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REVIEW PAPER

Evolution of consent and autonomy in forensic examination of sexual assault victims: a legal, ethical, and clinical perspective

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ABSTRACT

Historically, medico-legal practice has marginalised consent and autonomy in the forensic examination of sexual assault victims. Global and Indian frameworks have progressively emphasised survivors' rights, but implementation gaps persist. This is an attempt to trace the evolution of legal, ethical, and clinical standards regarding consent and autonomy in sexual assault forensic examinations, analyse current gaps in India, and recommend reforms aligned with international human rights and forensic medicine best practices. A narrative review of legal statutes, case law, and medico-legal guidelines from India and selected international jurisdictions (UK, US, and WHO) was done, supported by forensic audit data, human rights reports, and scholarly literature. It was observed that the principle of informed consent evolved from implied or blanket consent to segmented, stage-wise processes respecting survivor autonomy. Indian legal reforms post-2012, including the Criminal Law (Amendment) Act and Ministry of Health and Family Welfare Guidelines, mandate consent at every stage. However, challenges remain with uniform implementation, training, and survivor-centred facility design. To conclude, respect for survivor consent and autonomy is central to ethical forensic medicine and effective criminal justice. Harmonised legal, medical, and human rights frameworks, along with institutional reforms, are essential for upholding these principles in practice.

Keywords: *Consent; autonomy; forensic examination; sexual assault; BNSS Section 184.*

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INTRODUCTION

Consent and autonomy represent foundational ethical principles in medical practice, codified through international human rights law and national legal frameworks. In the context of a forensic examination of sexual assault victims, these principles gain heightened importance given the vulnerability of survivors, the invasive nature of examinations, and the potential for secondary victimisation. This paper reviews the evolution of consent and autonomy principles specifically in forensic examinations, with an emphasis on Indian practice and reforms following landmark cases such as the Nirbhaya incident (2012). The pressure placed on the survivor could

override their ability to exercise autonomous decision-making, especially when dealing with the cumulative impact of intersectionality, for example, race, socio-economic status, and gender identity.[1]

Legal and ethical evolution

Historically, forensic examinations of sexual assault survivors operated under a presumption of implied consent or law-enforcement-driven compulsion. This was globally criticised for violating bodily autonomy and human dignity.

International frameworks

WHO's 2003 guidelines for medico-legal care of sexual violence victims introduced trauma-informed, multi-stage consent protocols.[2] The United Nations Istanbul Protocol emphasised informed consent as a human rights obligation. In the US, the SANE (Sexual Assault Nurse Examiner) programme institutionalised detailed consent procedures from the 1990s onwards.

Indian legal reforms

Pre-2013: Section 164A CrPC (now Sec 184 BNSS) required consent but lacked procedural specificity. Post-Nirbhaya (2013): The Criminal Law (Amendment) Act reinforced the consent mandate. The two-finger test was explicitly prohibited.[3] In 2014, MoHFW guidelines were introduced for segmented consent for history taking, physical examination, sample collection, photography, and police reporting.[4]

Legal reasoning

Under Article 21 of the Indian Constitution (Right to Life and Personal Liberty), the Supreme Court in Lillu @ Rajesh and Anr vs State of Haryana (2013) ruled that non-consensual or degrading forensic practices violate fundamental rights.[5] The logic follows from both medical ethics (autonomy, non-maleficence) and procedural justice (CrPC Section 164A, BNSS equivalent Section 184).

EVOLUTION OF CONSENT MODELS

(i) Blanket consent (pre-1990s): One-time, generalised consent covering all procedures. However, it was criticised for its lack of specificity. (ii) Multi-Stage Written Consent (1990s–Present): Each procedure requires separate, documented consent, allowing survivors to opt-in or opt-out. (iii) Survivor-Centred Dynamic Consent (Emerging): A continuous process where survivors can pause, withdraw, or modify consent at any stage. Table 1 narrates the evolution of consent practices in forensic medicine.

Table 1 Evolution of consent practices in forensic medicine

Period	Model	Key features	Limitations
Pre-1990s	Blanket consent	Single signature for all procedures	No survivor control, risk of coercion
1990s–2010s	Multi-stage consent	Procedure-specific, opt-in/ opt-out	Administrative complexity
Post-2013 India	MoHFW segmented consent	Detailed forms, survivor autonomy	Implementation inconsistency
Emerging	Dynamic digital consent	Continuous, revocable, survivor-controlled	Technology and policy gaps

CURRENT PRACTICE IN INDIA: GAPS AND CHALLENGES

The surveys (CEHAT, 2018; HRW, 2017)[6,7] show 30–40% of public hospitals still use blanket consent forms, as shown in **Table 2.** Many facilities lack separate forms for different stages, such as history, examination, and evidence collection. Survivors report feeling compelled to consent under perceived police or institutional pressure.

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Table 2 Audit of consent practices in Indian States (Adapted from CEHAT, 2018)

State	Multi-stage consent in use (%)	Blanket consent in use (%)	Notes
Maharashtra	75%	25%	Post-CEHAT advocacy
Delhi	60%	40%	Variable across hospital tiers
Uttar Pradesh	45%	55%	Lack of training and infrastructure
Tamil Nadu	80%	20%	Leading in model consent form adoption

CASE LAW CONTEXT

(i) Lillu @ Rajesh and Anr vs State of Haryana (2013): Consent without degrading practices mandated.

(ii) State of Jharkhand vs Shailendra Kumar Rai (2021): Reaffirmed that medical evidence without proper consent is inadmissible [8]

INTERNATIONAL COMPARISONS

(i) UK SARCs (Sexual Assault Referral Centres): Legal advocates ensure survivor consent at every stage, monitored through audit systems.[9]

(ii) US SANE Protocol: Consent forms linked to forensic evidence kits, psychological services, police reporting, and follow-up care.[10]

(iii) Australia: National standards include informed consent as part of forensic nursing certification.

ETHICAL AND LEGAL REASONING BEHIND REFORM

(i) Bodily autonomy is integral to Article 21 of the Indian Constitution.

(ii) Informed consent is enshrined in the Indian Medical Council (Professional Conduct) Regulations, 2002.

(iii) Criminal justice must balance evidentiary needs with fundamental rights (as per Supreme Court rulings).

Medical examination of survivors of sexual assault can be invasive and traumatic, having long-term effects on their well-being. In several instances, the samples collected during forensic medical examinations may lack evidentiary value and could merely represent routine performative practices. It is critical to determine whether the survivor will consent to all steps of the medical examination after she is made aware of all materially relevant information regarding informed consent. A trauma-based model aims to prevent secondary traumatisation and the development of post-traumatic stress disorder by "having the patient actively engaged in making decisions about her care" and keeping control over the examination.[11]

From an ethical perspective

Autonomy entails that a survivor maintains control over their body and the actions performed upon it. Forensic procedures should be designed to avoid unnecessary harm. Equitable access to trauma-informed consent protocols should be ensured across all facilities.

SUGGESTIONS AND DIRECTIONS FOR THE FUTURE PROGRESS

Dynamic consent forms that are based on mobile devices or tablets and are linked to medical-legal databases are referred to as digital consent systems. The NMC requires the use of a uniform national consent proforma, which may include opt-in and opt-out options for each stage. An improved consent proforma for India has been proposed using the components that we have presented (**Table 3**). The presence of a survivor advocate: In every instance, legal or social work specialists are required to ensure that consent procedures are followed. The National Audit Mechanism is the Central Forensic Medicine Board, which is responsible for monitoring compliance with consent.

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Table 3 Proposed Indian consent proforma components

Component	Description
Section 1: Identity verification	Survivor's name, ID, legal guardian (if minor)
Section 2: Procedure-specific consent	History, physical exam, sample collection, photography, police reporting
Section 3: Rights explanation	Right to refuse, withdraw, or modify consent.
Section 4: Witness/advocate signature	Legal/social work professional verification
Section 5: Medical officer signature	Forensic examiner's attestation

CONCLUSION

International human rights and national laws prioritise consent and autonomy in medical ethics, particularly in forensic examinations of sexual assault survivors. This article analyses the evolving practices in India post-Nirbhaya, highlighting the inadequacies of prior consent frameworks, such as blanket consent, which undermined survivor dignity. Key reforms, including the 2013 Criminal Law Amendment and WHO guidelines, have introduced multi-stage consent processes that are survivor centred. Despite improvements, surveys indicate many Indian hospitals still use blanket consent forms and exert pressure on survivors.

The legal structure mandates informed consent as fundamental to bodily autonomy, necessitating trauma-informed practices in forensic examinations. The article advocates for digital consent systems and a national proforma to facilitate improved consent processes, underscoring the importance of respecting survivor autonomy within the criminal justice framework.

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