concealed and begins to gratify the clinician has stopped being a crossing. The two therefore describe points on a single continuum, not unrelated categories, which is why the same act can be either depending on context and motive.

AXIS	BOUNDARY CROSSING	BOUNDARY VIOLATION
WHOSE NEED IS SERVED	The patient's; consistent with the treatment	The clinician's; the treatment is subordinated to it
EFFECT ON THE PATIENT	Neutral or beneficial	Harmful; exploits the patient's vulnerability
EXPLOITATION	Absent	Present, by definition
DISCUSSABILITY	Openly acknowledged and documented	Concealed, rationalised or kept secret
REVERSIBILITY	Reversible; the frame is easily restored	Damages the frame, often irreparably
PATTERN	Isolated and self-limiting	Recurrent, escalating, part of a drift

MNEMONIC

Whose need? Reversible? Discussable? A pattern?

The four questions that sort a crossing from a violation. **Whose need** is served, the patient's or the clinician's (beneficence against self-interest). **Reversible**, can the frame be restored or is the harm done (non-maleficence). **Discussable**, could it be said aloud in supervision and the notes, or must it be hidden. **A pattern**, does it stand alone or is it one step in an escalating drift. Answer patient, yes, yes, no and it is a crossing; the reverse and it is a violation.

9.3 The domains in which boundaries operate

Boundaries are not confined to physical contact; they run through every dimension of the clinical encounter, and a violation can occur in any of them. Naming the domains matters because clinicians tend to watch only the most obvious one and miss a breach in another. The recurring domains are:

- **Role.** Keeping the clinical role distinct from social, business or personal roles; a **dual relationship** arises when a second relationship is superimposed on the treating one.
- **Time and place.** The scheduling, duration and location of contact; appointments drifting to the end of the working day, lengthening without clinical reason, or moving outside the clinical setting.
- **Money and gifts.** Fees, business dealings, borrowing or lending, and the giving or receiving of gifts and services beyond token courtesy.
- **Self-disclosure and language.** How much of the clinician's own life enters the room, and a shift toward an intimate or personal register.
- **Physical contact.** Touch of any kind, at the far end of which lies sexual contact, the gravest breach of all.

The value of the list is that it makes the drift visible. Serious violations rarely begin with the act that finally destroys the treatment; they begin with small, defensible-looking changes across

several domains at once, each innocuous in isolation. Watching all the domains, not only the physical one, is how a clinician catches a problem while it remains a crossing.

9.4 The slippery slope

The **slippery slope** is the observation that boundary violations characteristically develop by gradual progression rather than a single decisive act. A clinician rarely moves directly from correct practice to gross exploitation; instead a series of minor crossings accumulates, each normalising the next, until the relationship has slid far from its therapeutic purpose. A common progression begins with a subtle shift toward the personal and a growing sense that one patient is special, moves through appointments lengthened or rescheduled to the end of the working day, extra-clinical contact, the exchange of confidences and gifts, and meetings outside the clinical setting, and ends in sexual involvement. The precise sequence varies, but the shape is consistent: incremental, mutually reinforcing steps, each small enough to be rationalised.

The mechanism is what makes the concept clinically useful rather than merely descriptive. Because each step is small, it evades the clinician's own alarm; because transference makes the patient receptive and countertransference makes the clinician gratified, both are drawn along the slope rather than pulled back; and because the steps are concealed, the ordinary corrective of open discussion never operates. The practical implication is decisive: a violation is reliably prevented early, at the first crossings and the first stirrings of specialness, not at the edge of the sexual act, where the clinician's judgement has usually already been captured. This is why the doctrine treats trivial-looking early crossings with a seriousness that seems disproportionate until the trajectory is understood.

TRAP **Equating any boundary crossing with a boundary violation, or reserving the word violation for sexual contact alone.** Both errors lose marks. A crossing is not automatically wrong; a rigidly withholding clinician who never adapts the frame may serve the patient badly, and a crossing is distinguished from a violation by exploitation, harm and concealment, not by the mere fact of deviation. Equally, violations occur across every domain, and financial, social or dual-relationship exploitation is a genuine violation even where no sexual contact occurs. The candidate who defines the distinction correctly, and locates sexual misconduct as the gravest point on a continuum rather than the whole of it, answers the question actually asked.

9.5 Sexual misconduct: the paradigm violation

Of all boundary violations, sexual contact with a patient is treated as categorically the most serious. **Sexual misconduct** covers any sexual contact, relationship or exploitation of a patient by the treating clinician, and both professional consensus and the conduct codes treat it as absolutely prohibited for the duration of the clinical relationship. The prohibition is not softened by the patient's apparent willingness, and apparent consent is never a defence: even where the patient appears willing and has full decision-making capacity, the power asymmetry and the transference that treatment generates mean that agreement cannot make the clinician's sexual conduct permissible, and responsibility for avoiding exploitation remains entirely with the clinician. This clinical meaning of consent is distinct from the criminal-law meaning of consent in sexual-offences law, which has its own treatment in this chapter.

The harm is severe: exploited patients suffer damage resembling other betrayals of trust by a person in authority, including lasting difficulty ever trusting a clinician again. The former-patient question is the harder discrimination and a favourite of examiners. Because the transference and the imbalance of power do not end cleanly at the final appointment, the strictest professional position, often summarised as once a patient, always a patient, holds that a sexual relationship with a former patient remains unethical for as long as the residue of the therapeutic power imbalance persists. A candidate should state the in-treatment prohibition as absolute and treat the post-termination question as governed by the persistence of that imbalance, not by the mere ending of treatment. Where the patient is a minor, the conduct additionally engages the child-protection statutes, which belong to the Child psychiatry: assessment, treatment, services and protection notes and are named here rather than worked through.

GOOD TO REMEMBER

Treat the feeling of specialness as a clinical sign, not a private matter. When a clinician notices that one patient has become an exception, wanting to give them extra time, thinking of them between sessions, quietly bending the frame in their favour, the right response is to take it to supervision, not to act on it. Boundaries are protected far more reliably by routine self-monitoring, consultation and honest documentation than by willpower at the edge of the slope. The safe working test is that anything you would be unwilling to record in the notes or describe to a supervisor is already the problem.

9.6 Risk, prevention and the Indian setting

Boundary violations are not confined to a few predatory clinicians; ordinary practitioners are vulnerable under particular conditions. Recognised risk situations include the clinician passing through personal crisis, loss or loneliness, professional isolation without supervision, idealising or being idealised by a patient, and the seductive belief that this relationship is a unique exception to the rules. The protective measures follow from the mechanism of the slippery slope: regular supervision and consultation that make countertransference discussable, transparent documentation, attention to all the boundary domains rather than only the physical, judicious use of a chaperone, and a low threshold for referral where a conflict of interest cannot be contained.

The professional-conduct codes give this discipline its formal force. The duty not to exploit the therapeutic relationship for personal, social, business or sexual gain is stated in those four terms by the Indian Psychiatric Society's code of ethics; the operative statutory conduct code supplies the disciplinary consequence in its own terms, which are set out in this chapter's account of the professional codes of ethics and applied here rather than restated.

IN INDIA

The unavoidability of dual relationships in Indian practice makes the boundary discipline more demanding, not less. In a small town or close community the psychiatrist often cannot be a stranger to the patient outside the clinic, and shared social circles and family referrals are the norm. The frame then has to be defended deliberately: naming the clinical role where social and clinical worlds overlap, declining business or financial entanglement with patients, guarding confidentiality where relationships are interconnected, and referring on where a conflict of interest cannot be managed. The overlap of worlds is a fact of the setting; the exploitation of it is still a violation.

9.7 Accountability and the currency of the code

A proven boundary violation engages several distinct forms of accountability at once, and a complete answer names each. It is professional misconduct under the conduct code and can lead to disciplinary action up to erasure from the medical register. It can support a civil claim in professional negligence, whose elements must still be proved, and a deficiency in service can be pursued in the consumer forum; both have their own accounts in this chapter and are named here, not reworked. Where the conduct is itself criminal, the ordinary criminal law applies. A single violation can be actionable at once before a disciplinary body, a civil court and a consumer forum, and none forgives the others.

One currency point must be got right, because examiners use it to separate candidates. The provisions a clinician is held to are those of the operative Medical Council professional-conduct code; a more recent set of registered-medical-practitioner conduct regulations was notified by the National Medical Commission, came into force on publication, but was then held in abeyance and is not operative until a further Gazette notification. The earlier Council code therefore remains operative, including for a boundary violation. The exact editions, citations and dates belong to this chapter's account of the professional codes of ethics and are not asserted here.

PITFALL

Anchoring a misconduct analysis to the most recently notified conduct regulations as though they were the live code. It is natural to assume the newest professional-conduct regulations must be in force, and a clinician who does so will apply the wrong standard to a boundary breach. The recently notified registered-medical-practitioner conduct regulations came into force on publication but were then placed in abeyance and are not currently operative, so the earlier Medical Council code remains operative. Judging a disciplinary matter against a code not yet in force is a live-practice error with real consequences.

A boundary crossing is a minor, non-exploitative, discussable departure from the therapeutic frame that may even help the patient; a boundary violation is an exploitative, harmful departure that serves the clinician and betrays the fiduciary duty, and the slippery slope is the progression of unmonitored crossings that carries one into the other; sexual contact with a current patient is the paradigm violation, absolutely prohibited and never excused by apparent consent, because the patient's willingness cannot make the clinician's conduct permissible, and responsibility for every boundary rests always with the clinician.

10 · Ethics of research, publication and conflicts of interest

Why the marks sit here. Research is where a psychiatrist's two loyalties collide most sharply. Ordinary clinical work exists to help the person in the room; research exists to answer a question that may benefit no current patient at all. When the same doctor holds both roles over the same person, the informal safeguards of the consulting room are no longer enough, and a candidate is expected to show exactly how the ethical frame changes once a patient becomes a participant. Publication and conflict of interest share this subtopic because they are the downstream expressions of the same problem: whose interest is being served when data are gathered, written up and rewarded.

What this topic genuinely owns is the ethics specific to doing and reporting research: the way the general duties are re-shaped in the research setting, the Indian regulatory frame for clinical research, the management of competing interests, and the integrity of the published record. The principles of biomedical ethics and the elements of valid consent are taught elsewhere in these notes and are only invoked here, never relisted.

19(C)
THE CONDUCT REGULATION TYING RESEARCH TO ICMR GUIDELINES

2018
THE YEAR THE SUSPENDED 2023 CODE CITES FOR THE DRUG-TRIAL RULES

10.1 The dual role: treatment versus research

Clinical care is governed by a primary loyalty to the person in the room, so that, subject to the law and the narrow duties owed to others, everything the psychiatrist does is meant to help the patient being treated. Research answers to a different master. Its purpose is to produce generalisable knowledge, and the participant may gain nothing personally from taking part. This is not a flaw of research; it is its definition, and it is precisely why research needs a stricter apparatus than treatment. The error the examiner is probing is the **therapeutic misconception**: the participant, and sometimes the doctor, believing that study procedures are individualised treatment chosen for this person's benefit, when in fact they are dictated by a protocol and by the needs of the question.

Because the two roles pull in different directions, they must be held analytically apart even when one person carries both. The accompanying comparison sets out the axes on which they diverge, and the pattern to carry is that at every axis the research column demands an external check that clinical care can leave implicit.

AXIS	CLINICAL CARE	RESEARCH
Primary purpose	Benefit this patient	Generate generalisable knowledge
Duty runs to	The individual before you	The participant, whose welfare stays primary over science and society
What consent is to	An offered treatment	Voluntary participation, freely withdrawable
Independent oversight	Clinical governance	A prior, formal ethics-committee review
How risk is justified	Expected benefit to the patient	A favourable balance of risk against knowledge, with added protections

10.2 Informed consent for research

The same requirements, at a higher bar. The requirements of valid consent are taught in full under informed consent in psychiatry in these notes and are not reworked here. What changes in the research setting is their weight and their content. Voluntariness carries far more strain, because the person is often the doctor's own patient and may agree out of gratitude, dependence or fear that refusal will sour their care. The disclosure must be fuller and more honest than a treatment discussion, and it must be explicit about the things a therapeutic conversation can take for granted. A research consent conversation should establish:

- that the activity is research rather than individualised treatment, and what it is trying to find out;
- that participation is voluntary and that refusal will not compromise their ongoing care in any way;
- the right to withdraw at any time, without penalty and without giving a reason;
- the foreseeable risks and burdens, and the honest possibility of no personal benefit;
- the alternatives, including the standard treatment they would receive outside the study;
- how the confidentiality of their data will be protected, the duty and its permitted exceptions being set out under confidentiality and its limits in these notes.

Where a prospective participant's capacity to consent is impaired, as it may be in acute psychosis, severe mood disorder or cognitive impairment, the additional protections of the mental-health law apply, and these are addressed in the Mental health legislation and forensic psychiatry notes. Research involving children carries its own protective framework, addressed in the Child psychiatry: assessment, treatment, services and protection notes. The candidate's task is to name these safeguards and route to them, not to reconstruct them.

TRAP **Treating research consent as ordinary treatment consent.** Candidates assume that a patient who has agreed to be in a trial has consented the way they consent to a prescription. Research consent is a distinct, heavier act: it must name the research nature explicitly, promise that refusal will not affect care, and preserve an unconditional right to withdraw. A consent that a treating clinician obtains from their own patient without these features is the classic setting for the therapeutic misconception, and it is exactly what the examiner wants flagged.

10.3 The Indian regulatory frame

Research on patients or volunteers in India is governed by dedicated national instruments rather than by clinical convention. Under the newer National Medical Commission professional-conduct Regulations, at regulation **19**(C), clinical drug trials and other research involving patients or volunteers must comply with **ICMR guidelines** and the **New Drugs and Clinical Trials Rules, 2018** - the year as the suspended 2023 regulation itself records it. Consent that is not taken in accordance with those guidelines shall be construed as professional misconduct. The force of that phrasing repays attention: in that code's own terms a defect in the research consent process is not a documentary technicality but misconduct. Because that code is in abeyance, what makes such a defect actionable today has to be found in the operative conduct code, in the national research guidelines and the drug-trial Rules, and in the conditions of the ethics committee's own approval.

Two layers therefore sit over the same activity. The research-conduct layer routes the study through independent ethics-committee review and the national research guidelines; the professional-conduct layer makes a breach of those requirements a matter for the regulator. A candidate should be able to say that Indian research is anchored to primary national instruments, and should be careful about which conduct code is actually in force, because that is where the confident answer most often goes wrong.

IN INDIA

The practical machinery a clinician meets is the registered ethics committee and the national ethical guidelines for biomedical and health research. Regulated drug trials sit additionally under the New Drugs and Clinical Trials Rules and their consent and oversight requirements. The suspended 2023 professional-conduct code expressly requires the practitioner to disclose the dual role of treating doctor and investigator; independently of that suspended text, such disclosure remains sound ethical practice under the conflict-of-interest and consent principles, so that the participant understands the two hats being worn at once.

PITFALL

Do not cite the newer National Medical Commission Regulations as the professional-conduct code currently in force. They were notified and then held in abeyance, so the earlier Medical Council of India professional-conduct code remains the operative one. The codes themselves are set out under the Indian Psychiatric Society code of ethics in these notes; here the point is only that the research and conflict-of-interest duties are read from the code that actually governs, not from a notified-but-suspended one.

10.4 Conflict of interest

A **conflict of interest** arises whenever a secondary interest threatens to distort the primary duty owed to the patient or participant. The secondary interest need not be sinister: industry sponsorship, a gift or honorarium, academic advancement, the desire to publish, or simply the pressure to meet a recruitment target can all bend judgement without any conscious intent to do harm. That is why the profession treats the situation, and not merely the bad act, as the thing to manage.

The code does not pretend such situations can always be abolished. It requires the practitioner to recognise them, and to avoid or minimise them; where a conflict cannot be removed, the patient's interest should take precedence over any other consideration, and the honest course is to disclose the competing role rather than conceal it. In the research setting this bites hardest when the investigator is the patient's own psychiatrist, which is why separating the consent conversation from the treating relationship is the single most protective step available.

RULE **Disclosure does not resolve a conflict; it only makes it visible.** Naming a competing interest is the beginning of managing it, not a substitute for putting the patient first. Where the two genuinely cannot be reconciled, it is the research that yields, not the patient's welfare.

GOOD TO REMEMBER

Whenever you recruit your own patient into a study, say so out loud. Name your dual role, make explicit that declining will not change their care, and record that you did both. Routing the consent through an independent colleague, rather than obtaining it yourself at the bedside, protects the patient from the therapeutic misconception and protects you from the charge of exploiting the relationship. The ethics committee's part in this is the prior review that approves the consent process; it does not take the consent for you.

10.5 Publication and research integrity

The published record is the currency of science, and guarding its integrity is an ethical obligation continuous with the duties owed to participants. If consent protects the person, publication ethics protect everyone who will later rely on the result. Authorship is the first pressure point: it should reflect a genuine substantial contribution together with accountability for the work, and the recognised authorship criteria exist to keep credit and responsibility joined. Where they come apart, the familiar abuses appear:

- **gift authorship**, awarding or accepting authorship without a real contribution, often to a senior figure;
- **ghost authorship**, omitting a genuine contributor, classically an industry-employed writer;
- **redundant publication**, presenting the same data as though new, including slicing one study into several thin papers;
- **plagiarism**, presenting another's work, words or ideas as one's own;
- undisclosed conflicts of interest, and the selective or non-reporting of unwelcome results.

Beneath these lie the cardinal breaches of integrity, the ones that corrupt the data themselves rather than the credit around them. Prospective registration of trials, transparent reporting of methods and outcomes, and a willingness to share data are the countermeasures the field has adopted, and they matter clinically because the psychiatrist at the other end of the literature prescribes on the basis of what was published.

MNEMONIC

Fabricate, Falsify, Plagiarise

The three cardinal breaches of research integrity: inventing data that were never collected, altering data that were, and passing off another's work as one's own. Everything else, from gift authorship to redundant publication to a hidden conflict of interest, erodes the record more quietly, but these three are the ones that make a result simply false.

Research does not suspend the psychiatrist's duty to the patient; it adds a second, competing duty, and when the two collide the patient's welfare comes first. In India the research and conflict-of-interest duties are read from the professional-conduct code that is actually operative, research on patients or volunteers must comply with the national research guidelines and the drug-trial Rules, and a consent taken outside them is a substantive breach and not a paperwork slip, though which code makes it actionable depends on the code in force.

11 · Medical records, documentation and certification standards

Every duty in this chapter leaves a paper trail, and the paper is where the duty is proved or lost. Consent, the mental state examination, the risk assessment, the disclosure made to a third party, the opinion handed to a court - each of these is invisible after the encounter unless it was written down, so the record is the physical substrate on which the whole of forensic ethics rests. The marks in this topic are for knowing what a defensible record contains, how long it must be kept and who may see it, and the standard a psychiatrist is held to when signing a certificate. These are discrete, quotable points, and each is a place a hurried clinician, and a hurried candidate, comes to grief.

This fragment owns the record itself: its making, its keeping and the certificates drawn from it. It does not own the confidentiality rule that governs when the contents may be released, which belongs to the separate account of confidentiality and its limits in this chapter; nor the professional-conduct code whose provisions it applies, which belongs to this chapter's account of the professional-conduct codes. Keeping those boundaries clear - the document here, the disclosure rule there, the code elsewhere - is the discipline the examiner is testing.

11.1 Why the record carries the marks

The **medical record** is at once a clinical instrument and a legal document, and the two functions pull in the same direction. Clinically it is the memory of the treating team, the substrate of continuity when care passes between hands, and the audit trail that lets a later reviewer

reconstruct what was known and decided at each point. Legally it is the doctor's first and best evidence: in any dispute over what was done, the contemporaneous note carries a weight that recollection years later cannot, because it was made before anyone had a reason to shade the account. The medicolegal maxim - that what is not recorded is, in the eye of the court, treated as not done - is less a rule of evidence than a warning about the burden a silent chart throws back on the doctor.

Psychiatry sharpens this. The findings a psychiatrist relies on - the form and content of thought, the assessment of capacity, the judgement that a patient did or did not pose a risk - are matters of clinical opinion that leave no radiograph and no laboratory value behind them. If the reasoning is not on the page there is nothing to show it was ever done, and a note that records only a conclusion is far weaker in defence than one that shows the work.

> In law a clinical entry that was never recorded is hard to prove was ever done, and a silent chart throws the burden back on the doctor, so the record is the psychiatrist's primary evidence of what was known and decided.

11.2 The anatomy of a defensible entry

A record earns its evidentiary weight through the manner of its making. The qualities a court looks for, and that distinguish a defensible chart from a liability, are few and can be stated plainly:

- **Contemporaneous.** Made at the time of the encounter or as soon as practicable after it, so that the entry precedes any dispute and cannot be said to have been composed for the occasion.
- **Legible and attributable.** Readable, dated and timed, and signed with an identifiable name and designation, so that every entry can be traced to an author.
- **Accurate and factual.** Recording observation and reasoning, not speculation or gratuitous remarks about the patient, which serve no clinical purpose and read badly when the file is opened in public.
- **Complete for its purpose.** Carrying the findings, the assessment and the plan, and, for the decisions that matter medicolegally, the reasoning - the consent taken, the capacity judged, the risk weighed.
- **Unaltered.** Corrected only in the open: an error struck through with a single line that leaves the original readable, initialled and dated, never erased, overwritten or made to disappear.

The last of these is the one that turns a weak case into an indefensible one. An honest error in a note is forgivable and often irrelevant; a note that has been quietly changed after the event destroys the credibility of the whole record and, with it, the doctor's. This is why **tampering** - backdating, insertion, obliteration - is treated so gravely, and why the correct way to amend is always additive and transparent rather than concealing.

RULE **A record's value is a function of its being contemporaneous and unaltered; a correction is made by open amendment, never by erasure.** The point is not perfection at the moment of writing but honesty over time. An entry made late should be dated to the true date of writing and marked as retrospective, not slipped in under an earlier date, and an error should be struck through so the original stays legible, with the correction, initials and date beside it. A chart that can be shown never to have been secretly changed will defend a clinician who erred in good faith; a chart that has been doctored will sink one who did not.

GOOD TO REMEMBER

Write the note as though it will be read aloud in a courtroom with the patient present, because one day it may be. Record the reasoning behind decisions that carry legal weight - why capacity was accepted, why a risk was judged manageable - not just the conclusion. If you must add to a note after the event, say so openly and date the addition to the day you wrote it; the habit costs seconds and is the best protection you have.

11.3 Retention, ownership and the patient's right of access

Two questions follow the making of a record: how long it must be kept, and who may have it. On ownership the settled position is that the custodian - the institution or the self-employed practitioner - holds and preserves the physical record, while the patient has an enforceable right of access to the information within it and to a copy of it. The patient is entitled to a copy, not to carry off the original, and the duty to supply it runs to the patient, an authorised attendant, or a legal authority making a proper request.

3 years	5 working days
INPATIENT RECORD RETENTION UNDER THE 2023 REGULATIONS (IN ABEYANCE)	SUPPLY OF RECORDS ON A PROPER REQUEST

Currency is where this topic is won or lost. The clearest recent statement of a retention standard is the National Medical Commission's Registered Medical Practitioner (Professional Conduct) Regulations 2023; but those Regulations, though notified, were held in abeyance shortly afterwards and are therefore not the operative code. The live professional-conduct code remains the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations 2002, whose provisions are set out in this chapter's account of the professional-conduct codes. Read with that caveat, the 2023 Regulations provide at Regulation **13** that a self-employed practitioner shall maintain inpatient medical records for **3 years** from the date of last contact with the patient, in a standard **proforma** laid down by the Commission, and that records requested by the patient, an authorised attendant or a legal authority shall be supplied within **5 working days**. The same regulation would also require records to be fully digitised in due course, in compliance with information-technology and data-protection law. All of this describes the suspended 2023 text, not a prediction of the eventual operative code, which a further Gazette notification could revive, amend or replace; the requirement that binds a practitioner today is the one the operative 2002 code lays down.

TRAP **Quoting a retention period without the event it runs from, or across the wrong code.** Under the suspended 2023 Regulations the inpatient clock runs from the date of last treatment contact, not from admission and not from discharge, so a return for follow-up would reset it; the operative 2002 code's own starting point is owned by this chapter's account of the professional-conduct codes and must not be assumed identical to the suspended one. Candidates who quote a bare number of years without its starting point answer half the rule, and the starting point is exactly the half an examiner tests. State the period, the event it runs from, and which code you are quoting, or the figure means nothing.

IN INDIA

Access to records in India runs on parallel tracks. The professional-conduct code obliges the treating practitioner to furnish records on request; for a public hospital the same information is reachable through the right-to-information machinery; and the Mental Healthcare Act carries its own provisions on records and on a patient's access to information, which belong to the Mental health legislation and forensic psychiatry notes and are named, not restated, here. What may actually be released, and when confidentiality is set aside, is governed not by the retention rule but by the duty of confidentiality set out in this chapter's account of confidentiality and its limits.

PITFALL

Quoting the National Medical Commission Registered Medical Practitioner (Professional Conduct) Regulations 2023 as the code in force. They were notified and then held in abeyance, and the operative professional-conduct code remains the Indian Medical Council Regulations 2002. Citing them as live - in a report, an opinion or an examination answer - states as currently binding a code that commenced on publication but was then held in abeyance, and is the commonest currency error here. Name the 2002 code as operative and the 2023 Regulations as notified but in abeyance.

11.4 Certification and the duty of truthful attestation

A **medical certificate** is a formal attestation, over the doctor's signature, of a clinical fact - fitness or unfitness, the presence or absence of illness, a capacity or its lack. Its authority rests entirely on two things: that the signing doctor personally examined the patient and formed the opinion, and that the record behind it supports what the certificate asserts. A certificate is thus only as good as the notes from which it is drawn. The governing duty is truthfulness: the practitioner attests only what has been personally verified and does not issue a false, misleading or loosely worded certificate, a failing the professional-conduct code treats as misconduct, as set out in this chapter's account of the professional-conduct codes.

Psychiatric certification spans a distinctive range, and each type carries its own evidential demand:

CERTIFICATE	WHAT IT ATTESTS	WHAT THE RECORD MUST SHOW
SICKNESS AND FITNESS	Unfitness for, or fitness to resume, work or duty over a stated period	Dated examination findings and the functional basis for the opinion
MENTAL ILLNESS OR SOUNDNESS	The presence or absence of a mental disorder for a defined legal purpose	A recorded mental state examination and the clinical reasoning behind the finding
TESTAMENTARY AND OTHER CAPACITY	That the person could, at the material time, understand and weigh a specific decision	A contemporaneous, decision-specific capacity assessment, ideally at the time of the act
DISABILITY CERTIFICATION	The degree of disability arising from a mental condition, for statutory benefit	Assessment against the applicable schedule, with the instrument and findings on file

Two need a word of care. The **testamentary capacity** certificate is decision-specific and time-specific: it speaks to the person's ability to make a particular disposition at the particular moment, so a general statement of soundness recorded weeks before or after is of little value, and the strongest evidence is a capacity assessment documented at the time of the act itself. And a certificate touching a person's fitness to face criminal proceedings engages criteria that are not this fragment's to teach - the fitness-to-stand-trial criteria belong to the Mental health legislation and forensic psychiatry notes and are named, not restated, here; what this topic owns is the standard for the certificate and the record beneath it, not the legal test it serves.

11.5 When the record becomes evidence

The record's final role is one the clinician does not control. A chart can be summoned to court, produced under a legal authority's request, or made the foundation of an expert opinion, and at that point every quality discussed above is examined by an adversary. The treating record and the forensic report are different documents made for different masters - the first for the patient's care, the second for the court - and the discipline of keeping the treating role separate from the expert role belongs to this chapter's discussion of the psychiatrist as expert witness, named here rather than reworked. What the records topic contributes is the raw material: an opinion offered to a court is only as sound as the contemporaneous notes it is built on, and a report that cannot point back to a dated, unaltered record is opinion floating free of evidence. This is why documentation is not clerical housekeeping but the load-bearing wall of forensic practice, the place where good clinical care and defensible legal standing turn out to be the same thing.

12 · Ethical issues in involuntary treatment, restraint and end-of-life care

Every coercive act in psychiatry has to be justifiable to the person it is done to. Involuntary treatment, physical restraint and decisions about life-prolonging care are the three moments at which what a person wants is most openly at stake: the first two override an expressed wish, while withholding or withdrawing life-prolonging treatment is often instead the way a capacitous refusal or a recorded wish is honoured. They are examined together because one ethical spine runs through all three: coercion is defensible only as the narrowest, most proportionate response

to a genuine necessity, and it must stay answerable to the person's own will and preferences. The statutory machinery that gives that spine force - the emergency-treatment power, the prohibited and restricted procedures, the seclusion-and-restraint provision and the advance directive - is set out in the Mental health legislation and forensic psychiatry notes and is named here, not re-worked.

The four principles of biomedical ethics are invoked by name rather than re-defined, as laid out in this chapter's account of the principles of medical ethics; valid consent belongs to its account of informed consent in psychiatry, and the legal safeguards around seclusion and restraint to its account of the legal aspects of seclusion, restraint and involuntary treatment. What this topic owns is narrower: how those principles are weighed when a patient refuses the treatment thought to be in their interest, and how the weighing shifts from acute crisis, through restraint, to the end of life.

12.1 The ethical spine: least restriction, proportionality and will

Three ideas together decide whether an override of a patient's choice can be defended. The first is the **least restrictive alternative**: of the options that meet the clinical need, the one chosen must intrude least on liberty, bodily integrity and dignity, so restraint is used only when nothing milder will do and is stepped down the moment a gentler option becomes safe. The second is **proportionality**: the degree and duration of coercion must match the seriousness and imminence of the harm it prevents, so open-ended control is never the answer to a transient risk. The third, which most separates the current Indian frame from older paternalism, is that care must be anchored to the person's **will and preferences** - what this patient, knowing themselves, would want - not what a clinician judges good for a generic patient in that position.

These five conditions - necessary, proportionate, least restrictive, time-limited and reviewable - turn a vague sense that coercion is regrettable into a standard testable at the bedside and in the witness box. A measure that fails any one is not merely suboptimal; it is unethical, and increasingly unlawful.

RULE **Coercion is justified only as the least restrictive measure proportionate to a genuine and present necessity, and only for as long as that necessity lasts.** This one sentence is the whole topic in miniature. The question is never simply "is this good for the patient" but "is this the mildest thing that will meet a real and immediate danger, and can I stop it the moment the danger passes". Every rule that follows is an application of it.

MNEMONIC

Necessary, Proportionate, Least-restrictive, Time-limited, Reviewable

The five tests any coercive measure must pass. **N**ecessary (no non-coercive route will do); **P**roportionate (matched to the danger); **L**east-restrictive (the mildest effective form); **T**ime-limited (no longer than the necessity); **R**eviewable (open to reassessment and challenge). A measure you can defend on all five, you can defend anywhere.

12.2 Involuntary treatment and the narrow window of emergency

Treatment given against a refusal is the sharpest form of coercion, and the ethical burden is correspondingly heavy. It rests not on the fact of illness or the clinician's confidence that treatment would help, but on necessity, the absence of a less intrusive route, and wherever possible a substitute decision made through the person's chosen representative. Indian law keeps the power to treat outside ordinary consent exceptional and tightly bounded. The Act's emergency-treatment provision allows treatment only where it is immediately necessary to prevent death or irreversible harm, serious harm by the person to self or others, or serious damage to property flowing from the illness; where the nominated representative is available, emergency treatment is subject to their informed consent; and, most tellingly for proportionality, the power is capped in time. Emergency treatment is limited to **seventy-two hours**, or until the person is assessed at a mental health establishment, whichever comes first, and may extend to **seven days** only during a disaster or emergency declared by the appropriate Government.

Two features are ethically load-bearing. It is a bridge, not a treatment plan: it holds a person safely until proper assessment and consent can happen, which is why it expires. And it is no licence for any intervention the clinician thinks necessary; the emergency power shall not extend to electroconvulsive therapy, which cannot be given under cover of emergency at all. The detailed conditions are set out in the Mental health legislation and forensic psychiatry notes; what matters here is the shape - a power that is necessary, proportionate and self-terminating.

> **GOOD TO REMEMBER**
>
> Your defence for an emergency intervention is a contemporaneous note of the specific danger, the less restrictive options you weighed and why they failed, and the point at which you sought the nominated representative. "The patient was unwell" is not a justification; "the patient was about to act on a command to jump and refused oral medication" is. Record it while it is in front of you: the power is short-lived and the note is what proportionality is later judged against.

12.3 Restraint and seclusion: the least-restrictive ladder

Physical containment is where least restriction does its hardest work, because the measures form a ladder and the demand is to stay as low on it as safety allows and climb down fast. Restraint manages an immediate risk; it is never a treatment or a convenience, uses minimum force for the shortest duration that will contain the danger, and is released the moment that danger recedes.

- **Verbal de-escalation and environmental measures:** the first resort whenever it is safe and feasible, and often enough on their own; the least intrusive rung. Immediate physical restraint may still be required where it is the only means available to prevent imminent and immediate harm.
- **Seclusion and solitary confinement:** not a rung on the ladder at all; a person with mental illness shall not be subjected to seclusion or solitary confinement, which are barred outright and cannot be made lawful by monitoring or a time limit.
- **Physical restraint:** the highest rung short of the floor, minimum force for the shortest time; its exact authorisation and monitoring safeguards are set out in the Mental health legislation

and forensic psychiatry notes.

How physical restraint may lawfully be used, and its safeguards, belongs to the Mental health legislation and forensic psychiatry notes and to this chapter's account of the legal aspects of seclusion, restraint and involuntary treatment; seclusion and solitary confinement of a person with mental illness are prohibited outright. What the ethics fixes as an absolute is the floor beneath the ladder: no person with mental illness **shall be chained** in any manner or form whatsoever, and the bar holds because chaining is degrading regardless of the danger it might contain. Below a certain point, restraint stops being a graded response and becomes an assault on dignity, and the law draws that line without exception.

12.4 The absolute bars and the one conditional gate

The clearest ethical teaching here is the small set of procedures the law places out of bounds, each a point where consent and best interests are judged insufficient protection. Three are absolute. **Unmodified electroconvulsive therapy**, meaning electroconvulsive therapy given without muscle relaxants and anaesthesia, is prohibited outright and cannot be rescued by consent, because the harm it risks is not one a patient can validly agree to run. Sterilisation intended as a treatment for mental illness is prohibited, closing off a historic abuse in which reproductive capacity was removed under a therapeutic pretext. And chaining is barred in any form. The single conditional gate is electroconvulsive therapy for a minor: prohibited by default, but where the psychiatrist in charge of the minor's treatment is of the opinion that it is required, it shall be given only with the informed consent of the guardian and the prior permission of the concerned Board. The structure to carry is an absolute prohibition softened by a narrow, externally checked exception, not by clinician discretion alone.

MEASURE	ETHICAL AND LEGAL STATUS	WHAT THE FLOOR TURNS ON
CHAINING, IN ANY FORM	Barred absolutely	Degrading regardless of the danger contained
UNMODIFIED ELECTROCONVULSIVE THERAPY	Barred absolutely; consent cannot cure it	A harm a patient cannot validly agree to run
STERILISATION AS A TREATMENT FOR MENTAL ILLNESS	Barred	Closes a historic reproductive abuse
ELECTROCONVULSIVE THERAPY FOR A MINOR	Barred by default; a narrow gate	Guardian's informed consent plus prior Board permission
EMERGENCY INVOLUNTARY TREATMENT	Permitted but tightly bounded	Time-limited, and excludes electroconvulsive therapy

TRAP **Believing that consent can license an absolutely prohibited procedure, or that a grave enough emergency justifies electroconvulsive therapy.** Candidates reason that guardian or patient consent makes unmodified electroconvulsive therapy or a "therapeutic" sterilisation permissible, and that a serious enough emergency lets a clinician reach for electroconvulsive therapy. Both are wrong: the absolute bars operate above the level of consent, and the emergency power is defined so as to exclude electroconvulsive therapy. Consent is a gateway for permitted treatment, not a key to prohibited treatment.

12.5 End-of-life care: autonomy at the close of life

The same spine bends at the end of life, but it does not break. End-of-life care tests the will-and-preferences principle at its limit, because the patient may be dying, may have fluctuating or absent capacity, and may have recorded wishes long before the crisis. The psychiatrist's role is often not to decide but to assess: whether this patient can accept or refuse a life-prolonging intervention, and whether a treatable mental illness, depression above all, is so distorting the decision that an apparent wish to die is a symptom to treat rather than a settled preference to honour. Making that discrimination well, and documenting it, is the examinable core of the psychiatrist's end-of-life contribution.

Three distinctions carry the ethical weight. A refusal by a person with capacity, or through a valid advance instruction, is not the same as a request that the clinician actively bring about death; respecting the first is autonomy, the second a separate legal and moral question. Withholding or withdrawing an intervention of no proportionate benefit is not abandonment, because comfort, symptom relief and dignity are owed whatever else is stopped. And the **doctrine of double effect** is the frame invoked for proportionate sedation or analgesia given to relieve suffering where shortening of life is a foreseen risk rather than the aim; a relief-directed intention is necessary to it, but the doctrine's conditions are not reducible to intention alone, so it cannot be cited as a single-condition licence. Wishes recorded in advance should guide care as an expression of will and preferences; the statutory form and force of the advance directive belong to the Mental health legislation and forensic psychiatry notes.

12.6 Will and preferences over best interests

The deepest change the current Indian frame makes is a shift of default. The older posture was best-interests: the clinician decided what was good for the patient and acted on it. The newer posture is **supported decision-making**, in which the patient's own will and preferences govern and the clinician helps the person exercise their capacity rather than substitute a judgment for it. Coercion does not vanish but retreats to the margins, permitted only where a real necessity cannot be met any other way. The broader disability-rights statute underpinning this posture is set out in the Mental health legislation and forensic psychiatry notes.

> **PITFALL**
>
> The commonest real-world error is not cruelty but well-meant paternalism: a clinician sure they know best treats "best interests" as the deciding standard and reads the patient's stated wishes as an obstacle to manage rather than the thing that governs. Under a will-and-preferences frame that inversion is itself the fault. Start from what the person wants, treat capacity as something to be supported rather than presumed absent, and reserve override for genuine, documented necessity.

IN INDIA

The current mental health law is explicitly rights-based: it abolishes chaining outright, channels the most invasive procedures through consent and independent review, keeps the emergency power short and ring-fenced from electroconvulsive therapy, and subordinates treatment to the person's will and preferences rather than an unaided best-interests judgment. The working question shifts from "what is best for this patient" answered alone to "what does this patient want, and what is the least I must do to keep them safe".

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EMERGENCY TREATMENT: TIME-LIMITED, AND NO ELECTROCONVULSIVE THERAPY

95
PROHIBITED PROCEDURES: CHAINING, UNMODIFIED ELECTROCONVULSIVE THERAPY, STERILISATION

One test governs involuntary treatment, restraint and end-of-life care: coercion is permissible only as the least restrictive, proportionate response to a genuine and present necessity, no longer than that necessity lasts, and always anchored to the person's will and preferences rather than the clinician's unaided view of their best interests; chaining and unmodified electroconvulsive therapy are barred absolutely, sterilisation as treatment is barred, and electroconvulsive therapy for a minor is permitted only through guardian consent and prior Board permission.

13 · Telepsychiatry ethics and social media professionalism

Why the marks are here. Telepsychiatry moved from a fringe convenience to routine practice almost overnight, and the ethics did not keep pace with the technology. The examiner's interest is precise: does the candidate understand that a consultation delivered down a video link owes the patient exactly the same duties as one delivered across a desk, and does the candidate know which code actually governs it in India today. Both halves of the topic - the clinical encounter conducted remotely, and the doctor's separate life on social and public media - test the same instinct, which is that the medium never dilutes the obligation. The currency of the governing rules has also shifted recently, and that shift is a favourite trap.

What this section owns is the ethics of remote consultation and of a psychiatrist's conduct in the public digital sphere. The four principles that frame every ethical judgement are set out with the principles of medical ethics in these notes; the anatomy of valid consent is taught with informed consent in these notes; the default duty of confidentiality and the closed list of when a disclosure is permitted are taught with confidentiality and its limits in these notes; and the professional-conduct code itself is treated with the professional-conduct codes in these notes. Those are invoked here, not restated.

13.1 What telepsychiatry is, and why the medium raises the stakes

Telepsychiatry is the delivery of psychiatric assessment, treatment and consultation through information and communication technology when patient and clinician are not in the same room. It spans real-time video and telephone contact and the store-and-forward exchange of clinical information, and it reaches rural and underserved populations that would otherwise

never see a psychiatrist. That reach is its ethical justification and also its hazard: a discipline whose primary instrument is the interview loses part of that instrument at a distance. Subtle motor signs, the smell of alcohol, the atmosphere of a household, the collateral in the waiting room - a proportion of the mental-state examination simply does not travel down a video link. The ethical task is to decide, case by case, whether what remains is enough to discharge the standard of care, and to recognise when it is not.

The peculiar risk of psychiatry is that the high-risk presentations a remote service must be ready for - acute distress, suicidality, psychosis with impaired insight - are exactly those in which a remote encounter is least able to contain risk. Convenience and access must therefore be weighed against the clinical adequacy of the channel, not assumed to settle the matter.

13.2 The regulatory basis, and the currency question

Telepsychiatry in India is not a legal vacuum, but candidates routinely cite the wrong instrument as its source. The recently notified National Medical Commission Registered Medical Practitioner (Professional Conduct) Regulations address it directly: at Regulation **29**, consultation by telemedicine *is permissible*, but only on the condition that it follows the **Telemedicine Practice Guidelines**. That conditionality is the point: the permission and its precondition are a single rule, and telemedicine detached from the Guidelines is not authorised practice. The Guidelines themselves supply the operational scaffold - the modes of consultation, the identification of both parties, the framework for prescribing at a distance - which is applied, not reproduced, here.

The currency trap sits one layer up. Those Regulations came into force on publication but were then held in abeyance and are **not** currently operative; the code that actually governs a psychiatrist's conduct remains the earlier Medical Council of India professional-conduct code, treated with the professional-conduct codes in these notes. The safe posture in the exam and in practice is to take the substance of remote-consultation practice from the Telemedicine Practice Guidelines themselves, and to treat that regulation as notified-but-suspended text rather than transplanting it into the live code. A written answer that names the newer Regulations as the operative code is stating a code that came into force on publication but was then held in abeyance and is not currently operative.

IN INDIA

Remote consultation received its first clear national footing through the Telemedicine Practice Guidelines, later carried into the newer National Medical Commission Registered Medical Practitioner (Professional Conduct) Regulations at Regulation **29**. Those Regulations stand notified but in abeyance; the operative statutory code is still the Medical Council of India professional-conduct code, taught with the professional-conduct codes in these notes. Ground your answer in the live code and read the newer provision for its content.

13.3 Consent, confidentiality and the standard of care at a distance

Every ethical obligation of an in-person consultation survives the move to a screen; what changes is the effort needed to satisfy it. Valid consent, whose three elements are taught with informed consent in these notes, must additionally cover the modality itself: the patient should understand

that this is a remote consultation, its limits, what happens if the connection fails, and how an emergency will be handled. Confidentiality is governed by the same default duty and the same closed list of permitted disclosures taught with confidentiality and its limits in these notes; the remote setting does not create a fresh licence to disclose, but it multiplies the ways confidentiality can leak - an unsecured platform, a household member off-camera, a session recorded without consent, records held on a personal device. The **standard of care** is the anchoring construct: it is set by what a reasonable psychiatrist would do, and it does not fall because the encounter is remote.

OBLIGATION	IN-PERSON CONSULTATION	TELEPSYCHIATRY CONSULTATION
Consent	To assessment and treatment	Also to the remote modality and its limits
Standard of care	Reasonable clinical practice	The same standard, or refer to in-person care
Confidentiality	The room and the record	The platform, the setting at both ends, the stored data
Identity	Established directly; verified where required	Actively verified for patient and clinician
Emergency and risk	Managed in the room	Needs a pre-agreed local escalation plan

RULE **The medium changes the method, never the duty.** A remote consultation is held to the same standard of care, the same consent and the same confidentiality as a face-to-face one. Where the channel cannot support that standard for a given patient, the ethical answer is to convert to in-person care, not to lower the bar to fit the link.

TRAP **Believing the duties relax because the encounter is remote.** Candidates treat telepsychiatry as a lighter form of practice with softer obligations. The reverse is true: the same duties apply, and several - identity, confidentiality, emergency planning - actually demand more work to discharge at a distance.

13.4 When a remote encounter is not enough

Recognising the limits of the channel is itself an ethical duty, because persisting with an inadequate medium is a breach of the standard of care. Remote consultation is poorly suited, and often should give way to in-person assessment, in situations such as:

- acute suicidality or a patient who cannot be kept safe remotely;
- a first presentation of possible psychosis where insight and reality-testing must be examined directly;
- the need for a physical examination, an injectable, or supervised administration;
- a patient who cannot consent to or operate the technology, or lacks a private space;
- any encounter where identity, or the presence of a coercive third party off-camera, cannot be assured.

None of these forbids telepsychiatry outright; each demands a judgement that the remote channel can still deliver safe care, and a readiness to escalate to a physical review when it cannot.

13.5 Social media and public professionalism

A psychiatrist's conduct online is a professional matter and not merely a private one: the duties of confidentiality, restraint in advertising and general professional conduct that the operative code imposes follow the doctor onto the screen. The newer Regulations go further and address the medium directly: at Regulation **20**, a practitioner's conduct on social, electronic and print media *shall follow* the prescribed **Social Media Guidelines**, a dedicated framework that stands notified but in abeyance with the rest of that code. That provision is the codified form of what is better called **digital professionalism**: the recognition that a doctor carries the profession's standards into every public post. The recurring failures are specific to psychiatry. Confidentiality is breached by a case detail vivid enough to identify a patient even when the name is withheld. Boundaries erode when a treating psychiatrist accepts a patient's friend request or drifts into personal messaging, blurring the therapeutic frame that the work depends on. And the reach of a post multiplies both harms: an indiscretion that a corridor would swallow can travel to thousands. The corrective is to treat every public communication as though a patient, a colleague and a regulator will all read it, because any of them may.

GOOD TO REMEMBER

Keep one clear line between a professional presence and a personal account, and never take a treating relationship into either. Do not accept patients into your private social networks, do not discuss identifiable cases even in disguised form, and assume any post is permanent and public. If you use messaging for clinical contact, agree its scope with the patient and keep it inside the record, not on a personal phone.

13.6 Advertising, self-promotion and the boundary of legitimate announcement

The same conduct code that governs the consulting room governs how a psychiatrist may present a practice to the public, and here too the digital age has widened the temptation. The newer Regulations draw the line tightly: at Regulation **11** a practitioner may make only limited formal announcements - the starting, change or resumption of practice, a change of address, and a declaration of charges - and an institutional advertisement may not carry more than the name, the type of patients treated, the staff, the facilities and the fees. Everything beyond that factual minimum, particularly the soliciting of patients or the claiming of superiority, falls outside what an announcement may contain. The principle is old and survives the change of medium: a doctor informs the public of a service, and does not tout for custom. A polished website, a sponsored post or a testimonial reel is subject to the same restraint as a newspaper notice once was.

PITFALL

The commonest real-world error on this topic is citing the newer National Medical Commission Registered Medical Practitioner (Professional Conduct) Regulations as the operative code. They came into force on publication and were then held in abeyance, so a clinician who governs their advertising, telemedicine or social-media conduct by them alone is following rules that are not currently in force. The live code remains the Medical Council of India professional-conduct code, taught with the professional-conduct codes in these notes; read the newer provisions for substance but comply with the code that is actually operative.

Whatever the channel - a video link, a public post or an advertisement - the psychiatrist owes the same duty of care, confidentiality and honesty, and the currently operative code is the Medical Council of India professional-conduct code, not the newer Regulations still held in abeyance.

Disaster, prisoners and forensic special topics

14 · Disaster Management Act 2005 (psychiatric relevance)

A disaster statute earns its place on a forensic syllabus because it is administrative law the psychiatrist has to work inside, not around. Mass-casualty events - floods, earthquakes, industrial and transport accidents, epidemics - produce a predictable surge of acute stress reactions, grief, sleep disturbance, exacerbation of pre-existing illness and, in a minority, persistent post-traumatic and depressive morbidity. The clinician who wants to deliver care in that setting does not command the response; a statutory authority does. The examinable content is deliberately narrow: the architecture the Act builds, who heads each level of it, what the Act says disaster management is, and - the point most candidates miss - what it conspicuously does not say. Get those, and you can locate the psychiatric role precisely; miss them, and you will keep looking for a legal mandate the statute never wrote down.

Teach this as what it is: a piece of administrative machinery. The Act does not create clinical duties, define capacity, or authorise treatment; those belong to the mental-health statute and are developed in the Mental health legislation and forensic psychiatry notes. What it does is build a chain of authority from the national government down to the individual district, and then define the process those authorities are to run. The psychiatric role has to be read into that structure, because the structure will not hand it over.

14.1 A tiered command structure, not a clinical statute

The Act builds authorities at successive levels of government. It constructs a vertical chain: a national authority at the apex, a mirror authority in every State, and an operational authority in every district. Each is headed **ex officio** by the executive of its level, which is the deliberate design point - disaster response is treated as a whole-of-government function commanded from the top of government rather than by a technical body advising from the sidelines. At the

national and State tiers that head is the elected political executive; at the district tier it is the administrative executive - the Collector, District Magistrate or Deputy Commissioner - sitting alongside an elected local-authority co-chairperson. The comparison below fixes the section, the head and the establishing duty for each level; commit the section numbers, because a report or an answer that misplaces them signals unfamiliarity with the primary Act.

LEVEL	STATUTORY SECTION	CHAIRPERSON, EX OFFICIO	THE ESTABLISHING DUTY
National (apex)	section **3**	the Prime Minister	an authority shall be established for the purposes of the Act
State	section **14**	the Chief Minister of the State	every State Government shall establish an authority for the State
District	section **25**	the Collector, District Magistrate or Deputy Commissioner (co-chaired by the elected local-authority representative)	every State Government shall establish an authority for every district

The chain of authority the Act creates. Note that the head of each level is fixed by office, not appointed for expertise, and that the duty to establish the State and district authorities is mandatory and lies with the State Government.

Read the establishing duties for the modal verb, because it is examinable. At every level the statute is mandatory: the national authority *shall be established*, and every State Government *shall establish* both its State authority and a district authority for every district. There is no discretion in whether the machinery exists. What the Act leaves open is operational - how each authority discharges its functions - not whether it comes into being.

14.2 The apex and the State tiers

The national authority sets the policy floor. At the top the Act establishes the **National Disaster Management Authority**, under the establishment section set out above, chaired ex officio by the Prime Minister with not more than **nine** other nominated members. As the apex body its work is national in scope: it is the source of country-wide policy, plans and guidance, which is exactly why any national statement on how mental-health and psychosocial needs are to be met in disasters is issued from this level rather than written into the parent Act. Hold that distinction, because it explains where the mental-health content actually lives - in guidance under the machinery, not in the sections that build it.

The State authority mirrors the apex. One level down, the Act requires each State to constitute a **State Disaster Management Authority**, under its State-tier section, chaired ex officio by the Chief Minister. Its role is to translate national policy into a State plan and to coordinate the State's departments - health among them - so that a directive from the apex becomes a deliverable service on the ground. For the psychiatrist this is the tier at which mental-health

services are meant to be built into the State's disaster health response, alongside the rest of the health system.

14.3 The district tier, and why it is the one you will meet

This is where response actually happens. The **District Disaster Management Authority**, established under the Act's district-tier section, is the operational cutting edge of the whole structure - the level closest to survivors and the one that runs relief, rescue and coordination on the affected ground. Its chairperson is fixed by office: the Collector, District Magistrate or Deputy Commissioner heads it ex officio, and, distinctively at this level, the elected local-authority representative sits as ex officio co-chairperson, pairing the administrative head with local political representation. A clinician deployed into a disaster response is, in practice, working within this district authority's plan and under the district administration's coordination, not answering directly to the State or national bodies.

MNEMONIC

Prime Minister for the nation, Chief Minister for the State, Collector for the district

The head of each authority is the political or administrative executive of its own level, sitting by virtue of office rather than expertise. Only the district level adds a co-chairperson - the elected local-authority representative - which flags it as the tier where administration and local representation meet the survivor.

RULE **The Disaster Management Act is a chain of administrative authority, not a mental-health statute.** It mandates authorities at national, State and district level, each headed ex officio by the executive of that level, and defines the process they must run. It creates no clinical duty and names no psychiatric service, so the mental-health role must be located within its general functions, not read off an express provision.

14.4 What the Act means by disaster management - and its silence on mental health

The definition is broad, cyclical and process-oriented. The Act defines **disaster management**, at section **2(e)**, as a continuous and integrated process rather than a one-off emergency reaction. That process runs across the whole disaster cycle: preventing danger, mitigating risk and severity, building capacity, preparing to respond, mounting a prompt response, assessing the magnitude of effects, carrying out evacuation, rescue and relief, and finally rehabilitation and reconstruction. The pedagogical point is the shape: the statute conceives of management as spanning the time before, during and long after the event, which is precisely the time-course over which psychiatric morbidity emerges and recovers.

Now the omission that carries the marks. Read that definition again for what is absent. Nowhere in it does the Act name psychosocial or mental-health support as an express limb of disaster management. The functions it enumerates are physical and administrative - risk, rescue, relief, reconstruction - and the psychological dimension is simply not written in as a category of its own. This is not a drafting accident to be corrected in an answer; it is the settled position of

the primary text, and the honest teaching is to state it plainly and then show where the mental-health role has to be fitted instead: inside **capacity-building**, preparedness, response and rehabilitation, each of which can carry a psychosocial component even though none is labelled as such.

> **PITFALL**
>
> Assuming the Act itself contains an express psychosocial or mental-health provision, and then waiting for a statutory mandate that does not exist. Because national guidance on psychosocial support and mental-health services in disasters does exist, it is easy to project that content back onto the parent Act. It is not there. The clinician who understands this does not wait to be named in a section; they embed mental-health care within capacity-building, preparedness and rehabilitation, which is where the general functions leave room for it.

14.5 Locating the psychiatric role within the machinery

The role is real even though the statute is silent. The absence of a named limb does not make mental health optional; it makes it the clinician's job to insert it into the general process the Act defines. Disaster mental-health work maps onto that same cycle. Across it, the psychiatrist's contributions cluster into a few recognisable tasks:

- before the event - training first responders and building local capacity, so that psychological needs are anticipated rather than discovered;
- in the acute phase - **psychological first aid** and the triage of acute distress, distinguishing normal acute reactions from those needing active intervention;
- in relief and rehabilitation - continuity of treatment for people with severe mental illness whose medication and follow-up have been interrupted, and detection of the delayed post-traumatic and depressive morbidity that surfaces weeks to months later.

Continuity of care is the quiet emergency. The most avoidable harm in a disaster is not the new-onset disorder but the interruption of existing treatment: a person already stabilised on psychotropic medication who loses their supply, their prescriber and their records when services collapse. Restoring that continuity, and where necessary arranging care under the ordinary mental-health law, is squarely within the response and relief functions of the district authority, and the legal framework for such care sits in the Mental health legislation and forensic psychiatry notes, not in this Act. The disaster statute tells you which authority coordinates the response; the mental-health statute tells you how care may lawfully be given.

Equity is the ethical hinge. Disaster settings force allocation decisions - whose distress is attended to first when the need vastly exceeds the resource - and the principle of justice in the fair distribution of scarce care is the frame the psychiatrist brings to that. The principles of biomedical ethics are developed elsewhere in this chapter and are invoked, not re-listed, here; what matters for this topic is that the machinery gives you the coordinating authority, and the ethics gives you the priority rule for working within it.

IN INDIA

Because the definition of disaster management names no psychosocial limb, mental-health and psychosocial support in Indian disasters is delivered through guidance issued under the national authority and operationalised down the chain to the district level, rather than through an express section of the Act. In practice the clinician interfaces with the district authority under the Collector or District Magistrate, whose plan coordinates the response on the ground. Read the governing plan and the current national guidance from primary sources rather than from memory, because the Act itself will not point you to the mental-health role.

GOOD TO REMEMBER

If you are deployed, the authority you actually work within is the district one, headed by the Collector or District Magistrate, with the elected local representative as co-chair. That is where you register your service, plug into the coordinated response, and locate mental-health care inside the relief, response and rehabilitation functions. Do not wait for a statutory instruction naming psychiatry; the Act does not give one, and the role is yours to insert.

TRAP **Misassigning the heads of the three authorities.** The apex authority is chaired by the Prime Minister, the State authority by the Chief Minister, and the district authority by the Collector, District Magistrate or Deputy Commissioner, with the elected local-authority representative as co-chairperson. Candidates lose the mark by handing the State authority to the Governor or the district authority to the Superintendent of Police; each head is fixed by office at its own level, and only the district tier carries a co-chair.

3	14	25	2(e)
SECTION ESTABLISHING THE NATIONAL AUTHORITY, CHAIRED BY THE PRIME MINISTER	SECTION REQUIRING A STATE AUTHORITY, CHAIRED BY THE CHIEF MINISTER	SECTION REQUIRING A DISTRICT AUTHORITY, CHAIRED BY THE COLLECTOR	THE DEFINITION OF DISASTER MANAGEMENT

The Disaster Management Act builds authorities at national, State and district level, each headed ex officio - by the Prime Minister, the Chief Minister and the Collector or District Magistrate respectively, the district tier alone carrying an elected co-chairperson. Its definition of disaster management spans the whole cycle from prevention to reconstruction but names no psychosocial or mental-health limb, so the psychiatric role must be located within the general functions of capacity-building, preparedness, response and rehabilitation.

15 · Mental health of prisoners and forensic psychiatry services

Where this topic sits. A prison gathers, into one closed population, almost every risk factor a psychiatrist studies separately: poverty, substance use, head injury, trauma, social exclusion and untreated illness. It then strips away most of what protects mental health. The predictable result is that psychiatric morbidity in custody runs far above the community rate, while the services meant to answer it are thinnest exactly where the need is greatest. This topic asks two linked

questions: what is the mental health of prisoners, and what services, inside the prison and across the wider **forensic psychiatry** system, meet it.

What earns the marks here is not a table of prevalence figures but a service architecture and the single principle that organises it. You are expected to describe how psychiatric care actually reaches a prisoner, to place the Indian statutory backdrop correctly, and to keep a forensic psychiatry service distinct from the medico-legal assessments taught in neighbouring topics. The route by which a mentally ill prisoner is transferred into hospital care is developed in the companion account of the transfer and treatment of mentally ill prisoners, and the dignity and rights framing in the account of human rights and ethical issues in custodial psychiatry; the focus here is the burden and the service response to it.

15.1 The burden: psychiatric morbidity is concentrated in custody

Prisoners carry a marked excess of mental disorder across the whole diagnostic range. Relative to an age-matched community sample, custodial populations show more psychotic illness, more mood and anxiety disorders, far more substance use disorder, a high load of personality disorder, and an over-representation of intellectual disability and acquired cognitive impairment. This is a compounded burden, not a single condition, which is why a prison mental health service cannot be built around one diagnosis. The excess is real, large and consistent across settings; the precise magnitudes vary by jurisdiction and instrument.

Two mechanisms produce the concentration, and a good answer names both. The first is selection: people with mental illness are over-represented among those who enter custody in the first place, through offending linked to untreated illness, homelessness, substance use and the criminalisation of the mentally ill when community care is absent. The second is the effect of custody itself. Juvenile detainees sit under an entirely separate statutory framework and are dealt with in the Child psychiatry: assessment, treatment, services and protection notes; the clinical management of substance withdrawal and dependence in custodial settings belongs to the Substance use disorders notes. Both are named here, not taught.

15.2 Importation and deprivation: why prison generates and worsens disorder

The environment is part of the formulation. The excess morbidity is usually understood through two complementary models. The **importation** model holds that prisoners bring pre-existing vulnerability in with them: prior illness, developmental adversity, substance use and low social capital. The **deprivation** model holds that the custodial environment itself is pathogenic, independent of what a person arrives with. Neither model alone is sufficient; they operate together, and the clinical implication is that a prisoner's disorder cannot be treated as if it were context-free.

The deprivations of custody are specific and psychologically active. Loss of liberty and autonomy, overcrowding, enforced idleness, the threat of violence and bullying, separation from family and children, uncertainty about the future, and the collapse of privacy together constitute a chronic stressor field. Solitary confinement is the most concentrated form and is associated with acute deterioration, self-harm and psychotic phenomena. Because these are environmental

drivers, part of the treatment is sometimes environmental: relocation, occupation, family contact and the removal from isolation, alongside conventional psychiatric care.

15.3 The Indian statutory backdrop: the Prisons Act and its silence

Prison administration in India is still substantially governed by a colonial-era statute, and its treatment of mentally ill prisoners is notable for an absence. The Prisons Act of **1894** contains no substantive stand-alone section devoted to the care of mentally ill prisoners. The only hook is the State Government's rule-making power at section **59**, which at clause **(23)** authorises rules for the treatment, transfer and disposal of criminal lunatics or recovered criminal lunatics confined in prisons. Read the provision precisely: it is a discretionary power under which the State Government *may* make rules, not a substantive duty of care, and it uses the archaic term **criminal lunatic** that both modern law and clinical practice have long abandoned.

The lesson is structural: the primary prison statute does not itself build a mental health service or confer a right to treatment; it merely enables subordinate rules. The substantive machinery for actually moving a mentally ill prisoner into psychiatric care sits elsewhere, combining the older warrant power for removal with the mental-health statute's prisoner-specific provision, and is developed in the companion account of the transfer and treatment of mentally ill prisoners; the general mental-health law machinery belongs to the Mental health legislation and forensic psychiatry notes. That historical silence is why India's prison mental health provision has depended on the later statute, on prison manuals and on the courts rather than on the parent Act.

IN INDIA

The governing prison statute is over a century old and, on mental health, gives only a rule-making power rather than a service. The practical consequence is that a mentally ill prisoner's care depends on the mental-health law, on State prison manuals, and on directions issued by the constitutional courts, rather than on any express care provision in the Prisons Act. When answering, place the substantive rights and transfer route in the mental-health statute and treat the Prisons Act as the historical backdrop, citing the primary Act and clause rather than a remembered figure.

PITFALL

Reading the Prisons Act rule-making power as if it were a substantive care regime, and then treating a mentally ill prisoner's admission or transfer as a matter of prison rules. The enabling clause lets the State make rules; it does not itself authorise clinical care or lawful transfer. The care standard and the transfer route are set by the mental-health law, not by that rule-making power, and a clinician who looks only to the prison statute will not find the authority they need.

15.4 The architecture of forensic psychiatry services

A forensic service is a pathway, not a place. Forensic psychiatry is the subspecialty concerned with the assessment, treatment and risk management of the **mentally disordered offender** and with the interface between psychiatry and the courts. A mature forensic service is not a single

ward but a tiered system that meets the offender at each point of the criminal-justice pathway, from first contact with the police through to eventual return to the community.

SERVICE COMPONENT	WHERE IT OPERATES	PRIMARY FUNCTION
Court liaison and diversion	police station and courts	identify mentally disordered defendants at the earliest point and divert them to health care rather than custody where that is appropriate
Prison in-reach	within the prison	bring specialist mental health assessment and treatment to prisoners in situ, functioning as the prison's equivalent of a community mental health team
Secure forensic inpatient unit	dedicated secure hospital (graded levels of security)	treat offenders who need hospital-level care under conditions of physical, procedural and relational security
Forensic rehabilitation and community forensic team	step-down and community	rehabilitate, supervise and manage risk as the offender transitions out of secure care

The tiers of a forensic psychiatry service, arranged along the offender's pathway. Each tier answers a different need; a system missing any one tier tends to silt up at the level below it, most visibly when the absence of secure beds strands seriously ill offenders in the prison.

The tiers depend on one another. Diversion works only if there is somewhere to divert to; in-reach can identify a prisoner who needs hospital care but cannot deliver it without secure beds; and secure units block if no rehabilitation tier receives their recovered patients. This is why forensic planning is done as a whole system, and why the commonest failure is a bottleneck rather than an absent service.

RULE **Prisoners are entitled to the same standard of health care as the general community.** This is the principle of **equivalence of care**, and it is the organising rule for every prison and forensic mental health service: the fact of imprisonment removes liberty, not the right to health care. It sets the benchmark against which a custodial service is judged, and it is the reason care that would be routine in the community cannot be rationed away simply because the patient is a prisoner. The broader dignity and rights framing is developed in the account of human rights and ethical issues in custodial psychiatry.

15.5 Mental health services within the prison: screening, in-reach and continuity

The service inside the wall begins at the gate. The single most important service element is **reception screening**: a structured assessment at the point of entry, because the early days of custody are the highest-risk window for both crisis and undetected illness. It is not a formality; it is how a service finds the people it must treat before they deteriorate. Its aims are:

- to detect existing serious mental illness and any current treatment that must be continued without interruption;

- to identify acute suicide and self-harm risk in the first, most dangerous nights of custody;
- to flag substance intoxication or impending withdrawal for management under the appropriate protocol;
- to recognise intellectual disability and cognitive impairment that will shape how the prisoner copes and is managed.

From screening, a referral pathway feeds the prison's tiered response: primary mental health care delivered on the wing, specialist in-reach assessment for those who need it, and onward referral for the minority who require hospital-level care, the transfer route covered in the companion account. The quiet failure of prison mental health is discontinuity: care interrupted at the point of entry, or dropped at the point of release, when a person leaves custody without a prescription, a follow-up appointment or a receiving service. Release is a period of markedly elevated relapse and mortality risk.

GOOD TO REMEMBER

Screen at reception and act on it, rather than waiting for breakdown. The prisoners who die or deteriorate are disproportionately those missed in the first days, and the two decisions that change outcomes are continuing established treatment without a gap on the way in, and arranging a warm handover to a community service on the way out. Build the pathway around those two transitions.

15.6 Suicide, self-harm and the crisis end of custodial care

This is where the service is tested hardest. Suicide and self-harm are the sentinel outcomes of a custodial mental health system, and a disproportionate share occurs early in custody, in remand and in the first period after reception, when uncertainty, withdrawal and the shock of imprisonment converge. A credible service therefore runs a suicide-prevention system rather than relying on individual vigilance: identification at reception and at points of change, safer environments, graded observation for those at acute risk, peer support, staff training to recognise and escalate concern, and structured review after every serious incident so the system learns. This is where equivalence of care stops being abstract: the community standard for a person in suicidal crisis is active, urgent intervention, and custody must meet it.

TRAP **Confusing a forensic psychiatry service with the assessment of criminal responsibility.** The service exists to assess, treat and rehabilitate mentally disordered offenders and to run mental health care in prisons; it operates whether or not any insanity defence is ever raised. The criminal-responsibility doctrine, the insanity-defence test and the fitness-to-stand-trial criteria are a separate matter, taught in the Mental health legislation and forensic psychiatry notes. Candidates lose marks by collapsing the whole of forensic psychiatry into the courtroom question of responsibility, when the great majority of forensic clinical work is service delivery to offenders who are simply unwell.

1894	59	(23)
THE PRISONS ACT STILL FORMING THE BACKDROP TO PRISON ADMINISTRATION	ITS SOLE MENTAL-HEALTH HOOK, THE STATE RULE-MAKING POWER	THE CLAUSE ON TREATMENT, TRANSFER AND DISPOSAL OF CRIMINAL LUNATICS

Prisoners carry a large excess of mental disorder, driven together by importation of pre-existing vulnerability and by the deprivations of custody, and are entitled by the principle of equivalence of care to the same standard of mental health care as the community. In India the Prisons Act of 1894 creates no substantive care provision, only a State rule-making power over criminal lunatics, so the substantive care and transfer machinery lives in the mental-health law and the older warrant power it rests on, not in the Prisons Act; the forensic response is a tiered service running from court diversion through prison in-reach and secure inpatient care to community rehabilitation, anchored at reception screening and at the crisis prevention of suicide and self-harm.

16 · Transfer and treatment of mentally ill prisoners

A term of imprisonment does not suspend a person's mental illness, and the law has to answer a plainly administrative question - on whose authority, and to which bed, is a prisoner who is or becomes mentally ill moved for treatment. The examinable content here is narrow but exact, and the marks reward a candidate who can name the operative provision, state the order of preference it lays down, and keep its mandatory language distinct from the older discretionary power it rests upon. Get the sequence wrong, or soften a "shall" into a "may", and you have described a different rule from the one the statute actually enacts.

This account owns the transfer-and-treatment route only. The wider structure of mental health services inside prisons and the forensic psychiatry service belongs to this chapter's account of the mental health of prisoners and forensic psychiatry services and is named here, not rebuilt; the rights lens - dignity, least restriction, non-discrimination in custody - belongs to this chapter's account of human rights and ethical issues in custodial psychiatry. The general machinery of the Act, its definitions, the review board's constitution and powers, capacity and admission, is taught in the Mental health legislation and forensic psychiatry notes; the prisoner-specific transfer provision is what is grounded and taught in full below.

103	2017	30	1900
MENTAL HEALTHCARE ACT SECTION FOR PRISONERS WITH MENTAL ILLNESS	THE MENTAL HEALTHCARE ACT NOW IN FORCE	PRISONERS ACT SECTION IT CROSS-REFERS TO	THE OLDER ACT THAT PROVISION SITS IN

16.1 The provision that supplies the authority

The governing provision is the Mental Healthcare Act, 2017, at section **103**, and its first job is to solve a purely legal problem: what document is enough to lawfully admit a **prisoner with mental illness** into an establishment for care. The answer the section gives is that an order directing such admission, made under any of a specified set of Acts, is by itself enough. Among those specified sources is section **30** of the Prisoners Act, 1900, alongside orders made under the armed-forces Acts and under the criminal procedure law.

The operative words are that such an order "shall be sufficient authority" for admitting the person to the establishment to which they may lawfully be transferred for care and treatment. That

modal verb is the whole point. The section does not create a fresh discretion to be exercised at the prison gate; it declares that a validly made order already carries the legal weight needed, so the receiving establishment need not look behind it for some further sanction. This is **sufficient authority** in the technical sense - a completed legal warrant, not an invitation to reassess.

16.2 The first door: the prison's own psychiatric ward

Having settled authority, the section settles destination, and it does so with an order of preference that is the single most tested feature of the whole topic. The first proviso states that transfer of a prisoner with mental illness to the **psychiatric ward in the medical wing of the prison** shall be sufficient to meet the requirements of the section. In other words, the default and preferred response is to treat the prisoner inside the prison, in a dedicated psychiatric ward, rather than to move them out of custody into an external hospital.

The reasoning behind this preference matters for the answer, not only for practice. Keeping treatment within the prison medical wing avoids the security and continuity problems of moving a prisoner to and from an outside facility, keeps the person within a single accountable custodial system, and reflects the Act's commitment to the least disruptive appropriate setting. The examiner is testing whether you know that the in-prison ward is the statutory first line, because the intuitive answer - send the mentally ill prisoner to a mental hospital - is the second line, not the first.

16.3 The second door, the Board's permission, and the continuing safeguards

The second proviso supplies the fallback and hedges it with a condition. Where there is no provision for a psychiatric ward in the medical wing, the prisoner may be transferred to a **mental health establishment** with the prior permission of **the Board**. Two elements have to be stated together for the mark. First, the external transfer is contingent - it becomes available only when the in-prison ward does not exist, not as a free alternative. Second, it is gated: it requires the Board's permission in advance, not a post-hoc ratification. The review board itself, how it is constituted and what else it does, is a matter for the Mental health legislation and forensic psychiatry notes; here it functions as the authorising gate on the out-of-prison route.

The section does not stop at the moment of transfer. It builds in continuing oversight so that a prisoner moved for mental illness is not simply lost inside the system, and these duties are worth listing because a "state the safeguards" question turns on them:

- a quarterly reporting duty on the prison medical officer;
- powers of visitation exercisable by the Board;
- special reports at six-monthly intervals, giving a fixed rhythm of scrutiny beyond the routine quarterly report;
- a duty on the appropriate Government to establish a mental health establishment in the medical wing of at least **one** prison in each State and Union Territory, so that the preferred in-prison route is actually available and does not collapse into the external transfer for want of a ward.

That last duty is the structural safeguard behind the whole preference: the first-line option only means something if a psychiatric ward physically exists to receive the prisoner, so the statute obliges the Government to build the capacity its own order of preference assumes.

RULE **An order directing admission of a prisoner with mental illness is itself sufficient authority; the first option is the psychiatric ward in the prison's medical wing, and only where no such ward exists may the prisoner be transferred to a mental health establishment, and then only with the Board's prior permission.** The sequence is fixed and conditional, not a menu. Sufficiency of authority is declared in mandatory terms; the in-prison ward "shall be sufficient" to meet the section; the external transfer is the exception, unlocked by the absence of a ward and licensed by the Board in advance. Collapsing this to "a mentally ill prisoner is sent to a mental health establishment" states the fallback as if it were the rule.

16.4 The older statute the section rests on: the Prisoners Act warrant

Section **30** of the Prisoners Act, 1900, is the provision the current section expressly cross-refers to, and it is the historical engine that produces the very "order directing admission" the modern Act then treats as sufficient. Its language is of its era and should be read as such, but its structure is still live. Where it appears to the State Government that a person detained or imprisoned under any order or sentence of a court is of unsound mind, the State Government may, by a **warrant** setting out the grounds of that belief, order the person's removal to a lunatic asylum or other **place of safe custody** within the State, there to be kept and treated as the Government directs for the remainder of the term of detention or sentence.

Two features carry the marks. The power is discretionary - "may, by a warrant" - and it is exercised by the State Government on a stated belief of unsound mind, with the grounds recorded in the warrant itself, which is the accountability check built into an otherwise wide power. And it contains a continuation clause that reaches beyond the sentence: if, on the expiry of the term, a medical officer certifies that further detention under medical care or treatment is necessary for the safety of the prisoner or of others, the person may be kept until discharged according to law. That is how a person can lawfully remain in medical custody after the original sentence has run - not on the executive's say-so alone, but on a medical certification of necessity tied to safety.

16.5 Reading the two provisions together

The clean way to hold this is as one modern authority-and-destination rule sitting on top of an older warrant power. The Prisoners Act warrant produces the order; the Mental Healthcare Act declares that order sufficient and then dictates where the prisoner should go, ward first, external establishment only by exception. Keeping the two verbs straight - the discretionary "may" of the warrant, the declaratory "shall be sufficient" of the modern authority - is what separates a precise answer from an approximate one. The grid sets the contrast out.

AXIS	PRISONERS ACT WARRANT	MENTAL HEALTHCARE ACT PROVISION
FUNCTION	Creates the power to remove a prisoner of unsound mind	Declares an admission order sufficient authority and fixes the destination
WHO ACTS	The State Government, by warrant recording its grounds	The prison system, under the order, subject to the Board for external transfer
MODAL CHARACTER	Discretionary: "may, by a warrant" order removal	Mandatory/declaratory: the order "shall be sufficient authority"
DESTINATION	A lunatic asylum or other place of safe custody within the State	First the prison's psychiatric ward; an external establishment only if no ward exists, with the Board's prior permission
DURATION	Remainder of the term, and beyond it if a medical officer certifies continued detention necessary for safety	Governed by the originating order and applicable law, with quarterly and six-monthly reporting and Board oversight

TRAP **Stating external transfer to a mental health establishment as the standard response for a mentally ill prisoner.** Candidates recall that the prisoner is "sent for treatment" and name the outside hospital, missing that the section makes the psychiatric ward in the prison's own medical wing the first option and treats the external establishment as the exception - available only where no such ward exists, and only with the Board's prior permission. Answer with the order of preference, not with the fallback, because the fallback is the very thing the section is drafted to make secondary.

IN INDIA

This is an entirely Indian statutory scheme with no Western template to borrow. The current authority is the Mental Healthcare Act, 2017, which folded the prisoner provision into the same rights-based Act that governs civil admission, while expressly preserving the older removal power in the Prisoners Act, 1900. The practical gap the Act tries to close is the historical shortage of in-prison psychiatric wards, which is precisely why it lays a duty on the appropriate Government to build a mental health establishment in the medical wing of at least one prison per State and Union Territory.

GOOD TO REMEMBER

When advising on a prisoner who has become mentally ill, look first to the prison's own psychiatric ward, because that is the statutory first line, and reserve transfer to an outside establishment for where no such ward exists - flagging that the external move needs the Board's prior permission before it happens, not after. If care will be needed beyond the end of the sentence, the lawful route to continuation is a medical officer's certification that further detention is necessary for the safety of the person or of others, which is what turns the end of a sentence into grounded continued care rather than unlawful detention.

PITFALL

The section cross-refers to orders made under the criminal procedure law, and those references are to the provisions of the 1973 Code as they stood when the Act was passed. Since the criminal statutes changed on the first of July 2024, an author who cites the old procedural sections as current is quoting a superseded code; the savings position and the current successor provisions are treated in this chapter's account of the current penal-code framework and its transition to the new criminal codes, and should be cross-referred rather than restated here. Name the transfer authority from the Mental Healthcare Act and the Prisoners Act, which are grounded, and do not attach a procedural section number from memory.

An order directing admission of a prisoner with mental illness is sufficient authority under the Mental Healthcare Act, 2017; the first option is the psychiatric ward in the prison's medical wing, and only where no such ward exists may the prisoner be transferred to a mental health establishment, and then only with the Board's prior permission - the power to remove being drawn from the discretionary warrant of the Prisoners Act, 1900.

17 · Human rights and ethical issues in custodial psychiatry

A person does not surrender the right to health, to dignity or to protection from cruelty at the prison gate. Custodial psychiatry is where the ordinary ethics of the profession meet the extraordinary fact that the patient cannot walk away and often cannot freely refuse. The setting concentrates every rights problem the discipline has: liberty is already removed, the environment is coercive, the clinician answers to an institution as well as to the patient, and the people most affected are among the least able to assert a claim for themselves. The marks here are for the rights-and-ethics lens itself, not for the plumbing of prison mental health, and an examiner rewards the candidate who can name the rights at stake, the Indian authority that protects them and the ethical trap the custodial role sets.

What this topic owns is that lens. The structure of mental health services for prisoners belongs to this chapter's account of the mental health of prisoners and forensic psychiatry services, and the pathway for moving and treating a mentally ill prisoner belongs to this chapter's account of the transfer and treatment of mentally ill prisoners; both are named here and cross-referred, not reworked. The ethical frame for coercion and restraint in general is developed in this chapter's account of the ethical issues in involuntary treatment, restraint and end-of-life care, and its legal frame in the account of the legal aspects of seclusion, restraint and involuntary treatment. The clinical management of drug and alcohol problems in custody sits in the Substance use disorders notes.

17 Aug 1993	3 Oct 1994	19 Jun 2023
SUPREME COURT BARRED JAILING THE NON-CRIMINAL MENTALLY ILL	THE FOLLOW-UP ORDER ENFORCING THAT BAR	NHRC ADVISORY ON CUSTODIAL SELF-HARM AND SUICIDE

17.1 The rights lens: dual loyalty and the equivalence of care

Two ideas organise the whole topic. The first is the psychiatrist's problem of **dual loyalty**: a clinician working inside a custodial system owes the ordinary fiduciary duty to the patient in front of them, but the institution that pays and permits them wants order, security and compliance, and those two pulls do not always point the same way. A request to certify a prisoner fit for punishment, to medicate a difficult inmate for the convenience of the wing, or to disclose clinical information to custodial staff for reasons that are not the patient's, are all moments where loyalty to the patient and loyalty to the institution collide. The rights lens resolves the collision in one direction: the clinical relationship, and the patient's rights within it, come first, and the doctor's role is never to be an instrument of punishment or control dressed as treatment.

The second idea is the principle of **equivalence of care**: a person deprived of liberty is entitled to a standard of health care equivalent to what is available in the community, without discrimination on the ground of their legal status. Detention removes freedom of movement; it is not a sentence to worse medicine. Because the detained person cannot seek a second opinion, cannot easily complain and cannot leave, equivalence is a corrective for a captive population's structural disadvantage. Taken together, dual loyalty tells the clinician whom they serve, and equivalence tells them to what standard.

RULE **Loss of liberty is not loss of the right to health, to dignity or to consent; care in custody must be equivalent to care in the community and must never become an instrument of the institution against the patient.** Every specific rule that follows, the bar on jailing the non-criminal ill, the duty to screen, the limits on coercion, is an application of this one sentence. When a custodial question puzzles you, return to it: what would this person be owed outside, and what is the least the institution may do to them inside.

17.2 Sheela Barse: the non-criminal mentally ill do not belong in jail

The single most examinable Indian authority in this area is the **Sheela Barse** litigation, in which the Supreme Court confronted the practice of holding mentally ill persons who had committed no offence in ordinary jails, frequently under the label of "safe" or protective custody, for want of anywhere else to put them. By its judgment dated **17 August 1993** the Court strictly prohibited the confinement of non-criminal mentally ill persons in jails. The prohibition was not advisory and not conditional: a person whose only "offence" is their illness may not be warehoused in a penal institution, because a jail is a place of punishment and this person is not being punished.

The force of the ruling lies in how the Court framed the wrong. Confining the non-criminal mentally ill in jail was treated as a violation of their constitutional rights, and therefore as a matter attracting the Court's compensatory jurisdiction: not merely bad administration but an actionable breach for which the State could be held answerable. That the point had to be restated is itself the lesson: by the follow-up order dated **3 October 1994** the Court recorded its dismay that the earlier prohibition was still not understood, and reiterated it. For the exam, the case stands for a clean proposition: illness is not criminality, and the response to a person found wandering and unwell is care in a health facility, never a cell.

TRAP **Treating "protective" or "safe" custody of the non-criminal mentally ill as a benign holding measure.** Candidates soften the Sheela Barse bar into a matter of resources, reasoning that a jail is acceptable when no hospital bed is free. It is not: the prohibition on confining the non-criminal mentally ill in jail is a rights bar, not a preference, and the absence of an alternative is the State's problem to solve, not a defence to the wrong. The correct answer is always diversion to a health facility, and the pathway for a prisoner who does need psychiatric care sits in this chapter's account of the transfer and treatment of mentally ill prisoners.

17.3 Custodial self-harm and suicide: the duty to look

Suicide and deliberate self-harm are the sharpest rights problem inside the wall, because the State that has taken a person into its exclusive control has assumed a corresponding duty to keep them alive, and a custodial death raises at once the questions of what was known and what was done. The population is high-risk by construction: the shock of first reception, withdrawal from substances, isolation from family, the loss of autonomy and the concentration of untreated mental illness make the early days of custody especially dangerous. A rights-respecting system therefore treats detection as an active duty rather than waiting for a prisoner to declare distress they may be least able to voice.

The Indian regulatory answer is captured in the National Human Rights Commission advisory dated **19 June 2023** on mitigating deliberate self-harm and suicide attempts by prisoners, which recommends, among other measures, that mental health screening be included in the initial health screening report of every prisoner and that prison staff be trained in **Psychological First Aid** and mental health literacy. Note the two moves. Screening at reception catches the risk when it is highest and before the system has lost sight of the person; training the frontline staff, who see prisoners far more than any clinician does, turns wing officers into the first line of recognition rather than bystanders. These are recommendations of a rights body, not a statutory command, but they set the standard of humane practice against which a custodial system's failures are now measured.

GOOD TO REMEMBER

When you assess anyone entering custody, screen for suicide risk as a routine part of the reception health check, not only when a threat is voiced. Document what you asked and what you found, and flag those at risk to the staff who will actually be watching them overnight. In a custodial death the contemporaneous reception note is the first thing scrutinised, and "no concerns raised" is not the same as "screened and none found".

17.4 Consent, confidentiality and coercion behind the wall

The everyday ethics of the encounter are distorted by the setting. Consent given in custody is suspect on its voluntariness: a person who believes that refusing treatment will affect their parole, their classification or their handling by staff is not consenting freely, so the clinician must work harder to separate a genuine choice from a coerced one. Confidentiality is under constant pressure, because custodial staff routinely want clinical information, yet the duty follows the patient into custody and is not waived by their status; disclosure to the institution is justified only on the same narrow grounds that would justify it outside. The elements of valid consent and the

permitted grounds for breaching confidence are taught in this chapter's own accounts of those topics and are applied here, not restated.

Coercive control is the third pressure, and custody offers instruments a hospital does not. The ways the setting erodes rights are worth holding as a list, because each is a distinct place a clinician can be co-opted:

- segregation imposed for order being passed off as therapeutic seclusion;
- medication used for the convenience of the regime rather than the patient's illness, so-called chemical restraint;
- solitary confinement of a mentally ill prisoner, which can itself cause or worsen psychiatric harm;
- clinical information fed to custodial or disciplinary processes without the patient's interest in view.

The general ethics of restraint and seclusion, and their legal safeguards, belong to this chapter's accounts of the ethics and of the legal aspects of seclusion, restraint and involuntary treatment; the statutory restraint machinery itself sits in the Mental health legislation and forensic psychiatry notes. What the rights lens adds is the reminder that in custody every one of these instruments is more available and less visible, so the clinician's refusal to lend clinical authority to punishment is the safeguard that matters most.

PITFALL

The commonest real-world error is accepting a prisoner's consent, or their apparent calm, at face value. A man who agrees to depot medication because he fears the consequences of refusal has not truly consented, and a prisoner segregated "for his own safety" may be deteriorating in isolation rather than being protected by it. Read voluntariness in the light of the coercive environment, and do not treat isolation of a mentally ill person as a neutral administrative fact: a person with mental illness shall not be subjected to seclusion or solitary confinement, so safety must be met through lawful alternatives rather than isolation.

17.5 Non-discrimination and the standard-setting frame

Underlying all of the above is the principle of **non-discrimination**: legal status is not a permissible ground for delivering worse care, and the detained mentally ill are entitled to the same rights and quality of treatment as any other patient. This is why equivalence of care is stated as a right and not an aspiration, and why the Sheela Barse bar and the NHRC's reception-screening recommendation are best read together, one keeping the wrong person out of the penal system entirely, the other protecting the right person once lawfully within it.

The topic also sits within a wider architecture of standards. International minimum standards for the treatment of prisoners and for the protection of persons with mental illness, and India's own disability-rights and mental-health statutes, all articulate versions of dignity, equivalence and non-discrimination in custody; the domestic statutory machinery is set out in the Mental health legislation and forensic psychiatry notes and is applied here rather than restated. For the

practising psychiatrist the message survives the detail: the rights of the person in custody are the rights of any patient, made more fragile by captivity and therefore owed more vigilance, not less.

RIGHT AT STAKE IN CUSTODY	HOW THE SETTING THREATENS IT	THE RIGHTS ANSWER
LIBERTY OF THE NON-CRIMINAL ILL	Held in jail as "protective" custody for want of a bed	Absolute bar on jailing them; divert to a health facility
LIFE (PROTECTION FROM SELF-HARM)	High-risk population, distress unvoiced, watch diffuse	Mental health screening at reception; trained frontline staff
VOLUNTARY CONSENT	Refusal feared to affect parole, classification or handling	Test voluntariness against the coercive environment
CONFIDENTIALITY	Staff demand clinical information; no private space	Duty follows the patient; disclose only on the usual narrow grounds
EQUAL STANDARD OF CARE	Legal status used to justify inferior treatment	Equivalence of care and non-discrimination

A person in custody keeps every health-related right they had outside, made more fragile by captivity and so owed more vigilance: care must be equivalent to the community standard and free of discrimination, the non-criminal mentally ill may not be confined in jail at all, self-harm and suicide risk should be actively screened at reception as the NHRC advises, and the psychiatrist's clinical authority must never become an instrument of the institution against the patient.

Forensic Indian statutes and legal procedure

18 · Sexual offences law and Criminal Law Amendment (rape, consent, psychiatric assessment of survivors)

The law changed its numbers, not the reader's duty to get them right. This topic is the criminal law of sexual offences as it now stands: the definition of rape and its punishment in the current penal code, the exact legal meaning of consent on which the offence turns, and the part a psychiatrist plays when a survivor is examined or when a court needs to know whether a complainant could consent. The marks cluster in three places, and each is one where confident memory of the old law is a liability. The first is currency: the provisions were re-enacted when the colonial-era penal code was replaced, so the section a report cites must be the live one. The second is a conceptual trap: the criminal law's "consent" is a different construct from the consent a clinician takes before treatment, and the two are examined together precisely so that candidates conflate them. The third is the narrow but genuinely psychiatric interface, the short list of conditions - unsoundness of mind, intoxication, an inability to communicate - in which whether there was consent at all becomes a question a psychiatrist is competent to address.

A psychiatrist who assesses a survivor, or who is asked to opine on capacity to consent, works entirely inside this statutory frame. The full account of how the penal code changed, and the savings rule that decides which code governs a given matter, belongs to this chapter's account of the current penal code and its predecessor, and is named here rather than re-derived; the task here is the sexual-offences provisions themselves and the clinician who stands beside them.

18.1 The reform lineage: from a committee's report to the current code

Why the modern definition looks the way it does. The shape of the present offence is the direct product of a single wave of reform. After the Delhi gang-rape case that provoked national reform, the **Justice Verma Committee** was convened, and its recommendations were substantially enacted as the **Criminal Law (Amendment) Act 2013**. That amendment did two things that still dominate the topic. It broadened the offence of rape well beyond the older, narrow idea of peno-vaginal intercourse, replacing it with a defined set of sexual acts, penetrative and oral; and it recast consent as something that must be affirmatively communicated rather than merely not refused. When the penal code was later rewritten, these post-2013 amendments were not reopened: the broadened definition and the affirmative-communication consent standard were carried forward substantively unchanged into the current code. For the examinee this continuity is a gift and a trap at once: the settled understanding of the amended offence survives intact, but the section numbers moved, so an answer written in the old citations describes the right law under the wrong name.

18.2 The offence defined: rape under the current penal code

An act, done in a defined circumstance. The offence of **rape** is defined in the current penal code, the **Bharatiya Nyaya Sanhita**, at section **63**, the successor to the repealed penal code's rape provision. Its architecture is two-part, and the discipline is to hold both parts together: a defined physical act, performed under one of a defined set of circumstances. The amendment carried into this section widened the physical act into **four** categories of sexual conduct: penile penetration of the vagina, mouth, urethra or anus; insertion of an object or a body part other than the penis; manipulation of a part of the body so as to cause penetration; and application of the mouth to the vagina, anus or urethra. The first three turn on penetration or insertion; the fourth is complete on the application of the mouth, without proof of penetration, and a candidate who calls all four penetrative has narrowed the section. None of these is an offence in the abstract; each becomes rape only when done in one of the listed circumstances.

The circumstances, and where the psychiatry lives. The circumstances that make an act rape are a closed statutory list, and they repay grouping rather than rote recall. They run:

- against the woman's will, or without her consent at all;
- with a consent extracted by putting her, or someone she cares about, in fear of death or of hurt;
- with her consent, where the man knows he is not her husband and she consents because she believes he is another man to whom she is, or believes herself to be, lawfully married;

- with a consent given when, by reason of unsoundness of mind, intoxication, or a stupefying or unwholesome substance, she is unable to understand the nature and consequences of that to which she consents;
- where she is below the age the section fixes, in which case her consent is immaterial; and
- where she is unable to communicate consent.

The fourth and the last of these are the psychiatric heartland of the whole topic. Whether a person could, at the material time, understand the nature and consequences of a sexual act, or could communicate a choice about it, is not a lay judgement; it is a capacity assessment, and it is the point at which a court is most likely to want a psychiatrist. The section itself, by writing unsoundness of mind and intoxication into the definition, makes the clinician's assessment part of the legal question rather than a bystander to it.

MNEMONIC

Mind, Substance, Speech

The three circumstances in the rape definition that turn on the complainant's capacity rather than on the surrounding facts: **M**ind (unsoundness of mind), **S**ubstance (intoxication or an administered stupefying or unwholesome substance), and **S**peech (an inability to communicate consent). Each may call for clinical expert evidence rather than lay judgement, and the cause decides which expert: intoxication may turn on toxicological evidence and an inability to communicate on neurological or physical evidence, while the psychiatrist speaks only to the psychiatric question. Where the cause is psychiatric, whether there was consent has become, in part, a question about capacity, and that is the clinician's territory.

18.3 The legal meaning of consent, and why it is not clinical consent

Consent defined by the section, not by the clinic. The definition the offence turns on is the criminal-law meaning of **consent**, set out in Explanation 2 to the rape section, and it is the single most examined line in the topic. Consent means an **unequivocal voluntary agreement**, in which the woman, by words, gestures, or any form of verbal or non-verbal communication, communicates willingness to participate in the specific sexual act. The definition then closes a door that the older law had left ajar: a woman who does not physically resist the act shall not, by reason only of that fact, be regarded as consenting. Two features are load-bearing. Consent is affirmative and communicated, not inferred from the absence of a "no"; and it is act-specific, so agreement to one thing is not agreement to another.

A different construct that shares a word. This is where candidates lose marks, because the clinical doctrine of informed consent, its elements of capacity, adequate disclosure and voluntariness, is taught in this chapter's account of informed consent in psychiatry, and the two doctrines overlap far less than the shared noun suggests. Both ask for voluntariness, and both attach to a specific act rather than to a general willingness, and there the resemblance stops. Clinical consent is a prospective authorisation a competent patient gives a clinician for an intervention, built on capacity and on disclosure of risks and alternatives; the criminal law's consent is a retrospective factual question about whether an unequivocal, communicated

willingness to a specific act existed at a particular moment. The comparison below fixes the contrast so it cannot be blurred under pressure.

AXIS	CLINICAL (INFORMED) CONSENT	CONSENT IN THE LAW OF SEXUAL OFFENCES
The question it answers	May this clinician proceed with this intervention?	Did an unequivocal, communicated willingness to this specific act exist?
Where it is defined	The general doctrine of informed consent (its own topic in this chapter)	The Explanation to the rape section of the current penal code
Its core standard	Capacity, adequate disclosure of information, and voluntariness	An unequivocal voluntary agreement, communicated by word, gesture or other means, to the specific act
Orientation in time	Prospective: an authorisation given before the act	Retrospective: a finding of fact about a past moment
Effect of silence or non-resistance	Silence is not authorisation; a positive agreement is required	Failure to physically resist is not, by that fact alone, consent
Whose interest it protects	The patient's autonomy over their own treatment	The complainant's sexual autonomy against a criminal wrong

Two constructs that share the word "consent" and, beyond voluntariness and an act-specific agreement, little else. A report that answers the clinical-capacity question when the court asked the criminal-law-consent question, or the reverse, has misread the brief before it has misread the facts.

RULE **Criminal-law consent is an unequivocal, communicated, act-specific willingness, and the absence of physical resistance is not consent.** The definition is affirmative and positive: it asks what the woman communicated, not what she failed to do. It is tied to the specific sexual act, so agreement to one act does not extend to another. And it stands apart from the clinical doctrine of informed consent, which is a prospective authorisation for treatment built on capacity and disclosure. The two are examined side by side so that they will be confused; the mark is in keeping them separate.

TRAP **Answering the criminal-law consent question with the clinical capacity-and-disclosure test.** Asked whether a complainant consented, the unwary candidate reaches for the informed-consent checklist - was there capacity, was there disclosure, was it voluntary - and imports a treatment doctrine into a criminal statute. The section does not ask whether a valid clinical authorisation was obtained; it asks whether an unequivocal, communicated willingness to the specific act existed, and it treats the absence of resistance as no answer at all. Capacity enters the criminal analysis only through the circumstances the section names, unsoundness of mind, intoxication and inability to communicate, not as a free-standing test.

18.4 The exceptions and the punishment

Two exceptions, each with its condition. The offence carries two carve-outs, and each must be stated with its condition or not at all. A medical procedure or intervention shall not constitute rape, which shields the clinician performing a lawful examination or treatment. Separately, intercourse or sexual acts by a man with his own wife are not rape, provided the wife is not below

the age the section fixes: the exception operates only at or above that age threshold, and where the wife is below it the exception does not apply. Naming the **marital-rape exception** without its age condition is how a candidate turns a precise carve-out into a wrong general statement.

Punishment. The punishment for rape is prescribed at the section that follows the definition, section **64**, the successor to the repealed penal code's punishment provision. An offender shall be punished with rigorous imprisonment for a term which shall not be less than **ten** years, which may extend to imprisonment for life, and shall also be liable to fine. The modal verbs are the law: the minimum term is mandatory ("shall not be less than"), the extension to life is discretionary ("may extend"), and the fine is a mandatory addition ("shall also be liable"). A separate sub-section lists aggravated categories - among them a police officer, a public servant, a person in a custodial or fiduciary position of trust - for which a heavier term is prescribed, reflecting the abuse of power the section singles out.

PITFALL

Citing the repealed Indian Penal Code's rape and punishment sections as the governing law for a current offence, or without first establishing when the offence was committed. The wording of the offence was carried across largely intact, which is exactly why the error is so easy: the substance feels current even though the citation is dead. A medico-legal report that names a repealed code as the live one reads as out of date and invites the court to discount the opinion. Read the governing section from the current code, and let this chapter's account of the transition settle which code applies to an older matter.

18.5 The psychiatrist and the survivor

The clinician's role is real but bounded. The psychiatrist's involvement with a survivor of a sexual offence runs along several tracks, and the examinable skill is knowing which one is in play: assessing and documenting the survivor's mental state and the psychological sequelae, as treating clinician; assessing **capacity to consent** where the section's own circumstances of unsoundness of mind, intoxication or an inability to communicate are in issue; supporting a vulnerable survivor through the process of giving evidence; and providing continuing treatment for the psychiatric consequences.

The dual role, and the line not to cross. These tracks map onto the two roles that organise all forensic work, the treating clinician who owes duties to a patient and the forensic evaluator who serves the court, and the distinction between them is developed in this chapter's account of the psychiatrist as expert witness. The critical discipline is that a psychiatrist assesses mental state and capacity but does not pronounce on the ultimate legal question of whether there was consent, which is for the court alone to decide on all the evidence. An opinion that a survivor "did not consent", or that an account is true, usurps the court's function and is worth less, not more, for its overreach. The proper contribution is narrower: whether, at the material time, this person had the capacity to understand the nature and consequences of the act, or to communicate a choice about it.

How the assessment is conducted matters as much as what it finds. A survivor examination is itself a potential source of further harm, so the assessment is trauma-informed and unhurried, with the survivor's own authorisation sought for each step and the findings recorded contemporaneously and precisely. Where the survivor is a child, the dedicated child-protection statute applies alongside the applicable general provisions, and both the substantive framework and the special procedures for a child are the province of the Child psychiatry: assessment, treatment, services and protection notes, which are named here and cross-referred, not re-taught.

IN INDIA

The sexual-offences law is one of the most heavily reformed corners of the Indian criminal code, and the psychiatrist sits inside a defined medico-legal pathway. A survivor presenting after an assault is examined under a standardised medico-legal protocol, and a psychiatric opinion on capacity to consent is sought specifically where the statute's own circumstances - unsoundness of mind, intoxication or an inability to communicate - are raised. The practical safeguard is to write every such opinion against the current code read from the primary source, and to keep the clinical capacity finding distinct from the legal conclusion the court will draw from it.

GOOD TO REMEMBER

Before you commit any opinion in a sexual-offences matter, settle two things. First, which question the court is actually asking: a clinical-capacity question about whether this person could understand or communicate, or something the law reserves to itself. Second, that your report answers the first and never trespasses on the second. State the mental state and the capacity, document how you assessed both, and stop short of the ultimate issue of consent, which is the court's to decide.

63	64	10
CURRENT PENAL-CODE SECTION THAT DEFINES RAPE	THE SECTION THAT PRESCRIBES THE PUNISHMENT	YEARS, THE MANDATORY MINIMUM RIGOROUS IMPRISONMENT

Rape is defined and punished under those two sections of the current penal code by a mandatory minimum of rigorous imprisonment extendable to life; the definition, broadened after the post-2013 reforms and carried forward unchanged, turns on the criminal-law meaning of consent in Explanation 2, an unequivocal, communicated, act-specific willingness in which non-resistance is not consent. That construct is not the clinical doctrine of informed consent. The psychiatrist assesses a survivor's mental state and capacity to consent where unsoundness of mind, intoxication or an inability to communicate is in issue, and never pronounces on the ultimate legal question of consent, which is the court's.

19 · Section 105 BSA (formerly Section 84 IPC under BNS) and updated penal code provisions

Get the citation right, or the opinion is worthless. The examinable core of this topic is small, exact and unforgiving. The insanity defence and the rule about who must prove it are two

different provisions, sitting in two different codes, and the penal and evidence codes carrying these two provisions changed on **1 July 2024**. A psychiatrist who cites the wrong section, or a repealed code, in a report to a criminal court has undermined the one thing an expert is there to supply: a precise, current and defensible statement of the law the opinion is built on. The marks here reward accuracy, not breadth, and the commonest way to lose them is to answer confidently in the language of a code that no longer governs.

The heading a candidate is most likely to meet, pairing an evidence-code section number with the old insanity section, is itself wrong, and correcting it is half the answer. This topic fixes the mapping, states what each current section actually provides, and then teaches the transition rule that decides which code governs a given case. The cognitive test that the defence turns on, and the doctrine of the burden of proof, are developed in the Mental health legislation and forensic psychiatry notes and are named here, not re-taught; the courtroom procedure for referring and assessing an accused is carried in the accompanying forensic-procedure material.

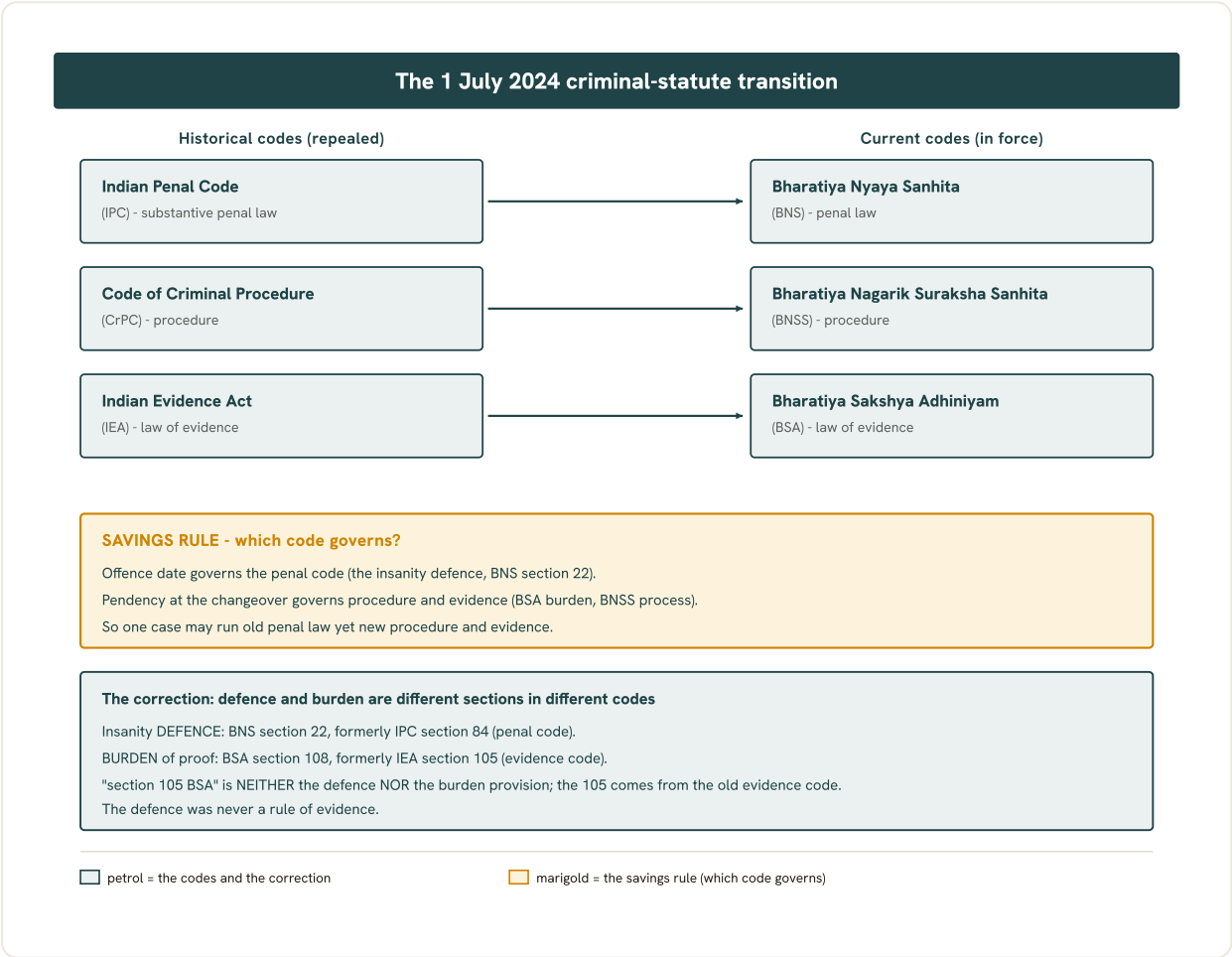

Fig 26.7. On 1 July 2024 the three colonial codes were replaced together, the Indian Penal Code by the Bharatiya Nyaya Sanhita, the Code of Criminal Procedure by the Bharatiya Nagarik Suraksha Sanhita and the Indian Evidence Act by the Bharatiya Sakshya Adhiniyam, with the offence date governing the penal code and pendency at the changeover governing procedure and evidence, so the insanity defence is BNS section 22 (formerly IPC section 84) and the burden of proof BSA section 108 (formerly IEA section 105), not section 105 BSA.

19.1 The correction: a defence and a burden, in two separate codes

Two functions, two statutes, two section numbers. The loose shorthand that files the insanity defence under an evidence-code section number collapses two entirely separate provisions into

one. The **general exceptions** to criminal liability, among them the exemption for the **act of a person of unsound mind**, live in the penal code; the rule about who must prove that an accused falls within such an exception lives in the law of evidence. These are not two names for one thing. One asks whether the act is an offence at all; the other asks who carries the risk of not proving the answer. The comparison below fixes both the function and the location.

AXIS	THE INSANITY DEFENCE	THE BURDEN OF PROVING IT
Question it answers	Given the accused's state of mind at the time, is the act an offence at all?	Once the defence is raised, who must establish that the accused was of unsound mind?
Where it lives	The penal code, among the general exceptions (the Bharatiya Nyaya Sanhita, formerly the Indian Penal Code)	The law of evidence (the Bharatiya Sakshya Adhiniyam, formerly the Indian Evidence Act)
Section, current and former	section **22**, formerly section **84**	section **108**, formerly section **105**
Nature of the rule	A general exception that exempts the act from criminal liability	A rule of evidence that places proof on the accused and directs the court to presume the exception absent

The two provisions the garbled heading conflates. Because the defence and the burden are separately located, no single section of the Bharatiya Sakshya Adhiniyam can carry the insanity defence: the popular phrasing borrows the repealed evidence-Act number and pins it to the new code, pointing at neither the defence nor its correct home.

Why the shorthand is not merely sloppy but wrong. The number in the heading was never the defence at all. In the old scheme, the exempting provision was the penal code's insanity section, and its successor is the general-exceptions insanity provision of the Bharatiya Nyaya Sanhita. The number the heading borrows belonged instead to the evidence Act's burden-of-proof provision, whose successor is the current burden section of the Bharatiya Sakshya Adhiniyam. So the correction is not a matter of updating a digit: it is recognising that the defence and the proof of it are different laws, and that the shorthand mixes an old evidence-section number with a new code's name to describe a provision that does not exist.

MNEMONIC

Defence in the Nyaya Sanhita, burden in the Sakshya Adhiniyam

The exemption for the act of a person of unsound mind sits in the penal Sanhita; the rule that the accused must prove it sits in the evidence Adhiniyam. Two functions, two codes: a single evidence-code section can never be the home of the defence, because the defence was never a rule of evidence.

RULE **The defence and the burden are different sections in different codes, and both codes changed at the transition.** The insanity exemption is a penal-code general exception (now the Bharatiya Nyaya Sanhita, formerly the Indian Penal Code); the rule that the accused must prove it is a provision of the evidence code (now the Bharatiya Sakshya Adhiniyam, formerly the Indian Evidence Act). No single provision holds both, so the popular pairing of the defence with an evidence-code number is a category error before it is a numbering error.

19.2 The insanity defence now: the penal code's act of a person of unsound mind

What the current section actually provides. The Bharatiya Nyaya Sanhita's general-exceptions insanity provision exempts from criminal liability an act done by a person who, at the time of doing it, by reason of **unsoundness of mind**, was incapable of knowing the nature of the act, or that it was wrong or contrary to law. Read the clause slowly, because each element does work: the incapacity must arise from unsoundness of mind, it must exist at the time of the act, and it is an incapacity of knowing, that is, a defect of cognition rather than of control or of motive. The exemption is framed as an absolute one, nothing done in that condition is an offence, which is why the defence, when it succeeds, negates criminal responsibility rather than merely mitigating it.

The test has a name, and it is deliberately not re-taught here. The cognitive standard the section encodes is the **M'Naghten standard**. Its limbs, the meaning of knowing the nature of the act, the distinction between legal and moral wrong, and the way the standard is applied and assessed in a real accused, are the doctrine of criminal responsibility and are developed in the Mental health legislation and forensic psychiatry notes; naming the test is the task here, unpacking it is not. One point of continuity is worth holding, however. The statutory wording of the current section is carried across word for word from the repealed penal-code provision, so the substantial body of case-law decided under the old section remains directly instructive, and nothing about the substantive test changed at the transition. What changed is the citation, not the content.

19.3 The burden of proving the defence: the evidence code's exceptions provision

The accused who raises the exception must prove it. The general rule of criminal proof, that the prosecution establishes guilt, does not extend to the general exceptions. When an accused claims to fall within an exception such as unsoundness of mind, the evidence code places the **burden of proof** on the accused: the burden of proving the existence of the circumstances that bring the case within the exception rests on the person asserting it, and the court shall presume the absence of those circumstances until they are established. The section's own first illustration is, tellingly, the insanity case itself, an accused charged with an offence who alleges that by reason of unsoundness of mind he did not know the nature of the act, on whom the burden of proof then lies. The provision does not decide guilt; it allocates who bears the risk on the question of the exception.

Where the statute stops and the doctrine begins. Note the exact structure, because candidates lose the mark by softening it. The burden is placed on the accused, and the court is directed to presume the exception absent, not merely permitted to. How heavy that burden is, and how it

interacts with the presumption of sanity and with the prosecution's own standard, is the doctrine of the burden of proof, which is developed in the Mental health legislation and forensic psychiatry notes and is named, not restated, here. What this topic owns is the location: the burden that used to sit in the repealed evidence Act now sits in the current exceptions provision of the Bharatiya Sakshya Adhiniyam, and that is the provision the garbled heading was reaching for and missing.

TRAP **Naming the evidence code's burden section as the home of the insanity defence.** The number in the garbled heading is borrowed from the repealed evidence Act's burden-of-proof provision, not from the penal code at all, and the defence never lived in the law of evidence. Candidates conflate the two because the exempting section and its burden are examined together, but the provision that exempts the act and the provision that allocates its proof are separate laws in separate codes, and an answer that fuses them has misunderstood the topic, not merely mistyped a digit.

19.4 The transition and the savings rule

The date is not a light switch. On the transition the three colonial-era codes were repealed and replaced together: the penal code, the evidence Act and the code of criminal procedure gave way to the Bharatiya Nyaya Sanhita, the Bharatiya Sakshya Adhiniyam and the **Bharatiya Nagarik Suraksha Sanhita**. Each replacing Act carries its own **repeal and savings** clause, and those clauses are the reason a clinician cannot simply assume that the newest code is the one in force for the matter in front of them. Repeal removes a statute going forward; the savings clause decides what happens to everything already under way.

The penal code follows the date of the offence. The savings clause of the penal Sanhita repeals the Indian Penal Code but preserves its previous operation for what has already happened under it. In particular it keeps the old code alive for offences committed before the change, so that the substantive law, including the insanity defence, is judged by the penal code in force on the **offence date**. Concretely, the savings clause preserves:

- the previous operation of the repealed code, and anything duly done under it;
- any right, obligation or liability already acquired, accrued or incurred;
- any penalty or punishment incurred for an offence already committed against the repealed code;
- any investigation, proceeding or remedy in respect of such a matter, which may be instituted, continued or enforced as if the code had not been repealed.

Procedure and evidence follow pendency, not the offence date. The savings rule for the other two codes turns on a different pivot. Where a trial, inquiry, application, appeal or investigation was already **pendency** pending immediately before the transition, that matter is dealt with under the old evidence Act and the old procedure code, as in force before the change, as if the new codes had not come into force. So the currency of procedure and evidence follows whether the proceeding was pending at the transition, while the currency of the penal code follows when the offence was committed. This asymmetry is the examinable subtlety: a single case can be governed

by the old penal code for its offence and defence, yet by the new procedure and evidence codes for its trial, if the offence predated the change but proceedings began after it.

19.5 Which code governs the matter in front of you

The first question in any criminal referral. The practical payoff of the savings rule is a discipline that must run before any opinion on criminal responsibility is committed to paper. The psychiatrist is not the arbiter of which code applies, that is for the court, but the report must be framed in the law that actually governs, and getting it wrong signals to the court that the expert is working from stale knowledge. Two questions settle the framing:

- When was the offence committed? That fixes the penal code, and therefore the section under which the insanity defence is judged.
- Was the proceeding pending at the transition? That fixes the procedure and evidence law, and therefore the provision under which the burden of proof is allocated.

Name the current provision by its current name. Once the two questions are answered, the report should cite the governing code and section correctly and consistently, and should not drift between old and new names within the same document. Where the current codes govern, the defence is the general-exceptions insanity provision of the Bharatiya Nyaya Sanhita and the burden rule is the exceptions provision of the Bharatiya Sakshya Adhiniyam. Where the savings rule keeps an older matter alive, the report should say so explicitly, rather than silently using whichever names the clinician happens to remember.

IN INDIA

For years to come, Indian forensic practice will run old-code and new-code cases side by side, because the offence date and pendency, not the calendar, decide which law applies. A psychiatrist writing reports today will still meet matters governed by the repealed penal, evidence and procedure codes, alongside matters under the new Sanhita, Adhiniyam and the successor procedure code, sometimes within a single case. The safe habit is to read the governing provision from the primary code rather than from memory or an old handout, and to state, in the report, the code and section the opinion is written against.

GOOD TO REMEMBER

Before you frame any opinion touching criminal responsibility, establish two facts and record them at the top of the report: the date the alleged offence was committed, and whether proceedings were already pending at the transition. Those two facts, not the current year, tell you which penal code carries the defence and which evidence and procedure code carries the burden and the process. Everything else in the medico-legal opinion is built on that footing.

PITFALL

Citing the Indian Penal Code, the Indian Evidence Act or the Code of Criminal Procedure as the current law in a report written after the transition. It is an easy error, because the wording of the insanity defence did not change and the old citations are deeply familiar, but a report that names a repealed code as the governing law reads as out of date and invites the court to discount the opinion. The wording continuing unchanged is exactly why the citation, not the content, is where the mistake hides.

22	84	108	105
BHARATIYA NYAYA SANHITA SECTION CARRYING THE INSANITY DEFENCE	THE REPEALED INDIAN PENAL CODE SECTION IT REPLACED	BHARATIYA SAKSHYA ADHINIYAM SECTION PLACING THE BURDEN ON THE ACCUSED	THE REPEALED INDIAN EVIDENCE ACT SECTION IT REPLACED

The insanity defence is the penal code's general exception for the act of a person of unsound mind (the Bharatiya Nyaya Sanhita, formerly the Indian Penal Code); the burden of proving it rests on the accused under the evidence code, which also directs the court to presume the exception absent (the Bharatiya Sakshya Adhiniyam, formerly the Indian Evidence Act). They are separate sections in separate codes, so an evidence-code number can never be the insanity defence. The penal code follows the date of the offence; procedure and evidence follow whether the matter was pending at the transition.

20 · Procedure for psychiatric assessment of an accused (Sections under CrPC/BNSS, court referral)

A criminal court cannot try a defendant it cannot reach. When an accused's mental state puts their ability to follow and answer the case in doubt, the criminal procedure code does not leave the matter to the clinician's goodwill: it lays down a defined pathway by which the court itself obtains, records and acts on a psychiatric assessment of an accused. This topic is procedure, not doctrine. It governs three linked steps - how the court refers, how the person is examined, and what the court does with the report - and the disposal that follows once a finding of incapacity is recorded. The marks reward the sequence and the exact duties, not the headline that an unfit accused is referred for assessment.

Two features frame everything below. First, the question can surface at two different points in a prosecution, and each has its own section: while a Magistrate is holding an **inquiry** before trial, and once the **trial** itself is under way. Second, the assessment is anchored to a present-tense question - whether the person is **incapable of making his defence** - which is the construct of fitness to stand trial. The criteria that decide fitness are developed in the Mental health legislation and forensic psychiatry notes and are named here, not restated; likewise the separation of the treating from the forensic role belongs to the accompanying material on the psychiatrist as expert witness, and the rules that govern how the resulting opinion is received in court belong to the accompanying material on court structure and the rules of evidence. What this topic owns is the procedural spine that connects them.

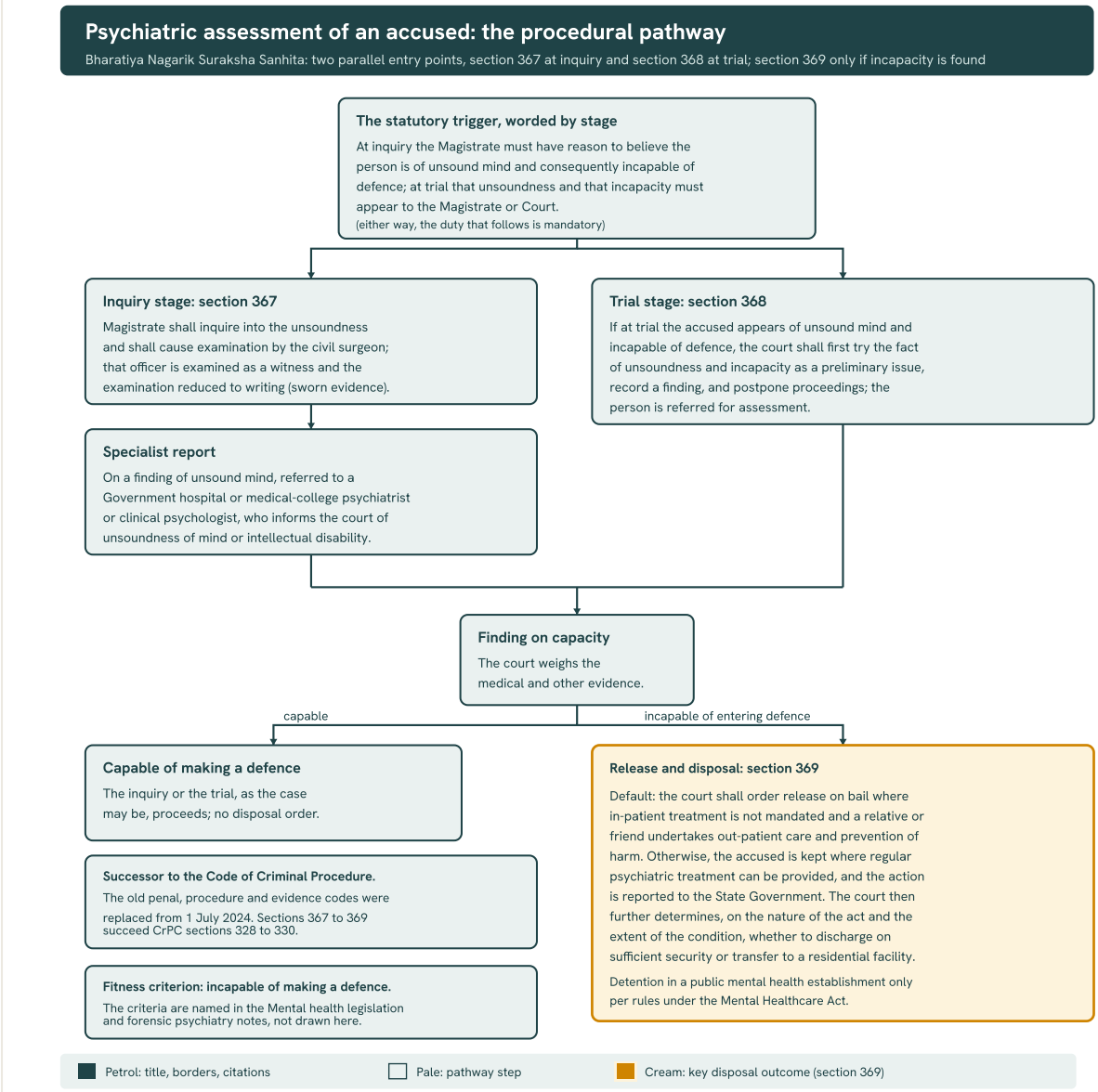

Fig 26.8. The psychiatric assessment of an accused under the Bharatiya Nagarik Suraksha Sanhita has two parallel entry points, worded differently. Under section 367, where a Magistrate holding an inquiry has reason to believe the person is of unsound mind and consequently incapable of defence, the Magistrate shall inquire into that unsoundness and shall cause the prescribed medical examination. Under section 368, where unsoundness and incapacity appear to the Magistrate or Court at trial, the court shall first try the fact of unsoundness and incapacity. A finding of capacity lets the inquiry or the trial proceed; a finding that the accused cannot enter a defence leads to disposal under section 369: release on bail where in-patient treatment is not mandated and an undertaking is given, otherwise safe custody with regular psychiatric treatment reported to the State Government, and a further determination whether to discharge on sufficient security or transfer to a residential facility. These provisions succeed Code of Criminal Procedure sections 328 to 330.

20.1 The pathway and the code it lives in

One question, two entry points, three provisions. The current procedure code is the Bharatiya Nagarik Suraksha Sanhita, the successor to the Code of Criminal Procedure. It carries the unsound-mind machinery in three consecutive sections that read as a single scheme: a referral-and-report provision for the inquiry stage, a parallel provision for the trial stage, and a disposal provision for a person found under either to be unable to enter a defence. The reason the law splits the referral across two sections is that the disability can become apparent before the case is

fully framed or only after evidence has begun, and the safeguard that no one is tried while unable to participate must be available at both moments. The disposal provision sits downstream of both, because a finding of incapacity raises the same practical question however it is reached.

The trigger is worth stating precisely, because it is where the court's duty attaches, and the two entry points word it differently. It is not enough that the accused is unwell or behaving oddly. At the inquiry stage the provision bites when the Magistrate has reason to believe the person is of **unsoundness of mind** and consequently incapable of making a defence; at the trial stage it bites when that unsoundness and that incapacity appear to the Magistrate or Court. The wording differs, the conjunction does not: a mental state together with its consequence for participation opens the pathway, and neither alone will do.

RULE **Once the Magistrate holding an inquiry has reason to believe the accused is of unsound mind and consequently incapable of making a defence, the duty to inquire and to obtain a medical examination is mandatory, not discretionary.** The statute says the Magistrate shall inquire into the fact of unsoundness and shall cause the person to be examined; it is not a power the court may exercise if it chooses. A candidate who writes "the court may refer" has changed the law, because a discretionary power and a mandatory duty are different provisions.

20.2 Referral, examination and report at the inquiry stage

The core provision, step by step. The referral-and-report section of the current code is the one to know in full, because the trial-stage provision and the disposal provision both take their shape from it. When a Magistrate holding an inquiry has reason to believe the person is of unsound mind and consequently incapable of making a defence, four mandatory steps follow in order:

1. inquire into the fact of the unsoundness of mind;
2. cause the person to be examined by the **civil surgeon** of the district, or such other medical officer as the State Government directs;
3. examine that surgeon or officer as a witness; and
4. reduce that examination to writing.

Each step is deliberate: the examination is sworn evidence taken on the record, so the court's later finding rests on testimony that can be tested, not on an informal impression.

From the first-line examiner to the specialist. The section then builds in an escalation. If the civil surgeon finds the accused to be of unsound mind, the surgeon shall refer the person to a psychiatrist or **clinical psychologist** of a Government hospital or Government medical college for **care, treatment and prognosis** of the condition. The specialist, in turn, shall inform the Magistrate whether the accused is suffering from unsoundness of mind or from **intellectual disability**. Two points repay attention. The specialist referral is triggered by the first examiner's finding, so the civil surgeon is the gatekeeper of the pathway rather than its endpoint; and the specialist's report is framed as the binary the court needs, unsoundness of mind or intellectual disability, because the two carry different implications for whether the person can be tried and

treated. An appeal against the specialist's opinion lies to a Medical Board, whose exact composition is recorded in this topic's gaps rather than asserted from memory.

MNEMONIC

Believe, Inquire, Examine, Report, Dispose

The five beats of the pathway in order: the court must have reason to **believe** the accused is of unsound mind and unable to defend; it must **inquire** into the fact; it must have the person **examine**d, first by the civil surgeon and then, on a finding, by a Government-facility specialist; the specialist must **report** unsoundness of mind or intellectual disability; and the court must then **dispose** of the person under the release provision.

20.3 The parallel provision at the trial stage

The same safeguard, one step later in the process. The trial-stage section is the mirror of the inquiry-stage provision for the point at which the case has reached trial. If, at the trial of a person before a Magistrate or a Court of Session, it appears to the court that the person is of unsound mind and consequently incapable of making a defence, the court shall, in the first instance, try the fact of that unsoundness and incapacity. It is a preliminary issue that must be resolved before the substantive trial can go further: the court considers such medical and other evidence as is produced, and if it is satisfied of the fact, it shall record a finding to that effect and shall postpone further proceedings in the case. The structure matters: the court does not simply accept the medical report but tries the fact on evidence, which is why the psychiatric assessment enters as evidence to be weighed rather than as a verdict to be rubber-stamped.

Fitness is the criterion, and it is not decided here. Both this provision and the inquiry-stage one turn on whether the accused is capable of entering a defence, which is the fitness-to-stand-trial question. What that capacity consists of - what the person must be able to understand and do to be tried fairly - is the fitness construct owned by the Mental health legislation and forensic psychiatry notes, and it is named here and cross-referred, not enumerated. This topic owns the machinery that surrounds the criterion: who refers, on what trigger, with what evidence, to what recorded finding. Keeping the fitness question apart from the responsibility question is the discipline the exam is testing.

TRAP **Reading this assessment as an opinion on the insanity defence.** The question this pathway asks is present-tense: can the accused understand and participate in the proceedings now. That is fitness to stand trial, decided by the court after medical evidence. It is a different question from criminal responsibility, which asks about the accused's mind at the time of the offence and is governed by the insanity defence and its burden - the criminal-responsibility doctrine developed in the Mental health legislation and forensic psychiatry notes. A report that answers the responsibility question when the court asked the fitness question has answered the wrong provision, and candidates lose the mark by fusing the two.

20.4 Release and disposal after a finding of incapacity

What happens to the person while the case stands still. The final section of the scheme governs the disposal of a person found, under either of the two referral provisions, to be

incapable of entering a defence by reason of unsoundness of mind or intellectual disability. Its default is liberty with treatment, and the modal force matters: whether or not the case is one in which bail may ordinarily be taken, the court shall order **release on bail** where the person's condition does not mandate in-patient treatment and a relative or friend gives an undertaking that the person will receive out-patient psychiatric treatment and be prevented from harm. Only where, in the court's opinion, bail cannot be granted, or where no appropriate undertaking is given, does the fallback apply: the court shall then order the accused to be kept in a place where **regular psychiatric treatment** can be provided, and shall report the action taken to the State Government. Drop the conditions and the answer is wrong: safe custody is not the norm but what remains when supervised community release is unavailable. The section does not stop there: keeping in view the nature of the act committed and the extent of the unsoundness of mind or intellectual disability, the court further determines whether release can be ordered, and may either discharge the accused on sufficient security or, where discharge cannot be ordered, transfer the accused to a residential facility for persons with unsoundness of mind or intellectual disability.

The one hard limit on where the person may be held. The section closes with a proviso that a candidate should be able to reproduce in substance: no order for the detention of the accused in a public mental health establishment shall be made otherwise than in accordance with the rules made by the State Government under the Mental Healthcare Act, **2017**. This is the seam where criminal procedure hands off to mental health law. The procedure code decides that the person is to be kept and treated; it does not itself authorise admission to a mental health establishment. The definitions, the admission machinery and the review boards under that Act belong to the Mental health legislation and forensic psychiatry notes and are named here, not taught.

GOOD TO REMEMBER

Write the report to the question the court actually asked. The referring provision wants to know two things: whether the person is of unsound mind or has an intellectual disability, and whether that condition makes them unable to follow and answer the case. Address prognosis and treatability, because the disposal provision turns on them, and say plainly whether supervised out-patient care under a relative's undertaking is feasible, the court's preferred route before custody for treatment. An opinion pitched at the wrong question, however clinically sound, does not help the court apply the section.

20.5 The psychiatrist's place in the pathway, and getting the code right

The expert serves the court, not the accused. Within this procedure the psychiatrist or clinical psychologist enters as an examiner and reporter to the court, a role distinct from that of a treating clinician who owes duties to a patient. Where the person is not already under one's care, the assessment is a forensic evaluation whose client is effectively the court, and the report must be framed accordingly: neutral, addressed to the statutory question, and defensible on cross-examination. The full separation of the treating role from the expert role, and the way opinion evidence is distinguished from fact evidence and received by the court, are developed in the

accompanying material on the psychiatrist as expert witness and the accompanying material on court structure and the rules of evidence.

Which code governs the case in front of you. Because the procedure code changed at the recent transition, the psychiatrist must be careful to frame the report in the law that actually governs. For matters already under way before the change, the corresponding provisions of the repealed Code of Criminal Procedure may still govern the proceeding, while current matters run under the successor sections described above. The savings rule that decides which code applies to a given case, and the wider transition from the old penal, procedure and evidence codes, is owned by the accompanying material on the current penal-code framework and the transition. What this topic asks of the clinician: read the governing section from the primary code, cite it correctly, and do not drift between the old and new names within a single report.

IN INDIA

The pathway is built around the public system. The first examiner is the district civil surgeon or a medical officer the State Government directs, and the specialist referral runs specifically to a psychiatrist or clinical psychologist of a Government hospital or Government medical college, not to any qualified practitioner the accused might prefer. Detention for treatment, when it comes to that, is permitted only in a place where regular psychiatric treatment can be provided, and admission to a public mental health establishment is tied to the rules made under the Mental Healthcare Act. In practice this concentrates forensic assessment in a small number of Government facilities, which is where delay and waiting-list pressure tend to accumulate.

AXIS	AT THE INQUIRY STAGE	AT THE TRIAL STAGE	ON A FINDING OF INCAPACITY
Governing section (current code)	section **367**	section **368**	section **369**
When it operates	During a Magistrate's inquiry, before trial	During trial before a Magistrate or Court of Session	After a finding under either provision that the person cannot enter a defence
What the court shall do	Inquire into the unsoundness and cause the person to be examined	Try the fact of unsoundness and incapacity as a preliminary issue	Order release on bail with an undertaking, or safe custody with treatment
Who examines or treats	Civil surgeon or directed medical officer, then a Government-facility psychiatrist or clinical psychologist	Court weighs medical and other evidence; specialist assessment on reference	A place where regular psychiatric treatment can be provided
The recorded output	Examination taken as sworn evidence and reduced to writing; report of unsoundness or intellectual disability	A recorded finding of unsoundness and incapacity; proceedings postponed	Action taken reported to the State Government

The three-provision scheme read across its two entry points and its single disposal route. The inquiry-stage and trial-stage provisions are parallel referral routes to the same fitness question; the disposal provision sits downstream of both.

PITFALL

Citing the Code of Criminal Procedure sections as the current law in a report or answer written after the transition. The old numbers are deeply familiar and the scheme has carried across largely intact, which is exactly why the error hides in the citation rather than the content. A report that names a repealed procedure code as the governing law reads as out of date, and a candidate who cannot say whether the old or the new code applies to a given matter has missed the savings rule that decides it.

328	329	330
THE REPEALED PROCEDURE-CODE SECTION FOR THE INQUIRY-STAGE REFERRAL AND REPORT	THE REPEALED TRIAL-STAGE PROVISION IT REPLACED	THE REPEALED DISPOSAL AND REPORTING PROVISION IT REPLACED

The psychiatric assessment of an accused runs on a three-section scheme in the current procedure code: a referral, examination and report at the inquiry stage; a parallel provision at the trial stage where the court shall first try the fact of unsoundness and incapacity; and a disposal provision under which the court shall order release on bail where in-patient treatment is not mandated and an undertaking is given, or safe custody with regular psychiatric treatment reported to the State Government, and shall further determine whether to discharge the accused on sufficient security or transfer them to a residential facility. The trigger is unsound mind that makes the accused incapable of defence, the duty to refer is mandatory, and the criterion is fitness to stand trial, which is named here and taught in the Mental health legislation and forensic psychiatry notes.

21 · Dying declaration and psychiatric assessment of competence

Why this earns marks. The **dying declaration** is one of the few rules of evidence in which the psychiatrist is not a bystander but a participant. The treating team is often the only body present when a fatally injured person names how the injury came about, and a court will later ask whether that person was in a fit enough mental state for the statement to be believed. Two competencies are being tested at once: a point of substantive evidence law, and a bedside psychiatric judgement about capacity. Candidates who can hold the two apart, and then join them, score cleanly. The evidence rule tells you what such a statement is worth in principle; the psychiatric assessment tells you what this particular statement, from this particular declarant, is worth in fact.

The provision must be read from the current code. The substantive criminal law of India was recently recast, and the older evidence statute is now historical; the transitional savings rule that decides which code governs a case already pending at the changeover is set out where this chapter treats the penal-code framework, and is not re-derived here.

21.1 The provision: what the statute makes relevant

The dying declaration is governed by section **26(a)** of the Bharatiya Sakshya Adhiniyam, the successor to what was section **32(1)** of the Indian Evidence Act. Ordinarily a statement made out of court by a person who is not before the court to be cross-examined is hearsay and cannot be received. The dying declaration is a recognised exception: a statement by a person as to the cause of his death, or as to any of the circumstances of the transaction that resulted in his death, is a relevant fact whenever the cause of that person's death comes into question. The rationale traditionally offered is twofold - necessity, because the best witness to the killing is now dead and cannot be produced, and a presumption of trustworthiness, the old intuition that a person who feels death approaching is unlikely to leave the world with a lie on the lips. The second limb of that rationale is exactly where Indian law then parts company with the tradition that produced it.

21.2 The Indian departure: no expectation of death, and any proceeding

This is the discrimination examiners most want to see. In the English common-law tradition the exception is narrow: the maker must have been under a settled, hopeless **expectation of death** at the moment of speaking, and the statement is admissible essentially only on a charge concerning the declarant's own homicide. The Indian statute is deliberately wider. The statement is relevant whether or not the maker was, at the time it was made, under any expectation of death, and whatever the nature of the proceeding in which the cause of death comes into question. A declarant who fully expected to recover, and who only later died, may still have made a relevant dying declaration; and the statement may be used in a civil suit as much as in a criminal trial. The maker's belief about survival has not been abolished from the analysis - it survives as a factor going to how much the statement is trusted - but it has been removed as a precondition of receiving it at all.

RULE **Under Indian law the maker need not have expected to die, and the statement is not confined to a homicide trial.** The statute makes the statement a relevant fact whenever the cause of death is in question, whatever the proceeding; the settled, hopeless expectation of death is the English precondition, not ours. The declarant's belief about survival goes to weight, never to admissibility.

Not required	Any proceeding	Fit mind
EXPECTATION OF DEATH	WHERE CAUSE OF DEATH IS IN ISSUE	WHAT THE STATEMENT'S WEIGHT TURNS ON

AXIS OF COMPARISON	ENGLISH COMMON-LAW TRADITION	INDIAN STATUTORY POSITION
Expectation of death	Required: a settled, hopeless expectation when speaking	Not required; relevant to weight only
Proceedings covered	Essentially the declarant's own homicide	Any proceeding where the cause of death is in question
Use in a civil dispute	Not available	Available
Effect if the maker expected to live	Statement excluded	Statement still relevant

TRAP **Importing the English precondition into Indian law.** Candidates who learned the topic from older or foreign texts write that the declarant must have abandoned all hope of life. In India that is wrong: the expectation of death was deliberately dropped from the statutory test, and stating it as a condition of admissibility loses the mark even when the rest of the answer is sound.

21.3 Admissibility is not reliability: the requirement of a fit mind

Where the psychiatrist enters. That the statement is a relevant fact settles only that the court may receive it. What the court then does with it - how far it relies on it, whether it convicts on it alone - is a separate question of weight, and here the declarant's mental state becomes decisive. A dying declaration carries no oath and cannot be tested by cross-examination, the two ordinary safeguards of testimony, so the court leans heavily on being satisfied that the maker was **compos mentis**. Fitness in this sense has two layers, and it helps to name them separately:

- A **physical capacity to communicate** - the declarant can produce a statement at all, by speech, gesture or sign.
- A **mental capacity** to understand what is asked and to give a rational, self-consistent account of it.

It is the second that is the psychiatric question. Note precisely what it is not: it is not whether the declarant told the truth, which is for the court to decide, but whether the declarant had the **capacity** to give a reliable statement in the first place. The psychiatrist assesses the instrument, not the tune played on it.

IN INDIA

A dying declaration is most safely recorded by a judicial magistrate, but the fatally injured are usually in casualty, and in practice the recording frequently falls to the attending medical officer or the investigating police. The settled expectation is that the treating doctor certifies, ideally both before and after the statement is taken, that the patient was conscious and in a fit state of mind to make it. Where a psychiatrist is available, that certification of mental fitness is exactly the contribution asked of them. The certificate should record the examination actually done, not merely assert a conclusion, because a bare line that the patient "was conscious" is worth little when it is later challenged.

21.4 The competence assessment at the bedside

The assessment is a focused mental-state examination directed at a single question: could this person, at this moment, take in a question, understand it, retrieve the relevant memory, and express a rational answer? The domains to examine are the familiar ones, sharpened to that purpose:

- **Consciousness and the sensorium** - alert, drowsy, fluctuating or obtunded; a clouded sensorium is a leading reason a declaration's weight is later doubted.
- **Attention and comprehension** - can the patient hold attention long enough to follow a question to its end and grasp what is being asked.

- **Coherence and memory** - a connected, internally consistent narrative of the event, drawn from recall rather than confabulated across a gap.
- **Freedom from tutoring** - whether the account was prompted, led or coached by relatives or police crowding the bedside. This goes to the reliability of the recording rather than to the declarant's mental capacity, so the clinician documents what was observed at the bedside and leaves the effect of any tutoring for the court to weigh.

MNEMONIC

Is the mind CLEAR?

Consciousness unclouded; **L**evel of attention sustained; **E**xpression coherent and comprehension intact; **A**nswers rational and internally consistent; **R**ecall of the event in the patient's own words. CLEAR is a bedside prompt, not a formula: fitness remains a case-specific conclusion supported by the recorded examination.

GOOD TO REMEMBER

Document the examination contemporaneously and in the patient's own words: the exact questions put, the exact answers given, the time, and the state of the sensorium at that time. A record showing the questions posed and the rational replies received is far stronger in court than a later assertion that the patient was "conscious and oriented". If the sensorium is fluctuating, assess and certify fitness immediately before the statement is taken, because capacity present an hour earlier does not establish capacity at the moment of the declaration.

21.5 Conditions that cloud the declarant's mind

Where competence actually fails. Almost every dying declaration is taken from a patient who is, by definition, gravely injured or ill, and the same processes that threaten life threaten the sensorium. The psychiatrist should look actively for the states below rather than presume fitness from the fact that the patient is talking; fluent speech and a clear mind are not the same thing. **Delirium** in particular can coexist with apparently purposeful conversation.

THREAT TO COMPETENCE	MECHANISM	WHAT THE ASSESSMENT FOCUSES ON
Extensive burns	Shock, toxaemia and hypoxia cloud the sensorium; pain and dehydration compound it	Alertness and coherence now, not the proportion of surface burnt, which does not by itself decide fitness
Head injury	Raised intracranial pressure, contusion and post-traumatic amnesia	Consciousness, orientation, and whether the event itself can be recalled
Haemorrhage and hypoxia	Cerebral hypoperfusion and hypoxaemia impair attention and thought	Sustained attention and fluctuation over minutes
Acute intoxication	Alcohol or other substances disinhibit and disorganise; withdrawal may bring delirium	Slurring, disinhibition, and the ability to give a consistent account
Sedation and analgesia	Opioids and sedatives blunt the sensorium precisely as pain relief is given	Timing relative to the last dose and the depth of sedation
Delirium	Fluctuating attention, disorganised thinking and altered awareness	Attention, fluctuation, disorganisation and perceptual disturbance
Psychotic or demented state	Delusional content or established cognitive impairment may distort the account	Whether the narrative is reality-based and internally consistent

A recurring bedside error concerns burns. The extent of a burn is frequently taken as a proxy for mental fitness, so that a very large burn is assumed to render the patient incompetent and a smaller one is assumed to leave competence intact. Neither inference is safe. The burnt surface tells you about prognosis and physiology, not directly about the sensorium, and a coherent contemporaneous assessment of mental state is what the question actually requires.

PITFALL

Do not anchor a report or certificate to the repealed evidence statute. The dying-declaration provision now sits in the Bharatiya Sakshya Adhiniyam; the corresponding section of the Indian Evidence Act is historical and reaches a case only through the transitional savings rule. A certificate that cites the old provision as the live law reads as out of date and quietly undermines the very reliability the psychiatrist is there to support.

21.6 Weight, corroboration and the limits of the opinion

Because it is untested by cross-examination, a dying declaration is scrutinised closely for reliability before a court acts on it, and a mentally fit declarant is central to that scrutiny; the general rules of evidence, and how a court treats and corroborates such a statement, are set out where this chapter treats the psychiatrist in court and the rules of evidence. The psychiatrist's contribution stays within its lane. We opine on capacity - whether the declarant was able to perceive, remember and communicate - and not on veracity, which is the court's exclusive

province. The separation of the treating clinician's role from that of the forensic evaluator, and of opinion evidence from fact evidence, is discussed where this chapter treats the psychiatrist as expert witness; the same discipline applies here, because the doctor who both resuscitates the patient and certifies fitness is wearing two hats at once and should say clearly which one each part of the record belongs to.

> A dying declaration is relevant under the Bharatiya Sakshya Adhiniyam whether or not the maker expected to die and in any proceeding where the cause of death is in issue; its weight, however, turns on the declarant having been of fit mind, and that fitness is the psychiatric question.

22 · Court structure, the psychiatrist in court and rules of evidence

Why the marks are here. A psychiatric opinion is only as good as the forum that receives it and the rule that lets it in. A report may be clinically impeccable, but if the psychiatrist does not know which court has summoned them, or cites the provision that admits their opinion in the language of a repealed code, the credibility of the whole exercise is undercut before a word of the clinical reasoning is read. Examiners test this because it is where a well-trained clinician is most easily caught out: the medicine is sound, the legal frame is out of date. Two things must be exact - the structure of the courts a psychiatrist may testify before, and the evidentiary rule under which their opinion is admitted.

This section teaches the statutory hierarchy of the criminal courts and the **rules of evidence** that govern how an expert opinion is received, both read from the current codes. The separation of the treating role from the expert role, and the advisory weight an opinion carries once admitted, are set out elsewhere in this chapter and are named here only; the substantive test of criminal responsibility, and the burden of proving it, belong to the Mental health legislation and forensic psychiatry notes and are not re-taught here.

22.1 The statutory ladder of the criminal courts

The current code of criminal procedure sets out, at section **6**, the classes of criminal court that exist in every State, and it is before these classes that a psychiatrist may be called to testify; the powers to summon a witness or to order a psychiatric assessment come from other provisions, not from this section. The provision is framed as a mandatory one: besides the High Courts and any courts constituted under other laws, every State shall have the classes of criminal court it enumerates. The enumerated classes are the **Courts of Session**; the **Judicial Magistrates of the first class**; the Judicial Magistrates of the second class; and the **Executive Magistrates** - the first three exercising judicial trial power in descending order, while the Executive Magistrate exercises executive and public-order functions rather than the trial of offences. The word "besides" does real work: it places the High Courts outside and above this list of State classes. The Supreme Court of India, higher still, is the constitutional apex, but its position is established by the Constitution and not by this section, which does not mention it.

The distinction the section draws between the two kinds of magistrate is the one most often missed. The Judicial Magistrate exercises judicial functions - trying offences, taking evidence, convicting and sentencing within the limits of the class - and it is before a Judicial Magistrate or a Court of Session that a psychiatrist's evidence on a contested criminal question is usually led. The Executive Magistrate performs executive and public-order functions rather than the trial of offences, and a psychiatrist encounters this office in the machinery that surrounds custody and order rather than in the trial.

COURT	PLACE IN THE LADDER	WHERE THE PSYCHIATRIST MEETS IT
Supreme Court of India	Constitutional apex, above the High Courts	Rarely in person; its judgments set the law the report must follow
High Court	Sits besides and above the State classes	Appeals and references turning on a psychiatric question
Court of Session	Highest of the State trial classes	Trial of the graver offences where responsibility is in issue
Judicial Magistrate (first and second class)	The magistracy exercising judicial trial functions	Trial of lesser offences; taking of evidence and committal
Executive Magistrate	Executive and public-order functions, not trial	Order-maintenance and custodial machinery, not the trial itself

The statutory classes under the current procedure code, with the High Courts and the Supreme Court above the State list. The section fixes the classes; which class hears a given matter turns on the offence and the stage of proceedings.

MNEMONIC

Sessions sit highest, Judicial magistrates try, Executive magistrates keep order

Read the State ladder top to bottom: Court of Session, then Judicial Magistrate of the first and then second class, then the Executive Magistrate. The first three are judicial and try offences; the last is executive and keeps public order. The High Courts sit besides and above the whole list, and the Supreme Court above them.

22.2 Why the forum matters to the report

The court decides the shape of the answer. Knowing the ladder is not academic. The court issuing the summons frames the question being asked and identifies the person to whom the duty of the evidence is owed, which is the court and not the party who arranged the attendance; the standard of proof, by contrast, is fixed by the nature of the proceeding and the law that governs it, not by the court that issues the summons. The scope of the opinion is set by the question the court has framed and not by the rank of the court that framed it: a magistrate's inquiry may call for a comprehensive assessment while a Court of Session may want one narrow issue answered, and accuracy, transparency and defensibility are owed in equal measure to every court. A psychiatrist who does not register what was actually asked either over-answers a small question or under-serves a large one. The pathway by which an accused is referred for assessment is a

separate topic set out elsewhere in this chapter; what matters here is that it ordinarily proceeds before one of the courts named above, subject to any special court constituted under another law.

GOOD TO REMEMBER

Before writing a line, establish which court has called you and in what capacity. Match the report to the forum: state the court, the question as the court framed it, and the material examined. Because a treating psychiatrist's own records can be summoned as evidence of fact in any of these courts, contemporaneous and legible documentation is a medico-legal protection long before a summons ever arrives.

22.3 The rule that admits an expert opinion

The ordinary rule of evidence is that a witness may speak only to facts they personally perceived, because drawing inferences from facts is the court's own work. The expert is the deliberate exception, and the current evidence code fixes that exception at section **39**, the successor to the corresponding provision of the repealed Indian Evidence Act. The rule is precise about when it operates: it is only when the court has to form an opinion upon a point of science, art, foreign law, any other field, or the identity of handwriting or finger impressions that the opinions of persons specially skilled in that field are, in the language of the code, **relevant facts**, and the persons who give them are called **experts**. The trigger is the court's own need for specialised knowledge it does not itself possess; where no such need arises, the exception does not open and an opinion is not received.

Two features of the current section repay attention:

- its illustrations expressly include the psychiatric question, one being precisely whether a person was, by reason of unsoundness of mind, in a particular mental state, the evidentiary hook on which psychiatric testimony hangs;
- it has been modernised for the digital age, a sub-section making the **Examiner of Electronic Evidence** an expert so that opinions on electronic records are admitted on the same footing.

For the psychiatrist the first of these is load-bearing: the code does not merely tolerate psychiatric opinion, it names unsoundness of mind as a paradigm of the specialised question an expert exists to address.

RULE **Expert opinion is admitted only where the court needs specialised knowledge to form its own opinion.** When the court has to form an opinion on a point of science, art, foreign law, any other field, or the identity of handwriting or finger impressions, the opinions of persons specially skilled in that field are relevant facts, and those persons are experts. The psychiatric question of unsoundness of mind falls squarely within the field the section describes.

22.4 A relevant fact, not a verdict

Calling the opinion a relevant fact is exact, and it marks the boundary of what the evidence rule delivers. Admissibility is one question and weight is another. The expert-opinion section makes the opinion admissible, that is, something the court is entitled to consider; it does not make it binding, and it does not transfer the decision to the expert. The distinction between fact evidence

and opinion evidence, and the advisory character an admitted opinion carries, is the treating-versus-expert material developed elsewhere in this chapter and is only named here. What the evidence rule itself contributes is narrower: it opens the door through which a specialised opinion may pass, on a defined class of question, given by a person specially skilled. What the court then does with the opinion is a matter of weight, not of the rule that let it in.

TRAP **Citing the repealed evidence and procedure codes as current.** Candidates and clinicians reach for the section numbers of the old Indian Evidence Act and the old Code of Criminal Procedure, the codes they trained on, when stating the rule that admits their opinion or the court that will hear it. Those codes are historical; the expert-opinion rule and the classes of criminal court are now provisions of the current evidence code and the current procedure code. An opinion built on a repealed citation is easy to discredit, however sound the psychiatry beneath it.

22.5 The psychiatric question inside the rules of evidence

Several distinct evidentiary questions bring the psychiatrist into this framework, and it is worth separating them so that each is answered under the right rule and the right owner. They are:

- the admissibility of psychiatric opinion itself, which is the expert-opinion rule owned here, with unsoundness of mind named in the section's own illustration;
- the substantive test of criminal responsibility and the burden of proving it, which the illustration points toward but does not decide, and which belong to the Mental health legislation and forensic psychiatry notes;
- the assessment of a declarant's competence when a dying declaration is offered in evidence, a distinct evidence rule set out elsewhere in this chapter;
- the procedure for referring and assessing an accused, whose pathway is likewise carried elsewhere in this chapter.

Keeping these apart is the discipline the topic rewards. The evidence rule tells you that a psychiatric opinion on unsoundness of mind is receivable; it does not tell you what the test of unsoundness is, nor who must prove it, nor how heavy that burden sits. Those belong to the doctrine of criminal responsibility, and answering them here would blur the very line the evidence rule draws. The section admits the opinion; the doctrine, taught in the Mental health legislation and forensic psychiatry notes, decides what the opinion must establish.

IN INDIA

Both provisions a psychiatrist relies on in a criminal court are now Indian statutes of recent vintage: the classes of criminal court are fixed by the current procedure code, which replaced a post-independence Code of Criminal Procedure, and the admissibility of expert opinion by the current evidence code, which replaced the colonial-era Indian Evidence Act. The Indian evaluator testifies within this specific statutory ladder and under this specific evidentiary rule, not a generic or textbook-Western frame, and the report should name whichever code actually governs the proceeding rather than reaching by habit for the Act it replaced.

22.6 Currency: testifying after the codes changed

The evidence code and the procedure code that carry these two rules are themselves the products of the recent replacement of the three colonial criminal codes, when the old penal, procedure and evidence Acts gave way to their current successors. The rule that decides which code governs a particular matter - the savings rule that turns, for procedure and evidence, on whether the proceeding was already pending at the changeover - is set out elsewhere in this chapter and is not re-derived here. What the psychiatrist must carry from it is practical: a matter that straddles the transition may be tried under the current procedure and evidence codes even where the offence and its defence are judged by the older penal law, so a report should cite whichever codes actually govern and never assume the newest code applies automatically.

Under the current evidence code, its expert-opinion rule makes the opinion of a specially skilled person a relevant fact whenever the court needs specialised knowledge, and unsoundness of mind is named in its illustrations; the current procedure code, through its classes-of-court provision, fixes the classes of criminal court a psychiatrist testifies before.

6	39
PROCEDURE-CODE SECTION FIXING THE CLASSES OF CRIMINAL COURT	EVIDENCE-CODE SECTION ADMITTING EXPERT OPINION

PITFALL

The recurring real-world error is a currency error, not a clinical one: a psychiatrist swears to or writes a report that grounds the admissibility of the opinion, or names the court, in a section of the Indian Evidence Act or the Code of Criminal Procedure. Those Acts have been replaced. The correct citations are the expert-opinion provision of the current evidence code and the classes-of-court provision of the current procedure code, and using the repealed numbers hands the other side an easy line of attack on an otherwise sound opinion.

23 · Legal aspects of seclusion, restraint and involuntary treatment

Why the marks sit here. Coercion is the point at which psychiatry is most likely to injure the very person it sets out to help, and it is therefore the point at which the law watches most closely. When a patient is shut in a room alone, held down, sedated to control behaviour, or treated over refusal, the ordinary architecture of clinical practice - liberty as the default and treatment by consent - has been suspended. The examiner's interest is not in whether these things ever happen, because they do, but in whether the candidate can say exactly what makes each of them lawful rather than an assault or a wrongful detention. This topic is the legal frame around the three coercive interventions: what the law permits, on what conditions, and with what safeguards attached. The moral reasoning behind that frame, and the rights lens that applies in prisons and custody, are developed elsewhere in this chapter; here the task is the legal skeleton.

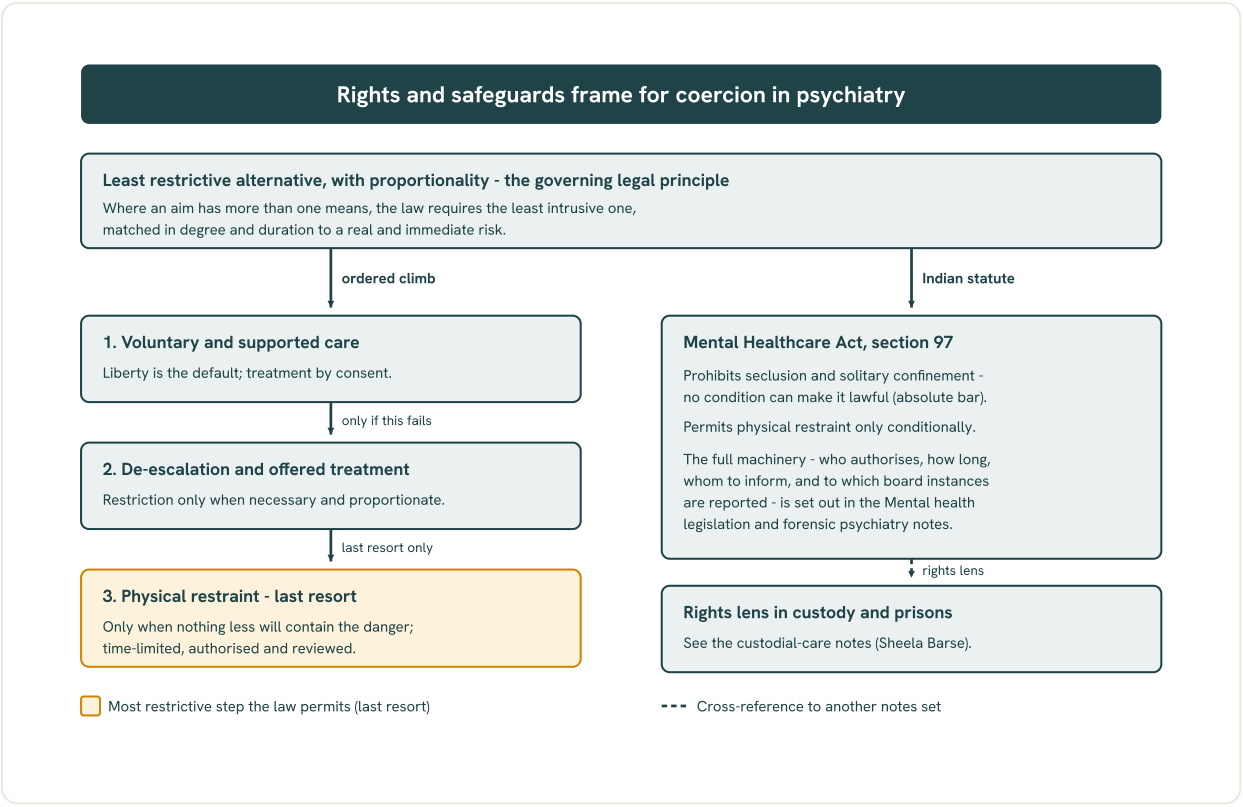

Fig 26.9. The rights-and-safeguards frame for coercion: the least restrictive alternative forces an ordered climb from voluntary care to time-limited, reviewed physical restraint, while Mental Healthcare Act section 97 bars seclusion and solitary confinement outright and permits restraint only conditionally.

23.1 The three coercive interventions and why the law singles them out

Three distinct interventions are gathered under this heading, and the first discipline is to keep them apart, because they carry different legal answers. **Seclusion** is the confinement of a person alone in a room or space they cannot freely leave; its extreme form, **solitary confinement**, isolates the person from all meaningful human contact. **Physical restraint** is the use of manual force or a mechanical device to restrict free movement. A third and quieter category is **chemical restraint**, the administration of medication whose purpose is to control behaviour or movement rather than to treat the underlying condition. Distinct again is **involuntary treatment**, the delivery of a medical intervention to a person who has not consented, or who has refused.

What unites them is that each is an exception to a legal default. The default is that an adult of sound understanding may not be confined, touched, or medicated without agreement; departing from that default requires positive legal authority, and the law grants that authority narrowly and conditionally. This is why coercion is examined as law and not merely as good practice: a restraint that is clinically understandable but legally unauthorised is still a battery, and a confinement that felt safe on the ward is still a false imprisonment if the conditions the statute demands were not met.

23.2 The least restrictive alternative as the governing legal principle

The single organising idea across the whole of coercive care is the **least-restrictive alternative**. It holds that where an aim can be achieved by more than one means, the law requires the means that intrudes least on the person's liberty, dignity and bodily integrity. It is not a counsel of perfection but a legal test with teeth: it makes the more restrictive option unlawful whenever a

less restrictive one would have worked. In practice it forces an ordered climb - environmental change, de-escalation and verbal engagement, offered medication, then, only if these genuinely fail, physical measures - and it treats each higher rung as justifiable only by the failure or inadequacy of the ones below it.

Its companion is **proportionality**: the degree and duration of any coercion must be matched to the seriousness and immediacy of the risk it answers, and no more. Proportionality is what stops the least restrictive option from being applied too hard or too long. Together they convert a vague clinical instinct into something a court can review after the fact: not "was the ward safer" but "was this the least intrusive step that would have contained the specific danger, and was it kept to the shortest span that danger required."

RULE **Coercion is lawful only as the least restrictive, proportionate means, and each form answers to its own threshold: physical restraint to a real and immediate risk, involuntary treatment to the conditions of the statutory pathway relied on.** Every coercive act must be justified twice over: that a less intrusive alternative was tried or genuinely unavailable, and that the intensity and duration were no greater than the danger demanded. A step that skips the ladder, or outlasts the risk, forfeits its lawfulness even if it was well intentioned.

Least	Nil	Exception
RESTRICTIVE ALTERNATIVE IS THE LEGAL DEFAULT	LAWFUL SECLUSION OR SOLITARY CONFINEMENT	INVOLUNTARY CARE DISPLACES CONSENT, NEVER RIGHTS

23.3 The rights and safeguards frame

The law does not simply permit coercion and walk away; it wraps every permitted instance in procedural safeguards whose function is to keep the intervention honest. These safeguards recur, in one form or another, across every jurisdiction and every code, and a candidate who can recite the frame can reconstruct almost any specific provision from first principles. The core safeguards are:

- **Necessity** - a lawful ground exists only on the test the governing provision itself sets: for physical restraint, that coercion is the sole realistic way to prevent serious, imminent harm; for involuntary treatment, the necessity written into the pathway relied on.
- **Proper authorisation** - the decision rests with a defined clinician, not with whoever is nearest or most senior on the floor.
- **Time-limitation** - the measure lasts no longer than the risk that justified it, with active review built in rather than a fixed licence.
- **Documentation** - the reasons, the alternatives tried, and the timing are recorded contemporaneously, because an unrecorded safeguard is indistinguishable from an absent one.
- **Notification** - the person's representative is told, so that coercion is never invisible to those outside the treating team.
- **External oversight** - instances are reported to an independent review body, moving accountability beyond the establishment that imposed the measure.

Reading down that list, the interventions sort themselves onto a continuum from tolerable-under-conditions to never-permitted, and the same axes explain why.

INTERVENTION	LEGAL STATUS	GOVERNING SAFEGUARD
Seclusion / solitary confinement	Prohibited outright	No condition can make it lawful
Physical restraint	Conditionally permitted	Necessity, authorisation, strict time-limit
Chemical restraint	A clinical description; its statutory position is not settled by the grounded text of the restraints and seclusion provision	The consent and involuntary-treatment rules governing the medication itself
Involuntary medication or treatment	Only under statutory authority	Applicable statutory pathway and decision-specific capacity; Board review where prescribed

IN INDIA

The Indian embodiment of this frame is the Mental Healthcare Act, whose restraints-and-seclusion provision is section **97**: it prohibits seclusion and solitary confinement absolutely, and permits physical restraint only conditionally. The full machinery of that section - who authorises, for how long, whom to inform, and to which body instances are reported - together with the Act's definitions, capacity provisions, advance directive, admission pathways and review boards, is set out in the Mental health legislation and forensic psychiatry notes and is named here rather than restated. The point to carry is structural: Indian statute encodes the continuum above, drawing the hard line at seclusion and hedging restraint with cumulative conditions.

23.4 Involuntary treatment as an exception to consent

Involuntary treatment raises a different legal question from restraint, because it engages the doctrine of consent directly. The starting position is that valid treatment requires the patient's informed agreement; the elements of that agreement - capacity, adequate disclosure, and voluntariness - are set out in this chapter's account of consent in psychiatry and are not re-derived here. Treatment without consent is lawful only where a specific legal authority displaces the ordinary requirement, and that authority depends on the applicable statutory pathway and on the patient's decision-making capacity, not on the diagnosis or the setting alone.

Two errors follow from losing sight of this. The first is to treat a mental illness as if it were itself the authority to override refusal; it is not, because many patients with serious illness retain capacity for the particular decision in front of them. The second is to assume that a lawful involuntary admission is a blanket warrant for any and all treatment. Admission answers the question of where the person may be kept; it does not by itself answer whether a given intervention may be imposed over refusal, which is a separate determination with its own conditions. The capacity standard, the advance directive that may speak for the patient's earlier wishes, and the admission categories themselves belong to the Mental health legislation and

forensic psychiatry notes; the legal principle to hold here is that involuntary treatment is a conditional exception and never a default that admission switches on.

PITFALL

The common clinical error is to read an involuntary admission as consent to everything that follows, and to medicate over refusal without a fresh, decision-specific capacity assessment. Admission and treatment authority are distinct legal questions; conflating them exposes the clinician to a claim of treatment without lawful authority even where the detention itself was sound.

23.5 Chemical restraint and the discriminations candidates miss

Chemical restraint is the category that most often escapes the frame, precisely because it looks like ordinary prescribing. A dose of a sedative can be a legitimate treatment of an underlying illness or a device to subdue difficult behaviour; the same drug, the same route, and only the purpose distinguishes them. Ethically the purpose matters more than the pharmacology: medication given to control behaviour rather than to treat is coercion in substance, and the safeguards that keep restraint honest - necessity, authorisation, time-limitation, documentation and review - are the right discipline to hold it to. Its legal authority is a separate question, because the statute's restraints-and-seclusion provision is written for physical restraint; medication over refusal has to be justified under the consent, capacity and involuntary-treatment rules that govern giving the drug at all. Calling it a "PRN" or writing it up as routine does not remove it from either frame.

The discriminations worth rehearsing are therefore three. Restraint answers an immediate danger, whereas treatment answers an illness over time. Restraint is measured against the least restrictive alternative and must climb the ladder of de-escalation first, whereas ordinary treatment is measured against consent and clinical indication. And restraint is time-limited by the risk, whereas a treatment course is governed by the condition. Blur these and a control measure is dressed up as care, which is both a legal exposure and, on the wards, a route to overuse.

TRAP **Treating sedation-for-behaviour as though it were outside the restraint safeguards.** Candidates and clinicians alike assume that because a drug is a treatment in other contexts, giving it here is treatment too. Purpose is what makes the label chemical restraint apt, and it is what the ethical safeguards attach to; the legal authority for giving the drug still has to be found in the consent, capacity and involuntary-treatment rules, however the dose is documented.

23.6 Documentation, oversight and liability

The safeguards frame is only as real as the record that proves it was followed, which is why documentation is the practical hinge of this whole topic. When a coercive act is later questioned - by a review body, a representative, or a court - the contemporaneous note of what danger was faced, what less restrictive steps were tried, who authorised the measure, and when it ended is the evidence that separates a lawful intervention from an actionable one. A coercive act that was in fact necessary and proportionate but was never recorded is, for the purposes of any later scrutiny, an act without a justification.

Liability flows along familiar channels. Coercion applied without a lawful ground can found a claim in the ordinary law of professional negligence, the standard-of-care analysis for which is developed in this chapter's treatment of professional negligence and is not restated here; coercion that is disproportionate or prolonged can breach the person's rights independently of any question of clinical skill. The rights lens that applies with particular force in prisons and custodial settings is taken up separately in this chapter. The through-line is that oversight is not an administrative afterthought but the mechanism by which the least restrictive principle is enforced after the event, when the clinical urgency that prompted the act has passed and only the record remains.

GOOD TO REMEMBER

Before any restraint, and while it is in force, write the ladder down: the danger, the less restrictive steps attempted, the authorising clinician, and the intended and actual end-point. This single habit satisfies the safeguards frame, shortens the intervention by keeping its end in view, and is the strongest protection against a later claim that coercion was imposed without lawful justification.

Every coercive intervention in psychiatry is lawful only as the least restrictive, proportionate, authorised and reviewable response to a genuine necessity; physical restraint answers a real and immediate risk while involuntary treatment runs through its own statutory conditions, and seclusion and solitary confinement have no lawful place at all.

Cross-cutting synthesis

24 · Cross-cutting synthesis

Every topic in this chapter is one question asked over and over. A patient says something in a consulting room. What happens to that sentence next - whether it is guarded, revealed to protect someone, spoken aloud in a witness box, or written into a record an inspector may later read - is not decided by the sentence. It is decided by who the psychiatrist is at that moment, and by what makes the telling lawful. Learn each of this chapter's topics on its own and you have a shelf of separate rules. See that they answer a single recurring question and you have the chapter, because the ethics, the consent, the confidentiality, the liability and the forensic role are not neighbours on a syllabus; they **interlock**, and the joint that holds them together is disclosure governed by role.

The marks for this synthesis are earned in the transitions, not in any one rule. An examiner who wants to separate a candidate who has memorised from a candidate who has understood gives a vignette that crosses roles: the treating doctor who is later summoned to court, the consent that turns out to be a capacity problem, the confidence that collides with a threat to a third person, the complaint that becomes a consumer matter, the accused a magistrate has ordered assessed. In every one of these, the facts do not change; the psychiatrist's relationship to them does, and with it the answer. This account owns that shared logic only. It names each rule in a clause and sends

you to the topic that teaches it in full; if it starts restating a section or a test, it has wandered into a sibling's territory.

Patient	Third party	Court	Regulator
CONFIDENTIAL BY DEFAULT, THE CLINICIAN'S OWN DUTY	A PROPORTIONATE DISCLOSURE THAT IS PERMITTED, NOT COMMANDED	A DISCLOSURE THE COURT'S OWN PROCESS CAN COMPEL	A RECORD REACHABLE ONLY UNDER A LAWFUL ORDER OR AN EXPRESS STATUTORY POWER

24.1 The two roles that decide everything

The organising fact of forensic ethics is that a psychiatrist can stand in one of two fundamentally different relationships to the same person, and the primary allegiance and much of what is owed change between them. In the first, the **treating clinician** owes their duties to the patient: to act for that person's welfare, to hold their confidences, to obtain their consent, to keep faithful records of their care. In the second, the **forensic evaluator** owes their primary duty not to the person in the chair but to the court that has asked for an opinion: to be objective, to serve the process of justice, to tell the tribunal what the clinical findings are even when they do not help the person being examined. This **dual role** is the spine of the whole chapter, and almost every discrimination the examination tests is a consequence of it.

The two roles pull in opposite directions on the one thing both handle, which is information. The treating role's instinct is to protect and withhold; the forensic role's obligation is to examine and report. That is why the same clinical detail is not one fact with one rule but a single fact whose governance shifts as the psychiatrist's relationship to the person shifts. The chapter's individual topics each sit on one side of this divide or describe a crossing between the sides, and the account of the expert witness elsewhere in this chapter, which separates the treating role from the expert role, is the place where the divide is drawn most sharply.

RULE **Ask the role before you answer the question.** No rule in this chapter can be applied until you have fixed which relationship the psychiatrist stands in. The role sets the duty, the duty sets what may be disclosed, and the same information carries a different answer depending on which of the two hats the psychiatrist is wearing when the question arrives.

24.2 One fact, several governances

Take a single piece of clinical information and watch how differently the law treats it as the setting changes. In the consulting room it is confidential, and the default duty not to reveal it is the clinician's own, owed to the patient. If that same information reveals a serious and specific danger to an identifiable other, it becomes something the clinician is permitted to reveal to avert the harm, a permitted **disclosure** that the Indian position allows without ever commanding; the full working of confidentiality and its recognised exceptions is taught in this chapter's account of confidentiality and its limits. Put the same clinician in a witness box under an order of the court, and the information can be compelled from them, because the authority over the telling has passed to the court's own process; being compelled makes them a witness, and the expert's duty to the tribunal arises only where that role has been separately defined. Written into the clinical file, that information becomes a record whose standards of keeping, and whose openness to

inspection by a regulator or a court, are the subject of this chapter's account of medical records and certification.

Nothing about the information itself changed across those four settings; the authority governing it did. This is the single most useful table to carry into the examination, because it turns a set of separate topics into one grid, and a vignette into a question of which column applies.

SETTING	WHO THE PSYCHIATRIST IS	WHAT GOVERNS THE INFORMATION	ON WHOSE AUTHORITY IT MAY BE DISCLOSED
THE CONSULTING ROOM	Treating clinician	The default duty of confidentiality	No one: it is kept, unless a recognised ground arises
A THREAT TO AN IDENTIFIABLE OTHER	Treating clinician exercising judgement	A permission to make a proportionate protective disclosure	The clinician's own bounded discretion, not a command
THE WITNESS BOX	Expert or compellable witness	The rules of evidence and the court's order	The court, which can compel the telling
THE CLINICAL RECORD	Record-keeper and certifier	Documentation and certification standards	The patient's consent, a lawful order, or an express statutory power of inspection
ANY OF THE ABOVE	Either role	Valid consent, where it can be and has been obtained	The patient, whose consent makes an otherwise closed disclosure lawful

24.3 Consent is the hinge, and capacity is the question under it

Running underneath the whole grid is **consent**, because a valid consent is the cleanest authority of all: within the scope of what the patient has actually authorised it can make lawful a disclosure that would otherwise be a breach, and it is the ground on which the treating relationship is built in the first place. This chapter teaches consent in full in its account of informed consent in psychiatry, with its elements and its special situations. The synthesis point is narrower and sharper: consent is not a signature, it is a state of the patient, and the moment you probe it you may find yourself asking a different question altogether.

That different question is **capacity**. A consent form is only as good as the decision-making ability of the person who signed it, so a consent question in a patient whose illness clouds judgement quietly becomes a capacity question, and a capacity finding is what determines whether the treating role can proceed on the patient's own authority or must fall back on the substituted machinery. The capacity determination itself, and the statutory scheme of advance directives, nominated representatives and admission that surrounds it, belong to the Mental health legislation and forensic psychiatry notes and are named here, not reworked. The seam to hold is the slide: an autonomy question about what the patient wants becomes a capacity question about whether they can decide, and only after that is answered does the disclosure or the treatment have a lawful footing.

GOOD TO REMEMBER

When a consent feels shaky, stop treating it as a consent problem and test it as a capacity problem. The two are asked in the same breath but answered by different tools, and the whole lawfulness of what follows - the treatment, the admission, the release of information to a family member - rests on getting that second question right rather than accepting the first answer at face value.

24.4 The handoffs a real case crosses

A single patient can walk the psychiatrist through most of this chapter. Real forensic difficulty comes not from any one rule but from the crossings between them, when a case moves from one role or forum to the next and the governing rule changes at the boundary. The recurring handoffs are these.

- **Treating clinician is summoned as a witness.** The doctor who has cared for a patient is called to speak about them in court. A summons does not by itself turn the treating clinician into the forensic expert: they ordinarily give evidence of fact and of the treatment they provided, and a separate expert role must be defined explicitly rather than assumed at the courtroom door. Keeping the two roles distinct is the discipline taught in this chapter's account of the expert witness.
- **A consent becomes a capacity question.** The autonomy the treating role respects turns out to depend on a decision-making ability the illness has compromised, and the answer moves from what the patient wants to whether they can decide, as above.
- **A confidentiality duty meets a duty to a third party.** The promise to the patient collides with the safety of an identifiable other, and the clinician must decide whether a permitted protective disclosure is warranted and how far it may go, a decision governed by proportionality and taught in this chapter's account of confidentiality.
- **A negligence claim becomes a consumer matter.** A grievance about care crosses from the language of professional negligence into a specific statutory forum with its own remedy, so the same allegation is litigated in a different place under a different frame; the standard of care and the forum are taught in this chapter's accounts of negligence and of the consumer-protection route.
- **An accused becomes a psychiatric subject by order.** A person facing trial is sent for assessment not by their own consent but by a court's direction, which converts a clinical encounter into a court-authorised examination whose procedural pathway this chapter teaches, while the substantive test of criminal responsibility belongs to the Mental health legislation and forensic psychiatry notes.

Notice that every handoff is a change in the authority over information or over the person: a duty owed to one party is joined, and to that extent limited, by a duty owed to another. That is why disclosure, and not any single doctrine, is the thread the chapter is strung on.

24.5 The forum, the code and the currency behind every answer

Two further layers sit behind the grid and quietly decide answers. The first is the forum: the place a dispute is heard shapes the remedy available, so a claim about deficient care is one thing framed as professional negligence and another routed into the consumer-protection forum, and an opinion is received under one set of rules in a courtroom that this chapter's account of the court and the rules of evidence sets out. The second is currency, and it is the trap that most often turns a correct-sounding answer wrong. The rules cited must be the ones actually in force. The professional-conduct code that governs a psychiatrist's ethics, taught in this chapter's account of the codes, is the operative one and not the later edition that was notified but held in abeyance. The substantive criminal law changed, and the framework and its savings rule are taught in this chapter's account of the penal-code transition; naming the superseded statutes as current is a currency error, not a substantive one, and it is caught all the same.

These two layers are why the synthesis is more than a tidy diagram. A candidate can identify the right role, the right duty and the right disclosure and still lose the mark by citing the wrong forum for the remedy or the wrong edition of the code for the duty. The frame tells you what the answer is about; the forum and the currency tell you whether the answer you have written is still the law.

IN INDIA

The Indian shape of this chapter is specific and examinable. Protective disclosure is a permission and not the positive duty of the American case law. The professional-conduct code in force is the earlier statutory edition, the later one being notified but not operative. Deficient medical service reaches a defined consumer forum. The criminal statutes have been recast, and the savings rule decides which version governs: the older penal law still governs offences committed before the change, while proceedings already pending at the change continue under the old procedure and evidence law. The child-protection and juvenile framework, and the general mental-health machinery, sit in the Child psychiatry: assessment, treatment, services and protection notes and the Mental health legislation and forensic psychiatry notes respectively; this chapter points to them rather than restating them.

PITFALL

The commonest real-world slip is not a wrong rule but a blurred role. A treating psychiatrist, asked casually by a lawyer or a relative, writes a forensic-sounding opinion about fitness or responsibility into a discharge summary, without a court's referral or any other properly defined retaining authority, and without flagging that they are no longer speaking as the treating doctor. The opinion then carries the weight of an expert's while resting on none of an expert's safeguards, and the confidences of treatment leak into a quasi-legal document. Fix the role in writing before you offer the opinion, or decline until the proper role and authority are in place.

24.6 How it interlocks: the master frame

Assemble the pieces and the chapter resolves into a single decision procedure that fits every vignette it can throw at you. Fix the role. Identify the information at stake. Ask what may be told,

to whom, and on whose authority. Check that the code, the statute and the forum you are relying on are the ones currently in force. Where a rule belongs to a sibling topic, apply it by name and reason from it rather than restating it. The reason this works is that the whole chapter was built on one seam: the psychiatrist's two roles and the single question of disclosure they govern between them.

MNEMONIC

Two hats, three questions

The master frame for any forensic-ethics vignette. First the **two hats**: is the psychiatrist the treating clinician, who owes duties to the patient, or the forensic evaluator, who owes candour to the court? Then, of the information in play, the **three questions**: **What** may be told, **to Whom**, and on **Whose authority** - the patient's consent, the clinician's bounded discretion, a court's order, or a regulator's power. Fix the hat, run the three questions, and every rule in this chapter falls into its place.

Fix the role first: it decides the duty, the duty decides what may be disclosed, and the same fact carries a different lawful answer under each hat.

TRAP **Answering a role-crossing vignette with a single rule.** Candidates read the clinical detail, reach for the one doctrine it looks like - confidentiality, or consent, or negligence - and answer as though the setting were fixed. The examiner wrote the vignette precisely because the setting moves, and the mark is for tracking the information across the crossing: what was confidential becomes compellable, what looked like consent was a capacity question, what began as negligence is heard as a consumer complaint. Name the role at each stage and the moving answer becomes visible; assume one role throughout and you answer only the first frame.

Apply and consolidate

25 · Applying the chapter

Why worked vignettes earn their marks. The examiner rarely asks you to recite a rule; they hand you a short case in which two rules pull in opposite directions and watch how you reason to a defensible answer. A vignette is therefore a test of judgement under a stated constraint, not of recall, and the candidate who has only memorised isolated provisions freezes precisely where the marks are. The cases below are deliberately built at the seams this chapter has been teaching, so that each one forces the same first move: work out which role the psychiatrist is in, then work out on whose authority anything may be done or disclosed. Everything else follows from those two questions.

These vignettes assert no new rule of their own. Each reuses only what the chapter has already established and cross-refers, by name, to the material owned elsewhere. Read each one as a rehearsal: cover the answer, decide what you would do and why, then check your reasoning

against the model. Between them the four cases span the four families of question this chapter can throw at you, and the closing case draws them back into a single frame.

25.1 How to read a medico-legal vignette

Before the individual cases, fix the method, because the same skeleton unlocks every vignette in this territory. The first and decisive move is to name the psychiatrist's **dual role**: are you the treating clinician, who owes duties of care, confidence and consent to the patient in front of you, or the forensic evaluator, who owes an impartial opinion to a court and owes the person examined no therapeutic loyalty? Almost every trap in this domain is baited by a scenario that quietly switches your role halfway through, or asks you to act in one role using the duties of the other.

With the role fixed, the rest of the reasoning is a short, ordered checklist you can run on any case:

- What exactly is the decision point, and who is asking for the decision - the patient, the family, an employer, a court?
- Which duty is in tension with which, and is one of them a default that may yield rather than an absolute?
- What is the governing authority - the patient's own valid consent, a statutory permission, or a court order - and is that authority actually present here?
- What is the least intrusive action that discharges the duty, and how will you record the reasoning so a later reviewer can follow it?

MNEMONIC

The four C's - Consent, Confidentiality, Conduct, Court

Every question this chapter can set falls into one of four families, and the four C's name them in the order the chapter taught them: **C**onsent and capacity; **C**onfidentiality and its limits; professional **C**onduct, negligence and boundaries; and the **C**ourt, where the psychiatrist becomes an expert and an accused is assessed. Under all four sits the one recurring question - what may be disclosed, to whom, and on whose authority. Place the case in its C, answer that question, and the vignette resolves.

RULE **Name your role before you answer.** Whether you are the treating clinician or the forensic evaluator determines every duty that follows, so it is the first line of any good answer, not an afterthought. A candidate who states the role explicitly has already earned marks and has protected themselves from the commonest way these vignettes are lost, which is answering in the wrong hat.

25.2 Vignette: consent and capacity in a special situation

A man in his thirties is brought to the emergency department by his family after a deliberate act of self-harm. He is now medically stable. He is drowsy, his attention drifts, and he is refusing admission and any further care, saying he wants to leave. The family are divided: some insist he

be kept, one pleads that he be allowed home. The decision point is sharp - may he be allowed to refuse, and if not, on whose authority is he held?

The reasoning a candidate must show turns on **capacity**, and the key insight is that capacity is decision-specific and time-specific, not a fixed property of the person. The task is to assess, at this moment and for this decision, whether he meets the statutory test of decision-making capacity, a test set out in the mental health legislation and taught in the Mental health legislation and forensic psychiatry notes, applied here rather than restated. A fluctuating sensorium immediately after an overdose is a classic special situation, but clouded consciousness does not by itself settle the question: the legislation starts from a presumption of capacity, so the refusal stands unless an immediate, documented assessment against that statutory test shows the required abilities are absent, and the correct response is not to override him permanently but to treat what is immediately necessary, protect him from foreseeable harm, and reassess capacity when he is lucid. The second thread is **voluntariness**: a decision squeezed by family pressure in either direction is not fully free, and that too must be weighed. Where capacity is genuinely absent and the risk is high, the lawful route is the involuntary pathway set out in the mental health legislation, not an open-ended clinical override; the machinery of admission, the capacity provisions and the safeguards belong to the Mental health legislation and forensic psychiatry notes and are applied, not reinvented, here.

The answer, then, is layered: give emergency treatment to the extent necessary to prevent serious harm; do not accept a refusal made without capacity as though it were valid; reassess capacity as the clinical picture clears and honour a capacitous refusal if one emerges; and, if involuntary care is needed, use the statutory pathway and its safeguards rather than force alone. One further point earns marks and protects the patient: the man and his nominated representative have a right to information they can actually understand about the nature of the illness and what the treatment involves, a right set out in the mental health legislation and owned by the Mental health legislation and forensic psychiatry notes; the explanation is pitched in plain terms he can take in - his risk, his current confusion and what the treatment is for - rather than left as unexplained clinical jargon.

25.3 Vignette: confidentiality and the duty to warn

A patient in ongoing treatment discloses persistent, detailed thoughts of seriously harming a named colleague, describing a specific and plausible plan. The colleague is identifiable. The decision point is one candidates reliably mishandle: must the psychiatrist warn the colleague, may they, or must they say nothing?

The reasoning must begin from the default, which is that **confidentiality** is owed, and then locate the edge at which it yields. The chapter's teaching on the **limits of confidentiality** is that what the law permits is the disclosure necessary to protect another person from harm, and even then it must be proportionate and minimal - enough to avert the harm, no more; the seriousness and specificity of the threat guide how far a proportionate disclosure may reasonably go. The distinctively Indian move, and the one the examiner is testing, is that this is a permission, not an American-style blanket mandate to warn: the mental health legislation permits a proportionate

disclosure in the interest of protecting a third party rather than imposing an automatic positive duty, and the exact statutory permission sits in the Mental health legislation and forensic psychiatry notes. Before breaching anything, the candidate should show they considered the alternatives that avert the danger without disclosure at all - intensifying treatment, or arranging admission so the risk is contained clinically.

The defensible answer is graded rather than reflexive: assess the seriousness and specificity of the threat; reduce the risk within the therapeutic frame where you can, and where disclosure is necessary to protect the person threatened from harm, make the narrowest disclosure that will do it, to those who can act on it, without delaying a protective disclosure the danger has already made necessary; and document the reasoning at every step, because the justification for the breach is itself examinable and later reviewable. Taking no reasonable protective step in the face of a credible, specific threat may expose the clinician to criticism, though the Indian position frames this as a permission to disclose rather than a positive command to warn; warning reflexively at the first hostile thought needlessly destroys the alliance and exceeds the permission.

GOOD TO REMEMBER

When you decide a disclosure is justified, disclose to the person who can actually reduce the risk and tell them only what they need to act - not the case history. Proportionality is measured by what averts the harm, and a breach wider than that is itself a fresh wrong, however good the original reason.

25.4 Vignette: professional conduct, negligence and boundaries

A psychiatrist volunteers at a free mental health camp and gives advice to an attendee who, months later, alleges she was harmed by that advice. Separately, over the same period, the psychiatrist has accepted a personal gift from a regular patient, begun exchanging friendly messages outside sessions, and drifted into a relationship that is no longer purely clinical. Two decision points sit in one vignette: is a free service beyond the reach of a consumer complaint, and has the psychiatrist crossed a professional line?

On the first, the reasoning must resist a tempting shortcut. Whether the encounter grounds a claim in **negligence** turns on whether a duty of care arose, whether the conduct fell below the standard expected of a reasonable practitioner, and whether that shortfall actually caused the harm alleged. Whether the consumer-protection forum is even available turns on how the service was charged for: a service given free to every attendee falls outside it, whereas free treatment given at an establishment that charges the patients who can afford to pay is within its reach - so the shortcut that a service given without a fee is always outside, and the opposite assumption that it is always inside, are both wrong, and an ordinary negligence action may lie regardless; the reach of that forum is taught with its own case law elsewhere in this chapter. On the second, the issue is a **boundary violation**, and whether these facts have already become one: gifts, out-of-session contact and dual roles mark the slow slide from a therapeutic relationship into a personal one, and how far along that slide a case has travelled is judged against the test taught in this chapter's account of boundaries, applied here rather than assumed. The reasoning to show is that

boundaries are protective of the patient, not merely proprieties, and that the earliest crossings are the ones to name.

TRAP **Treating the four-D mnemonic as the legal test of negligence.** The familiar teaching list - duty, dereliction of that duty, damage, and direct causation - is a memory aid, not the courts' formulation. The Supreme Court's own statement is tighter: it asks for a duty, a breach of that duty, and resulting damage, with causation embedded in the last, and it holds that criminal negligence needs more still - gross negligence coupled with a guilty mind. Reciting the D's as though they were the ratio, or blurring civil and criminal thresholds, loses the mark.

PITFALL

The recurring real-world error in conduct cases is citing the wrong professional code. The operative code a disciplinary body actually applies is the long-standing Medical Council of India professional-conduct regulations; the successor National Medical Commission practitioner-conduct regulations, though formally notified, were held in abeyance and are not in force. Answering, or worse advising, from the newer notified rules treats notification as though it were commencement, and it is confidently wrong.

25.5 Vignette: the forensic role, the expert and the accused

A psychiatrist has been treating a patient for some months. The patient is now charged with an offence, and the family asks the treating psychiatrist to appear in court and give an opinion on the patient's mental state at the time of the alleged act. The decision point is whether the treating clinician can, or should, also serve as the forensic evaluator in the same case.

The reasoning must foreground the dual-role conflict this whole chapter has been building toward. As the treating clinician the psychiatrist is an advocate for the patient's clinical welfare, bound by the alliance and by confidentiality; as an **expert witness** the same psychiatrist would owe an impartial opinion to the court, must set therapeutic loyalty aside, and gives opinion evidence that is distinct from the fact evidence a witness ordinarily offers. Holding both roles compromises each: the court cannot fully trust an opinion coloured by therapeutic allegiance, and the patient's trust is betrayed if their doctor becomes the instrument of their examination. Best practice is to separate the roles, so that an independent evaluator conducts the forensic assessment. The question the family poses - the patient's mental state at the time of the alleged act - is one of criminal responsibility, whose insanity-defence test and burden of proof are owned by and cross-referred to the Mental health legislation and forensic psychiatry notes, named, not restated, here. It is distinct from fitness to stand trial, which turns on the accused's present capacity to defend; the court-referral procedure for assessing an accused is taught in this chapter, and it is engaged by that present-capacity question alone, never by the question of the mental state at the time of the act. The rules of evidence that govern how the opinion is received are the court's, and the substantive criminal law now runs on the recodified penal, procedure and evidence statutes, with a savings rule deciding which regime applies to a given case - taught in full within this chapter's statute material.

The answer is to decline the conflated role, or at least to make the conflict explicit and let the court decide, and in any event to confine any opinion given to what is within competence and to disclose its limits. A treating psychiatrist dragged into the witness box against their own patient is the sharpest instance of the two hats colliding, and naming the conflict is itself the mark-worthy move.

IN INDIA

The forensic vignette is answered from Indian primary sources, and their currency is itself examinable. The older penal, procedural and evidence codes have been superseded by their successors, so an answer that names the historical statutes as current law is wrong; the offence date governs which penal code applies, while pendency at the point of transition governs procedure and evidence. Where a child is the survivor or the accused, the child-sexual-offences and juvenile-justice framework is not this chapter's to apply - it belongs to the Child psychiatry: assessment, treatment, services and protection notes.

25.6 The common thread across the four cases

One skeleton, four skins. Set side by side, the four vignettes are the same reasoning wearing different clothes. Each opens by fixing the role, each turns on a duty that is a default rather than an absolute, each is decided by locating the governing authority, and each is lost in the same way - by importing a foreign rule, a stale statute or the wrong hat. The table below lays the four domains on shared axes so the pattern is visible at a glance.

DOMAIN	THE DECISION POINT	THE GOVERNING FRAME	THE CLASSIC TRAP
Consent and capacity	May this refusal or agreement stand?	Capacity, voluntariness, and the statutory pathway when capacity is absent	Treating a clouded refusal as valid, or overriding without the lawful route
Confidentiality	May I, or must I, disclose?	A default of confidence, with a proportionate permission at its edge	Importing a foreign mandatory duty to warn instead of a permitted disclosure
Conduct and negligence	Did the conduct fall below what was owed?	Duty, breach and resulting damage; the current professional-conduct code	Reciting the four-D mnemonic as law, or citing the code held in abeyance
Court and the accused	In which role am I answering?	Treating role separated from the impartial expert opinion to the court	Serving as expert for one's own patient, or naming superseded statutes

Notice that the right-hand column is a single family of mistakes: each is a rule applied from the wrong place - the wrong country, the wrong version of a statute, or the wrong role. That is why the method in this closer leads with role and authority. Get those two right and the specific rule usually falls out; get them wrong and even a correctly remembered rule is deployed in the wrong case.

Every forensic-ethics vignette resolves to the same two questions - which role you are in, and on whose authority you may act or disclose - and naming both is the first mark of a defensible answer.

26 · Consolidation

A chapter you have read is not a chapter you can retrieve. This closing section is a self-test, and it works only if you use it as one. The prompts below are questions with no answers printed beside them, and that is deliberate: **active recall** - forcing an answer out of memory before you look it up - is what fixes material for an examination, and an answer sitting next to the question quietly converts the exercise back into rereading, which feels productive and teaches almost nothing. Cover the notes, work down the list, say or write your answer in full, and only then turn back to the topic that owns it to check yourself.

Everything asked here was taught earlier in this chapter; nothing new is introduced and no prompt reaches for a fact the chapter never covered. The questions are grouped into the three sub-areas the chapter is built from - professional ethics with consent and confidentiality, the special settings of disaster, prisoners and custody, and the forensic statutes with legal procedure - and each group ends where the material ends, so that a blank you draw is a topic to revisit, not a trick.

26.1 How to use this list

Before the questions, fix the frame that answers most of them. Two facts run under this whole chapter. The first is the **dual role**: at any moment the psychiatrist is either the **treating clinician**, who owes duties to the patient, or the **forensic evaluator**, whose duty runs to the court. The second is that almost every rule is really a rule about **disclosure** - what may be told, to whom, and on whose authority. Run each prompt through those two facts before you reach for a specific rule, and the specific rule will usually announce itself.

RULE **Retrieve first, review second.** The value of this list is destroyed the instant you read an answer before you have tried to produce one. Attempt every prompt from memory, out loud or on paper, and treat the checking as the reward for the attempt, not a substitute for it. A prompt you cannot answer marks the exact topic to reopen.

26.2 Sub-area one: professional ethics, consent and confidentiality

These prompts sweep the ethical foundations and the two constructs the chapter stresses hardest - consent and disclosure. Answer each fully before checking the owning topic.

1. Name the principles of biomedical ethics, and say what a clinician actually does when two of them pull in opposite directions in a psychiatric decision.
2. State the essential elements of a valid informed consent and name the Indian judgment that anchors them; then explain the moment a consent question quietly becomes a capacity question.

3. Recall the grounds on which the duty of confidentiality may be lifted, and state precisely how the Indian position on disclosing to protect an endangered third party differs from the American doctrine; name the leading Indian judgment on breaching confidentiality to protect an identifiable person at risk, and be clear about what it did and did not decide.
4. Give the teaching mnemonic for the components of negligence, then state the components in the Supreme Court's own formulation, and say what criminal negligence adds to the civil standard.
5. Name the test that fixes the standard of care and the later gloss that qualified it, and explain vicarious liability in a single sentence.
6. Identify the current statute under which a patient pursues a claim for deficient medical service, what it replaced, the landmark that brought medical service within it, and when a free service falls outside it.
7. Separate the treating role from the expert role - to whom does each owe its primary duty - and say why the expert is the courtroom's exception to the bar on opinion evidence.
8. State which edition of the professional-conduct code is operative and which was notified but held in abeyance, and which of the two carries the graduated levels of professional misconduct; then name the profession's own code of ethics and the meeting that adopted it.
9. Distinguish a boundary crossing from a boundary violation, describe the slippery slope between them, and say what makes a clinical record defensible and its certification truthful.

26.3 Sub-area two: disaster, prisoners and custody

Here the vulnerable population meets the coercive institution, and the answers are Indian statutes and Indian judgments. The clinical management of substance use in these settings is not asked, because it belongs to the Substance use disorders notes.

1. Describe the tiered command structure the disaster-management statute creates, and identify the tier a psychiatrist most often works within.
2. State what that Act means by disaster management, and name what is conspicuously absent from its scheme.
3. Explain the two mechanisms by which imprisonment both generates and worsens psychiatric disorder.
4. Say what the principal Indian prisons statute provides for mental health care, and why its position is a problem.
5. State the principle of equivalence of care and the problem of dual loyalty as they arise behind the wall.
6. Name the provision that authorises the transfer of a mentally ill prisoner for treatment, and the two doors it opens.
7. Recall the judgment holding that the non-criminal mentally ill do not belong in jail, and state its practical consequence.

8. Describe the custodial duty around self-harm and suicide, and how consent and confidentiality actually operate for a detained patient.

26.4 Sub-area three: forensic statutes and legal procedure

These prompts cover the recodified criminal-legal interface. Two doctrines the chapter deliberately does not teach - the insanity-defence test with its burden of proof, and the child-sexual-offences framework - are cross-referred, and the prompts respect that boundary.

1. State the savings rule that decides which criminal regime governs a case after the recodification: what governs the penal question, and what governs procedure and evidence?
2. The insanity-defence test itself, and the burden of proof, are taught in the Mental health legislation and forensic psychiatry notes; state only the correction this chapter makes - in which code does the defence now sit, and in which separate code does the burden sit?
3. Distinguish the legal meaning of consent in sexual-offences law from clinical informed consent, and outline the psychiatrist's role with a survivor; the child framework belongs to the Child psychiatry: assessment, treatment, services and protection notes and is only named.
4. Trace the procedural pathway by which an accused is sent for psychiatric assessment: which recodified statute now houses it, what happens at referral and report, and what follows a finding of incapacity - with the fitness criteria themselves left to the Mental health legislation and forensic psychiatry notes.
5. Say what makes a dying declaration relevant and admissible, and how the Indian rule departs from the common-law requirement of a settled expectation of death.
6. Admissibility is not reliability: state what the psychiatrist must assess about a declarant's mind, and the conditions that can cloud it.
7. Recall the statutory ladder of the criminal courts, and the rule of evidence that admits an expert's opinion at all.
8. Explain why the expert's opinion is a relevant fact and not a verdict, and the currency check you must run before testifying after the codes changed.

GOOD TO REMEMBER

Do not run this list once the night before. Retrieval strengthens memory most when it is spaced and repeated - sweep the three groups now, mark the prompts you missed, and return to those alone after a gap of some days. The prompts you answer cleanly need no revisiting; your time belongs to the blanks.

26.5 The currency check that flips answers

A right rule stated as the wrong version is a wrong answer. More marks are lost on this chapter to stale law than to genuine ignorance, because the ground has shifted twice and the superseded answers still read as natural. Before you accept any answer you have retrieved, ask whether the code or statute you named is the one actually in force. The grid below is the coverage map: read across each row to confirm you can answer the recurring question, name the currency or limit

that most often flips it, and place the neighbouring doctrine you must cross-refer rather than re-teach.

SUB-AREA	THE RECURRING QUESTION TO ANSWER FROM MEMORY	THE CURRENCY OR LIMIT THAT FLIPS THE ANSWER	THE NEIGHBOUR TO NAME, NOT RE-TEACH
ETHICS, CONSENT, CONFIDENTIALITY	Whose is the information, and on whose authority may it be disclosed?	Which conduct code is operative, and is protective disclosure a permission or a command?	the Mental health legislation and forensic psychiatry notes (capacity, advance directives, admission)
DISASTER, PRISONERS, CUSTODY	Who owes care to a detained person, and to what standard?	The principal prisons statute's want of a substantive care standard, and the authority that permits transfer	the Substance use disorders notes (substance use in custodial settings)
STATUTES AND PROCEDURE	In which role, and under which code now in force, is the opinion given?	Are you citing the recodified statutes or the superseded ones - and what does the savings rule say?	the Mental health legislation and forensic psychiatry notes (insanity test, burden) and the Child psychiatry: assessment, treatment, services and protection notes (the child framework)

PITFALL

The recurring real-world error this chapter exists to correct is a currency error. Treating the notified-but-suspended successor professional-conduct regulations as the operative code, or citing the superseded criminal, procedure and evidence statutes as current after the recodification, is confidently wrong in exactly the way that reads as right. A disclosure permitted under the Indian regime is also misremembered as a positive duty to warn imported from foreign case law. If a prompt above returns one of these, that is the topic to reopen first.

IN INDIA

Every answer on this list is an Indian primary-source answer, and most of them differ from the Western textbook default: protective disclosure that is permitted rather than commanded, an earlier statutory conduct code still in force while its successor waits in abeyance, a consumer forum that reaches into medical practice, and a criminal law recently recast with a savings rule. When a prompt tempts you toward the familiar Western answer, that temptation is itself the signal to recall the Indian position instead.

26.6 The master frame to run on any vignette

The whole chapter collapses into one short procedure you can run against any question it throws at you. It is not new content; it is the chapter's own spine, gathered into four moves so that a vignette becomes a sequence of decisions rather than a scramble for the one rule it resembles.

MNEMONIC

HATS

The master frame for any forensic-ethics question. **H**at: fix the role first - is the psychiatrist the treating clinician who owes duties to the patient, or the forensic evaluator who owes candour to the court? **A**uthority over the information: of what is in play, ask what may be told, to whom, and on whose authority - the patient's consent, the clinician's bounded discretion, a court's order, or a regulator's power. **T**est the currency: is the conduct code the operative one and not the suspended successor, and is the criminal, procedure or evidence code the version in force under the savings rule? **S**ource and sibling: read the primary source, and where a doctrine belongs to another chapter, name it and reason from it rather than restating it. Fix the hat, run the three, and every rule in this chapter falls into place.

TRAP **Recognition mistaken for recall.** Reading an answer and thinking "yes, of course" feels identical to knowing it, and it is not - recognising a stated answer is a far weaker trace than producing one unprompted. The candidate who reviews by rereading walks into the hall confident and empties out under a blank page. Cover the answer, force the retrieval, and let the failures on this list, not the successes, direct your last days of revision.

Fix the hat, ask what may be disclosed and on whose authority, and check that the code you cite is the one in force - and you can reason through any forensic-ethics vignette this chapter can set.

Previously asked

There is no indexed past-question bank for this chapter, so nothing in the table below is a catalogued past question and no board or year is claimed for any of them. Attributing a paper the index does not hold would be a fabrication, so in place of a board of origin each row is marked Representative, and the questions are written in the register an examiner uses. Forensic ethics, consent and legal procedure are examined heavily and in every form the paper allows, as long answers, as short notes and in the viva, so the list maps the examined spine of this chapter rather than one board's recent record. Read it as a high-yield revision map, not as a set of questions on record.

QUESTION	MARKS	ASKED
Enumerate the four principles of biomedical ethics and discuss how they come into conflict in a psychiatric decision, with an example of how such a conflict is resolved.	10	Representative
Discuss informed consent in psychiatric practice: its essential elements, the assessment of capacity to consent, and the special situations that complicate it.	10	Representative
Confidentiality and its limits in psychiatry. Discuss the duty to warn, the position under the Mental Healthcare Act, and the relevance of Tarasoff and of Mr X v Hospital Z.	10	Representative
Professional negligence and medical malpractice. Explain the four Ds, the standard of care, and the distinction between civil and criminal medical negligence in Indian law.	10	Representative
Medical services under the Consumer Protection Act. Short note.	*5*	Representative
The psychiatrist as an expert witness: the role, the distinction between opinion and fact evidence, and the conduct expected in court.	*5*	Representative
Boundary violations in the therapeutic relationship. Short note.	*5*	Representative
The Indian Psychiatric Society code of ethics and the current statutory professional-conduct code. Short note.	*5*	Representative
The insanity defence and the burden of proving it under the current criminal law, and the transition from the earlier codes on the first of July 2024.	10	Representative

QUESTION	MARKS	ASKED
Describe the procedure for the psychiatric assessment of an accused person, from the court's referral to the report and its consequences.	10	Representative
Sexual offences law and the psychiatric assessment of a survivor. Discuss the legal meaning of consent.	*5*	Representative
Mental health of prisoners: the transfer and treatment of a prisoner with mental illness, and the human-rights safe-guards in custodial psychiatry.	*5*	Representative
The legal aspects of seclusion, restraint and involuntary treatment, and the least-re-strictive principle. Short note.	*5*	Representative

The shape of these questions is worth reading before their content. A ten-mark question that opens with enumerate or describe wants a structured map rather than a definition, and the marks are won on the discriminations this chapter turns on: the difference between a permission to disclose and a positive duty to warn, the difference between the insanity defence and the burden of proving it, the difference between civil and criminal negligence, and the difference between the treating role and the forensic role. A short note carries fewer marks but the same demand for the exact provision and the exact modal verb, because a permission and a duty are not interchangeable and an answer that names a repealed code as the current law reads as one that has not opened the statute. This is the one part of the paper whose answer is checkable against a primary text, which is precisely why the examiner rewards the candidate who cites the current provision and marks down the one who cites the old one by reflex.

The quick review

One table, read down the left column and cover the right. Every line is taught in full somewhere above and nothing here is new: each is that provision's single must-hold line, the rule lifted from the passage that teaches it, so a line you cannot recover is a section to reread rather than a fact to memorise here. Modal verbs are load-bearing: an exception that permits disclosure is not a command to disclose, and where the statute says shall it is kept as shall. Currency is this chapter's spine. The operative professional-conduct code is the Medical Council of India (Professional Conduct, Etiquette and Ethics) Regulations 2002; the National Medical Commission RMP Regulations 2023 were notified, then held in abeyance, and are not operative. The criminal codes are the Bharatiya Nyaya Sanhita, the Bharatiya Nagarik Suraksha Sanhita and the Bharatiya Sakshya Adhiniyam, in force from 1 July 2024, with the

Indian Penal Code, the Code of Criminal Procedure and the Indian Evidence Act as their historical predecessors; the offence date governs the penal code and pendency governs procedure and evidence.

ASK	HOLD
PROFESSIONAL ETHICS, CONSENT AND CONFIDENTIALITY	
THE FOUR PRINCIPLES OF BIOMEDICAL ETHICS	Respect for autonomy, beneficence, non-maleficence and justice, developed by Beauchamp and Childress; each is a prima facie obligation to be balanced against the others when they conflict.
INFORMED CONSENT, THE THREE ELEMENTS (SAMIRA KOHLI)	Consent to treatment must be real and valid, which the Court defines by three elements: the patient must have the capacity to consent, the consent must be voluntary, and it must rest on adequate information about the nature of the treatment.
CONSENT SCOPE AND THE DISCLOSURE STANDARD (SAMIRA KOHLI)	Consent is confined to the specific procedure consented to, so consent for a diagnostic procedure is not consent for therapeutic treatment, and that unauthorised additional surgery benefited the patient is no defence; the disclosure standard adopted is the Bolam real-consent standard, not the higher Canterbury prudent-patient test.
CONFIDENTIALITY, THE RIGHT AND ITS LIMITS (MHCA S.23)	The person has a right to confidentiality and all health professionals a duty to keep the information confidential; the enumerated exceptions (to protect another from harm, to prevent a threat to life, on the order of the Board or a court, for public safety) permit disclosure, they do not command it.
DUTY TO WARN OR PROTECT, THE US ORIGIN (TARASOFF, 1976)	A therapist who determines, or under professional standards should determine, that a patient presents a serious danger of violence to another incurs an obligation to use reasonable care to protect the intended victim; the protective privilege ends where the public peril begins.
CONFIDENTIALITY AGAINST AN IDENTIFIABLE THIRD PARTY (MR X V HOSPITAL Z, 1998)	The Indian analogue: disclosure of the patient's HIV-positive status to the woman he was about to marry was held not to violate confidentiality or the right to privacy, because an identifiable person was saved from a real risk; the right to privacy is not absolute.
THE IPS CODE AND THE OPERATIVE CONDUCT CODE	The Indian Psychiatric Society code of ethics was approved at its Cuttack conference in 1989, the foundational Indian psychiatry-specific code; the operative professional-conduct code for doctors is the MCI 2002 Regulations, because the NMC RMP 2023 Regulations were notified, then held in abeyance, and are not operative.
NEGLIGENCE, THE FOUR DS AND THE COMPONENTS (JACOB MATHEW)	The teaching mnemonic is the four Ds (duty, dereliction, damage, direct causation); the operative law is Jacob Mathew's three essential components, duty, breach and resulting damage, with causation as the fourth element (the plaintiff must prove the breach caused the injury, from Bolitho).

ASK	HOLD
THE STANDARD OF CARE, BOLAM QUALIFIED BY BOLITHO	Bolam: a professional is not negligent if he acts in accordance with a practice accepted as proper by a responsible body of professional opinion (adopted in India via Jacob Mathew); Bolitho qualifies it, so that opinion protects only if it can withstand logical analysis.
CRIMINAL MEDICAL NEGLIGENCE (JACOB MATHEW)	Far higher than the civil bar: mens rea must be shown and the negligence must be gross or of a very high degree; the words rash or negligent act are read as qualified by grossly, and negligence that is neither gross nor of a high degree may ground a civil action but cannot found a prosecution.
CONSUMER PROTECTION ACT 2019 AND IMA V V.P. SHANTHA	The 2019 Act repealed the 1986 Act; service (s.2(42)) excludes any service rendered free of charge or under a contract of personal service, and deficiency (s.2(11)) includes any act of negligence causing loss or injury; IMA v V.P. Shantha holds paid medical service is service, while service rendered free of charge to everybody is not.
THE EXPERT WITNESS, OPINION VERSUS FACT (RAMESH CHANDRA AGRAWAL)	An expert is not a witness of fact; his evidence is of an advisory character, his duty being to furnish the court with the scientific criteria to test the conclusions so the judge can form an independent judgment; the court is not bound by the expert's opinion.
BOUNDARY CROSSING VERSUS BOUNDARY VIOLATION	A crossing is a minor, non-exploitative, discussable departure from the frame that may even help the patient; a violation is an exploitative, harmful departure that serves the clinician and betrays the fiduciary duty; the slippery slope carries one into the other, and sexual contact with a current patient is the paradigm violation, absolutely prohibited and never excused by apparent consent, because responsibility for the boundary rests always with the clinician.
RESEARCH, RECORDS AND TELEPSYCHIATRY ETHICS	Under the NMC 2023 framework (notified, then held in abeyance; the operative code is the MCI 2002): research on patients or volunteers must comply with ICMR guidelines and the New Drugs and Clinical Trials Rules 2018; a self-employed RMP keeps inpatient records for three years from the last contact and supplies them on request within five working days; telepsychiatry follows the Telemedicine Practice Guidelines.
DISASTER, PRISONERS AND FORENSIC SPECIAL TOPICS	
DISASTER MANAGEMENT ACT 2005 STRUCTURE	A three-tier ladder: the National Disaster Management Authority (s.3, Prime Minister ex officio Chairperson), a State Disaster Management Authority in every State (s.14, Chief Minister ex officio Chairperson) and a District Disaster Management Authority in every district (s.25, Collector or District Magistrate or Deputy Commissioner ex officio Chairperson); the Act's own definition does not name psychosocial or mental-health support as an express limb.

ASK	HOLD
PRISONERS WITH MENTAL ILLNESS (MHCA S.103)	An order directing admission of a prisoner with mental illness is sufficient authority; transfer to the psychiatric ward in the medical wing of the prison is the first option and suffices, and only where there is no such ward may the prisoner be transferred to a mental health establishment, with the prior permission of the Board.
THE REMOVAL WARRANT (PRISONERS ACT 1900 S.30)	Where a detained or imprisoned person appears to be of unsound mind, the State Government may, by a warrant setting forth the grounds, order his removal to a lunatic asylum or other place of safe custody for the remainder of the term; this is the provision MHCA s.103 cross-refers.
CUSTODIAL HUMAN RIGHTS (SHEELA BARSE)	The Supreme Court strictly prohibited confining non-criminal mentally ill persons in jails, treating such confinement as a violation of constitutional rights.
FORENSIC STATUTES AND LEGAL PROCEDURE	
SEXUAL OFFENCES, RAPE AND ITS PUNISHMENT (BNS S.63, S.64)	BNS s.63 (successor to IPC s.375) defines rape by four act-types under seven circumstances, the capacity circumstances including consent given when, by reason of unsoundness of mind or intoxication, she is unable to understand the nature and consequences, being under eighteen, and being unable to communicate consent, with a marital exception where the wife is not under eighteen; s.64 punishes rape with rigorous imprisonment of not less than ten years, extendable to life, and fine.
CONSENT IN SEXUAL-OFFENCES LAW (BNS S.63, EXPLANATION 2)	Consent means an unequivocal voluntary agreement, communicated by words, gestures or any verbal or non-verbal communication, of willingness to the specific sexual act; a woman who does not physically resist is not, by that fact alone, to be regarded as consenting.
THE PENAL TRANSITION, SECTION 22 VERSUS SECTION 108 (THE CORRECTION)	The insanity defence is BNS s.22 (formerly IPC s.84); the burden of proving it is BSA s.108 (formerly IEA s.105); they are separate sections in separate codes, so section 105 BSA is not the successor to s.84; the penal code follows the offence date, procedure and evidence follow whether the matter was pending at the transition.
PROCEDURE FOR ASSESSING AN ACCUSED (BNSS S.367 TO S.369)	Where the accused appears of unsound mind and incapable of making his defence, the court shall first try that fact on medical and other evidence and postpone proceedings, at the inquiry stage (s.367) or at trial (s.368); s.369 governs disposal, release on bail where a relative undertakes out-patient treatment, else kept where regular psychiatric treatment can be provided, with the action reported to the State Government. Successors to CrPC s.328 to s.330.

ASK	HOLD
THE DYING DECLARATION (BSA S.26)	A statement by a person as to the cause of his death, or the circumstances of the transaction that resulted in it, is a relevant fact when the cause of that person's death comes into question, and is relevant whether or not the maker was, at the time, under expectation of death (successor to IEA s.32(1)).
COURT STRUCTURE (BNSS S.6)	Besides the High Courts, every State has Courts of Session, Judicial Magistrates of the first class, Judicial Magistrates of the second class and Executive Magistrates; the Supreme Court is the constitutional apex above them.
EXPERT-OPINION EVIDENCE (BSA S.39)	When the court has to form an opinion on a point of science, art, foreign law or any other field, the opinions of persons specially skilled in that field are relevant facts and such persons are called experts; Illustration (b) covers the question of unsoundness of mind (successor to IEA s.45).
SECLUSION AND RESTRAINT, THE LEGAL ASPECTS (MHCA S.97)	Seclusion and solitary confinement are absolutely prohibited; physical restraint may only be used when it is the only means available to prevent imminent and immediate harm and is authorised by the psychiatrist in charge, kept no longer than absolutely necessary, never as punishment or for staff shortage, the nominated representative informed within twenty-four hours and every instance reported monthly to the Board (the least-restrictive principle).

References

Every specific in this chapter is bound to one of the sources below, and the count is the number of claim rows each carried. The statutory and case-law rows were read at the primary Act on India Code, at the primary judgment on Indian Kanoon, or at the primary notification of the National Medical Commission and the Gazette of India, rather than from any textbook summary, because a stale or paraphrased section changes what a clinician is legally obliged to do. Three currency positions were read at their current form and are load-bearing for this chapter: the operative professional-conduct code is the Medical Council of India Regulations of 2002, because the National Medical Commission Registered Medical Practitioner Regulations of 2023 were notified and then held in abeyance, so the 2023 code is named as drafted but not yet in force; the substantive criminal law was read at the Bharatiya Nyaya Sanhita, the Bharatiya Nagarik Suraksha Sanhita and the Bharatiya Sakshya Adhiniyam, in force from the first of July 2024, with the Indian Penal Code, the Code of Criminal Procedure and the Indian Evidence Act named as the superseded predecessors; and the consumer-protection route was read at the 2019 Act, not the 1986 Act. Of the 61 claim rows, 58 are recorded at verified confidence and 3 at partial, the latter authored from established ethical and clinical knowledge and checked by the adversarial content pass rather than bound to a single primary quote; 14 further specifics were declared as gaps and taught around rather than supplied from memory. The must-have-papers cross-check was NOT performed for this Paper III chapter, because the paper lists do not yet exist in the intel index; for Paper III the topic

bank plus the syllabus scaffolding is the completeness authority. This table records provenance, not proof: it says where each specific came from, not that the chapter's prose uses it correctly, which the content pass and the ship review test.

SOURCE	CLAIMS CARRIED
Indian Kanoon (primary Act and judgment text)	**27**
India Code, Ministry of Law and Justice (primary Act text)	**13**
Other primary source (verbatim quote and URL on file)	**13**
National Medical Commission and the Gazette of India (primary notification text)	**8**

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