Praise for *Perils in Practice*

"Being a doctor is not easy. In rural India, where public healthcare infrastructure is decrepit, doctors face a heightened risk at work, more so if one is a government doctor. In emergency situations, a patient brought to such a centre might die for want of facilities. Emotions can run high in such circumstances, even leading to physical assaults… Nothing can justify using foul language or physical attacks on a health worker. This book aims to throw light on the perils of the profession from the practitioner's eyes."

– **K. R. Balasubramanyam**
Senior Journalist, Bengaluru

"Increasing instances of violence against healthcare workers and institutions are being witnessed across India, resulting in devastating effects on the morale of healthcare workers and also adversely affecting society. Equipping the healthcare workers and sensitising the community will go a long way in effectively combating this menace. This book admirably fulfils this requirement by way of analysing the challenges and providing workable solutions to the problem."

– **Gauri Kumar, IAS (Retd.), Former Secretary (Border Management),**
Ministry of Home Affairs

"Women are easy targets and extremely vulnerable during violence against healthcare workers. This book analyses the causative factors and offers implementable solutions to healthcare providers and related agencies. This menace can only be overcome through collaborative initiatives between key stakeholders in the healthcare system for the overall well-being of the community at large."

– **Dr. Kiran Mazumdar-Shaw, Executive Chairperson**
Biocon and Biocon Biologics

"One of the most valuable books that equips healthcare professionals with the necessary knowledge and skills to deal with violence in the workplace, which is now assuming pandemic proportions. The book is a compilation of years of wisdom, experience and knowledge from several experts and renowned professionals in the field of medical practice, and addresses almost all aspects of preventing violence against healthcare professionals in an open, objective, impartial and transparent manner. The book provides an in-depth understanding of the subject and is a must-read not only for healthcare professionals but for every member of society who is even remotely connected with the medical profession—that truly means *everyone*."

– **Air Marshal (Dr.) Pawan Kapoor AVSM, VSM, Bar (Retd.)**

"This exemplary work titled *Perils in Practice: The Prevention of Violence Against Healthcare Professionals* shall be of immense benefit to every single person involved in healthcare delivery, from policy makers to caregivers to healthcare facility managers. This would certainly enable the healthcare workers to keep abreast of matters relating to healthcare delivery and to better equip themselves to handle situations of violence in the workplace. This all-inclusive book, with each chapter being admirably handled by experts in the field, will certainly be of great value to healthcare workers."

– **Dr. Mohan Lal Swarankar, Chairperson Emeritus**
Mahatma Gandhi University of Medical
Sciences and Technology, Jaipur

"I very much appreciate the suggestions made in this book to protect healthcare professionals from violence while performing their medical duties. It is not something peculiar to India; the world over, healthcare professionals are at peril of being attacked whenever their efforts fail to yield positive results. The provisions in the Indian Penal Code are not sufficient to protect them. I feel that a new statute containing specific provisions for measures to protect them is absolutely necessary."

– **Justice K. T. Thomas,**
Former Judge of the Supreme Court of India

Perils in Practice

The Prevention of Violence Against Healthcare Professionals

Edited by

Alexander Thomas, Sahajanand Prasad Singh and Divya Alexander



Juris Press

Perils in Practice
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Dedicated to the memory of Dr. Archana Sharma



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FOREWORD

A long time ago, a medical student in London went to the library and asked for a title on "Medical Ethics." The librarian looked sternly at him and said, "Medical Ethics! We have none. Go to the theology section!"

Today, we have hundreds of titles on that subject.

This valuable editorial venture addresses one of the burning civilisational issues of our times, namely, the near collapse of the relationship, once considered sacred, between doctor and patient. This is attributable to a variety of factors: the changing culture of the medical profession, the increasing influence of diagnostic technologies and the forces of unhealthy commercialisation of the profession. They hold a mirror to modern society and tell us what we really are.

This publication is a collection of sensitive and comprehensive reflections on the many strands of this twisted theme. Any enquiry of the extremely delicate issue is in itself an invitation to the congeries of hopes and fears of our society, and the progressive degeneration of manners, an indication of civilisational decline. When manners and tolerance decline, the nation declines. The issue of the declining doctor–patient relationship is just one strand in the bundle of factors of the larger theme of man's social contract of "what we owe each other." The volatility of public mood and cynicism are products of disillusionment. Cynicism is a tool of destruction.

A group of eminent personalities, having bestowed their precious reflections, have provided an insightful analysis.

> *Over 75% of doctors across the country have faced some variant of violence in their professional working environment. This is the major finding of a recent nationwide study conducted by the Indian Medical Association (IMA) in India. Alarmingly, the gravity of violence against medical professionals is touching the magnitude of grievous hurt or murder and therefore attracts society's immediate attention. However, this phenomenon goes back about 135 years and has a global presence. Naturally, India is no exception.* The Lancet *has mentioned growing violence against doctors (particularly in China) in its two editorials in 2012 and 2014. International organisations such*

as the International Labour Organization (ILO), International Council of Nurses (ICN), World Health Organization (WHO), and Public Service International (PSI) launched a joint programme in 2002 for the prevention and elimination of violence in the health sector.

Dr. Alexander and his co-editors present a comprehensive and penetrating analysis of the various facets of the problem. The negative publicity that the medical profession is exposed to is another factor which ignores the enormous good that doctors, nurses and support staff have provided to very large numbers as against a few cases of medical negligence that receive disproportionate publicity. Patients who receive professional services must also have an assurance of a credible system to examine professional standards and provide for compensatory restitution. Peer scrutiny has not acquired the requisite standards of credibility.

In a different context, Dr. Ambedkar in the Constituent Assembly cautioned against agitational methods in public life which, if unchecked, may pave the way for anarchy.

The establishment of credible systems for the investigation of medical negligence will help reduce tensions. The topic needs a wider, healthy debate.

The expert group has observed that:

In spite of its magnitude, few scientific studies have been conducted in India to understand the pathology of the problem. This in itself can easily be listed as the major cause for the lack of a creative strategy to curb the concerning phenomena.

The editors Dr. Alexander Thomas, Dr. Sahajanand Prasad Singh and Divya Alexander have done immense service to the society by turning the searchlight onto the "pathology of the problem."

M. N. Venkatachaliah
Former Chief Justice of India

ASSOCIATION OF HEALTHCARE PROVIDERS – INDIA

The Association of Healthcare Providers – India (AHPI), which represents the vast majority of healthcare providers in our country, is a not-for-profit organisation registered under the Indian Society Registration Act of 1860. The AHPI works with all stakeholders in order to establish a national system where the common man can avail assured universal access to basic health services, while facilitating its members and partnering bodies in carrying out health improvements to serve the community effectively and efficiently. In doing so, AHPI also collaborates and partners with other associations, accrediting bodies, regulatory agencies, councils, research organisations and academic institutions. The association, with its 20 regional chapters, undertakes advocacy for healthcare reforms, infrastructural issues, taxation and tariff issues, matters concerning health insurance and addresses other difficulties faced by HCOs or the community, relating to quality healthcare delivery.

The AHPI Institute of Healthcare Quality develops and conducts various healthcare management courses focusing on patient safety and healthcare quality. The AHPI Healthcare Certification Centre develops standards for different categories of healthcare establishments, certification of compliance of various standards by the healthcare agencies and provides customised certified training programmes (QMS and Healthcare managerial training) for the sector.

The AHPI played a pivotal role during the Covid-19 pandemic by effectively coordinating between its member hospitals and the Central and State governments in an implementing and advocacy role, as well as providing much-needed equipment support to many of its member hospitals. In recognition of these services rendered with distinction, AHPI received the prestigious Waterfalls Global Award 2022 instituted by the Government of the United Arab Emirates.

INDIAN MEDICAL ASSOCIATION

The Indian Medical Association (IMA), started in the year 1928, is the only national voluntary organisation representing doctors of the modern scientific system of medicine. The IMA strives to ensure the well-being of the community at large, while at the same time looking after the interest of the doctors serving the community. The IMA has a membership strength of over 3,75,000 and is a well-established organisation with its headquarters in Delhi and over 1,750 local branches in 34 states and union territories.

The IMA has been rendering yeoman services in the field of healthcare delivery, disease control and eradication. Its services to the community during natural calamities such as earthquakes, drought, floods and epidemics have been highly lauded. In addition, many local branches offer services to the community through ambulance facilities, blood banks and so on.

The IMA is also involved in the formulation and implementation of various national programmes for which it has been appreciated and recognised by the Central and State governments, the World Health Organization (WHO) and UNICEF.

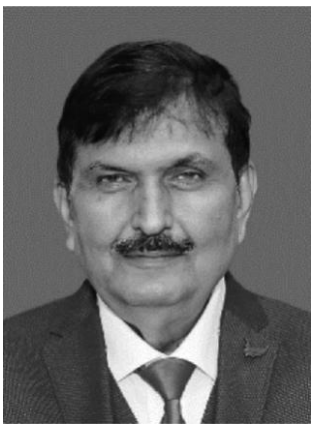
The IMA has two wings, one for family physicians, called the IMA College of General Practitioners, and the other for specialists, called the Academy of Medical Specialities. Alongside this, the IMA also offers various welfare programmes for its members such as the IMA Family Welfare Program, the IMA Professional Protection Scheme, the IMA Covid Martyrs Fund and other such supportive programmes. Over 1,500 members of IMA were martyred combatting the Covid-19 pandemic.

The IMA played a pioneering role in the Prevention of Violence against Medical Professionals and Damage to Properties Act which has been enacted in over 20 states in India.

ABOUT THE EDITORS



Dr. Alexander Thomas is the President of AHPI, former President of the Association of National Board Accredited Institutions (ANBAI), and Founder-President and Patron of the Consortium of Accredited Healthcare Organisations (CAHO). He has effected far-reaching policy changes within the healthcare landscape at the national and the State level, pioneered numerous training initiatives and received several awards for his contributions to the healthcare sector. His recent publications on issues affecting the health sector include books on communication, climate change, ethics and law, technology, healthcare quality, and white papers submitted to the Government of India. He was awarded the Waterfalls Global Award 2022 by the Government of the UAE for exceptional contributions to the community during the Covid-19 pandemic.



Dr. Sahajanand Prasad Singh is the President of the Indian Medical Association, a Fellow of the Academy of Medical Specialties, a Fellow of the IMA College of General Practitioners, a practicing general surgeon and teacher. He is a permanent member of the National Medical Commission, a past member of the Medical Council of India, and current Registrar of the Bihar Medical Council. He has numerous publications to his credit in national and international journals. Renowned and commended nationally and

internationally for his effective organisation of relief activities and mass immunisation programmes, he has won several awards including the Dr. B. C. Roy National Award (2017) for outstanding service in the field of socio-medical relief.



Divya Alexander has 15 years of expertise in health and public policy research, having drawn up policy recommendations and drafted healthcare legislation through her work with AHPI, UNFPA and Amnesty International USA. She provided technical expertise for the development of the Karnataka State Public Health Policy, the Committee for SDG Goal 3 (Health) to the Government of Karnataka, and projects for the World Bank, UNDP and UN Women. She has co-edited three books and several papers for the health sector on communication, climate change and policy. She read for her Master's degree at the University of Oxford as a Commonwealth Scholar and is a gold medalist from Bangalore University (Mount Carmel College), India.

PREFACE

Dr. Archana Sharma, a 42-year-old gynaecologist in Rajasthan, died by suicide on 29 March 2022. She took this extreme step when the police registered a case against her under Section 302 for the death of a patient whose baby she had delivered. A doctor's sadness at having lost a patient to maternal death despite her best efforts, turned into numbness that she was being blamed for her death. It is difficult to think about Dr. Sharma's last moments: the pain, fear and humiliation she must have felt for herself and for her family with the threat of arrest hanging over her head; the feeling of helplessness that drove her down this path; the sense of horror and injustice of being booked for murder when her whole life had been dedicated to saving lives.

Her death sent shockwaves across the medical fraternity. Doctors, nurses and allied health workers are sadly no stranger to abuse and assault, but this case was all the more unfortunate because of how many wrong turns were taken before the unhappy end: the police, unaware of the special law for medical professionals, registered the FIR against her in contravention of a Supreme Court order; Dr. Archana herself likely unaware that as a doctor, she would be protected from arrest without a complete investigation; and the private hospital perhaps unaware that steps could be taken to protect their healthcare workers from harassment and intimidation by the 200-strong mob that gathered outside after the patient died.

It is in this sorrowful context that the Association of Healthcare Providers – India (AHPI) and the Indian Medical Association (IMA) have joined hands to bring out this book titled *Perils in Practice: The Prevention of Violence against Healthcare Professionals.*

The goal of the book is to educate and empower healthcare workers in dealing with the challenges of aggressive and violent behaviour at clinics and hospitals. It also aims to sensitise the general public on the consequences of violence against healthcare workers to the healthcare delivery system and to society at large. This book is the result of extensive and detailed analysis by experts across the country from different fields: medical, legal, policy-making, law enforcement, communication, media and the community at large. They

have all contributed their expertise to come out with precise recommendations to improve the situation.

It is important to note that just a few decades ago, the medical profession was seen as a noble one, with doctors viewed as healers and guides. Unfortunately, the situation has changed drastically since then, and there is an urgent need to introspect and assess the downslide in the patient–doctor relationship. An analysis of the causative factors for this decline points towards high expectations on the part of the patients, inadequate communication by healthcare workers and anti-social elements in the community. Including the medical profession under the Consumer Protection Act has adversely affected the trust factor between patient and doctor, pushing doctors towards defensive practice, and consequently escalating the cost of healthcare. The high cost of medical education has also contributed to the situation. It should be made affordable, while producing healthcare professionals who can provide quality care to the nation's citizens with empathy and compassion.

This book analyses the above factors and explores how they can be resolved. By providing a wide range of perspectives on the topic of violence against healthcare professionals, we hope to provide solutions that address the root of the problem. It examines the value of effective communication, self-regulation and ethics, the legal framework, policy changes, the regulator's perspective and the role of the media. It provides guidance on the protection of healthcare workers, including safety measures in healthcare facilities, the power of networking and the importance of law enforcement. The chapters use case-study scenarios to depict the extent of the issue, and provide suggestions for empowering stakeholders.

Our healthcare workers serve society with commitment and dedication even at the cost of their own lives, as was evident during the pandemic. It is the editors' ardent hope that this offering enables our healthcare workers to feel empowered, protected and supported, so that no more valuable lives are lost.

Dr. Alexander Thomas
Chief Editor

ACKNOWLEDGEMENTS

On behalf of my co-editors, I would like to place on record our deep appreciation and grateful thanks to the numerous people who gave unstintingly of their time and efforts to support the development of this book on a very short timeline.

- The former Prime Minister of India **Shri. H. D. Deve Gowda** for lending his voice to our cause and writing the introduction to this book.
- The former Chief Justice of India **Shri**. **M. N. Venkatachaliah** for his inspiring and thought-provoking foreword.
- My co-editors, **Dr. Sahajanand Prasad Singh** and **Ms. Divya Alexander**, for the foundation and development of the manuscript.
- The members of the editorial board **Dr. Hema Divakar, Dr. V. C. Shanmuganandan** and **Ms. Seethalakshmi S.** for their insightful feedback after reviewing the manuscript.
- The distinguished chapter authors listed below, each of whom gave generously of their time and knowledge pro bono to create this handbook for the health sector. Their brief profiles are available at the end of the book.
  1. Dr. Vinay Aggarwal
  2. Ms. Divya Alexander
  3. Dr. Glory Alexander
  4. Dr. R. V. Asokan
  5. Justice S. R. Bannurmath
  6. Dr. S. N. Basu
  7. Prof. (Dr.) Bhabatosh Biswas
  8. Mr. D. V. Guruprasad
  9. Prof. Omprakash Nandimath V.
  10. Ms. Bagmisikha Puhan
  11. Dr. Ravisankar T. N.
  12. Dr. Devi Prasad Shetty
  13. Dr. Sahajanand Prasad Singh
  14. Dr. Satyajit Singh

15. Dr. K. K. Talwar
16. Dr. Olinda Timms
17. Ms. Seethalakshmi S.
18. Dr. Shivkumar S. Utture

- The **Association of Healthcare Providers – India** (**AHPI**) for sponsoring the production of this book and making it available on an open access platform.
- My colleagues in AHPI – **Mr. Shadrach Thangaraj, Mr. Jerald James** and **Mr. Antony George** for their tireless efforts in managing this project.
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- **Dr. Arjun K. R.** and **Col. Binu Sharma** for compiling the appendix.
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- The **family of Dr. Archana Sharma**, who in the midst of their grief, graciously allowed the book to be dedicated to her memory, a symbol of hope for a better future for healthcare professionals.

Dr. Alexander Thomas
Chief Editor

INTRODUCTION

The growing negative perception of the healing profession in India over the last few decades has led to an increase in violence against healthcare workers, reaching a peak during the pandemic crisis. The quest for affordable and accessible quality healthcare in our country that is available uniformly to all cross-sections of society, is being hindered by this unpleasant treatment of our healthcare workers. What can be done about it?

There are many challenges to affordable and quality medical education and healthcare services, and some of these challenges are directly tied to causes of violence against healthcare professionals. There is a need for a drastic policy change from construction to creation of labour in public hospitals. In many places, medical colleges and hospitals do not have adequate staffing. Human resources need to be strengthened with an efficient and accountable administration to deliver quality services. Delegation and decentralisation of powers, especially in public sector hospitals, will help in this regard.

If we look at medical education in our country, at present there are close to 700 medical colleges in India, with 90,000 undergraduate medical seats and 46,000 post-graduate medical seats. Sixty per cent of the doctors passing out from these colleges are women. The distribution of these colleges across the nation is interesting: nearly 60% of the medical colleges are located in Southern India, which has 40% of the country's population, and the remaining 40% are distributed in the Northern and Eastern parts of the country, where 60% of the population lives.

In a few of these institutions there are more students than patients, thus limiting their clinical exposure and hands-on experience. This may result in less skilled doctors. However, this is a situation where both quality and quantity need to be carefully balanced: there has been a long-standing debate about the shortage of specialists, especially since the current working atmosphere is not favourable. The growing number of cases of abuses and assaults on doctors, healthcare workers and hospital properties has reached alarming proportions, with some even leading to death. Although the Government of India as well as State governments have enacted laws to protect the medical community against violence, proper enforcement is a challenge. In some

situations, criminal cases are booked against the doctors even without any preliminary investigation by a team of medical experts, despite this requirement being laid down by the Supreme Court.

One key reason for violence against doctors is the perception of profit motives regarding the cost of healthcare. Although the Government of India has introduced national health schemes and some States also have their own independent health schemes, some of these schemes do not support complete patient care, but only cover procedures or surgical interventions. Post-operative procedural complications which crop up later, for example, are not covered under many schemes. There is a need to include many more procedures under the scheme. Most of the government schemes utilise the services of private hospitals, which provide about 70% of the healthcare services in our country. Annual revisions of the package rates are also necessary. Many have not been revised for years, and in several cases, these rates have been set arbitrarily. As a result, the rack rates of similar procedures in private hospitals seem astronomical, leading to violence and abuse at the time of billing. To bring down the cost of treatment, medical equipment and consumables should be exempt from GST and other statutory duties. To combat undue influence on medical workers, the National Medical Commission has recommended rules and regulations that restrict the Indian pharmaceutical sector's contribution to medical research and doctors' continuing medical education. Rather than be treated with suspicion, these contributions should be allowed, as is done globally, otherwise doctors will be deprived of learning about the newer aspects and discoveries of medical science.

It is said that "treatment should not be more harmful than the disease." It is important for doctors and hospital staff to also assess and understand the financial capability of patients, and provide appropriate counselling. Communicating with patients with empathy, sympathy and kindness, too, is crucial. When they fail to do so, some patients and attendants use it as an excuse to take law into their own hands. Society has reached such a stage that they want a brought-dead person to walk home. Despite a doctor's best efforts, if anything happens to the patient, it is branded as medical negligence, which exerts tremendous pressure on doctors and paramedical staff to such an extent that many doctors are becoming patients.

We need to empower our healthcare professionals in facing the challenges of aggressive, violent and destructive behaviour at hospitals and clinics. There are serious long-term consequences if this epidemic of violence against healthcare workers is not arrested: hospitals and clinics will shut down, the costs of healthcare will go up, communities will suffer for lack of local

healthcare facilities, and bright young students will no longer see healthcare as a viable career option, driving us further away from the goal of affordable, accessible and quality healthcare for the nation. The subsequent cost to society is too great.

Shri. H. D. Deve Gowda
Former Prime Minister of India

Chapter 1

PROTECTING HEALTHCARE PROFESSIONALS IN INDIA: AN ANALYSIS OF LAW AND POLICY

Omprakash Nandimath V., S. R. Bannurmath, Devi Prasad Shetty and Bhabatosh Biswas

Introduction

Over 75% of doctors across the country have faced some form of violence in their professional working environment. This is a major finding of a recent nationwide study conducted by the Indian Medical Association (IMA) in India.[1] Alarmingly, the gravity of violence against medical professionals is touching the magnitude of grievous hurt or murder and, therefore, is attracting society's immediate attention.[2] However, this phenomenon goes back about 135 years[3] and has a global presence. Naturally, India is no exception.[4] *The*

1. See generally, Kanjaksha Ghosh, "Violence against doctors: a wakeup call," *Indian Journal of Medical Research*, 148(2) (2018): 130–133.
2. See generally, Ping W., Ding G., Tang Q., & Xu L., "Continuing violence against medical personal in China: a flagrant violation of Chinese Law," *Bioscience Trends*, 10 (2016): 240–243.
3. Assaults upon medical men. *JAMA*, XVIII(13) (1892): 399–400. doi:10.1001/jama.1892.02411170025008 accounts for episodes of attack on physicians.
4. See generally, N. M. Mirza, A. I. Amjad, A. B. Bhatti, F. tuz Zahra Mirza, K. S. Shaikh, J. Kiani, . . . & S. Z. Imam, "Violence and abuse faced by junior physicians in the emergency department from patients and their caretakers – a nationwide study from Pakistan," *Journal of Emergency Medicine*, 2011; A. Magar, "Violence against doctors in Nepal," *Journal of Nepal Medical Association*, 2013; M. M. Kitaneh & M. Hamdan, "Workplace violence against physicians and nurses in Palestinian public hospitals, a cross sectional study," *BMC Health Survey Research*, 2012; S. Kaya, I. B. Demir, S. Karsavuran, D. Urek, & G. Irgun, "Violence against doctors and nurses in hospitals in Turkey," *Journal of Forensic Nursing*, 2016; and "Ending violence against doctors in China," *Lancet*, 2012.

Lancet has mentioned growing violence against doctors (particularly in China) in its two editorials in 2012 and 2014.[5] International organizations such as the International Labour Organization (ILO), International Council of Nurses (ICN), World Health Organization (WHO) and Public Service International (PSI) launched a joint programme in 2002 for the prevention and elimination of violence in the health sector.

The sudden death of a patient, non-improvement in health conditions of the patient for a long period of time, short supply of lifesaving drugs, diagnostic equipment, lack of infrastructural facilities (commensurate with fees charged) and delays in attending to the patient are identified as major causes of the eruption of violence against medical professionals.

In spite of its magnitude, few scientific studies have been conducted in India to understand the pathology of the problem. This in itself can easily be listed as the major cause for the lack of a creative strategy to curb the concerning phenomena.

Underlying Causes

Instead of noting the issue of violence against medical professionals in isolation and syntactically, it has to be seen in the macro context of the changing working environment. Two prime pointers in this regard are the ever-increasing trust deficit between doctor and patient, and the lack of training and capacity-enhancement opportunities.

The ever-increasing trust deficit between doctor and patient: "*Sarve jana sukhino bhavantu*" – the Sanskrit verse roughly translates to mean "may all live happily, may all be free from illness, may all see what is auspicious, may no one suffer." It indicates the value of traditional knowledge that has guided us (and particularly the State) to ensure a better lifestyle, most importantly including health, for everyone. The right to health and healthcare has long been declared a human right.[6] The Indian Constitution too identifies health as a fundamental

5. Ending violence against doctors in China. *The Lancet*, 379(9828) (2012): 1764. DOI: https://doi.org/10.1016/S0140-6736(12)60729-6; Violence against doctors: Why China? Why now? What next? *The Lancet*, 383(9922) (2014): 1013. DOI: https://doi.org/10.1016/S0140-6736(14)60501-8.
6. Article 25 of the Universal Declaration of Human Rights, 1948, observes health as part of the right to an adequate standard of living. International Covenant on Economic, Social and Cultural Rights, 1966, recognise health as a fundamental human right. The Right to health was emphasised by the Constitution of the World Health Organization (1946) as "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being." These are a few references to indicate health is been recognised as a human right.

right.[7] The directive principles of State policies impose an active obligation upon the State to ensure the effective realisation of the right to health.[8] The jurisprudential basis of this discourse is an overall benefit that accrues to society if the health of an individual is protected and promoted. An intrinsic value of adequate health security is to reduce the vulnerability of societies to health threats. However, a candid observation to be made is that very little is being done by the State to realise this constitutional goal.

Instead of taking over the responsibility of providing healthcare by itself, the State has strategically allowed the private sector to provide healthcare; and purchase healthcare for its deserving category of the public. The State shouldering the sole constitutional responsibility of providing healthcare for all has shrunk from 92 per cent in 1946 to a minuscule 30 per cent today.[9] It is estimated that the private sector holds 60 per cent of IPD beds and 85 per cent of tertiary care beds. During the first and second waves of the Covid-19 pandemic, the private sector provided 76.4 per cent of total care, with government facilities contributing the remaining. This clearly indicates how dominant the private sector has become in India.

With the population escalating three-fold since independence, the State, with its responsibility to discharge its constitutional duty of healthcare, partnering keenly with the private sector is understandable. This partnership has placed the State in the position of performing the dual role of both **purchaser** of healthcare and **regulator** of healthcare provisioning. If the State has to provide quality healthcare to all (as envisaged in the Universal Healthcare plan), then it has to necessarily shell out a large amount of public money. Therefore, it is obvious that many (such as the class that can afford it) are kept out of the purview of State-funded healthcare and are forced to meet their healthcare needs by out-of-pocket spending, making the relationship between doctor and patient into one of consumerism. This forms the philosophical premise for the emergence of pure consumer behaviour: the patient (consumer) expecting quality service to produce the desired result, rather than accepting the reality of the situation, sometimes leading to violence against the doctors.

The State as a regulator is pushing hard for the private healthcare sector to offer quality healthcare at low or reasonable cost, imposing immense pressure upon the doctors, which manifests in cutting corners. The cost of healthcare is moving upwards due to an increase in the cost of drugs and medical devices,

7. Article 21 of the Indian Constitution guarantees a fundamental right to life and personal liberty. Vide judicial interpretation the said Article is widened to include right to health as inherent to a life with dignity.
8. Articles 38, 39, 42, 43 and 47.
9. The 1946's scenario is based on the estimation of the Bhore Committee Report.

which are not as stringently regulated as hospitals. The typical behaviour of consumers is to demand service quality commensurate with their spending. While the disgruntled "civilised" consumer litigates against the doctor (the alarming increase in the rate of litigation stands testimony to this fact), the unruly disgruntled consumer would resort to violence.

Unfortunately, in a few setups,[10] there is a strong profit motive. Moreover, many such entities are promoted by non-medical professionals. Most of them are listed on stock exchanges (where their shares are traded). The management or ownership of such entities is to maximise profit and consistently produce shareholder value. On the other hand, the doctors are trained professionally to treat the patients with higher ethical value. Naturally, medical professionals find themselves in a tricky situation and find it difficult to navigate ethically. The slightest slip on their part would expose them to a greater risk of violence.

The quality of primary healthcare and low per capita healthcare spending by the State, low literacy, imbalanced media coverage and involvement of local politicians are also additional related causes to be noted.

Lack of training and capacity enhancement opportunities: The training and education of the medical professionals are yet to attune themselves to cater to the changing paradigm. Most published case studies on the subject indicate lack of proper communication between patients, their attendants and doctors as the major erupting cause of violence.[11] There is ample evidence to indicate how every doctor is overburdened with work pressure,[12] adding further to the lack of communication skills among medical professionals. Therefore, the doctor finds it difficult to give sufficient time to interact with the patient and relatives, giving the impression that doctors are careless in the discharge of their duty. In bigger hospital establishments, a team of doctors, along with a sizeable number of paramedical teams treat the patient. The patient and the relatives keep interacting with all of them. There is a natural possibility of these communications not being in harmony with each other,

10. Popularly referred to as "corporate hospitals." However, the expression corporate healthcare set up is used here to mean all such organisations that provide healthcare for consideration with a profit motive.
11. See generally, P. Ambush, "Violence against doctors in the Indian subcontinent: a rising bane," *Indian Heart Journal*, 68 (2016): 749–750; T. Anand, S. Grover, R. Kumar, M. Kumar, & G. K. Ingle, "Workplace violence against resident doctors in a tertiary care hospital in Delhi," *The National Medical Journal India*, 29 (2016): 344–348; Kanjaksha Ghosh, "Violence against doctors," p. 130.
12. Even now, India faces a huge shortage of healthcare workforce at all levels. For instance, against the WHO ideal of 1 doctor per 1000 population; currently, we have about 0.65 doctors per 1000.

which might seed some element of suspicion among the patient and relatives. Adding to this, jargon-heavy conversation makes both the patient and the relatives impatient.

Reforming medical education and training cannot be stressed enough. Budding young doctors should be creatively and effectively taught the art of communication and the use of "human language." The exhibition of empathy by the doctors and other healthcare professionals would do wonders in improving the situation. The renewed longitudinal programme of professional training on attitude, ethics and communication should be given proper priority.

Communication is a skill and it has been recently included in the medical curriculum of both UG and PG. Not just doctors, but every healthcare worker should be trained in communication. This aspect is dealt with in Chapter 3 titled "The Importance of Effective Communication."

Legal Framework

The legal environment dealing with violence against doctors can be placed in the following three categories namely, (i) general law regime (both criminal and common law); (ii) specific laws prevalent in the many States of India; and (iii) Healthcare Service Personnel & Clinical Establishments (Prohibition of Violence and Damage to Property) Act, 2019.

The General Law Regime

It can be said that the entire legal regime (not specific to medical professionals) *inter alia* attempts to protect three basic human interests (3-Ps) namely, the person (bodily integrity), the property (movable, immovable and intellectual) and personality (reputation) of an individual. The law considers any human act[13] violating these basic interests as wrong. Depending upon its gravity, wrongs are further classified into "criminal" and "civil." The magnitude of criminal wrong is relatively greater and is therefore referred to as wrong against society,[14] whereas wrongs of lesser magnitude (in comparison with crimes) are recognised as civil wrongs. Unlike crimes, in civil wrongs, the affected individual is allowed to fight for his or her infringed right, by using his or her discretion. If proved (in court), a criminal wrong would generally result

13. The expression "act" includes "omissions" as well.
14. Therefore, procedurally the corrective action against wrong is directly or indirectly initiated by the State (which is the representative organ of society).

in imprisonment of the wrongdoer, while a civil wrong is generally redressed by an award of damages (monetary compensation).

The criminal law: Although it does not address specifically the issue of violence against medical professionals, the Indian Penal Code, 1860, addresses general issues of violation of person and property. Sections 322 (voluntarily causing grievous hurt), 320 (grievous hurt), 319 (hurt), 351 (assault), 503 (criminal intimidation) and 425 (mischief) are key provisions which can be used to address violence against medical professionals. The provisions of the IPC are more than sufficient to address any issues of violence, no matter against whom the same is inflicted. But the enforcement of these provisions (by enforcement agencies) is the weakest link in the chain. Therefore, special laws are thought of in some deserving cases, including violence against the medical fraternity.

Special laws to protect against violence against the medical fraternity are discussed at length below. The special laws would provide a remedy with surgical precision, as they are solely created keeping in mind very specific issues faced by the society or certain sections of the population. 23 States in India have dedicated laws in this regard. Those States with no such special laws rely on the provisions of the Indian Penal Code. However, it must not be forgotten that the provisions of IPC can be used for traction (and for interpretation) along with the special statutory provisions, if available.

The common law: The generic expression "common law" can be explained *inter alia* in the following ways namely, (i) the law derived from common sense (and applied as law by law courts); (ii) the unwritten or unmodified law (in comparison with written or codified law) and (iii) that part of civil law which is common to all jurisdiction (probably with little plausible variation). This branch of civil law is known as tort law. It provides remedies of civil nature and attempts to protect humans from external aggression in general.

Assault, battery and defamation are three critical branches for our context. Assault is creating reasonable apprehension that battery would be committed against one's body. Battery is the use of unjustified force against a human body. In defamation, the loss of reputation is attempted to be protected. As explained above, these are general prescriptions for everyone; and can also be used by the medical professionals to protect their interests, when attacked. In the absence of any special law, the affected medical doctor or hospital may attempt to recover their loss in monetary terms, by recursing to common law remedies. There are a few other civil law concepts such as trespassing on property (unauthorised entry into the premises) which can also be used to some extent.

The remedies available in all these actions are civil in nature. Claiming monetary compensation for the loss that occurred would be the most sought-after

remedy under this category. To seek remedies under this segment, a jurisdictional civil court has to be approached.

State-specific special laws: In the Indian constitutional scheme, subjects such as public health and maintenance of law and order are included in the State list. Other related subjects such as drugs (quality and control), and professional regulation fall under the concurrent list, meaning that both the Central and State governments can exercise their authority. In addition to general law, special laws are passed to protect the specific interests of a few communities. Women, children, scheduled castes, scheduled tribes, and so on, are a few examples. Due to special circumstances, general law is found to be insufficient or ineffective in the protection of these vulnerable sections of society. Due to the increasing enormity of the issue, the community of health professionals are also placed in the category of a special community. Therefore, there are many States in which special laws are passed to protect both medical professionals and medical establishments. Table 1.1 captures the details in this regard.

Twenty-three provincial States have passed dedicated laws in protecting the interest of the healthcare professionals and property, with varying names and scopes of treatment.[15] All these statutes typically attempt to address the issue of increased violence against the medical fraternity. The prohibition of violence against medical service personnel or damage to property in a medical centre forms the soul of all these statutes. Most of these statutes declare prohibited acts (violence against medical professionals) to be cognisable and non-bailable offences. Cognisable offences are generally heinous crimes; such as murder, rape, kidnapping, dowry death, and so on, where procedural law allows the enforcement officer (police) to arrest the suspect without seeking any warrant from the court, provided the officer has reason to believe that the person has committed the offence and is satisfied that the arrest is necessary on certain enumerated basis. The Law Commission in its 177th Report opined that cognisable offences may warrant the immediate arrest of culprits.[16] All the statutes also prescribe enhanced sanctions for the prohibited acts.

There is no clear data to analyse the effectiveness of these special statutes in protecting doctors' interests. More often than not, doctors decide against

15. Andhra Pradesh, Odisha, Punjab, Haryana, Rajasthan, Tamil Nadu and West Bengal have had such laws since 2008. States such as Bihar, Chhattisgarh, Goa, Gujrat, Himachal Pradesh, Kerala, Maharashtra, Manipur, Tripura, Uttarakhand and Andhra Pradesh are the recently included States in this category.
16. One Hundred and Seventy Seventh Report on Law Relating to Arrest, Law Commission of India, 2001.

Table 1.1 The Special Laws to Protect Medical Professionals Listed by State

	State	Special Law to Protect Medical Professionals
1	Andhra Pradesh	The Andhra Pradesh Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage to Property) Act, 2008
2	Arunachal Pradesh	The Arunachal Pradesh Protection of Medical Service Personnel and Medical Service Institutions (Prevention of Violence and Damage or Loss of Property) Act, 2019
3	Assam	The Assam Medicare Service Persons and Medicare Service Institutions Act, 2011
4	Bihar	The Bihar Medical Service Institution and Person Protection Act, 2011
5	Chhattisgarh	The Chhattisgarh Medicare Service Persons and Medicare Service Institutions Act, 2010
6	Goa	The Goa Medicare Service Personnel and Medicare Service Institutions (Prevention of Violence and Damage or Loss of Property) Act, 2013
7	Gujarat	The Gujarat Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage or Loss of Property) Act, 2012
8	Haryana	The Haryana Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage to Property) Act, 2009
9	Himachal Pradesh	The Himachal Pradesh Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage to Property) Amendment Act, 2017
10	Karnataka	The Karnataka Prohibition of Violence against Medicare Service Personnel and Damage to Property in Medicare Service Institutions Act, 2009
11	Kerala	The Kerala Healthcare Service Persons and Healthcare Service Institutions (Prevention of Violence and Damage to Property) Act, 2012
12	Madhya Pradesh	Madhya Pradesh Chikitsak Tatha Chikitsa Sev Se Sambaddha Vyaktiyon Ki Suraksha Adhiniyam, 2008
13	Maharashtra	The Maharashtra Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage or Loss to Property) Act, 2010
14	Manipur	The Manipur Medicare Service Personnel and Medicare Service Institutions (Prevention of Violence and Damage to Property) Act, 2015
15	Odisha	The Orissa Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage to Property) Act, 2008
16	Punjab	The Punjab Protection of Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage to Property) Act, 2008

Table 1.1 (*Continued*)

	State	Special Law to Protect Medical Professionals
17	Rajasthan	The Rajasthan Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage to Property) Act, 2008
18	Tamil Nadu	The Tamil Nadu Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage or Loss to Property) Act, 2008
19	Telangana	The Telangana Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage to Property Act), 2008
20	Tripura	The Tripura Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage to Property) Act, 2013
21	Uttar Pradesh	The Uttar Pradesh Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage to Property) Act, 2013
22	Uttarakhand	The Uttarakhand Medicare Service Persons and Institutions (Prevention of Violence and Damage to Property) Act, 2013
23	West Bengal	The West Bengal Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage to Property) Act, 2009

registering minor incidents of violence, as that would mean litigating against some of their patients and neighbourhood. For doctors who do decide to register violent incidents, many complaints at the police station are suppressed using multiple methodologies. The authors recollect a few incidents and narratives explaining how uphill a task it is to register a complaint at the police station. This is despite of the Supreme Court ruling in *Lalita Kumari* v. *Government of Uttar Pradesh*, that all complaints pertaining to any kind of violence at a hospital shall be registered as a First Information Report (FIR) by the concerned police officials.[17] It has been observed that less than 10% of cases of violence are registered under these Acts and would be looked into by the courts after submission of the chargesheet. Most of these result in the acquittal of the accused. Interactions with medical associations indicate that despite dedicated laws, the doctors in these States do not feel secure due to poor implementation of the respective statutes in their jurisdiction.

17. Judgment delivered on 12 November 2013.

The Epidemic Diseases (Amendment) Act, 2020: This Act received the assent of the President on 28 September 2020,[18] and amends the Epidemic Diseases Act of 1897.[19] The amendment renders protection for healthcare personnel while combating epidemic diseases, and expands the powers of the Central Government to prevent the spread of such diseases as well.

At the very outset, the Act prohibits any act of violence against a healthcare service personnel and also damage or loss to any property during the epidemic.[20] It states that whosoever either commits or abets such an act of violence, shall be punished with a minimum imprisonment of three months, which can further extend up to five years. The law also prescribes the imposition of a fine from Rs. 50,000 to Rs. 2,00,000 along with any term of imprisonment.[21] During any act of violence, if any healthcare professional is grievously hurt, then the gravity of punishment increases to a minimum imprisonment of six months to seven years; with a minimum fine of one lakh to five lakh rupees. In case of damage or loss to the property, a compensation twice the amount of fair market value of the damaged property shall be awarded by the court.[22]

Procedurally, this law includes the following few more critical points namely, (i) act of violence against medical professionals is held to be cognisable and non-bailable; (ii) the case is to be investigated by a police officer not below the rank of Inspector, who shall complete the investigation within 30 days from the date of registration of the FIR and (iii) the enquiry or trial of the case shall be completed as expeditiously as possible, preferably within one year.[23] Importantly, the law presumes the culpable intent on the part of the assailant. Therefore, the burden of proof to escape liability lies upon the assailant and not the prosecution.[24] The present law defines the "act of violence" to include (i) harassment impacting the living or working conditions of healthcare service personnel and preventing them from discharging their duties; (ii) harm, injury, hurt, intimidation or danger to the life of such healthcare service personnel, either within the premises of a clinical establishment or otherwise; (iii) obstruction or hindrance to such healthcare service personnel in the discharge of their duties, either within the premises of a clinical establishment

18. Act No. 34 of 2020, gazetted on 29 September 2020. This Act also repealed earlier ordinances in this regard.
19. The Act *inter alia* provides for the prevention of the spread of dangerous epidemic diseases.
20. Section 2B of the amended Act.
21. Section 3(3) of the Act.
22. Section 3E(2) of the Act.
23. Section 3A of the Act.
24. Sections 3D and 3C, respectively, of the Act.

or otherwise; (iv) loss or damage to any property or documents in the custody of, or in relation to, such healthcare service personnel.[25] It needs to be emphasised that this law operates only in situations of the epidemic. During normal situations, the State legislation will operate to protect the life and property of medical professionals, wherever prevalent. In those States where there are no dedicated statutes, the situation is governed by the general provisions of the IPC, as explained above.

There are far and few judicial pronouncements touching upon the issue of violence against the medical fraternity. In response to one of the petitions filed by a medical doctor, the Supreme Court has directed the State (especially the Police Administration) to provide necessary security at all places where medical services are rendered, particularly where Covid-19-positive patients were quarantined.[26] The High Court of Jammu and Kashmir lamented that in spite of 23 States having dedicated statutes to protect medical professionals, there has not been a considerable improvement in the scenario.[27] The same court also added further that such a critical matter needs the immediate attention of everyone and, if needed, some amendments should be carried into the existing statutes.

Placing the Legal Framework in Context

Law is a very powerful tool invented by civil society for regulating human behaviour. However, the law also has its own limitations. There are multilateral studies that have attempted to understand the correlation between the criminalisation of an act and its effect on deterrence.[28] All these studies primarily find out that criminalisation and enhanced punishment for criminalised acts seldom have a deterrence effect. There might be a decline in crimes which are conducted with careful planning, but other crimes which occur due to fits of the moment do not have any correction with criminalisation or enhanced punishment. Many crimes take place due to a lack of rational

25. Section 1A(a) of the Act.
26. See generally, *Jerry Banait* v. *Union of India*, PIL filed on 8 April 2020. http://indiankanoon.org/doc/147127045.
27. See generally, *Azra Usmail* v. *Union Territory of Jammu and Kashmir*, 2020 SCC Online J&K 219.
28. See generally, M. Baron, "Justifications and Excuses," *Ohio State Journal of Criminal Law*, 2 (2005): 387; B. Boonian, *The Problem of Punishment* (Cambridge University Press, 2008); J. Chalmers & F. Lovesick, "Fair labelling in criminal Law," *Modern Law Review*, 71 (2008): 2170246; Ben Johnson, "Deterrence theory in Criminal Justice Policy—a primer," Report submitted to Minnesota Legislature, 2019.

decision-making ability on the part of the assailant. Many occurrences of violence against doctors happen in emotionally distressing situations. Therefore, a mere increase in the punishment or criminalisation alone would not have a deterrence effect, neither is it reasonable to expect one.

Constitution of designated special courts to try these matters can be tried. The beauty of the law lies in its implementation; otherwise, these laws are mere showcase toys. However, a lot lies in education and sensitisation among society regarding the long-term effects of such violent acts, *inter alia*, closure of health facilities leading to non-availability of healthcare facilities in the region, an increase in the delivery of health costs, shutting down of smaller nursing homes with fewer doctors fearing inadequate strength to defend themselves effectively in case of violence, and so on. Social awakening would go a long way in this regard. This is imperative, as the law, and enforcement agencies alone cannot completely prevent incidents of violence against healthcare professionals.

It must be emphasised that providing safety to human life is the ultimate responsibility of the State and its agencies. Therefore, it has to be conveyed abundantly clearly to the State that any report of violence against healthcare professionals shall be taken as a failure of State machinery (as it is done in cases of rape, rail accidents, etc.). This pressurises the State agencies to not only investigate aggressively but even work to prevent the occurrence itself. The medical establishments must realise that it is their primary responsibility to provide security to their working force. Therefore, appropriate organisational mechanisms need to be developed and implemented.

It is noted that most hospitals (including many well-known ones) do not have an optimal grievance redressal system in place. Such a system could absorb the growing tension and frustration of the patient and relatives, and help the medical community to develop insights into patients' belief systems. The global trend is now inclined toward holding the employer (i.e., organisation) accountable for preventing and address workplace violence.[29] A well-articulated "reporting system" is also lacking in these establishments. The healthcare workforce must be trained to report any threat or intimidation situations to the authorities. This will reduce the possibility of smaller stray incidents taking mammoth proportions at later points in time.[30]

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29. The WHO framework guidelines indicate the responsibilities of employers which include ensuring the health and safety of workers, elimination of risks, routine assessment of the incidence of violence and its causes, developing policies to combat violence, setting up adequate mechanisms for reporting and so on.
30. See generally Neeraj Nagpal, "Incidents of violence against doctors in India: Can these be prevented?" *The National Medical Journal of India*, 30(2) (2017): 97–100.

Conclusion and Take-Home Messages

Undoubtedly, violence in any form against anyone is unacceptable, and if it occurs, it needs to be addressed as a priority. When professionals who have taken an oath to keep our society healthy are subjected to violence, as a civil society, it's everyone's responsibility to proclaim zero tolerance for this violence. Former President A. P. J. Abdul Kalam once said, "Don't read success stories, read failure stories," because these are the case studies that help us learn better life lessons. Many real-life challenges faced by doctors should form case studies in teaching at medical colleges. This chapter has examined the legal and policy framework for violence against the medical fraternity in India.

1. Legally, this is been communicated by special statutes in 23 States. If other States follow suit, it will go a long way in increasing confidence in the medical community.
2. We need to devise means and methods to better enforce these laws. Enforcement officials (police) and members of the judiciary should be sensitised about the long-lasting impacts of violence against healthcare professionals, enabling them to place priority on such reported instances.
3. Society as a whole also needs to be sensitised about the long-term repercussions of violence against healthcare professionals in their communities, on healthcare delivery costs, and availability of healthcare in their region at all.
4. There should be made increased opportunities for capacity building and soft skills training for healthcare professionals to improve communication.
5. The medical establishments must provide security to their working force and institute the appropriate organisational mechanisms, including a reporting system for employees threatened by patients, and a grievance redressal system for unhappy patients.

Chapter 2

REGIONWISE CASE STUDIES OF VIOLENCE AGAINST HEALTHCARE PROFESSIONALS IN INDIA

S. N. Basu and Bagmisikha Puhan

Introduction

The World Medical Association has most recently defined violence against health personnel as an "international emergency that undermines the very foundations of health systems and impacts critically on patient's health."[1] The World Health Organization defines workplace violence as the "intentional use of power, threatened or actual, against another person or against a group, in work-related circumstances, that either results in or has a high degree of likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation."[2]

While the true extent of workplace violence in healthcare is difficult to estimate, the majority of data pertaining to workplace violence in this sector come from the geographic regions of Europe, the United Kingdom, Australia and North America.[3] The report suggests that compared to the average risks for assault and threats across all occupations, healthcare workers in the United Kingdom have three to four times higher risk for these forms of violence.

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1. World Medical Association, 73rd World Health Assembly, agenda item 3: Covid-19 pandemic response (2020). https://www.wma.net/wp-content/uploads/2020/05/WHA73-WMA-statement-on-Covid-19-pandemic-response-.pdf (last accessed on 9 July 2022, at 1044 hrs).
2. WHO. "Violence: a public health priority" (Geneva: World Health Organization, 1995).
3. Ibid, p. 4.

Compared to this, in India, according to a study by the Indian Medical Association (IMA), over 75 per cent of doctors have faced violence at work.[4] This IMA study also went on to clarify that about 12 per cent of cases of violence led to physical attacks on the doctors; and that about 70 per cent of the violence has been caused by the escorts/relatives of the patients. This leads us to one critical consideration of how difficult it would be for healthcare workers to ascertain what and where to expect workplace violence from, when the miscreants could be the ones who are related and involved as an attendant to their patient.

The fear in the country amongst doctors is not just about physical violence which may be caused by the relatives of the patients, passers-by or criminals, but also extends to the harassment which some feel is caused by the police personnel; the threat of being sued by the patient where they do not feel they have "objectively" received the care in lieu of what they have "paid for"; the threat of political vilification; and of being criminally prosecuted without sufficient investigation into the matter which may have led to an adverse consequence.

There have been reports of doctors and other healthcare workers being beaten up for the death of infants and senior citizens; for demands to be treated by doctors who are of equal or higher caste; for cautioning patients about physical-distancing measures implemented during the Covid-19 pandemic;[5] or due to mob violence.

In a diverse community like ours, with disparities in access to affordable healthcare amongst the population, healthcare practitioners are treated in extremes, either with reverence or with disdain. Multiple factors such as poor communication, poor infrastructure, difficult access to affordable healthcare and a skewed physician-to-patient ratio can result in violence against healthcare professionals. Due to the very nature of the activities that are carried out in healthcare, especially in an emotionally charged environment with multiple external influences, the healthcare professional becomes especially vulnerable to the violence outside.[6]

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4. Neeraj Nagpal. "Incidents of violence against doctors in India: can these be prevented?" *The National Medical Journal of India*, 30 (2017): 97.
5. Sankuru Santosh K. Dora, Humera Batool, Rifath I. Nishu, & Pousette Hamid,"Workplace violence against doctors in India: a traditional review." https://www.cureus.com/articles/28089-workplace-violence-against-doctors-in-india-a-traditional-review#references (last accessed on 17 June 2022, at 1012 hrs).
6. V. Di Martino, "*Workplace violence in the health sector – country case studies Brazil, Bulgaria, Lebanon, Portugal, South Africa, Thailand, plus an additional Australian study: Synthesis Report*" (Geneva: ILO/ICN/WHO/PSI, 2002), Joint Programme on Workplace Violence in the Health Sector, forthcoming working paper.

It is in this context that we proceed to examine the issues which have been prevalent in the Indian healthcare sector. This chapter evaluates whether there have been any region-wise specific trends with respect to the violence against healthcare workers, and also attempts to appreciate the legal framework which exists to cater to the conflicts and delve deeper into what else could be addressed under the law, or within the practice of medicine, to put healthcare workers at relative ease.

Apparent Causes of Violence

Amongst several causes which lead to workplace violence in the sector, we will discuss the ones which have gained most prominence:

(1) **Change in perception**: As mentioned earlier, the reverence with which physicians were earlier treated, has somehow been replaced by the image of "money-hungry," "business-minded" professionals and the discussions in the media have helped to build on this image. The manner in which these reports are played out, make it seem like the physician must be apprehended for negligence[7] without even allowing the physician or staff to state their side. This attitude is further fuelled by the fact that in the private sector, the costs are sometimes high, so the patients/their relatives walk in with the expectation of getting their "value for money," which loosely translates into a healthy discharge.

(2) **Inadequate infrastructure:** Particularly in government hospitals, the absence of sufficient healthcare workers (leading to overburdened staff), lack of easy access to healthcare, poor infrastructure, shoestring budgets, poor quality healthcare, lack of a comfortable environment, poor hygiene and sanitation and so on have all led to a large, disgruntled set of patients and families. The ratio of available physicians and capable staff in the rural sector, cannot be compared to what is even remotely required for serving the needs of a locality or region. The eviscerating system just acts as a catalyst in supporting violence against care providers.

(3) **Low literacy levels:** In addition to the failure at the level of infrastructure, we have also witnessed that low literacy on health has led to the public assuming that if a patient does not rely upon another to be admitted to a healthcare facility, they will most likely come back home, on their feet. It is possible that there is a gap in communication between

7. Neeraj Nagpal, "Violence against doctors in India," pp. 97–100.

the patient's family and the providers, but this has to overcome the unrealistic expectations that are carved out by the patient and family.

(4) **Poor communications training:** The healthcare sector is also riddled with doctors who are conversant with clinical aspects, but do not necessarily possess a good bedside manner, nor the empathy that is needed to interact with the patient and family, while discharging their services. With the poor physician–patient ratio, deficient staff services, and lack of time, there is not enough training given to the providers to be empathetic, and communicate clearly with the patient and the family.

Regional Incidents in India

We have noticed that the incidence of violence against healthcare workers in the country is not limited to a specific socio-economic class, region or a specific religion, but ranges across all parts of the country, the importance of which has been felt only recently by the government. This will be discussed in the next part of the chapter which deals with regulatory and judicial discussions around the subject matter.

More often than not, in cases of violence in the health sector, the cause is owing to the death of the patient, or delays in receiving care. In other cases, violence may stem from the aggressive behaviour of the attendant/s or relatives, or discrimination (caste- or class-based), or sometimes because of the lack of effective communication from the physician.

The following few incidents reflect the situation across the country:

(1) In January 2017, an MP and his associate were accused of beating up three doctors in a private hospital in Sirsi, Karnataka, for allegedly not treating the MP's mother properly.[8] When the hospital authorities did not report the issue, the Sirsi New Market Police registered a *suo motu* case on the basis of the CCTV footage received from the hospital. The Member of Parliament was released on bail in 2017, but the matter is pending trial for lack of witnesses.

(2) In July 2017, a resident doctor at Sion Hospital in Mumbai was assaulted by the kin of the patient who died; this is after the doctor had clocked in at least 36 hours of duty.[9] The doctor went into a state of trauma after the

8. Express News Service (15 June 2019), "How doctor–patient violence plays out: A report card from other states." https://indianexpress.com/article/india/bengal-protests-how-doctor-patient-violence-plays-out-a-report-card-from-other-states-5781528/ (last accessed on 19 June 2022, at 1718 hrs).
9. The Hindu (21 March 2017), "I don't want to get back to work." https://www.thehindu.com/news/cities/mumbai/i-dont-want-to-get-back-to-work/article17547412.ece (last accessed on 19 June 2022, at 1627 hrs).

attack. The patient had been earlier discharged from the hospital against medical advice. According to the doctor, once she was re-admitted, she was given all treatment due to her in her medical condition. The doctor went on record to state that he would not immediately go back to work, for he felt humiliated after the incident; the doctor, afflicted by polio, said that work pressure on resident doctors was so high that his leg caliper broke within a few months of starting work. The incident sparked an "indefinite mass leave" by resident doctors across Maharashtra, which led to the cancellation of about 500 surgeries at public hospitals in Mumbai.

(3) In August 2018, a doctor in NRS Hospital in Kolkata was thrashed after a 37-year-old patient died: the doctor sustained injuries after a mob attacked him in the hospital premises, with claims from the relatives of the deceased patient that he was not given treatment in due time and died upon the administration of an injection. This led to the junior doctors going on a strike seeking arrest of the culprits, and only after about 9 hours of this chaotic situation, could the doctors be convinced to go back to work.[10]

(4) In September 2018, a lady doctor was brutally beaten up by over a dozen men, in the premier maternity hospital in Kashmir, after a patient delivered a still-born baby.[11] The relatives of the patient called in more relatives to attack the doctors. While several other doctors left the operation theatre to avoid the attack, the victim doctor was caught in the corridor and beaten up ruthlessly with sticks. This led to the Doctors Association of Kashmir requesting once again an ordinance to make violence against doctors a non-bailable offence.[12]

(5) In September 2018, doctors at a hospital in Benares were beaten up, and a police booth, bikes were set on fire after a scuffle broke out between junior doctors and family of the patient.[13] The hospital staff

10. TNN (27 August 2018), "Doctors thrashed after 37-year-old dies at NRS, patients bear the brunt." https://timesofindia.indiatimes.com/city/kolkata/doctors-thrashed-after-37-year-old-dies-at-nrs-patients-bear-the-brunt/articleshow/65556801.cms (last accessed on 19 June 2022, at 1627 hrs).
11. Samaan Lateef (17 September 2018), "Lady doc beaten up at Lall Ded after patient delivers stillborn." https://www.tribuneindia.com/news/archive/j-k/lady-doc-beaten-up-at-lall-ded-after-patient-delivers-stillborn-654420 (last accessed on 19 June 2022, at 1635 hrs).
12. A non-bailable offence is a serious offence where bail is a privilege and only the courts can grant it. On being arrested and taken into custody for a serious or non-bailable offense, a person cannot ask to be released on bail as a matter of right.
13. FE Online (25 September 2018), "BHU on fire! Doctors at Sir Sunderlal Hospital beaten up, police booth, bikes set ablaze after scuffle." https://www.financialexpress.com/india-news/bhu-on-fire-doctors-at-sir-sunderlal-hospital-beaten-up-police-booth-bikes-set-ablaze-after-scuffle/1325694/ (last accessed on 19 June 2022 at 1736 hrs).

had communicated to the patient's family that there was no immediate availability of beds in the male surgery ward, and the relatives resorted to violent protest. The scuffle was swiftly followed by suspension of all classes and the closure of five BHU hostels, accompanied by the heavy deployment of police forces around the campus.

(6) In October 2018, a doctor belonging to a Scheduled Tribe community in Jabalpur was assaulted by the relatives of a patient, as they wanted treatment from an upper caste doctor.[14] While the doctor had already instructed for immediate medical intervention, relatives accosted the doctor seeking details about his caste, and manhandled the doctor before removing the patient from the hospital.

(7) In June 2019, two people were arrested after a medical superintendent in Mangalore's Wenlock Hospital filed a police complaint alleging that a patient's friends had threatened doctors on duty at the hospital in the early hours of the morning, and had also filmed it on a mobile phone.[15] This was during the time that medical services in Karnataka and major Indian cities were hit after the Indian Medical Association's call for a nationwide strike. The police arrested two persons after identifying them from the video.

While there are several aspects to unpack, it is important to note here that these reports are not sufficient to identify a single significant cause of the violence against healthcare professionals. A Joint Working Programme of the International Labor Office, the International Council of Nurses, the World Health Organization and Public Services International on Workplace Violence in the Health Sector has carried out in-depth country case studies examining influencing factors and identifying settings in which such violence takes place. These studies need to be conducted in the country in order to assess what the violence stems from and why it is gaining prominence. Only when an assessment of this is made, can better resolutions be made in terms of legislation.

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14. Express Web Desk (14 October 2018), "MP: Demanding treatment by upper caste person, patients' kin 'assault' doctor from Scheduled Tribe." https://indianexpress.com/article/india/madhya-pradesh-doctor-claims-patients-kin-assaulted-him-wanted-to-be-treated-by-upper-cast-person-5401649/ (last accessed on 19 June 2022, at 1733 hrs).
15. Prajwal Bhat (18 June 2019), "Two arrested in Mangaluru after video of man abusing hospital staff goes viral." https://www.thenewsminute.com/article/two-arrested-mangaluru-after-video-man-abusing-hospital-staff-goes-viral-103861 (last accessed on 19 June 2022, at 1655 hrs).

From what has been discussed here, there is no clear reason, or a singular cause which perpetuates discord leading to violence to the doctors. It is unfortunate that healthcare providers have to face such severe work conditions for long periods of time while striving to ensure the best healthcare to their patients.

Judicial Precedents

While we have discussed reports from newspapers and other media outlets, it is also important to examine how courts of law have addressed these issues across the country. A few are highlighted here to demonstrate the general tone and concern that flows through the nerves of the judiciary when it comes to the welfare of healthcare professionals.

(1) ***Jerryl Banait* v. *Union of India***
Citation: 2020 SCC OnLine SC 357
The Hon'ble Supreme Court took cognisance of the violence against medical staff who had to screen persons suspected of coronavirus, in furtherance of a writ petition under Article 32 of the Constitution of India filed by a registered medical practitioner as a Public Interest Litigation praying for various directions in reference to COVID-19. The apex court laid down guidelines for the use of PPE equipment, and further emphasised on the duty of the State and the police administration to provide necessary security to medical staff. The Court also directed the State to take necessary action against those persons who obstruct and commit any offence in respect to the performance of duties by healthcare staff on COVID duty.

(2) ***Sanpreet Singh* v. *Union of India***
Citation: WP (PIL) No. 52 of 2020
A writ petition was filed under Article 226, espousing public cause for the benefit of healthcare workers involved in the ongoing fight against the COVID-19 pandemic. The High Court of Uttarakhand directed the State Government to ensure proper nourishment and necessary care to medical workers who were unable to visit their respective residences. Furthermore, District Magistrates were directed to look into the grievances of healthcare workers in their respective districts, for executive intervention.

(3) ***Azra Usmail* v. *UT of Jammu and Kashmir***
Citation: WP(C) PIL No. 4/2020
During the course of the litigation, the Court ordered a look into the grievances of the family members of healthcare workers who are unable

to look after their homes because of commitment to their duties. In the same case, a judicial note was made that violence against healthcare workers is not new and that there is a need for a proper legislative framework.

(4) ***Devinder Negi* v. *State of Himachal Pradesh and Others***
Citation: WP No. 404 of 2007
The case pertained to a doctor's right to go on strike, in response to incidents of violence against medical professionals. The Court noted that the public cannot be permitted to resort to violence and take law into their own hands. In the event where medical professionals are subjected to violent actions or in any manner prevented from performing their duty in a proper atmosphere by any member of the public, including relatives and attendants of the patients, the doctor shall have the right to take assistance of the security guards or the police personnel to evict such persons from the hospital premises.

(5) ***Sarita Singh* v. *State and Others***
Citation: WP (S/B) No. 284 of 2017
A doctor was shot dead while discharging his duties at the hospital. The State of Uttarakhand, in order to curb the violence against doctors and medical institutions, had enacted the Uttarakhand Medicare Service Persons and Institutions (Prevention of Violence and Damage to Property) Act, 2013. The Court directed the State Government to enforce the provisions of the above-mentioned Act, both in letter and in spirit.

(6) ***Rashid Bakkel* v. *State of Kerala***
Citation: Bail Application No. 6644 of 2019 for CRIME NO.419/2019
This case pertained to a pre-arrest bail application filed by a person, charged under Section 353 of the Indian Penal Code and Sections 3 and 4 of the Kerala Health Care Service Persons and Health Care Service Institutions (Prevention of Violence and Damage to Property) Act, 2012. The applicant had allegedly attacked a doctor of a government hospital upon his refusal to treat members of the applicant's family. The Court noted that though no serious injuries were inflicted, the relief of pre-arrest bail cannot be granted to the applicant. The Court further stated that an incident of physical abuse against medical service personnel would have to be viewed very seriously.

It is important to note that several of the cases cited pertain to the Covid-19 pandemic, when for the first time we saw patients threatening the healthcare practitioners by risking contracting the virus, when the objective of these

frontline workers was to ensure effective and early treatment, and preventive care. It is saddening that even doctors of advanced age have been victims of unprovoked violence in their line of duty.

A Physician's Perspective

It is not usually wrong to assume that a person who chooses to be a doctor or healthcare professional wants to do good to the society at large. However, this hope is stifled when they are forced to work in settings with understaffed facilities, insufficient resources and crumbling infrastructure, with the constant threat of workplace violence. As discussed in the cases above, the incidents do not just bring in fear to the individuals but also become a cause for humiliation, discouraging their willingness to return to work and perform their societal functions.

The doctors have had to go on strikes on numerous occasions just to have their issues addressed, and this persists across the nation, even during stressful times like the Covid-19 pandemic.[16] It has come to a point where some doctors now feel there is a pressing need to seek an arms license to protect themselves against attacks by patients and their family members.[17] Furthermore, it is also disheartening that the hospital authorities and healthcare workers have had to rely on the services of private security agencies to address their security than being able to rely on the government for the extended support, and requisite sensitisation amongst the public.

It is unfortunate that the physicians during times of distress, working extended hours, in a gratuitous manner, are forced to choose between working in exceptionally threatening situations, retire early, or suffer in silence.

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16. Press Trust of India (19 June 2021), "Doctors protest in Delhi over violence against healthcare professionals." https://www.ndtv.com/delhi-news/doctors-protest-in-delhi-over-violence-against-healthcare-professionals-2466984. Press Trust of India (18 June 2021), "Around 3.5 lakh doctors to protest on Friday demanding law on violence against medicos." https://www.ndtv.com/india-news/indian-medical-association-3-5-lakh-doctors-to-protest-on-friday-demanding-law-on-violence-against-medicos-2466485. Press Trust of India (21 April 2020), "Coronavirus: 28,000 Gujarat doctors to participate in Indian Medical Association's protest." https://www.ndtv.com/india-news/coronavirus-28-000-gujarat-doctors-to-participate-in-indian-medical-associations-protest-2215794 (last accessed on 20 June 2022, at 0917 hrs).
17. TNN, (11 August 2017), "IMA seeks arm license for doctors as assault cases spike." https://health.economictimes.indiatimes.com/news/industry/ima-seeks-arms-licence-for-doctors-as-assault-cases-spike/60020550 (last accessed on 20 June 2022, at 0919 hrs).

Laws and Their Effectiveness

Violence against healthcare professionals in the country is regulated through a combination of general and special laws. The Indian Penal Code, 1860, which applies to all in India, is also applicable to doctors, and includes provisions such as "hurt," "grievous hurt," "assault"and so on. Several States, on the other hand, have their own special laws, which specifically address violence against healthcare professionals and establishments. A draft Protection of Medical Service Persons and Medical Service Institutions (Prevention of Violence and Damage or Loss of Property) Act, 2017, prepared by the Indian Medical Association (IMA), was submitted to the Health Ministry in 2017. No action was taken with respect to the same until the Hon'ble Minister of Health and Family Welfare, Shri Harsh Vardhan, in 2019 circulated a copy of a draft Healthcare Service Personnel and Clinical Establishments (Prohibition of Violence and Damage to Property) Bill, 2019 (Draft Bill) to the State chief ministers, and sought for them to also legislate and implement a law on similar lines. The IMA called for a Central law to protect doctors, seeking a 10-year jail term and a fine of Rs. 5 lakhs for perpetrators.[18]

The Draft Bill defined violence to include:

i. harm, injury, hurt, grievous hurt, intimidation to, or danger to the life of, a healthcare service personnel in discharge of duty, either within the premises of a clinical establishment or otherwise; or
ii. obstruction or hindrance to a healthcare service personnel in discharge of duty, either within the premises of a clinical establishment or otherwise;
iii. loss of or damage to any property or documents in a clinical establishment.[19]

This Draft Bill stood out in comparison to the IPC, in the sense that it increased sentences of imprisonment and prescribed higher quantum of fines. Also, the Draft Bill uniformly made the offence of violence against healthcare personnel and clinical establishments cognisable and non-bailable and imposed mandatory minimum punishments. The Draft Bill *per se* does not criminalise any new conduct or state of mind, and existing provisions of the IPC already

18. FE Online (18 June 2019), "IMA renews call for central law to protect doctors: Draft seeks 10-year jail, Rs 5 lakh fine for perpetrators." https://www.financialexpress.com/india-news/ima-renews-call-for-central-law-to-protect-doctors-draft-seeks-10-year-jail-rs-5-lakh-fine-for-perpetrators/1610780/ (last accessed on 19 June 2022, at 1746 hrs).
19. Section 3(d), Draft Bill.

provide punishment for all aspects of violence which the Draft Bill sought to criminalise.

It has been a general trend that FIRs registered by doctors end in out-of-court settlements; doctors usually tend to favour reconciliation due to humiliation and loss of face, and the chance to return to work. Sometimes this settlement is seen as their admission of guilt. It is also very difficult to reveal reported judgments which concern themselves with State legislations, with the judgments only discussing bail applications or compensation claims, instead of prosecutions under these legislations; prosecutions under these laws and circumstances have been extremely low.

It is imperative to understand that the physicians in the country are not left without legal recourse; however, a profession which dedicates their life's work to help alleviate others' pain deserves the sympathy of society, and to this end, there has to be a social change to supplement any law that is put in place. We conclude by suggesting the following basic reforms to restore some hope within the fraternity.

Suggested Reforms

- **Improved training modules:** To better prepare the professionals, it is always advisable to have the training of physicians, healthcare workers to include communication skills and training in empathy. To that end, the Attitude, Ethics and Communication Module (AETCOM) has been implemented in all medical schools to improve the training and educational regime of medical students, in order to acquire the necessary competence in the attitudinal, ethical and communication domains. The National Board of Examinations in Medical Sciences, Ministry of Health and Family Welfare, Government of India, has constituted a Committee for the Development and Implementation of Curriculum for Professional Development and Communication in Healthcare.
- **Stress on communication skills in training of healthcare professionals:** This topic is explored in chapter three titled *The Importance of Effective Communication.*
- **Health literacy:** These issues need to be addressed so that the public becomes aware of how to be responsible about their health and the health of their family. The Government of India is working towards improving Public Health Education but a lot more needs to be done.
- **Address public perception concerns:** It is important to address public perception; the complexity of the healthcare system has to be brought to the fore while explaining the limitations of the overburdened healthcare system, sensitising the public in their expectations from the

healthcare system. This does not mean that this is to be used as an excuse to underdeliver. This will allow the patients and families to empathise with the working conditions.

- **Risk assessment actions:** To ensure that any victim of workplace violence is able to resume their work as normal, it is important that a risk assessment be completed before the victim's return, to ensure that the worker's immediate environment is safe. Changes in patient waiting time (which also acts as a trigger in several cases) and security at the facility premises, will lend greater faith to the practitioner in the environment.
- **Recruitment policy revisions:** Appropriate staff must always be considered in offering healthcare services in any institution. As the patient's family spend a lot of time interacting with the staff, they play a crucial role in preventing violence. Shortages can cause treatment delays, frustration amongst patients and fewer staff available to help colleagues out when an incident occurs.[20]
- **Education about the use of social media platforms:** This applies to the public at large as well as the healthcare professionals.
- **Media reporting:** Across all print and digital media, television and OTT platforms, restraint should be exercised and facts ascertained before any reporting is done. Trial by media is not recommended at all as it only serves to fan mistrust, anger and animosity towards healthcare professionals and greatly increases the chance of violence towards healthcare professionals.
- **Empathy for healthcare workers:** Empathy cannot always be one sided – the doctors and their families also deserve empathy. This has to be conveyed to the patients, and they must be sensitised about these issues.

Conclusion and Take-Home Messages

Quoting Cicero is appropriate here: *"In nothing do men more nearly approach the gods than in giving health to men."* The discussions above refer to multiple causes and scenarios that can lead to workplace violence in the sector.

1. We see reasons and causes in overcrowded hospitals, lack of health literacy, insufficient resources, inadequate staff, inappropriate equipment and a culture fostering acceptance or tolerance towards violence.

20. Jon Richards, "Management of workplace violence victims," (Geneva: ILO, 2003) Joint Programme on Workplace Violence in the Health Sector, p. 15.

2. While the demand for justice will always be a guiding factor for patients and their families, one should be able to evaluate the actual conditions under which any [serious] adverse event occurred; it is fraught with the threats that linger against the well-being of the healthcare workers.
3. There has to be a balancing act where the investigation, if and so required, is carried out by experts (in health and law), as opposed to any vigilante justice acts being carried out against doctors.
4. The laws must be deliberate and dedicated to ensure that there are no unruly, unjust or targeted attacks on those very professionals who are responsible for the health and safety of society at large.

Chapter 3

THE IMPORTANCE OF EFFECTIVE COMMUNICATION

Divya Alexander and Glory Alexander

Case Study

Mr. Venkatesh has been waiting in the Emergency Department for almost two hours after registration, waiting for his injured brother to be seen. He has not eaten or drunk anything for a while, and is becoming frustrated about his brother having to wait in pain for so long. He finally calls out angrily to a passing nurse, who fearfully calls a doctor to speak to Mr Venkatesh. The doctor is annoyed at being interrupted and says, "Listen, you may have been waiting here for 2–3 hours but I have been working all day saving lives in the hospital. I haven't even eaten my dinner and I still can't stop. Anyway, I don't need to explain anything to you. Don't you know how the emergency department works? Please just wait your turn and your brother will be seen when the more urgent cases have been taken care of." As he leaves, he says to the nurse, "Don't bother me about anything else unless it's important," leaving Mr Venkatesh seething with anger.

Whether one can relate to the above situation as the doctor or the patient, this is a prime example of poor communication in a healthcare setting. Read on to find out how this situation could have been handled better.

Introduction

Global studies show various causes of violence in hospital settings. Patient dissatisfaction stemming from overcrowded emergency services, excessive waiting times, denial of admission, shortage of healthcare personnel and the consequent lack of time that doctors can spend with patients, unrealistic expectations by the patient, substance abuse by the patient and/or relatives, patients' and relatives' lack of understanding of the complexities of medicine and poor communication skills by healthcare workers have all been cited as

reasons.[1,2] In addition, the perception of doctors in society today, especially in India, has changed markedly. Where once they were seen as noble healers, negative media portrayals have resulted in them being seen today as nothing more than "money-making machines."[3] All these factors have contributed to making the healthcare profession an unsafe one, with doctors and nurses having to deal with one of the highest incidences of workplace violence.

While other chapters will examine the systemic changes required in order to address some of the above factors, this chapter will explore how poor communication skills, including miscommunication and lack of communication, have contributed to a fraught environment where violent outbursts from patients and their relatives are more likely. As an empowering solution, this chapter attempts to provide guidance to healthcare workers on how to effectively communicate with patients and their relatives.

For healthcare workers, conveying bad news (such as disclosure of a disease, poor prognosis, failure to treat, or death) is a daily part of their job, and they should know how to deal with this delicate subject sensitively. Hence, the chapter also includes a section on how to appropriately deliver bad news to patients and their relatives. The next section examines the importance of communications training for healthcare students. Finally, since there are many other causes and factors for violence against healthcare workers, effective communication may not entirely keep it at bay. Thus, the last section of the chapter will offer some guidelines to follow while a crisis is brewing, during the crisis, and after the crisis.

Effective Communication in the Healthcare Setting

Effective communication can be described as communication where the speaker in an interaction sends a message to the listener in such a way that the message received by the listener is what the speaker intended to convey. Effective communication should be clear and complete. In a healthcare setting, it should also be respectful and compassionate.

Communication in any environment has several important components. For effective communication in a healthcare facility, three components are

1. I. R. Reddy, J. Ukrani, V. Indla, & V. Ukrani (2019). "Violence against doctors: A viral epidemic?" *Indian Journal of Psychiatry*, 61(Suppl 4) (2019 Apr.): S782–S785. doi: 10.4103/psychiatry.IndianJPsychiatry_120_19.
2. Suresh K. Pandey, & Vidushi Sharma (2019). "Aggression and violence against doctors: How to address this frightening new epidemic?" *Indian Journal of Ophthalmology*, 67(11) (2019 Nov.): 1903–1905. doi: 10.4103/ijo.IJO_1322_19.
3. Telugu 360 (2015). "Are you doctors or money-making machines?" https://www.telugu360.com/doctors-money-making-machines-governor/.

paramount during patient–caregiver interactions: verbal communication styles, non-verbal communication and active listening. The following section will expand on these three particular components.

A. Verbal Communication

Verbal communication can be of many styles: passive, aggressive, passive–aggressive and assertive are a few of them. Assertive communication is considered to be the most useful for effective communication in business and professional situations as it is confident and forthright without needing to demean or belittle other viewpoints. Assertive communicators consider not just their own needs but also the needs of the people they are speaking to, making it easier to remain positive and solution-oriented.

In the healthcare setting, it is recommended that healthcare professionals use assertive communication that is respectful and empathetic while talking to patients. Bearing in mind that patients are generally people who are under some amount of stress, in many cases even in distress, sensitive communication goes a long way in calming them down and giving them confidence in the doctor–patient relationship. The Institute of Healthcare Advancement has created a list of the most common communication errors that healthcare providers make.[4] Based on that list, here are some guidelines that healthcare workers can follow while using assertive communication to interact with patients:

1. Let the patient speak without interruption. Interruptions will make the patient lose their train of thought, and they might forget important details that will help form a diagnosis.
2. Speak in a measured pace, not too fast and not too slow, so that every word is clear and easy to understand.
3. Minimise the use of medical jargon when it is unnecessary. One's role as a healthcare worker is to impart information to the patient about their condition rather than to impress them with intimidating medical terms. Explain the condition using simple language, using visual aids for complete clarity if required.
4. Use open-ended questions and the concept of "teachback" to ensure that the patient has understood the explanation of the condition and treatment protocols.

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4. "10 Common errors healthcare professionals make communicating with their patients," *Nurse Educator*, 33(6) (2008 Nov.): 240. doi: 10.1097/01.NNE.0000334796.37923.c5.

5. Allow the patient to ask questions rather than rushing them off. Answer any questions adequately to improve the doctor–patient bond of trust.
6. Ensure that the patient receives medical information in his or her first language and be aware of cultural sensitivities during patient interactions.
7. Do not criticise other forms of legally recognised systems of medicine or badmouth colleagues to patients. To maintain basic professional conduct, they should be referred to with respect and dignity.

B. Active Listening

The difference between hearing and listening is like the difference between seeing and watching. One is a physiological process, and the other is a wider process that includes the physiological portion, understanding or extracting meaning from and responding to the seen or heard, stimulus. Even with listening, there can be passive or active listeners: passive listeners are those who are genuinely invested in hearing and understanding the speaker's view but do not actively participate in the interaction, whereas active listeners also contribute to the interaction, verifying and consolidating the information received from the speaker. An active listener is fully present physically, mentally and emotionally, in the interaction.

Research shows that people speak at a rate of 150–175 words per minute, while the mind can process 400–500 words per minute.[5] This means that a listener has ample opportunity to think about something else, become distracted, or try to multi-task, while a speaker is speaking. But for effective communication, it is important to stay focused on what the speaker is saying. For a healthcare worker, this may include the need for compartmentalisation. A physician cannot give her full attention to the patient currently in her office if she is still thinking about a patient who died earlier that morning.

For healthcare professionals, active listening should be categorised as an essential clinical skill, one that they can master with constant practice. The following tips taken from *Communicate. Care. Cure. A Guide to Healthcare Communication*,[6] can make you proficient at active listening:

1. Be aware of your body language during the interaction with the patient. Maintain adequate eye contact with the speaker (a focused stare can be intimidating, while the other extreme of not looking at all can seem

5. Hargie, O. (2011). *Skilled Interpersonal Interaction: Research, Theory, and Practice*. Routledge, p. 195.
6. A. Thomas and D. Alexander. (2019). *Communicate. Care. Cure. A Guide to Healthcare Communication (Third Ed.)* Wolters Kluwer.

dismissive). Sitting forward, nodding occasionally and conveying interest and attentiveness are good ways to demonstrate undivided attention. Raised eyebrows or crossed arms can be construed as negative body language and could make the speaker think you disagree with what he or she is saying, and consequently shut down.

2. Use encouraging words and gestures ("I see," or "Oh, that's interesting…") at appropriate times to let the speaker know that you are interested and listening to what he or she is sharing.
3. Paraphrase, or repeat the speaker's ideas back to them in your own words. This helps ensure that the correct message was received, and gives an opportunity to correct it if not. An example would be, "So, if I have understood correctly (and continue in your own words)…"
4. Be aware of the patient's emotional state, and try to respond empathetically if you see signs of them being scared, upset or anxious. "I know you must find this hard to hear…" or "You seem to be upset about…" Validating their feelings will help them feel seen and acknowledged.

C. Non-verbal Communication

Non-verbal communication is communication that does not use words. It could include facial expressions, gestures, body positions, personal appearance, body language, tone and volume, and even silence. Non-verbal communication can provide clues about how a person is feeling. For example, if a patient who has been kept waiting for a long time has a dissatisfied expression on his face but verbally expresses that "it's fine," the nurse or doctor seeing him should recognise his non-verbal cues of dissatisfaction, acknowledge his annoyance and sincerely apologise for the delay.

A patient's non-verbal cues can also give healthcare workers a better understanding of their state of health. Wincing or squeezing one's eyes shut can communicate one's level of pain tolerance during a procedure. A study from 2006 shows that non-verbal communication can be an important tool for diagnosis.[7] Conversely, a doctor's nonverbal cues can also affect a patient's satisfaction and even treatment compliance. A doctor who rarely makes eye contact with a patient, because she is having to write notes, or look up records on a screen during the consultation, loses an important opportunity to connect with the patient. Consequently, the patient leaves feeling barely "seen" by the

7. D. L. Roter, R. M. Frankel, J. A. Hall, & D. Sluyter (2006). "The expression of emotion through nonverbal behavior in medical visits: Mechanisms and outcomes," *Journal of General Internal Medicine*, 21 Suppl 1(Suppl 1) (2006 Jan.): S28–S34. doi: 10.1111/j.1525-1497.2006.00306.x.

doctor, has less confidence in the treatment prescribed, and is less inclined to adhere to it.

Types of non-verbal communication include:

1. Eye contact – can indicate attraction, hostility, interest, etc.
2. Facial expressions – smiling, frowning, raising eyebrows or a blank expression convey different emotions.
3. Tone and volume of voice – clear or muffled speech, warm or hostile tones, mumbling or shouting; all of these can indicate positive or negative feelings.
4. Gestures – deliberate body movements with specific meaning, for example, making a stop sign with the hand, shaking the head, waving, etc.
5. Silence – can imply deep thought, agreement, disagreement, etc.

Breaking Bad News Sensitively[8]

Breaking bad news forms a necessary part of patient–professional caregiver communication. Done sensitively, it develops a constructive relationship and a helping partnership between the patient, the relatives and the healthcare provider. In the medical profession, there is no way to avoid this task. The need to deliver bad news exists in all clinical specialties and settings – the diagnosis, the explanation of disease progression, a change in the functional status of an individual, response to therapy, poor prognosis of a disease and declaration of death.

Breaking bad news sensitively is a combination of active listening, using gestures and body language, and showing empathy. The skill of delivering bad news humanely can be learnt, and its component skills transferred from an experienced senior professional to an unskilled junior colleague.

It is absolutely necessary for the healthcare professional to be prepared before proceeding to deliver bad news. Discuss the disease, diagnosis, prognosis and course of the illness.

- Have the patient and relatives involved in order to discuss their understanding and perception of the disease, and how that might affect them.
- Explore the patient's reaction to the bad news and determine to what extent the patient wishes to participate in decision-making.

8. R. Samal (2019). "Tread with care: Breaking bad news to patients, their family and relatives," in A. Thomas & D. Alexander, (Eds.) (2019). *Communicate. Care. Cure. A Guide to Healthcare Communication (Third Ed.)*, Wolters Kluwer.

- Discuss the treatment plan with the patient and provide guidance on how to adhere to the plan of therapy.
- Offer and discuss counselling, psychotherapy or other ongoing support for the patient and relatives.

Preparation: Before breaking bad news, one must prepare oneself, the place and the patient. The doctor, ideally a senior doctor who has been the primary doctor, should be professional, well-informed and empathetic. It should take place in a quiet room or area that allows for privacy. The news should be disclosed in an unhurried manner, with no interruptions and plenty of time set aside to answer questions and doubts by the patients and relatives.

Performance: The doctor should use simple language to explain the diagnosis, with visual aids if necessary. The doctor should also ask questions to ascertain whether the listeners have understood the explanation, while observing and acknowledging the emotions that they may be experiencing (such as grief, shock, denial), and make empathetic statements in response.

Palliation: Palliation has to do with furnishing supportive responses to patients when they react to the bad news being broken to them. Gently touching the shoulder in reassurance, or engaging in compassionate eye contact plays a major role in expressing empathy, acknowledging the pain and offering comfort and encouragement. Empathising and active listening help the patients give vent to their thoughts and feelings.

Planning: Planning forms the final phase of the process of breaking bad news to a patient and should commence after the patient and relatives have had the needed time to compose themselves and collect their thoughts (the sign that they have assimilated the news). It reassures the patient that he or she is not being abandoned and that a multidisciplinary team will be actively engaged with him or her on an ongoing basis.

Communication Courses for Healthcare Workers and Students[9]

Until recently, medical colleges in India did not have a formal curriculum for teaching and learning communication, imparting ethics or inculcating the right attitude in students. The lack of formal training in these skills and the resulting inability of medical students to communicate effectively cause a large amount of stress, frustration, anger, resentment, misunderstanding and

9. I. Arneja & J. Mehta (2019). "Teaching by example: Communication for medical students," in A. Thomas & D. Alexander, (Eds.) (2019). *Communicate. Care. Cure. A Guide to Healthcare Communication (3rd Ed)*, Wolters Kluwer.

disappointment. Medical errors, inaccurate diagnoses, inaccurate treatment, compromised patient safety, and patient noncompliance are some of the immediate results of poor communication. It is, therefore, one of the contributing factors to the increased amount of distrust in healthcare.

The AETCOM Module (Attitude, Ethics and Communication Module) was introduced into the Indian medical education curriculum in 2019. It prepares medical graduates for the role of a clinician, communicator, leader, lifelong learner and professional. Integrating effective communication skills with the regular medical education curriculum through AETCOM is an important milestone in the journey of reducing medical errors, improving patient compliance and creating greater patient satisfaction.

Every medical graduate should be prepared adequately in the following areas of communication: conducting patient interviews successfully using the correct body language, effective spoken language and active listening skills; practicing informed and shared decision-making; sensitively announcing serious diagnoses or adverse events and documenting what is communicated. All of these skills should be acquired in the context of knowing and respecting patients' rights, privacy and preferences.

Defusing Difficult Situations

Violence against healthcare workers can occur in the form of threats, harassment, verbal abuse or even physical abuse. Whether the causes are due to socioeconomic reasons (such as out-of-pocket expenditure), infrastructural reasons (lack of facilities or denial of admission), patient-related issues (substance use) or training issues (poor communication), violence against a healthcare worker is never justifiable. Strategies can be categorised into prevention (to reduce the risk of violence), protection (how to handle a violent incident while it occurs) and post-incident approaches (to reduce the negative impact of the violence that has occurred).

Prevention: Pre-empting Violence in the First Instance

1. Try to address the above reasons in the system. If long delays and crowded waiting rooms are inevitable, the situation can be alleviated to some extent simply by effective communication: providing information about approximate waiting times and apologies for the delay can improve the situation as it acknowledges the patient's frustration.
2. Prominent signage with clear text can act as a deterrent when tempers are running high. Ensure that there are signs reminding patients that the area is monitored by CCTV, that violence of any form will not be tolerated

against hospital staff and that offenders will be prosecuted. It may also be useful to put up numbers of a grievance cell for dissatisfied patients to complain. In the emergency department, signs explaining the triage process will help patients understand the workflow.

3. Put security systems and protocols for the protection of healthcare workers in place beforehand. This should include a trained security team on the premises at all times, escape routes from departments with high incidences of violence, CCTV coverage, controlled access (especially at night), and training for staff in all the above. Research shows that the emergency and OBGYN departments are particularly susceptible to incidents of violence,[10,11] hence, devote additional resources to these departments.

Protection: When a Crisis Occurs

1. While it is not always possible to detect volatile patients in time, there are certain warning signs before an act of violence. Healthcare workers can learn to look out for these to prevent a larger fallout. Some examples of initial indicators are pacing, hostile body language and using excessive sarcasm. This can progress to more obvious indicators such as belligerence (talking loudly and aggressively), using insulting gestures, agitated movements, clenched fists or hitting a wall or other items.
2. As soon as any initial indicators are observed, the security team should be discreetly called to the area while simultaneously, an experienced healthcare worker who is trained in de-escalating these kinds of situations should approach the person in a non-threatening manner, and speak in clear and respectful tones using empathetic language. Do not encroach into his personal space and ensure that he does not feel cornered, and make sure that objects that could be used as weapons are not readily available.
3. Use the person's name, offer an explanation using calm tones, acknowledge that he is angry and validate his emotions. Avoid prolonged direct eye contact as it may seem threatening, but remain at eye level. Be mindful of your body language: do not raise your voice, make a fist or point a

10. Ma J, Chen X, Zheng Q, Zhang Y, Ming Z, Wang D, …, Li X. Serious Workplace Violence Against Healthcare Providers in China Between 2004 and 2018. *Frontiers in Public Health*, 15(8) (2021): 574765. doi: 10.3389/fpubh.2020.574765. PMID: 33520908; PMCID: PMC7841458
11. Reddy, IR, Ukrani, J, Indla, V, & Ukrani, V. (2019). Violence against doctors: A viral epidemic?. *Indian Journal of Psychiatry*, 61(Suppl 4) (2019): S782–S785. S785 doi: 10.4103/psychiatry.IndianJPsychiatry_120_19

finger. Avoid phrases such as "calm down" and "relax" as these tend to worsen the situation. Remain courteous and respectful while speaking to him.

A different way of handling the situation described at the beginning of this chapter could include the above guidance as follows:

> *"Mr. Venkatesh, may I speak with you for a minute? I am sorry that we have not yet been able to see to your brother. I am aware you have both been waiting for a very long time. I understand what a frustrating experience it must be for you. It is almost midnight and you must be very tired. I have come to apologise for the delay and explain why it has taken so long. There was a collision of two minivans on the highway, and several people have been badly injured. It took us some time to stabilise them before we could proceed to the other patients who have been waiting here in emergency. I really appreciate your patience especially given how concerned you are about your brother. Thank you. Shall we discuss what we need to do for him?"*

4. Know your limits. If you feel that the de-escalation techniques are not working, remove yourself from the situation and let the security team take over.

Post-incident: After the Crisis Has Occurred

1. Procure assistance and support for the victims, both medical and psychological. Experiencing violence is extremely demoralising, and there should be a backup system to relieve the healthcare worker from work for that day, he or she should be counselled about the incident, and adequate support should be offered by the management, department and seniors.
2. Follow the steps required to file an FIR (outlined in Chapter 5 titled *Law Enforcement*) and initiate legal proceedings against the perpetrator. Even if the perpetrator apologises, trying to justify that he was under stress and did it in the heat of the moment, an FIR will deter future violence.
3. A report should be made for the hospital records including a description of the perpetrator, details of the incident and information of actions taken.
4. An investigation should be conducted to review the interventions for analysis and improvement in safety and security protocols.

Conclusion and Take-Home Messages

Healthcare workers are in a vulnerable position, and workplace violence is increasing, particularly in India. The causes are many, and the solution is rooted in a commitment from our political leaders, healthcare leaders

and community leaders to create a less fraught environment for healthcare professionals. However, there are a number of steps that healthcare workers themselves can take to defuse tensions. This chapter has described how effective communication can curtail or prevent some violent incidents from occurring, including:

1. How to become an effective communicator with patients and their relatives, especially verbally, nonverbally and through active listening.
2. How to deliver bad news sensitively.
3. The importance of including soft skills courses in the medical education curriculum.
4. Strategies to follow for prevention, protection and post-incident approaches to violence.

Chapter 4

CONSUMER PROTECTION AND HEALTHCARE: THE NEED FOR A RETHINK

K. K. Talwar

Introduction

The Consumer Protection Act (CPA) was enacted in 1986. It did not explicitly refer to medical services. However, in its 1995 decision in *Indian Medical Association* v. *Shantha*,[1] the Supreme Court declared that medical services fall within the four corners of the CPA. The Court opined that all services are included under the CPA, save and except those which are exempted by the Central Government by notification. In 2019, a new Consumer Protection Act was enacted by Parliament. In October 2021, the Bombay High Court dismissed as "thoroughly misconceived" a petition seeking a declaration that medical services are not covered under the 2019 legislation.[2] The Court also imposed costs of Rs. 50,000 on the petitioner in that case, an entity called "Medicos Legal Action Group." In April 2022, the Supreme Court is reported to have dismissed a Special Leave Petition challenging the judgment of the Bombay High Court.[3]

It is my view that the wisdom of including medical services within the purview of such legislation needs to be urgently debated and revisited. Experience has shown that the application of the CPA to medical services is

1. (1995) 6 SCC 651; AIR 1996 SC 550.
2. Judgment reported as 2021 SCCOnline Bom 3696. https://www.scconline.com/blog/post/2021/11/10/healthcare-service/.
3. The Economic Times (2022). "Healthcare services covered under the Consumer Protection Law: SC." Available at https://economictimes.indiatimes.com/news/india/healthcare-services-covered-under-the-consumer-protection-law-sc/articleshow/91185877.cms?from=mdr

counterproductive. It has weakened and worsened the doctor–patient relationship rather than strengthening it.

The mushrooming of medical negligence claims has fostered, unfortunately but perhaps inevitably, a defensive and "play-safe" mindset in the medical profession. This has led to an increase in healthcare costs, through the increased prescription of avoidable and sometimes unnecessary medical investigations and tests.

It is vital that we realize the limitations of medical science and the immense pressures that doctors operate under. We must also not lose sight of the simple scientific truth that one straitjacket cannot fit all – the effect of the same medicine, for example, may vary in different individuals. I am reminded of the words of William Osler, who is considered the "father" of allopathic medicine. He said, "*Medicine is a science of uncertainty and an art of probability*." Even with the best possible education and training, no doctor can be a miracle worker. Despite the best intentions and efforts of doctors, and even with the highest quality scientific learning and technological advancement, favourable outcomes cannot be guaranteed. The status quo in our country, therefore, deserves a rethink, and this chapter examines whether medical services should reasonably be covered under the Consumer Protection Act, and provides some options for alternatives.

Landmark Cases of Medical Negligence under the CPA

The very nature of medical services is inherently different from other transactions and services. The unique nature of medical and healthcare services must be properly appreciated before dealing with legal issues relating to these services. Medicine is truly a science of uncertainty. Each drug could have a different degree of effect on different individuals. Some may develop side-effects, which others do not. There are known complications of different lines of treatment, which may arise in individual cases without any negligence on the part of the professional. These complexities and limitations can only be fully understood by a person with the requisite professional background and experience. It is unreasonable to expect a layperson to be able to fully comprehend these intricacies.

Of course, it is not as if the legal system in India has not been alive to this position. Our courts have often taken note of these realities. In this context, a reference to a few decisions of the Supreme Court of India would be apposite. The case of *Jacob Mathew* v. *State of Punjab*[4] is one in which the Court delivered a perceptive, balanced and well-considered judgment – one which is

4. (2005) 6 SCC 1.

worth reading in its entirety. The decision of the Court was pronounced about 17 years ago and remains a leading authority on the subject of medical negligence under our legal regime. The case arose out of an FIR registered against two doctors who were working at the Christian Medical College (CMC) in Ludhiana, on account of the death of a patient. The Supreme Court ultimately quashed the criminal prosecution of the doctors. It held that in such cases the investigating officer should, before proceeding against the doctor accused of negligence, *"obtain an independent and competent medical opinion preferably from a doctor in government service, qualified in that branch of medical practice*." It also held that a doctor accused of rashness or negligence *"may not be arrested in a routine manner (simply because a charge has been levelled against him). Unless his arrest is necessary for furthering the investigation or for collecting evidence or unless the investigation officer feels satisfied that the doctor proceeded against would not make himself available to face the prosecution unless arrested, the arrest may be withheld."*

While arriving at its decision, the Court carried out a detailed analysis of the law relating to negligence, with particular reference to allegations of negligence against professionals. It wisely observed that the subject of negligence in the context of medical professionals *"necessarily calls for treatment with a difference."* After all, as noted by the Court, no sensible professional would intentionally commit an act or omission which would result in loss or injury to the patient as the professional reputation of the person is at stake. A single failure could cost them dear in their career.

The Court took note of the fact that no physician can assure the patient of full recovery in every case, and that a surgeon cannot and does not guarantee that the result of surgery would invariably be beneficial. It also appreciated the position that, at times, medical professionals could be called upon to adopt a procedure which involves a higher element of risk, but which they honestly believe as providing greater chances of success. It took cognizance of the fact that the human body and medical science are both too complex to be easily understood, and that it would be imprudent to hastily arrive at a conclusion of negligence without an in-depth understanding of working of the profession and the nature of the job.

Another seminal judicial pronouncement is the decision of the Supreme Court in *Martin F. D'Souza* v. *Mohd.* Ishfaq.[5] The Court, in this case, was hearing an appeal against an order of the National Consumer Commission. It ultimately exonerated the doctor concerned of the charge of medical negligence, and in doing so it overturned the decision of the National Consumer Commission. The following passages from the judgment of the Court are worth highlighting:

5. (2009) 3 SCC 1.

> *Before dealing with these principles two things have to be kept in mind: (1) Judges are not experts in medical science, rather they are lay men. This itself often makes it somewhat difficult for them to decide cases relating to medical negligence. Moreover, Judges have usually to rely on testimonies of other doctors which may not necessarily in all cases be objective, since like in all professions and services, doctors too sometimes have a tendency to support their own colleagues who are charged with medical negligence. The testimony may also be difficult to understand, particularly in complicated medical matters, for a layman in medical matters like a Judge; and (2) A balance has to be struck in such cases. While doctors who cause death or agony due to medical negligence should certainly be penalized, it must also be remembered that like all professionals, doctors too can make errors of judgment, but if they are punished for this, no doctor can practice his vocation with equanimity. Indiscriminate proceedings and decisions against doctors are counter-productive and serve society no good. They inhibit the free exercise of judgment by a professional in a particular situation.* (emphasis added)
>
> *The courts and Consumer Fora are not experts in medical science, and must not substitute their own views over that of specialists. It is true that the medical profession has to an extent become commercialized and there are many doctors who depart from their Hippocratic oath for their selfish ends of making money. However, the entire medical fraternity cannot be blamed or branded as lacking in integrity or competence just because of some bad apples.* (emphasis added)
>
> *It must be remembered that sometimes despite their best efforts the treatment of a doctor fails. For instance, sometimes despite the best effort of a surgeon, the patient dies. That does not mean that the doctor or the surgeon must be held to be guilty of medical negligence, unless there is some strong evidence to suggest that he is.* (emphasis added)

The Court went to the extent of warning police officials "*not to arrest or harass doctors unless the facts clearly come within the parameters laid down in Jacob Mathew's case (supra), otherwise the policemen will themselves have to face legal action.*"

It also merits mention that the Court had issued another positive direction to the effect that:

> *[W]henever a complaint is received against a doctor or hospital by the Consumer Fora (whether District, State or National) or by the Criminal Court then before issuing notice to the doctor or hospital against whom the complaint was made the Consumer Forum or Criminal Court should first refer the matter to a competent doctor or committee of doctors, specialized in the field relating to which the medical negligence is attributed, and only after that doctor or committee reports that there is a prima facie case of medical negligence should notice be then issued to the concerned doctor/hospital.*

The Court believed that a direction of this nature was necessary "*to avoid harassment to doctors who may not be ultimately found to be negligent.*" However, subsequent decisions of the Supreme Court expressed the view that a general direction of this nature is *per incuriam*, and, therefore, not binding.[6] It was, nonetheless, left open to the consumer fora to call for expert evidence if the facts of a particular case should so necessitate.

The Repercussions of Medical Negligence Claims

Despite these notes of caution sagaciously struck by the highest court in the land, medical negligence claims under the consumer protection laws have risen unabated. When a complaint is filed against a doctor, it appears to readily attract publicity, thereby immediately tarnishing the reputation of the doctor concerned. The fact that the case takes many years to be decided, first in the original forum and thereafter through the process of appeals, compounds the sense of harassment. Add to the mix the high cost of the litigative procedures, and we have an obnoxious cocktail. The process itself becomes punitive. It is impossible to compensate the doctor for the torture undergone, despite his or her best intentions in treating the patient, even if he/she is ultimately exonerated or vindicated by the legal process. The professional and personal costs are sky high.

Cases drag on for years, creating a sense of fear and frustration in the minds of doctors. In the process, a feeling of distrust is engendered between patient and doctor, which taints this most sacred of human associations. Even naturally arising complications during the course of treatment are viewed through the lens of suspicion and negligence. An overall lack of respect and regard for the medical profession as a whole is the result, with long-term ramifications as far reaching as discouraging our brightest young minds from taking up the medical profession.

A good example is found in recent reports in the press, which have drawn attention to a case where the national consumer forum exonerated an obstetrician and her hospital after 21 years of litigation.[7] In yet another case, the national forum exonerated an anaesthetist from Rajasthan about 25 years after the litigation in the case had commenced.[8] Of course, one cannot predict

6. *V. Kishan Rao* v. *Nikhil Super Speciality Hospital & Anr.* (2010) 5 SCC 513.
7. Misra, B. (2021). No medical negligence: NCDRC exonerates obstetrician after 21 years. https://medicaldialogues.in/news/health/medico-legal/no-medical-negligence-ncdrc-exonerates-obstetrician-after-21-years-95647
8. Relief of anesthetist after 25 years: NCDRC holds death of patient post surgery not conclusive proof of negligence. https://medicaldialogues.in/mdtv/medico-legal-update/relief-to-anesthetist-after-25-years-ncdrc-holds-death-of-patient-post-surgery-not-conclusive-proof-of-negligence-95872.

whether either of these cases will be taken up to the Supreme Court, and how long they will remain pending there.

What is more, the plight of the patient or the complainant is an equally sorry one. The costly and lethargic system does not serve him/her well either. The inordinate delays demoralize, and virtually penalize, the patient/complainant too. Realisation often dawns belatedly that cases are easier instituted than contested. Litigation begins to feel, perhaps, like catching a tiger by its tail!

It would be worth collecting and analysing data in regard to the number of medical negligence cases filed in our country, the time taken for the case to attain finality and the ultimate outcome in each case. Despite my best efforts, I have been unable to find such data in the public domain. Perhaps an analysis of this data will show the true extent of the malaise.

Alternative Options

The grant of relief under consumer protection laws is premised on a finding of "deficiency in service." The word "deficiency" is defined in the 2019 Act as meaning:

> *[A]ny fault, imperfection, shortcoming or inadequacy in the quality, nature and manner of performance which is required to be maintained by or under any law for the time being in force or has been undertaken to be performed by a person in pursuance of a contract or otherwise in relation to any service.*

The statutory definition clarifies that the word "deficiency" would include negligence in providing the service. What should also be remembered is that a doctor is expected (and bound) to provide treatment as per the established norms and protocols, and in accordance with his/her professional training. These norms, protocols and professional training are regulated and monitored by statutory regulatory bodies. These regulatory bodies operate, currently, under a recent parliamentary legislation titled the "National Medical Commission Act, 2019." The regulatory bodies include not only the National Medical Commission itself, but also other autonomous boards such as the Ethics and Medical Registration Board. They are manned, substantially, by trained medical professionals themselves, and are much better equipped to deal with complaints of professional negligence and the like. Even from the standpoint of timely decision-making, while the process of litigation takes years and years to arrive at a final decision, these bodies could be equipped to act much faster.

It deserves serious and sober consideration, therefore, whether one or more of the regulatory bodies under the National Medical Commission Act, 2019,

should be entrusted with the duty of dealing with complaints of medical negligence, rather than consumer protection forums which comprise persons having no knowledge or background whatsoever in medicine.

There could, perhaps, be a feeling that the professional regulatory bodies would tend to favour their own professional brethren and colleagues, that is, the doctors. However, suitable safeguards can be put in place to address this apprehension. These could include procedural safeguards to ensure that the proceedings remain transparent, open and above-board. Of course, the procedural requirements must be designed to avoid the rigmaroles of the current system, and the existing legalistic and overly adversarial architecture must not be replicated. Further confidence-building measures can also be considered. For instance, respected and eminent professionals from other fields, including other scientific disciplines, could be included on the bodies tasked with deciding medical negligence complaints, in addition to qualified medical professionals.

Conclusion and Take-Home Messages

This chapter has examined why including medical services within the purview of the CPA needs to be urgently debated and revisited. Let us not blindly follow the American litigative culture, which has only added to the commercialization of a noble profession like medicine. Instead, India should lead the way and emerge as a role model for the rest of the world. A more efficient and balanced system must replace the current one.

1. Any new system should be geared to provide more optimal outcomes for all stakeholders, patient and doctor alike.
2. Sympathy for the patient and his/her family, and fairness for the doctor, must be the twin guiding lights.
3. A system which implements a speedy and credible decision-making process, with outcomes steered by scientific evidence, is the need of the hour.

Chapter 5

LAW ENFORCEMENT

D. V. Guruprasad

Case Study

On a Tuesday night, Dr. Krishna, an Assistant Professor in a private medical college, was on duty in the accident and emergency wing of his hospital. At 11.00 PM, a 30-year-old male patient with history of motor vehicle accident was wheeled into the triage chamber. As he was being examined, the patient's vitals went haywire and his heart stopped. All efforts to resuscitate the patient failed. The patient was declared dead at 11.40 PM.

A staff nurse went to break the news to the dozen waiting relatives and attendants outside. When they heard the news, they became agitated and started shouting, questioning the nurse as to how a young person with no apparent external injury could suddenly die. The nurse asked Dr. Krishna to intervene.

Dr. Krishna came out and explained the cause of death. The relatives wanted to take the body away, but he refused stating that it was a medico-legal case. One of the attendants became angry, collared Dr. Krishna and gave him a resounding slap. They accused the doctor of medical negligence and started raining blows on him. Dr. Krishna ran inside the ER room. The crowd followed him there, but unable to find him, damaged whatever they could lay their hands on. The skeletal security and housekeeping staff could do little to prevent them. Someone called the police control room. When the police arrived, the assailants had vanished with the body of the deceased. Dr. Krishna was asked to give a complaint, and did so.

The next day, the medical college staff went on strike and submitted a memorandum to the district authorities demanding better safety and security. The officers assured them of quick action and persuaded the striking staff to resume work. Dr. Krishna was so shaken by this incident that he quit his job and went abroad for further studies.

This is not a stray incident. Despite such incidents coming under the purview of special legislation, attacks on doctors and other healthcare professionals have become common.

Introduction

Let us begin by examining the existing laws to tackle violence against healthcare professionals. The primary criminal law in India is the Indian Penal Code.[1] In this act, if anyone unauthorisedly enters any premises with intention to commit a criminal act, such entry is deemed as criminal trespass and he is punishable (447 IPC – 3 months jail time). Threatening anyone with injury to his person is called intimidation and is covered under 506 IPC (2 years jail time). Assaulting and causing hurt is covered under Sections 323 IPC to 326 IPC. The act of endangering lives and personal safety of others (in the ER room in this case) is also an offence. If criminal acts are committed by a group of five or more persons, it is covered under Section 147 IPC (rioting), for which all of them are liable to be jailed for 2 years.

IPC is indeed a tough law. But from the year 2000 onwards, when violent acts against healthcare professionals and institutions started to increase, there was a serious reaction. Some hospitals were shut down and the public was put to great inconvenience. Affected by this, many sections of society mounted pressure on their respective State governments, and a new law to provide stringent punishment to the offenders was enacted, as they thought that the provisions of the IPC were not sufficient enough.

As health is a State subject under the Constitution of India, the pressure was on State governments to protect healthcare professionals. Many States in India enacted special legislations to protect doctors and nurses, some of them as early as in 2005.[2,3] As explored in Chapter 1 titled *Protecting Healthcare Professionals in India: an Analysis of Law and Policy*, it is reported that 23 States in the country have enacted such special laws.

The State of Karnataka enacted a law in 2009 called "Prohibition of Violence against Medicare Service Personnel and Damage to Property in Medicare Service Institutions Act, 2009." Though its name is very long, the Act has only seven Sections. While the first Section deals with the title, Section 2 deals with explanations to the terms used in the Act. It defines "Medicare Service Institutions" as all institutions providing medicare services to people, either under the control of State or Central Government or Local Bodies and so on, including any private hospital, any private maternity home and any private nursing home or a convalescent home. Medicare Services

1. Indian Penal Code; https://www.indiacode.nic.in/bitstream/123456789/2263/1/A1860-45.pdf.
2. India Code – Digital Repository of State Acts – https://www.indiacode.nic.in/.
3. Kamath Y, Bansal M, Zadey S, Wille C, & Haar R. (2021). 133 Attacks in a year: How India is failing its health workers. https://www.thequint.com/voices/opinion/133-violent-attacks-in-a-year-how-india-is-failing-its-health-workers#read-more#read-more#read-more.

covers Registered Medical Practitioners, working in medicare institutions; (ii) registered nurses; (iii) medical students; (iv) nursing students; and (v) paramedical workers employed and working in medicare service institutions.

Section 3 of this Act prohibits "any violence against medicare service personnel or damage to property in a medicare service institution." Any offence committed under this Act shall be cognisable (arrested by police without a warrant by a Court of Law) and non-bailable. Any person who commits any act in contravention of Section 3, shall be punished with imprisonment for a period of three years with a fine which may extend up to Rs. 50,000/-. The culprit is also liable to pay a penalty of twice the amount of purchase price of medical equipment damaged and loss caused to the property as determined by the court trying the offender. If the offender doesn't pay the penal amount determined by the court, the specified sum can be recovered under the provisions of the Karnataka Land Revenue Act, 1964, as if it were to be an arrears of land revenue.

The provisions of this Special Act can be used in addition to any other law being in force. This means that the IPC can also be used to cover offences committed during such violent incidents.

The Rise in Violence Despite Special Legislations

It is observed that many police officers, being unaware of the special laws, are not using them. A study conducted in Karnataka revealed that from 2010 to 2017, 25 cases on an average were registered by the police every year under the Karnataka Prohibition of Violence against Medicare Professionals Act. Of these 25, only four cases went to court. And during the seven-year period, only three ended in conviction. In all three cases, no compensation was paid to victims. This indicates that most people accused of assaulting healthcare professionals and damaging hospital properties went scot-free.

It should be understood that the low conviction rate is not limited only to the Special Act under consideration. It is the norm with respect to most criminal cases. The percentage of assault cases that ended in conviction in India in 2020 was an abysmal 30.6% as per the statistics provided by the National Crime Record Bureau.

If one examines whether stricter laws solve the problem, the answer seems to be in the negative. For instance, if we look at the crime of rape, the IPC was amended subsequent to the Nirbhaya case, adding new provisions to protect women and children, including the ultimate punishment as a deterrent: the death penalty. But this has not resulted in the decrease of rape cases. So what is the answer? The answer is prevention of such acts altogether. If we examine the causes for violence in healthcare institutions, we will know how to prevent them.

Causes for Violence against Healthcare Professionals

The preceding chapters have already looked at many of the underlying reasons that give rise to violence in hospitals, big or small. In my experience, one of the most important causes is the sudden and unexplained death of a patient, in the ER, ICU or even the wards. Perceived excess billing also causes adverse reactions. Similar causes are delayed discharge of patients, not handing over the bodies of patients who die in the hospital, and so on. Communication is especially crucial in all these situations.

Secondly, the perception of medical negligence by the patient/relatives also causes violence. A recent example is that of the case against Dr. Archana Sharma in Dausa, Rajasthan. A patient died in Dr. Sharma's hospital due to post-partum haemorrhage in March 2022. Following this, the relatives of the deceased protested in front of the hospital and demanded an FIR to be lodged against Dr. Sharma. The police promptly registered a case of murder against her. We shall examine whether the action of the police was right or wrong a little later.

Cases of perceived molestation of female patients and children are bound to result in serious violence (in addition to filing of criminal case against the concerned doctor or litigation against the clinic/hospital). A case study is cited here: a married woman came to the stand-alone clinic of a male dermatologist in Bangalore for consultation. As the doctor was examining her, she objected to his touch and raised a hue and cry. Her husband, who was waiting outside, rushed inside and on hearing that the doctor had tried to molest his wife, he beat the doctor black and blue. He then took his wife to the police station and made her give a complaint. When the doctor went to the same police station to lodge his complaint, he was promptly arrested as an accused in a molestation case. He underwent tremendous mental agony and was forced to part with a heavy amount to be set free.

These situations can be prevented by the following:

Investing in Better Security Systems

Security comes at a price. Hence, many institutions go in for the barest minimum of security. What should be noted is that a good security system can save millions of rupees over a period of time. The installation of centrally monitored CCTV cameras is a must. In addition to having an eye on the hospital as a whole, it can pick up signs of trouble so that remedial actions can be initiated immediately. This will also prevent pilferage and so on. Manguarding, however, cannot be neglected. At least in vulnerable places (such as accident and emergency departments, ICUs, delivery rooms, OTs), young,

energetic and tough security guards have to be placed 24x7. They should be trained in communication, but at the same time, be firm and able to handle any unforeseen situation.

Developing a Good Rapport with the Police Department

Any healthcare institution (whether a small clinic, a medium nursing home or a big hospital) must establish a close rapport with the jurisdictional police. However, it is a tendency amongst us to reach out to police only when we face trouble. Healthcare institutions cannot remain aloof from the police. Some responsible person representing the institution must establish contact with the jurisdictional SHO. Greeting the police on New Year's Day, greetings during festivals, organising free medical camps, giving discounts on medical bills to police officers and their families are some of the measures already being employed. Bigger hospitals can consider hiring a former police official for this liaison work, as it can prove very useful.

It is quite possible that the jurisdictional police may not be co-operative. If we revisit the case of Dr. Archana Sharma, registering a murder case against her was blatantly wrong. Even a fresh recruit to the police should know that death by negligence does not attract the provision of 302 IPC. Registration of a murder case indicates that the local police were under pressure from the side of the patient or were hostile towards Dr. Sharma or her nursing home for some reason. One way of solving this is for the head of the healthcare institution to find out the causes for such animosity and iron them out. He or she can also keep in touch with some senior police officials of that district or Police Commissioners. In case it is difficult for one single hospital/individual to meet the higher ups in the district administration to air their grievances, a delegation of hospital administrators is the answer. Associations can help in this regard.

It is worthwhile having a lawyer or panel of lawyers to advise the institution in such times of need. If the local police are found to be non-cooperative, or unaware of any law, these lawyers could be utilised to become a bridge between the healthcare professionals and the police. I also advocate that media should be kept abreast on your side of any incidents. In many situations where violence is caused, some local TV channels hype up the incidents and bring bad press to the hospital. The PR wing of the hospital should take care of this.

Sensitisation of Hospital Staff

It is worthwhile getting the hospital staff trained on the following important aspects:

Filing of FIRs

The FIR (First Information Report) is the most important document in any criminal case. Often, the complainants concerned do not give a written complaint, and usually orally report the incident to the police, and the police write it down. The concerned police officials are expected to read out whatever they have written and if correct, take the signature of the complainant. Many times, this does not happen and the complainant signs the FIR blindly. If the sequence of events are not clearly brought out in the FIR, the case falls apart in court. Therefore, it is always necessary to draft the FIR properly and ascertain that it is correct.

Identification of the culprits

Many a time, while lodging the FIR, the complainant does know the name or address of the culprit/s. Police have to then find out who is responsible for the crime, for which the investigating officer examines witnesses other than the complainant and also sees the CCTV footage, if available at the scene of the offence. When the police finally locate the culprit, he has to be identified by the complainant as the person responsible for the crime. But the complainant ends up being reluctant to identify the culprit. This should be avoided.

Pursuing the case with the police during investigation

Many complainants, especially healthcare professionals, are not interested in pursuing the progress of investigation of their cases. When the complainants themselves lose interest, the investigating officers tend to take the case lightly. As is well known, most police officers are overburdened with cases, and the case by a healthcare professional is just one of many. It is, therefore, incumbent on the hospital administration to pursue them. Without this, it is more likely that the police close the case as either undetected or having insufficient evidence.

Attendance when the case comes to trial in court

In most cases, the complainant avoids going to the court when summoned to depose against the accused in the case. Such absence is taken advantage of by the accused and he goes scot-free. When this happens, cases of violence or harassment rise.

To address the above issues, hospitals should organise regular training programmes for the staff. They should invite senior police personnel to their hospitals for the sensitisation programmes. This serves two purposes: firstly, a good rapport would be established between the police department and the

hospital, and secondly, the healthcare personnel will be trained in dealing with procedures related to reporting acts of violence in their institutions. Lawyers can also be called as resource persons for such programmes.

To monitor the cases of violence against healthcare professionals, a group of hospitals or associations should hire a criminal lawyer to assist the complainant from the time of registration of the FIR till the end of the trial in court. This would improve the rate of conviction.

Counselling Victims of Violence

Effective counselling for the victims of violence is a must. Such victims suffer mental trauma and need help. For example, if Dr. Archana Sharma had been advised that mere filing of FIR against her would not make her a criminal, or if she had been properly counselled by a competent person, she might not have taken the extreme step.

The Role of the Police

Though governments have enacted special laws to protect healthcare professionals, most police officers are not aware of this law. Top brass in the police departments should make the SHOs aware of the significance of this law and the consequences of attacks on doctors and hospitals.

Police personnel must make efforts to defuse the crisis as a first response as soon as they reach the trouble spot. They must be sensitised to take up cases promptly, arrest the accused without loss of time and finalise prosecution within a short time frame. Hospitals can also keep copies of the Special Act related to this topic and show it to the policemen when they come to the hospital for the registration of any case of violence. Further joint programmes between medical teams and police can be facilitated in order to enable prompt action when required.

Conclusion and Take-Home Messages

This chapter has examined the role of the police and law enforcement in tackling violence against healthcare professionals, and has provided the following strategies to combat the issue:

1. Training in effective communication of the hospital staff and sensitisation in procedures relating to filing of FIRs and follow-up of cases.
2. Establishing good rapport with the police department and the district administration.

3. Ensuring that sufficient and appropriate safety measures are implemented at vulnerable areas such as security, CCTV, and so on.
4. Counselling victims of violence after a traumatic incident.
5. Following up FIRs lodged to their logical end.

Chapter 6

TACKLING VIOLENCE THROUGH THE POWER OF NETWORKING

Satyajit Singh and Sahajanand Prasad Singh

Case Study

A 35-year-old patient, the only breadwinner of his family, underwent a hair transplant procedure in a city hospital. That same evening, the patient started developing acidosis with symptoms of swelling and redness on the face and neck, suggestive of petechial bleeding. The doctors tried to manage the symptoms, but the redness was progressing fast. Realising that the situation was going out of control, the medical team on duty referred the patient to a higher centre. At around 10.00 AM in the morning, the patient reached the emergency department of a tertiary-care hospital with anaphylactic shock. He was immediately shifted to the intensive care unit, and adrenaline and inotropic support medicine was administered intravenously. However, the patient's life could not be saved and he was declared dead at around 2.30 PM. By 5.00 PM, more than 50 relatives of the patient reached the hospital and started creating a commotion outside the hospital premises, blaming negligence of the hospital staff. Most of the relatives had no knowledge of the sequence of events. They did not know that the patient's condition had deteriorated at the hair transplant unit itself, and that he was already in anaphylactic shock when he had been brought to this hospital. They were emotionally charged and wanted to take revenge. Finally, the hospital management had to call the police, who dispersed the gathering, after which the medical team proceeded with the post-mortem examination.

The above case study is an example of mob violence against healthcare workers. Violence against healthcare workers includes all violent events that care providers have to face during or after providing care in a healthcare setting.

Introduction

Violence against healthcare workers negatively effects their morale, the health of the patients and, consequently, the effectiveness of health services.[1,2] In the long run, the psychological impact of violence on healthcare workers may be greater than even the physical impact. The incidences of violence against healthcare workers have grown to epidemic proportions[3] but the real size of the problem is largely unknown.[4] To tackle the menace of violence against care providers, various governments and law enforcement organisations have initiated different measures, but these have not yielded the desired results. At the World Health Assembly 2020, the World Medical Association urged the WHO member countries to take special measures to handle this important issue.[5]

Healthcare Workers at Risk

From the legal point of view, it is the right of medical officers to work in a safe and secure workplace. However, due to failure by government agencies, nearly 75% of doctors have dealt with some form of violence during their practice. This includes verbal, emotional, sexual, psychological, physical and cyber intimidation, threats, abuse and occasionally even extreme bodily harm and injury caused by patients, patient-attendants or even mobs of "miscreants." As many as 62.8% of doctors are unable to see their patients without any fear of violence; 13.7 per cent fear criminal prosecution most days of the week and 57.7 per cent of doctors have thought of hiring security in their premises.[6]

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1. Ruchi Garg, Neeraj Garg, D. K. Sharma, & Shakti Gupta, "Low reporting of violence against healthcare workers in spite of high prevalence," *Medical Journal of Armed Forces India*, 75(2) (2019 Apr.): 211–215.
2. Amandeep Kaur, Farhad Ahamed, Paramita Sengupta, Jitendra Majhi, & Tandra Ghosh, "Pattern of workplace violence against doctors practising modern medicine and subsequent impact on patient care," *PLoS One*, 15(9) (2020 Sep.): e0239193. doi:10.1371/journal.pone.0239193.
3. S. K. Dora, H. Batool, R. I. Nishu, & P. Hamid, "Workplace violence against doctors in India: A traditional review," *Cureus*, 12(6) (2020 Jun.): e8706. doi:10.7759/cureus.8706.
4. IMA, as reported by the https://thewire.in/health/behind-the-violence-against-healthcare-workers-in-india-lies-a-failed-system (last accessed on 11 June 2022).
5. World Medical Association, 73rd World Health Assembly, agenda item 3: Covid-19 Pandemic Response. (2020). https://www.wma.net/wp-content/uploads/2020/05/WHA73-WMA-statement-on-Covid-19-pandemic-response-.pdf (last accessed 7 June 2022).
6. Behind the Violence Against Healthcare Workers in India Lies a Failed System. *The Wire*. https://thewire.in/health/behind-the-violence-against-healthcare-workers-in-india-lies-a-failed-system (last accessed on 12 June 2022).

Health workers are at the risk of violence the world over. Between 8 per cent and 38 per cent health workers suffer physical violence at some point in their career; many suffer verbal abuse and threats. The most vulnerable departments are the accident and emergency department and critical care units. The healthcare workers most vulnerable to violence are nurses and junior doctors.[7] The perpetrators are mainly patient relatives, unknown sympathisers, criminal offenders and even politicians.[8]

Acts of violence against healthcare workers make no distinction between government versus private set-ups or the level of care provided. Cases have been reported across the country in all types of healthcare facilities. However, they are mostly reported by small nursing homes and secondary care settings in the urban areas. The primary cause of violence reported in emergency and critical care settings are perceived deterioration of the patient's condition, perception of wrong or delayed treatment given and death of the patient. Bill-related issues, unavailability of beds, drugs, investigations, early discharge and special preferences were other major causes of the violence.[9] Disgruntled patients (mostly educated), of the tertiary and quaternary care settings seemingly take their fight to social and print media along with judicial routes.

Recommendations

There are various measures which can be taken to avert or forestall violence against healthcare workers. They can be categorised into three broad categories: legal measures, hospital-based approach and network-based approach.

Legal Framework

An effective legal framework works as an important deterrent to violence against healthcare workers. There is a need to either implement the Draft Bill of Healthcare Service Personnel and Clinical Establishments (Prohibition of Violence and Damage to Property) Bill, 2019, which proposes criminalising violence against healthcare personnel, or develop the effective implementation of the existing Indian Panel Code, 1860 (IPC).

7. WHO. Preventing violence against health workers. https://www.who.int/activities/preventing-violence-against-health-workers (last accessed 11 June 2022).
8. Solving systemic violence against healthcare workers in India. *thebmjopinion*. https://blogs.bmj.com/bmj/2021/10/04/solving-systemic-violence-against-healthcare-workers-in.
9. Amandeep Kaur, Farhad Ahamed, Paramita Sengupta, et al. (2020). Pattern of workplace violence against doctors practising modern medicine and subsequent impact on patient care. PLOS One. https://doi.org/10.1371/journal.pone.0239193.

Since any law is only as effective as its implementation, there is a need to develop effective enforcement systems at the State Government level.

Hospital-Based Approach

a) **Involvement of patients and patient attendees:** The biggest ambassadors for doctors and healthcare institutions are their patients. Patients arriving at the hospital must be welcomed with compassion and transparency from admission to discharge. Digital patient appointment systems, online billing, frequent information of patient prognosis in critical care unit and digital payment systems establish a healthy network with patients.

b) **Restricting the number of relatives/attendees:** Patient relatives are required to be involved in care processes and hence they must be given access, but it may be useful to limit the access to only one relative or attendant at a time.

c) **Communication system within the hospital:** At the time of admission through accident and emergency, visitors' passes (with photo identity card) should be issued, and only these identified relatives should be given updates on the patient's conditions and prognosis. Security staff, nurses and doctors on floor duty must be sensitised and trained to identify troublemakers by their body language, tone of talk and hint of threat.[10]

d) **Effective surveillance:** Hospitals must have CCTV cameras to identify relatives threatening or aggressively arguing with staff members. Active surveillance of impending troublemakers and direct intervention of hospital or clinic management can avert violence. At the earliest sign of violence, the likely perpetrator must be brought to the administration department, where a healthcare worker can calmly talk to the patient or relative about his/her complaints. Many a time, a patient hearing can solve lot of problems.

e) **Involvement of senior consultants:** Studies have shown that senior doctors face less violence than junior doctors. Therefore, in explosive situations, senior, more experienced doctors should get involved, as they can better explain the situation to patients and their relatives.

f) **Effective use of security:** In case any violent activity begins, guards at the central monitoring system must alert other security personnel with a yellow alert warning, to mobilise additional security

10. Luck, L, Jackson, D, & Usher, K. (2007). STAMP: Components of observable behaviour that indicate potential for patient violence in emergency departments. *Journal of Advanced Nursing*. 59: 11-9. DOI: 10.1111/j.1365-2648.2007.04308.x.

persons at the scene of occurrence, as mobs tend to become subdued on seeing huge security deployments. Senior administrators should be informed about the events to handle them appropriately.

g) **Designated person to coordinate with legal authorities:** There must be a designated person to liaise with local police officials. In the events of any disputes the designated person should immediately talk to the local police station and ask for their help. Chapter 5 titled *Law Enforcement* deals with this topic in more detail.

h) **Engaging legal officers in troublesome cases:** Engaging legal officers and using their services is much easier than struggling with patients and trying to rationalise with disgruntled customers. Patients should be politely given a chance to take legal recourse if the issue remains unresolved, rather than forcing them to accept the hospital's stance. Every hospital must have their own lawyer who can be contacted for legal advice and pursue cases lodged with local law authorities.

Networking-Based Approach

In cases of violence, the power of networking must be utilised to its maximum potential. Networking includes engaging community influencers, police, administration, legal experts, media, professional bodies, hospital associations and so on.

i) **Networking with community influencers**: A strong networking of community influencers in the primary catchment area (including local leaders and prominent citizens) of the hospital has been reported to be of use by many successful administrators, from both government and private hospitals. Regular social activities, loyalty programmes for the community and influencers, need-based rebates on bills of patients referred by the influencers and other such activities will earn goodwill and strengthen the social network with community influencers who can intervene in times of trouble.

j) **Involvement of people's representatives:** Hospitals must always be in contact with local government, civil and police authorities. In rural areas, it is important to develop a strong relationship with local representatives of panchayat and municipal bodies who can play very useful roles in case of violence. They can play an even more effective role in counselling aggrieved relatives.

k) **Engaging professional bodies:** Regular communication with doctors in the form of Continued Medical Education (CME) and social get-togethers, improves connections with networks of professional bodies. Where events of violence arise due to difference of medical opinion or involving medical practitioners, lawyers, police

personnel and so on, as aggrieved parties; hospitals should request to convene urgent meeting/s of the local Indian Medical Association (IMA) chapter, which, after a critical analysis of the case, should issue a public clarification and/or initiate suitable steps to show solidarity. Hospitals must be in continuous contact via telecommunication with medical bodies such as IMA, the Association of Healthcare Providers (AHPI), and so on, and seek their help at the time of violence.

l) **Role of social and print media:** The use of social and print media has been the most preferred outbound marketing strategy for image building of healthcare institutions. In case of violence also, social and print media can be used to establish instant communication with all concerned persons, especially fellow doctors and adjoining hospitals. In extreme circumstances, press and electronic media along with IMA, AHPI and other professional bodies should be engaged to bring the facts before the public. The media needs to understand that doctors cannot be held accountable for every death that occurs in the hospital.[11]

m) **After-care support to the patients:** After discharge is complete, engagement with the patient plays a very important role in developing trust between patients and hospital, leading to loyalty, and consequently preventing violence. Enquiring about the discharged patient's well-being, following up on the next consultation date and time, facilitating care for distant patients and arranging telehealth consultations are some of the popular aftercare initiatives that hospitals may adopt.

n) Conducting systemic research on violence against healthcare workers: Administrators, academicians and policymakers should continuously conduct research to understand the magnitude of the problem, develop different mechanisms to handle violence and to find out the effectiveness of different violence prevention and management measures.

Operationalising the Network Approach

Across the globe, network-based approaches have gained huge popularity in handling violence against the homeless, children, teachers and other groups of working professionals. The growing popularity of networks in the digital world

11. Reddy I R, Ukrani J, India V, & Ukrani V. "Violence against doctors: a viral epidemic?" *Indian Journal Psychiatry*, 61 (Suppl 4) (2019): S782–S785. DOI: 10.4103/psychiatry.IndianJPsychiatry_120_19.

is due to its potential to transmit the information (especially through social networks) and consequent ability to provide quick support. It is important to develop a sustainable network at the local, regional, State and country level.

The key steps to operationalise your network are summarised below:

1. **Identify a key person:** Each hospital and professional body should identify one key person who will be responsible for coordinating communication and handling issues inside the hospital.
2. **Develop Standard Operating Procedures (SOP) to handle violence against healthcare workers:** The SOP should be developed in consultation with stakeholders such as other hospitals, administration, security agencies, police, professional bodies and media. The SOP should address the following key points:
    a. **Different scenarios of violence:** The act of violence must be identified.
    b. **List of violent events which would need external support:** Hospitals and groups of hospitals who are part of a local support network should define the events (e.g. a gathering of more than 15–20 people at the hospital, etc.) which would require external support.
    c. **Events-wise external agencies or organisations to be approached:** As described in Hospital-Based Approach above, different networks can be used for handling violence against healthcare workers. The SOP should describe which network should be used in which conditions. This will ensure clarity among hospital administration as well as network partners.
    d. **List of events that would be flagged:** A list of events categorised according to level (local, regional and national levels) for the network to be activated. For example, any event which requires quick security should activate the local network of security; for broader political and legal support, State and national networks must be informed.
    e. **Broad approach to handling violence:** Different types of violence need different approaches and support from different stakeholders. The SOP on Network-Based Violence Management should broadly cover these aspects. A few such examples are given below:
        i. **Developing a shared security arrangement at different levels:** In some areas of Bihar, smaller hospitals have made arrangements with security staff who arrive at the violence site with a single call, and handle the mob. The cost of such security staff is borne by all network members. This approach not only reduces small hospitals' expense on security but also gives a

sense of confidence among healthcare workers to work in a safe environment.

ii. **Developing a digital platform or common communication network:** A common digital platform can be created as a support system along with common communication network which can be used in case of violence.

iii. **Involvement of the media in case of threat to public image:** The hospital's relationship with the media is always a tricky situation. But when dealing with influencing people or strong organisations with a potential threat to the image of hospital or healthcare professionals, the media should be involved to provide the true sequence of events and avoid misrepresentation of facts in public.

f. **Self-reporting of the violence against healthcare workers:** Any event of violence must be reported to professional network bodies such as the IMA, AHPI, and so on, who should analyse and develop measures for handling different scenarios and suggest policy-level interventions.

Conclusion and Take-Home Messages

A multipronged strategy is necessary in order to handle violence against healthcare workers. This chapter has discussed key measures including the following:

1. Policy-makers must continuously monitor these events and initiate proactive measures[12] including effective law enforcement systems at the State Government Level, so that there is a sense of security among healthcare workers.
2. The hospital administrators and healthcare providers must be vigilant[13] and keep tabs on likely trouble in their hospital and have constant communication with patient relatives and other stakeholders.
3. The power of networks with patients, relatives, local community, medical authorities and medical associations must be used to handle any incidences of violence against health workers and make policy interventions.

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12. CJI voices concern over violence, false cases against doctors. *The Hindu*. https://www.thehindu.com/news/national/cji-voices-concern-over-violence-false-cases-against-doctors/article65392143.ece (accessed on 17 June 2022).
13. Kanjaksha Ghosh, "Violence against doctors: a wake-up call," *Indian Journal of Medical Research*, 148(2) (2018 Aug.): 130–133. doi: 10.4103/ijmr.IJMR)1299_17.

Chapter 7

ETHICAL PRACTICE AND THE ROLE OF REGULATORS (COUNCILS) IN REDUCING VIOLENCE AGAINST HEALTHCARE WORKERS

Shivkumar S. Utture

Case Study

A patient's son recently filed a complaint against a medical practitioner that was heard in the Ethical Committee meeting. The son alleged that his father was admitted in the ICU under the care of the said doctor, and that on admission, he was assured that his father would recover. Unfortunately, the father passed away after five days. The son also alleged that during these five days, the concerned physician did not inform him that his father was deteriorating, nor were any family members counselled regarding the same. Emotions ran high and the family members resorted to assaulting the hospital staff and vandalising the hospital.

When it was the turn of the RMP to put forward his say, he stated that the condition of the patient was critical on admission, and that is why he was being treated in the ICU. The doctor's defence was substantiated by the necessary documents and patient reports. The Committee was also informed of the treatment details which were as per standard protocol. On hearing the doctor's side, the complainant argued that he was never counselled regarding his father's clinical condition and was in fact falsely assured of his recovery. He said that if he had been aware of all the details stated by the doctor at the Ethical Hearing, his reaction would have been different.

The above case study demonstrates how important it is to frankly and sensitively put forth the true nature of a patient's clinical condition to the relatives without exaggeration, and, especially in critical cases, regularly communicate

with the patients and their relatives, so that they are made aware of the ongoing treatment and daily response of the patient. Though the RMP was exonerated by the Ethical Committee in the above case study, it would have saved him a lot of time, money, physical assault and mental harassment if he had followed these Ethical Tenets in his day-to-day practice.

Introduction

In a detailed study,[1] 61.9 per cent of healthcare participants reported exposure to some form of workplace violence. Of these, 42.5 per cent reported exposure to non-physical violence, and 24.4 per cent experienced physical violence in a single year. Verbal abuse (57.6 per cent) was the most common form of non-physical violence, followed by threats (33.2 per cent) and sexual harassment (12.4 per cent).[1]

The most common reasons attributed to violence were intolerance to the news of the patient's death in 26 per cent incidents, alleged delays in treatment in 17 per cent events, poor communication and substance use among caregivers in 9 per cent events each. Under hospital management issues, 6 per cent were due to inadequate specialists and facilities.

The prevalence of violence against HCWs was particularly high in Asian and North American countries, in Psychiatric and Emergency departments, and among nurses and physicians. The Chinese Medical Doctor Association in 2014 showed that over 70 per cent of physicians ever experienced verbal abuse or physical injuries at work.[2] In Germany, severe aggression or violence has been experienced by 23 per cent of primary care physicians.[3] In the United Kingdom, a Health Service Journal and UNISON research found that 181 NHS Trusts in England reported 56,435 physical assaults on staff in 2016–2017.[4] In the United States, 70–74% of workplace assaults occur in

1. J. Liu, Y. Gan, H. Jiang, L. Li, R. Dwyer, K. Lu, & . . . Z. Lu, "Prevalence of workplace violence against healthcare workers: a systematic review and meta-analysis," *Occupational and Environmental Medicine*, 76 (2019): 927–937. doi: 10.1136/oemed-2019-105849. Epub 2019 Oct 13. PMID: 31611310.
2. S. Z. Yang, D. Wu, N. Wang, T. Hesketh, K. S. Sun, L. Li, & X. Zhou, "Workplace violence and its aftermath in China's health sector: implications from a cross-sectional survey across three tiers of the health system," *BMJ Open*, 9 (2019): e031513. doi: 10.1136/bmjopen-2019-031513.
3. F. Vorderwülbecke, M. Feistle, M. Mehring, A. Schneider, & K. Linde, "Aggression and violence against primary care physicians – a nationwide questionnaire survey," *Deutsches Arzteblatt International*, 112 (2015): 159–165. doi: 10.3238/arztebl.2015.0159.
4. Andy Cowper, "Violence against NHS staff: A special report by HSJ and Unison," (2018). https://guides.hsj.co.uk/5713.guide (last accessed 7 June 2020).

healthcare settings.[5] The Indian Medical Association report (2015) says more than 75 per cent of doctors had faced violence at work.[6]

The consequences of violence against HCWs can be very serious: deaths or life-threatening injuries,[7] reduced work interest, job dissatisfaction, decreased retention, more leave days, impaired work functioning,[8] depression, post-traumatic stress disorder,[9] decline of ethical values and increased practice of defensive medicine.[10] Workplace violence is associated directly with a higher incidence of burnout, lower patient safety and more adverse events.[11]

In public hospital/services, insufficient time devoted to patients and therefore insufficient communication between HCWs and patients, long waiting times, overcrowding in waiting areas, lack of trust in HCWs or in the healthcare system, dissatisfaction with treatment or care provided, degree of staff professionalism, unacceptable comments of staff members, and unrealistic expectations of patients and families over treatment success are thought to contribute towards healthcare violence. Indeed, in public hospitals worldwide, staff shortages prevent frontline HCWs from adequately coping with patients' demands. In private hospitals/services, extended hospital stays, unexpectedly high bills, prescription of expensive and unnecessary investigations are key contributory factors.

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5. Occupational Safety and Health Administration, *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers (OSHA, 3148-04R)* (OSHA, 2015). https://www.osha.gov/Publications/osha3148.pdf (last accessed 7 June 2020).
6. TNN, "Over 75% of doctors have faced violence at work, study finds," India News – Times of India. https://timesofindia.indiatimes.com/india/Over-75-of-doctors-havefaced-violence-at-work-study-finds/articleshow/47143806.cms (last accessed on 24 May 2019).
7. Workplace violence in the health sector, World Health Organization Survey Questionnaire ONU. Rapporto Italia. Rome (2019). https://portale.fnomceo.it/sanita-ricerca-oms-nursing-up-un-infermiere-su-10-ha-subito-violenza-fisica-sul-lavoro-e-il-4-e-stato-minacciato-con-una-pistola-nellultimo-anno/ (last accessed 7 June 2020).
8. N. Magnavita, T. Heponiemi, & F. Chirico, "Workplace violence is associated with impaired work functioning in nurses: an Italian cross-sectional study," *Journal of Nursing Scholarship*, 52 (2020): 281–291. doi: 10.1111/jnu.12549.
9. G. D'Ettorre, V. Pellicani, & A. Vullo, "Workplace violence against healthcare workers in Emergency Departments. A case-control study," *Acta Biomed*, 90 (2019):621–624. doi: 10.23750/abm.v90i4.7327.
10. D. M. Toraldo, U. Vergari & M. Toraldo, "Medical malpractice, defensive medicine and role of the media in Italy," *Multidisciplinary Respiratory Medicine*, 10 (2015):12. doi: 10.1186/s40248-015-0006-3.
11. S. Berlanda, M. Pedrazza, M. Fraizzoli, & F. de Cordova, "Addressing risks of violence against healthcare staff in Emergency Departments: the effects of job satisfaction and attachment style," *BioMed Research International*, 2019 (2019): 5430870. doi: 10.1155/2019/5430870.

Healthcare is a key aspect of any developing nation and the need for quality, accessible and affordable healthcare is a fundamental necessity. A particularly central role in healthcare delivery in modern societies is that of the physicians, who have a pivotal role to play in the context of ethical behaviour in healthcare markets.

Healthcare specialists and healthcare institutes are dedicated to excellence within the professional practice of promoting individual, family, organisational and community health. Guided by common goals to improve the human condition, healthcare providers are responsible for upholding the integrity and ethics of the profession as they face the daily challenges of making decisions.

The responsibility of all healthcare specialists is to reach the highest possible standards of conduct and to encourage ethical behaviour of all those with whom they work.

Responsibility to the Public

A healthcare provider's ultimate responsibility is to educate people for the purpose of promoting, maintaining and improving individual, family and community health.

Responsibility to the Profession

Healthcare providers should be responsible for their professional behaviour, for the reputation of their profession and for promoting ethical conduct among their colleagues.

Responsibility to Employers

Healthcare providers should recognise the boundaries of their professional competence and be accountable for their professional activities and actions.

Responsibility in the Delivery of Healthcare

Healthcare providers should promote integrity in the delivery of health. They should respect the rights, dignity, confidentiality and worth of all patients by adapting strategies and methods to meet the needs of diverse populations and communities.

Ethics can be described as "knowing the difference between what you have a right to do, and what is right to do."

The Primary Responsibilities and Duties of Healthcare Providers

Responsibilities of the healthcare provider:

1. Healthcare providers should support the right of individuals to make informed decisions regarding their health, as long as such decisions pose no risk to the health of others.
2. Healthcare providers should encourage actions and social policies that promote maximising health benefits and eliminating or minimising preventable risks and disparities for all affected parties.
3. Healthcare providers should accurately communicate the potential benefits, risks and consequences associated with the services and programmes that they provide.
4. Healthcare providers should accept the responsibility of acting on issues that can affect the health of individuals, families, groups and communities.
5. Healthcare providers should be truthful about their qualifications and the limitations of their education, expertise and experience in providing services consistent with their respective level of professional competence.
6. Healthcare providers should be ethically bound to respect, assure and protect the privacy, confidentiality and dignity of individuals.

Duties of the healthcare provider:

1. Notification of births and deaths
2. Notification of notifiable diseases to the appropriate authorities
3. Reporting of cases of poisoning
4. Reporting of suspected causes of death
5. Reporting of cases covered under privileged communication
6. Responding to calls for emergency services
7. To treat and to continue to treat and maintain the professional secrets of the patients
8. To obtain consent of the patients for medical examination
9. To obtain informed consent before any procedure
10. To issue medical certificate, fitness certificate, death certificate, vaccination certificate or certificate of disabilities
11. To conduct post-mortem examination as per the requirement and request from appropriate authorities
12. To attend to cases of accidents and medical emergencies

Regulator's Perspective

The last decade has seen a paradigm shift in understanding how a healthcare system should function, and there has been a churning in the expectations of patients and the administration in viewing the medical field as more of a service industry than a professional one.

Owing to the new knowledge obtained from medical studies and the diversity of not only lifestyles, but also moral and religious values in modern societies, medical involvement and decision-making processes associated with healthcare are becoming more and more complicated. Moreover, noticeable economic pressure is being experienced by healthcare systems throughout the nation, as the awareness of ethical implications in medicine has been raised through public, political and medico-legal discussions.

What Are the Basic Principles of Medical Ethics?

The Code of Ethics is grounded in fundamental ethical principles including promoting justice, doing good and avoidance of harm. Bioethicists often refer to the four basic principles of healthcare ethics when evaluating the merits and difficulties of medical procedures. Ideally, for a medical practice to be considered "ethical," it must respect all four of these principles: autonomy, justice, beneficence and non-maleficence.

Autonomy

This requires that the patients have autonomy of thought, intention and action when making decisions regarding healthcare procedures. Therefore, the decision-making process must be free of coercion or coaxing. In order for a patient to make a fully informed decision, she/he must understand all the risks and benefits of the procedure and the likelihood of success.

Justice

This requires the healthcare provider to consider four main areas when evaluating justice: fair distribution of scarce resources, competing needs, rights and obligations, and potential conflicts with established legislation.

Beneficence

This requires that the procedure be provided with the intent of doing good for the patient involved. This demands that healthcare providers develop and

maintain skills and knowledge, continually update training, consider the individual circumstances of all patients and strive towards a net benefit.

Non-maleficence

This requires that a procedure does not harm the patient involved or others in society.

Medical Councils have a dual role to play in these situations:

1) Prescribing ethics in medical practice
2) Educating health professionals on ethical practice

Health education should lay a heavy emphasis on the importance of communication skills, ethical practice, patient's rights and professionalism throughout their training programme.

Practicing professionals should have regular refresher courses to understand the nuances of good ethical practice. Medical Councils should,

- Notify ideal consent forms;
- Standardise prescription formats;
- Encourage medical organisations to prepare Standard Treatment Protocols; and
- Put in place Grievance Redressal Cells in every institute.

One of the most effective methods of avoiding potential confrontation in a medical establishment is to set up an Internal Redressal Committee or similar institutional mechanism to offer assistance in addressing ethical issues that arise in patient care and facilitate sound decision-making that respects patient-care values, concerns and interests. An Internal Redressal Committee or Hospital Ethics Committee is characterised as a body of persons established by a hospital or healthcare institution and assigned to consider, debate, study, take action on, or report on ethical issues that arise in patient care.

To be effective in providing the intended support and guidance in any of these capacities, the Internal Redressal Committee should,

(a) Serve as advisors and educators rather than decision makers;
(b) Respect the rights and privacy of all participants and the privacy of committee deliberations and take appropriate steps to protect the confidentiality of information disclosed during the discussions;
(c) Ensure that all stakeholders have timely access to the committee's services in order to facilitate decision-making;

(d) Be structured, staffed and supported appropriately to meet the needs of the institution and its patient population;
(e) Uphold the principles to which the institution is committed; and
(f) Make clear to patients, physicians and other stakeholders that the institution's defining principles will inform the committee's recommendations.

The next section examines a few landmark cases regarding medical negligence and misconduct.

Principals of Standard of Care

Dr. Laxman Balkrishna Joshi v. Dr. Trimbak Bapu Godbole and Another (1969)

A young boy had suffered fracture of the femur. The accused doctor, while putting the leg in plaster, used excessive force during manual reduction, with the help of three assistants. Such traction is never done under morphine alone but done under proper general anaesthesia. The boy went into vasovagal shock, causing his death. Based on these facts, the Supreme Court held that the doctor was liable to pay damages to the parents of the boy.

Medical Profession under CPA

Indian Medical Association *v.* V. P. Shanta (1995)

This landmark judgment decided that services rendered by medical professionals come under Section 2(1)(0) of the CPA, hence applying the Consumer Protection Act to medical practitioners. It defined conditions such as the following:

- Who is a consumer?
- What is medical negligence?
- What is deficiency in service?
- What are the patent conditions under which medical practitioners can be held responsible?

Medical Negligence

Poonam Verma *v.* Ashwin Patel & Ors. (1996)

The professional may be held liable for negligence on the ground that he does not possess the requisite skill which he professes to have.

Misrepresentation of Degree and Competence

Dr. Louie *v.* Smt. Kannolil Pathumma

The National Consumer Commission held that Dr. Louie showed herself as an MD although she was only MD Freiburg, a German degree which is equivalent to an MBBS degree in India.

Liability of Hospital and Employees

Spring Meadows Hospital *v.* Harjol Ahluwalia

A child was admitted for typhoid fever. The nurse asked the father of the patient to procure injection Lariago, which she then administered to the patient. The child immediately collapsed, suffering a cardiac arrest on account of the medicine having being injected, which led to brain damage. The National Commission held that the cause of cardiac arrest was intravenous injection of a high dose of Lariago. The doctor and nurse and the hospital were found liable and Rs.12.5 lakhs was awarded as compensation to the parents.

Emergency Medical Care Is a Must

Pt. Parmanand Katara *v.* Union of India & Others, (1989)

A profusely bleeding scooterist involved in a road accident was picked up and taken to the nearest hospital. The doctors refused to attend to him, and without giving primary treatment, referred the patient to another hospital located 20 km away authorised to handle medico-legal cases. The injured was then taken to that hospital but succumbed to his injuries before he reached.

The doctor-patient relationship is one based on mutual trust and respect between the two parties. However, the rapid changes in the medical field and the corporatisation of the healthcare system have strained the age-old good relations between the patient and the treating physician/surgeon. The legal, ethical and moral liabilities of the doctors are enshrined in the Hippocratic Oath that doctors take when being ordained into the medical fraternity. The relationship between a physician and a patient must be inviolable. Included among the elements of such a relationship of trust are open and honest communication, including disclosure of all information necessary for the patient to be an informed participant in her/his care. This relationship is not to be constrained or adversely affected by any consideration other than what is best for the patient. The existence of other considerations, including financial or contractual concerns, is, and must be, secondary to the fundamental relationship.

The increasing number of medico-legal cases filed in the courts and with the medical councils has made it necessary for hospitals and medical administrators to become aware of the medico-legal aspects to minimise civil and criminal litigation and ensure quality medical care.

Conclusion and Take-Home Messages

Violence against healthcare personnel is a common worldwide phenomenon and undermines the very foundation of health systems. On an average, 70% of doctors around the world have faced some degree of violence in the workplace. The consequences of violence are increased job dissatisfaction, depression and post-traumatic stress with decreased retention amongst doctors. This chapter has examined the importance of ethical practice and the role of regulators in reducing violence against healthcare workers.

1. Physicians have a pivotal role to play in the context of ethical behaviour in delivering quality, accessibility and affordable healthcare.
2. Regulators (Medical Councils) have a central role in ensuring that medical practitioners follow the basic principles of autonomy, justice, beneficence and non-maleficence in their day-to-day practice.
3. The concept of good ethical practice should be ingrained in doctors right from undergraduate education.
4. Effective Internal Redressal Committees should be in place at every medical establishment to avoid potential confrontation between patients and healthcare workers.

Chapter 8

SAFETY MEASURES ON THE GROUND FOR HEALTHCARE ORGANISATIONS

Ravisankar T. N. and Alexander Thomas

Case Study

A booked obstetric case came in late at night with labour pain to the single-owner obstetric hospital with all the necessary facilities available 24x7. The patient was advised a caesarean section by midnight, but her relatives took time to give consent for the same.

The obstetrician noted the time and date when the consent for LSCS was requested. The delay of 25 minutes to receive the consent and another delay of 15 minutes for the arrival of the anaesthetic resulted in the loss of the baby.

Even before coming out of the surgical theatre, the obstetrician alerted the police and a patrol police jeep soon reached the spot, as the hospital had a good rapport with the nearby police station. The relatives refused to take the body of the dead baby, demanding an explanation. By early morning, a group of doctors (including paediatricians) reached the hospital, explained everything to the crowd repeatedly and answered all their questions, at the end of which the relatives finally accepted the body of the dead baby.

In the meantime, the case sheet was prepared with the help of the other doctors and handed over to the police. A group of doctors belonging to the association gave a media interview to clear doubts; this was broadcast on satellite channels chasing "juicy news" for their TRP ratings.

The above scenario is a classic case of how to properly handle a crisis using the following steps:

1. Documenting the time when LSCS was advised.
2. Calling the police and staff in preparation for a hostile response from the relatives.
3. Making an SOS call to fellow colleagues.

4. Using colleagues' help to complete documentation, as it is difficult to document appropriately in a preoccupied frame of mind during a crisis.
5. Conducting a public information session for the media organised by the association office-bearers.
6. Wasting no time in handing over the dead body to prevent swelling of the crowd with multiple opinions that can flare up the situation.

Introduction

The uniqueness of healthcare is that it is the only labour-intensive sector working around the clock and involving all categories of staff from different backgrounds. In addition, it is a highly demanding vocation.

Violence is defined as any "behaviour involving physical force intent to hurt, damage or kill." Violence in any form against anybody or anything is against universal law. In recent years, healthcare establishments and professionals are being exposed to violence at increasing rates. Sometimes, case outcomes can be unpredictable and unexpected. An unexpected outcome combined with inadequate communication on the part of the healthcare provider can be the cause of outrageous behaviour by the public. In the event of an unfavourable outcome for the patient, the violent events that follow despite offering the best of their expertise can lead to significant mental trauma for the concerned doctor or healthcare worker. Therefore, it is important that the mental health of the healthcare provider is accorded due importance.

Healthcare establishments are also unique in the fact that the majority of its employees are women, who are at higher risk for violence and harassment. It is all the more important that they are provided adequate security and work safety to perform to their best of ability. It would be advisable on the part of the government to announce hospitals as safe zones with zero tolerance for violence, and give top priority for immediate and swift action during incidents of violence.

Types of Violence against Healthcare Workers

Violence against healthcare professionals could range from harassment and verbal abuse to physical assault, even leading to death. They include acts of intimidation, blackmailing, cyber bullying, mob lynching and harassment. Acts of violence can be directed at healthcare workers, equipment and infrastructure. Violence could occur either as an immediate or delayed reaction. Mob psychology gives people the confidence to create violence in any form while feeling assured of no consequences since they are in a large crowd.

Studies have revealed that 50 per cent of violence takes place in the ICU, 45 per cent in the ER and 70 per cent of violence initiators are patient's escorts. Another study in 2018 revealed that 50 per cent of attacks are reported during the night shift.

Causes and Consequences of Violence

The causes of violence against healthcare professionals have been explored in the previous chapters. They include inappropriate communication such as poor communication and body language by staff, arguments between hospital staff, unwillingness to refer or discharge patient on attender's or patient's request, demanding signatures repeatedly without proper explanations, repeated requests for information on patient's status with no response. Other causes are unexpected events including death, unwillingness to pay the bill (out of pocket expenses), denial or delay in treatment in the ER, non-availability of consultants and other staff, and so on.[1]

There are several consequences of violence against healthcare workers, including physical injury, mental trauma, loss of trust in the doctor–patient relationship, social and financial loss, disturbed work environment (including the loss of work hours) and the rise of defensive medical practice. Long-term consequences include an increase in the cost of healthcare along with the likelihood of healthcare facilities shutting down, thus disadvantaging the local community.[2]

Early Signs of Violent Reactions

It is imperative that healthcare workers, security and other hospital staff be trained to identify relatives or attendants who are potential troublemakers. These are the people who walk around in the hospital premises, often having conversations about the patient and their progress. Employees must be taught to inform their immediate supervisors about any suspicious behaviour or provoking conversations, so that the management and doctors can take the requisite precautions while making the necessary efforts to talk to those attenders and clear their apprehensions in order to keep violent reactions at bay.

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1. M. Kumar, M. Verma, T. Das, G. Pardeshi & J. Kishore, "A study of workplace violence experienced by doctors and associated risk factors in a Tertiary care hospital of South Delhi, India," *Journal of Clinical and Diagnostic Research*. 10 (2016). DOI: . 10. LC06-LC10. 10.7860/JCDR/2016/22306.8895
2. Framework guidelines for addressing workplace violence in the healthcare sector. [2020 Jun.]; https://apps.who.int/iris/bitstream/handle/10665/42617/9221134466.pdf.

The cash counter and front-office employees will be able to identify these dissatisfied relatives/attendants from their non-cooperative attitude or reluctance to accept a consultant's opinion or review. Quite often the consultant's inability to communicate appropriately could contribute to the root cause for violence. Such events should be reported to the senior clinicians and management to be handled correctly.

It has to be ensured that during weekends and long holidays, appropriate and sufficiently detailed hand-overs are done, and provision for adequate staffing is made in order to respond to patients' needs.

An ICU patient's attendants are usually amongst the most demanding. It is recommended that an ICU with over six beds have a medical counsellor to communicate with the patient relatives as frequency demands. It is also necessary for the clinicians to meet the relatives of very sick patients at least twice a day to provide updates, and these meetings need to be recorded and documented.

Preventing Violence

The following pages provide guidance on steps to be taken to avert the possibility of violence, what can be done during an incident of violence and what should be done after such an incident. Many of the below-mentioned strategies were introduced and used in real-life situations at a well-known city hospital headed by one of the authors, and were found to be useful in averting many a crisis.

Strategies for Prevention

1. All categories of staff are to be trained in communication. This is now a requirement of the National Accreditation Board of Hospitals and Healthcare Providers (NABH) certification. Healthcare communication has also been introduced into the medical education curriculum. It is important to remember that one should communicate firmly but sensitively, keeping in mind that the patients' attendants are going through an emotional time. More details on communicating appropriately can be found in Chapter 3 titled *The Importance of Effective Communication*.
2. Retired police personnel could be employed for purposes of security, training and liaising between the hospital and local police stations. This topic is expanded upon in Chapter 5 titled *Law Enforcement*.
3. The presence of adequate staff is a must in order to attend to patients promptly, especially in emergency and critical care departments.

4. A solid infrastructure with adequate availability of equipment (wheelchairs, stretchers, etc.) should be ensured for the quick and effective care of patients.
5. The hospital entrances and exits should be designed in such a way that entry can be restricted by closing one or two entrances as and when required. Good lighting of the corridors and work place is essential.
6. It is important to install CCTV monitoring for the entire hospital especially in areas such as ER, ICUs and OBG departments as a tool to pick up early signs of violence, as well to act as a deterrent to violence from patients and their relatives. If, in a situation where awareness of the CCTV camera and monitors can provoke a violent mob to destroy it, it is necessary to have a few hospital staff recording the event in hiding from close quarters.
7. Attendants' visits should be restricted after visiting hours, especially during night times.
8. Security systems at night and during long holidays must not be compromised.
9. Any untoward incidents or signs of impending violence must be reported to the management concerned.
10. Women employees must always be accompanied by security personnel or male staff when they are shifting the patient to other establishments.
11. Settling of bills on a periodic regular basis should be encouraged to avoid piling up of huge outstanding amounts.
12. There should be prominent signage announcing that attacks on hospitals are non-bailable offences with stringent punishments.
13. The hospital staff should have access to legal advice or be trained in basic and relevant legal aspects.
14. A well-advertised, easily accessible and widely displayed round-the-clock patient redressal system/helpline, assuring a prompt response from a senior hospital official, will go a long way in building confidence among patients and averting any untoward incidents. The senior hospital official could, if necessary, personally interact with the complainant and resolve the grievance. The email address of the institution head can also be displayed to ensure that unresolved issues can be attended to.
15. For times outside regular duty hours (including evenings, weekends and holidays), a resident administrator system can be set up. The resident administrator, preferably a senior nurse, posted on rotation is appointed to take overall charge of the hospital in relation to food quality, alertness and readiness of security, availability of ambulance, ensuring that telephonic queries are appropriately answered, being a point of contact for any sudden issues, and so on.

16. The resident administrator can be supported by senior staff who can do night rounds on rotation.
17. A daily report by the resident administrator (either by email or WhatsApp) to the core group of hospital officials every morning will be beneficial in understanding any day-to-day problems, areas of concern and the necessary remedial actions to be taken.

Handling a Violent Situation

1. All hospitals should become familiar with using **Code Violet** over the public address system.[3] Code Violet is now accepted as the code for the hospital response when a violent incident is taking place. The phrase "Code Violet" is announced thrice over the local PA system to alert the staff to make their way to the place where the incident is taking place. Trained personnel should form a protective circle around the victim being subjected to violence. They should only protect the staff and equipment and should not retaliate or enter into an altercation with the mob.

Awareness regarding the Code Violet facility should be generated widely among the staff and hospital employees. Code Violet can be made effective only with mock drills at frequent intervals. The role of the individual must be predetermined, and only mock drills can reemphasise the responsibilities and identify the gaps to be closed on the next occasion. Mock drills are an effective way to keep the hospital staff alert. The steps include the following:

1. Informing hospital administration
2. Security staff or their supervisors calling for the police to counter the violent mob or persons
3. Restricting entry into hospital
4. The senior staff or medical superintendent gathering a team for discussions to defuse the crisis

With the assistance of the police force to defuse the crisis, the hospital management can attempt to initiate a dialogue with the violent mob. The primary aim should be to move the body or the patient away from the hospital premises rather than recovering payment for the treatment process or such related

3. Dial Code Violet for Violence Against Doctors. *Medical Dialogue*. https://medicaldialogues.in/dial-code-violet-for-violence-against-doctors-guidelines?infinitescroll=1.

matters. The commercial aspect can be taken care of at a later time, or the hospital can use a legal forum to recover the same.

After a Violent Incident

The main steps are outlined here and examined in greater detail in Chapter 5 titled *Law Enforcement*.

1. File FIR
2. Follow up with the police station
3. Follow up with the court
4. Conduct a root cause analysis of the incident to prevent a reoccurrence
5. Address the mental health of the victim through counselling, work backups, and so on.

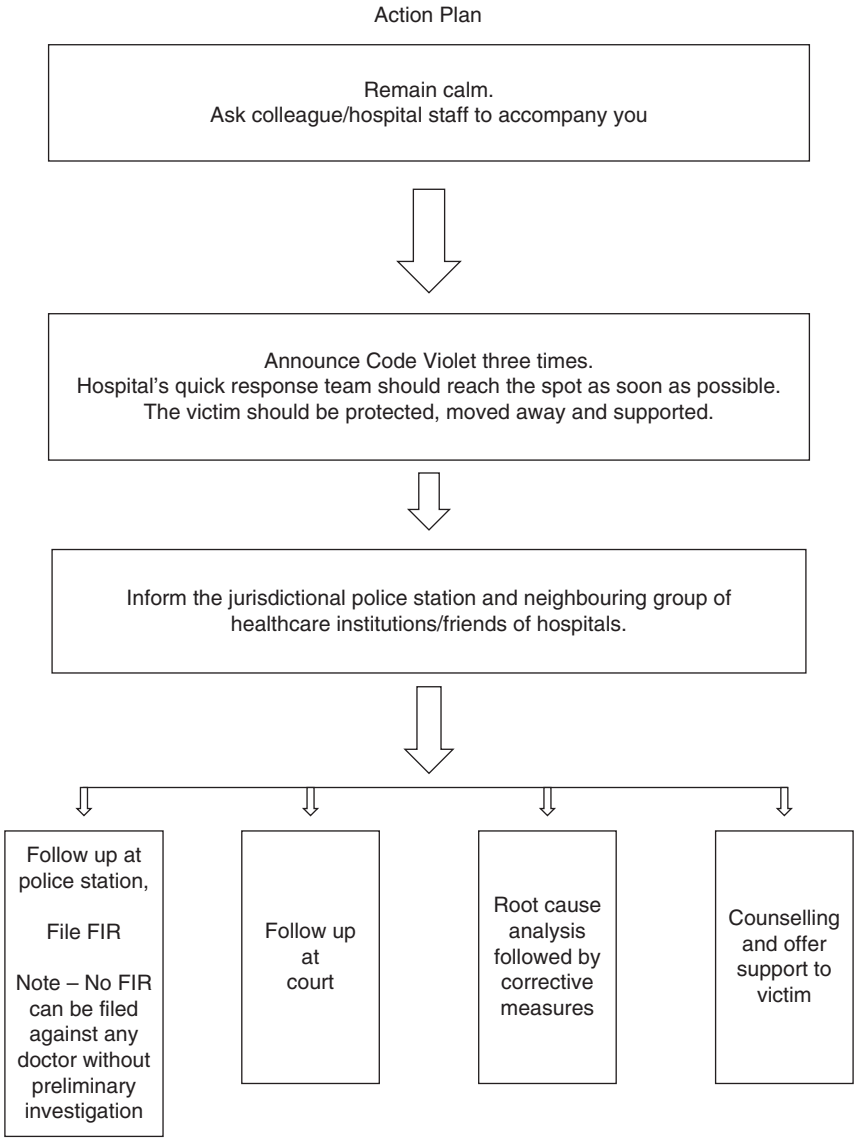
Small Clinics or Individual Practitioners

In smaller clinics and individual private practice set-ups, the security systems are not as advanced as those in bigger healthcare facilities. Hence, violent persons and mobs need to be handled differently.

1. Effective communication with the patient and relatives is crucial.
2. Apart from seeking immediate police assistance, the clinic head should also seek the support of pre-determined groups (nearby clinics and local healthcare institutions) through WhatsApp groups or other mechanisms so that they can physically come to the clinic's aid.
3. It is more likely that a family practitioner would have a more personal and deeper rapport with influential persons who may be patients at the clinic, and hence he/she should handle a violent situation with a call to those who may be able to defuse the crisis.
4. Recording of the event and training staff accordingly is advisable.
5. It is always necessary for a single clinic owner to have a referral hospital where they can refer patients who develop complications while providing treatment so that the hospital can also join the defense of their professional action.

Conclusion and Take-Home Messages

This chapter has explored the causes and consequences of violence against healthcare professionals, and provided guidance for on-the-ground safety measures that can be implemented in healthcare organisations (Flowchart 8.1).



Flowchart 8.1 Action Plan after a Violent Incident

1. Prevention is better than cure: communication is key, and all hospital employees should be trained in effective communication.
2. The mental health of healthcare workers should be given due importance.
3. Develop a system through staff/CCTV to pick up signs of impending trouble and try to resolve it before it manifests in a violent outbreak.
4. Set up an independent helpline for patients/attendees to reach administrators directly.
5. Ensure the periodic settlement of bills.
6. In case of an actual incident, put into practice a pre-determined SOP with the aim of protecting victim and hospital.
7. Conduct mock drills frequently.
8. Follow up with the police and courts to discourage future incidents of violence.

Chapter 9

SELF-REGULATION AND THE HEALTH PROFESSIONAL

R. V. Asokan, Olinda Timms and Vinay Aggarwal

Case Study

Dr. Patel could not control the group shouting aggressively in the foyer. They demanded to know why the patient's final bill was so much higher than the estimate of charges given at admission. They rejected Dr. Patel's explanation that treatment and surgery may not always go as planned; the cholecystectomy was more complicated than expected, and the patient needed ICU care for two days post-surgery. The family members accused the hospital of extortion, and threatened to complain. Dr. Patel summoned security and rang up the Medical Superintendent.

Introduction

Ever since medical care was recognised as a profession, it has been mostly self-regulated. Doctors hold themselves accountable to ethical standards enshrined in the Codes of Ethics drawn up by the profession in the larger interest of social good. Self-regulation was inevitable and even understandable, given the specialised body of knowledge and skills in medicine. Medical professionals themselves create the curriculum, are directly involved in training and skilling, and also conduct all certification examinations. However, along with self-regulation, the responsibility of ensuring professional standards of practice and behaviour is also placed squarely on the shoulders of doctors themselves. They are expected to define not just the standards of clinical care but also, importantly, of ethical behaviour and conduct in practice.

This level of autonomy is rarely encountered in other professions, and includes a system through which doctors are answerable to their peers through a Governing Council for professional misconduct, and not to external bodies. The privilege of autonomy can only prevail as long as there is perceived

internal accountability.[1] If doctors renege on this aspect of self-regulation, there is bound to be social backlash as was experienced recently, in the form of mistrust, violence and a call for external checks and controls on the medical profession.

Loss of trust erodes the social contract of the profession to serve and to prioritise patient's needs above all other considerations. These values are enunciated in every code of ethics and medical oath and serve to foster trust in this social endeavour. Trust is central to the doctor–patient relationship, a relationship that is intrinsically unequal: the patient on one hand, vulnerable, suffering and unaware of the complexities of medical science, and on the other hand, the doctor with the skill, knowledge and professional autonomy. The doctor–patient relationship is therefore a "fiduciary" one, defined by patient's trust in the doctor that demands professionalism and accountability from the doctor in return. When this contract of trust is abused or broken, it is harmful not only to the individual but to society as a whole, and discredits the reputation of the profession. Doctors are at risk of being vilified and disrespected, and violence is just the next step in the downward spiral of distrust.

Ethical Values in Changing Times

It is certainly an unacceptable situation for all stakeholders; far from such adversarial positions, the social objective of the medical profession is to serve society and care for those in need. It is a moral enterprise that is valued as a social good, with the role of doctors traditionally held in esteem. In order to regain this trust and respect in an atmosphere that is regretfully charged with suspicion, the need of the hour is introspection and strict self-regulation that will hold doctors and health institutions accountable.

Today, patient complaints tend to be mostly about incomplete information, lack of transparency and unaffordable care. This is not only about individual doctors and small clinics; with the advent of the large corporate hospital setting, care delivery patterns have drastically changed, altering expectations and experiences of the patient. While doctors are held to ethical standards, hospitals and corporate health institutions are accountable to industry regulations, and this dichotomy leads to dissatisfaction for both doctors and patients who then become victims of this dystopia. In the face of changing scenarios of modern settings, technological advancements and newer

1. R. Collier (2012). "Professionalism: the privilege and burden of self-regulation," *Canadian Medical Association Journal*, 184(14) (2012 Oct.): 1559–1560. doi: 10.1503/cmaj.109-4286.

treatments, it is all the more essential to remain true to the goals of medicine and hold on to ethical values in order to preserve trust in the profession.[2]

The core values of ethical practice will hold in any healthcare setting and should be the touchstone against which new institutions, processes or protocols of care are evaluated or approved. The World Medical Association lists these values as compassion, competence and respect for patient autonomy.[3] These values, along with non-maleficence and justice, are relevant even today. It is essential to integrate these values into professional training, behaviour and practice in order to foster trust in the profession and health facilities. They must naturally extend to all health institutions created and used by doctors and patients, where rights and vulnerabilities remain the same, as do duties and responsibilities. When health institutions are patient-centered, service-oriented and ethically managed, they will earn the trust of patients and have lower litigation. Given the nature of the healthcare enterprise, particularly in low- and middle-income countries like India, that do not have universal healthcare or social security, and where large sections of the population depend on free care from the government, healthcare models that are high-cost or focused on profitability are more likely to encounter patient dissatisfaction.

Sometimes a crisis arises when ethical doctors work in commercial establishments whose priorities are not always aligned with the profession; where shareholders and investors' interests decide key policy matters. Doctors are incentivised by high salaries, posh working conditions and other perks; the temptation to just look away and remain silent, is strong. Here, doctors may need to assume the responsibility of taking these core values of medicine and ethical standards into healthcare institutions and other places of work, designing systems and processes that are patient-friendly and inclusive, sensitive to feedback and prioritising care and service. As a key stakeholder, doctors cannot relinquish their power to advocate on behalf of patients and families for what is just and right; patients can very easily become victims of a commercial interest and "commission" practice.

Much is argued about comparisons with other professions and the general drop in ethical standards across society, while higher standards are expected of doctors. Instead of dropping our own standards in vexation, it is far better that we recall the status and regard for doctor by society mainly because of the role and responsibility assumed by the profession in serving it. Rather than defensive practice, strikes and calls for severe punishment of perpetrators of

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2. H. Bauchner, P. B. Fontanarosa & A. E. Thompson (2015). "Professionalism, governance, and self-regulation of medicine," *Journal of American Medical Association*, 313(18) (2015):1831–1836. doi: 10.1001/jama.2015.4569.
3. Edited by J. R. Williams, *The World Medical Association* (2005). pp. 134. ISBN 9299002819.

violence, we need to introspect as a profession on how far we have come from our ideals, and our role in advocating for change.

Accountable Patient-Responsive Hospitals

The concept of a clinic took shape in the late eighteenth century[4] and was a paradigm shift for modern medicine. The second half of the twentieth century saw the rise of organised multidisciplinary hospitals. Technology has advanced the frontiers of medical care and growing affordability and consumerism is redefining relationships. At the same time, the information explosion through the internet causes confrontations in doctor–patient interactions. As hospitals in the private sector take on aspects of the hospitality industry, the expectations of the patients have expanded into luxury and comfortable rooms and food, and other amenities. Patient self-negligence including delay in seeking care, non-compliance with treatment and aggressive behaviour is another facet faced by the doctor. The challenges in running a hospital are now multidisciplinary and complex, requiring nuanced and sophisticated responses from the health industry and the profession.

Huge capital investment and professional management of private and corporate hospitals in the last four decades have led to this sector of healthcare being described as an industry. Far from being independent, the professional is now an employee and subject to policies defined by profit objectives. Private health insurance and TPAs set the agenda. The for-profit nature of the private healthcare and the business management principles are at odds with the professional code of ethics that prioritises the needs of the patient, thus straining the doctor–patient relationship. The voice and influence of the professional on matters of policy is weak at both government level and industry level. Yet, doctors continue to remain the face of healthcare.

This dichotomy in leadership and allegiance is the root cause of violence against doctors. Abusive relatives and difficult patients are more commonplace, bringing physical violence, verbal abuse, threats, social media trolling and trial by media into the health sector today. This leads to an atmosphere of fear and distrust, mentally tortured and demoralised doctors and hospital staff, and a huge amount of workplace stress.

There is a need to restore patient care as the core objective and focus of the health industry. Even while the role of the medical profession may be relegated to a secondary status in the institutional set-up, the clinical needs of a patient are still attended to by the doctor. Both the patient and the doctor try

4. Micheal Foucalt, *The Birth of the Clinic: An Archaeology of Medical Perception*. https://www.skepticsvocabulary.in/paradigms-of-medical-perception/.

to manage their relationship within the new parameters set by the system, but the trust is uneasy and the doctor is not always acting autonomously. This discomfort can be mitigated by putting in place patient-responsive and patient-friendly institutional mechanisms.

Hospitals must share accountability with the doctor in all aspects of patient safety. A bonafide accreditation process comprehensively ensures the structural and clinical needs of patient safety. The National Accreditation Board of Hospitals and Healthcare Providers (NABH) even has an entry-level certification process which takes care of the infrastructural and clinical processes. There are criticisms that these processes result in less time for patient care and unchanged overall outcomes.[5] However, accreditation certainly adds to quality consciousness, structured patient care, protocols and a better legal defence. Professionalism in care, ancillary services and documentation is the way forward in determining outcomes and patient satisfaction. Defining and disseminating best practices and internal audits strengthen the professional management of hospitals. Promptness, politeness and time management have to be ensured as well as counselling of patients and relatives.

It has been suggested that dynamic real-time costing and pricing coordinated by the quality evaluation and maintenance team could help, as well as a transparent and efficient billing system. Feedback evaluation with quick response teams and a credible grievance redressal mechanism go a long way to foster trust in the institution. Professional counselling of patients and health education teams should focus on expectations and limitations of care. Inclusive decision-making and honest sharing of information are steps in the right direction. Another aspect is a mechanism for medical error acknowledgement, rectification and peer evaluation, to build trust. Morbidity and mortality meetings, and hospital ethics committees can play a role here.

With emphasis on the patient experience, the attitude and behaviour of the entire health and administrative team can be redirected at serving the patient. They need to be sensitised in patient-friendly behaviour and communication that builds trust. The patient should not only feel welcome and comfortable, but also safe and trustful that the actions of the doctor are in his best interest.

Case Study

Twenty-five-year-old Sunitha, a journalist in her second trimester of pregnancy, arrived at the hospital for her check-up, and was pleasantly surprised when the receptionist greeted her

5. Lam MB, Figueroa JF, Feyman Y, Reimold KE, Orav EJ, Jha AK. Association between patient outcomes and accreditation in US hospitals: observational study. *BMJ* 18(363): k4011. https://www.bmj.com/content/363/bmj.k4011.

with a smile and briskly helped her through the formalities. A nursing assistant offered to accompany her to the obstetrician on the third floor.

Unexpectedly, the lift stalled and she began to panic. The nursing assistant was resourceful; offered her a stool to sit on, and switched on the fan while she called for help on the lift telephone. It took just five minutes for the technicians to remedy the situation but felt like a lifetime for Sunita, as she was claustrophobic. She was pleased to see the duty doctor waiting at the lift door. The staff quickly wheeled her into the casualty where she was examined, and the doctor spoke reassuringly. She was offered water and comforted, and her predicament quickly came to an end.

The obstetrician was friendly and engaged her in conversation during the ultrasound scan. When she discreetly asked her if she could know the sex of the baby, the obstetrician politely declined and counselled her. The consultation ended on a positive note and the nursing assistant helped her to procure the drugs from the pharmacy.

Sunita felt she should leave a word of appreciation in writing. The surprised PRO told her that she had hardly received any appreciation notes from patients. In fact, doctors and the hospital staff were apprehensive about aggressive patients and trolling on social media. Sunita glimpsed doctors and nurses in the now familiar uniforms. For a moment her mind flashed back to what she had read the day before; that 2000 doctors had perished in the Covid-19 epidemic. She thought the silent and dignified sacrifice of the doctors and health workers deserved acknowledgement, and made a note to write a piece on the topic.

Not every encounter in a private hospital is predatory and disappointing, and many doctors and health institutions strive against all odds to ensure that patients get the care they need. Media does tend to focus on negative incidents and this tars all health establishments and all professionals with the same brush. For this reason, it is important that doctors lead and participate in policy formation and protocols in private hospitals so that the objective of patient care is achieved. According to the proposed new National Medical Commission Professional Conduct Regulations, 2022, "RMPs bound by these regulations will not engage in any activities which violate these regulations and *should not enter into any employment or other contract that engages in activities in violation of any of these regulations*."[6]

Recommendations for Ethical Standards in Hospitals

Ethics in the medical profession is defined in terms of the doctor's responsibility and not the hospital's, for which it remains uncharted territory. This is

6. National Medical Commission, Draft Regulations (May 2022). https://www.nmc.org.in/MCIRest/open/getDocument?path=/Documents/Public/Portal/LatestNews/NMC%20RMP%20REGULATIONS%202022%20Draft%20Final%20YM.pdf

an opportunity as well as a challenge. While the objective may be patient care, hospital policies when left to the market forces also focus on profitability, which may compromise the interest of the patients. Ethical standards of the medical profession must guide any institution dealing with patient care. Sustainability and profitability of the private hospitals, while desirable, need not be at odds with this concept, as demonstrated by many non-government hospitals established across the country. Areas of possible conflict and stress should be identified, defined and addressed. Some hospitals develop a unique identity and brand value based on their motivation and quality of service. The relationship between the medical profession and the hospitals can be likened to the software and hardware of a computer. The soul of the hospitals, in principle, should be aligned with the medical profession rather than with an industry or business. The success of a hospital is directly proportional to the goodwill and trust generated by upholding the traditional values of compassion and caring.

Since market forces cannot be allowed to dictate the quality of care, there is a strong case to regulate and tax hospitals on an entirely different footing from other commercial institutions. Corporate private hospitals are responsible to shareholders and must abide by the laws of the land that apply to such institutions. As business institutions, they have their own rights and legal privileges, and may be perfectly justified in looking after the interest of their shareholders. Nevertheless, business interests and conduct do not sit comfortably in the health sector of low- and middle-income countries where universal health care is yet to be realised and large populations have no access to quality care. The purpose of a hospital remains compassionate care and patient safety. Business interests must be subjugated to broader social needs and responsibilities. On this borderless frontier is the rubicon of the medical profession. The curbing of sharp business practices is a bonafide step in consonance with professional ethics and social expectations in healthcare in order to demonstrate trustworthiness of institutions.

Hospitals are institutions where the laws of corporate governance, professions and labour merge, and the interest of the staff members and the employees of the hospitals are protected by labour laws. Hospitals are regulated as shops, trade and industry. Yet clinical services are professional in nature and the nature of regulation should reflect the services provided. This mismatch of regulation and the nature of services ultimately affects the doctor–patient relationship and trust in institutions. There is an urgent need to regulate the hospitals as professional institutions with a social role and duty of imparting care.

The Clinical Establishment Act (CEA) adds to the fifty-plus legislations regulating hospitals and health institutions.[7] The only area left that had been

7. The Clinical Establishments (Registration and Regulation) ACT, 2010. http://www.clinicalestablishments.gov.in.

unregulated in a hospital was the clinical protocols and the treatment/consultancy fees. The CEA attempted to address this[8] but government-prescribed clinical protocols are often seen as an attempt to rein in medical professionals. Medical care is a constantly evolving science and art, and professional societies across the world struggle to distil the essence of the voluminous evidence generated into care protocols. This updating of evidence has undone several dogmas and what is current today can become obsolete tomorrow. The bureaucratic administration of clinical protocols traps doctors in a time warp and can become a legal nightmare.

Regulating hospitals in the same way as trade and commerce and insisting on regulating fees can be unfair, as the scope of services can vary widely in each case depending on the complexity of the case and the patients need. Several government schemes are known to fix prices of services well below the costs incurred, and this is then applied to private players too! The government has failed to reveal an acceptable costing mechanism, and as expected, there is heavy subsidy of costs. The attempt to regulate charges in the private sector is directly linked to the failure of successive governments to invest in health, expand government services and reach wider populations; instead of expecting the private sector to provide these essential services at a low cost.

India is blessed with a large active middle sector in health services which is an asset. Doctors as entrepreneurs have established clinics as well as small and medium hospitals. Popularly known as "nursing homes," they provide primary and secondary care. In a country with low government investment in health and high out-of-pocket expenses, this middle sector prevents catastrophic health expenditure at least for patients from the middle and lower middle socio-economic class. There is some evidence that this middle sector run by the medical professional is gradually diminishing in size for multiple reasons, some of which are viability, burdensome regulatory compliance, the recent spate of violence against doctors and the reluctance of younger generations to carry on the legacy of their doctor parents. Unwarranted medical negligence claims and high compensations can deal a body blow to such institutions. There is a strong case to regulate them differently as they serve an important sector, and exempt such health institutions from the Clinical Establishments Act, mandating an approved accreditation process instead. These single or couple doctor practices can be registered as professional institutions in a separate provision under the State Medical Councils and regulated under the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations,

8. http://www.clinicalestablishments.gov.in/En/1068-standard-treatment-guidelines.aspx.

2002. In these cases, the concept of medical ethics governing hospitals will gain traction. Professional governance of these institutions by doctors will also bring in ethical norms and protocols making it patient-friendly and service-motivated. Perceptions of these hospitals will then improve, with a possible reduction in violence and litigation.

Conclusion and Take-Home Messages

This chapter has examined how violence against doctors and hospitals has a complex origin and is a product of mismatch between expectations and limitations in access, availability, affordability and regulation of healthcare. Careful introspection on the part of professionals, hospital leadership and authorities will provide some way to reverse this trend. It is important that this sector is handled sensitively, with political will and good governance, to the satisfaction of both patient and doctor.

1. Peer pressure, awareness of ethical standards and peer recognition of good practices can change professional practice.
2. An institutional-level reset that prioritises patient safety and satisfaction can positively impact the attitude of healthcare workers and the experience of patients.
3. As the apex body governing medical practice and training, the National Medical Council can revise and promote ethical guidelines at regular intervals, advocate for laws and regulation that are appropriate for different health institutions, and lead a process by which all health institutions, whether private or government, are governed by ethical guidelines that are consonant with medical codes of ethics, in the interest of patients.

Chapter 10

THE MEDIA EYE

Seethalakshmi S.

Case Study 1

It was a windy afternoon in December 2013 when a three-year-old girl in a South Bengaluru neighbourhood was playing with her friends, when she accidentally hurt her elbow. When the pain did not recede the next day, her parents took her to the Sanjay Gandhi Institute for Trauma and Orthopaedics. After examining the little one, doctors advised surgery for the child's elbow. That was the last time the parents saw their daughter smile. She was wheeled into the OT at 8.30 AM for what was meant to be a 30-minute procedure. But when she was brought out nine hours later, she was in a coma. An overdose of anaesthesia had resulted in bradycardia and hypoxia – a condition where the oxygen supply to the brain was cut off.

Eight years later, the child continues to be in a vegetative state at her home. The family claimed that they sold their home and spent nearly Rs 30 lakh on her treatment, but there was irreparable damage to the little girl's brain. The doctors who treated the three-year-old were temporarily suspended by the Karnataka government following public outrage and extensive reporting by the media as it was a case of alleged medical negligence. They were back to work six months later. But life in the child's household continues to be topsy turvy since that unfortunate December afternoon in 2013.

Case Study 2

June 2021: It was Dr. Seuj Kumar Senapati's second day of work at the Covid-19 care centre in Hojai district in Assam. When he found a Covid-positive patient unresponsive, he examined him and found that the patient had passed away. All hell broke loose when Dr. Senapati informed the family of the death. They hurled chairs at him, beat him with a bedpan, dragged him outside the Covid-19 centre and assaulted him till he was covered in blood, screaming in pain and fear. After a police complaint was filed by the doctor, police rounded up 36 persons for assault.

In the child's case, public sympathy was on her side and the anger with the doctor, while in Dr. Senapati's case, the sympathy was with the doctor and the anger with the patient's family. For the media and the public at large, both the case studies have a common thread – alleged negligence.

Could the second case study be considered medical negligence? On the face of it, no – as the doctor had noticed the patient to be unresponsive and examined him only to realise that he was dead. Going by media reports, there was *prima facie* no fault on the part of Dr. Senapati whatsoever.

Introduction

In a newsroom, there are 100 questions while reporting the incident. How long has the patient been in a state of unresponsiveness? How did he get into that state? Was it due to lack of attention to his deteriorating condition? What medicines were administered to him? Were they administered at the right time? Were all protocols for a Covid-19 patient followed for this patient? Why didn't Dr. Senapati's colleagues (who had treated him before Dr. Senapati came into the scene) observe the patient earlier and treat him if his condition had been deteriorating? Did that Covid-19 treatment center lack sufficient doctors (since in June 2021, India was at the peak of the second wave of the pandemic)? Did the patient have any underlying conditions that were not treated by the doctors before Dr. Senapati entered the scene?

Emotions, they say, defy logic. And that, at best, explains this situation where the family of the patient took law into their own hands and assaulted the doctor. To the family of the patient, the truth in front of them was that their loved one was dead. And therefore, they decided to shoot the messenger – in this case, Dr. Senapati.

One of the biggest question marks in India about medico-legal cases is the ambiguity at various stages while the courts and the police deal with cases related to doctors. Often, Section 45 of the Indian Evidence Act, 1872, is invoked to get an "expert opinion" when dealing with a case on a point of science. It is crucial for the media to flesh out all aspects of the story/news report before it is made public and to avoid unnecessary public opinion.

Due Diligence

While no act of violence against the healer (read doctor) should be tolerated, the challenges for the media are one too many. This is where the media's due diligence comes to play. It is crucial for reporters (the writer) to stay neutral, not take sides, look at all aspects of the story and remain unbiased throughout its reporting (a news report is referred to as a story in the newsroom and in

journalistic parlance). The fundamental job of reporters in every media house is to speak to all stakeholders and get as much information as possible even before sitting down to write the report for the newspaper/television channel.

The chief reporter is responsible for clearing these stories for print, and the double responsibility of ensuring that all facts were intact in the news copy. His/her job is to ensure that it is absolutely unbiased reporting from the journalist, and therefore from the newspaper. This is at the core of reporting while clearing the copy for publication, and it is applicable to every single story that is published every single day.

Biased reporting can occur for various reasons. In the two cases mentioned above, the journalists/media houses could be friends/relatives of the doctors or the families or could simply have been pressured into writing the incident in their favour. This is one of the biggest challenges for the media: staying unbiased and reporting only the facts, leaving the readers to make their own judgement.

The public tends to accept and believe however the media portrays the incident, leading to perceptions, bias, prejudices and judgements evolving in the mind of the public. In the child's case, because of the daily bombardment of human-interest stories on the three-year-old, a negative perception was built around the entire medical fraternity: a belief that doctors can get away with negligence.

Hence, it is vital for media persons to do a deep dive into every story, do a 360-degree view during every report (including routine updates to the reader) and not get carried away by hearsay and unverified data/statements. The rule of the game is to cross-check and verify or question statements (to get more information) so as to not defame anyone and create unnecessary public opinion. This is unbiased reporting.

The previous chapters have dealt with the myriad causes and contributions to violence against healthcare workers. Violence and assault against doctors have occurred when patients die in the hospital. There have also been many cases of vandalism on the hospital premises (with an intent to hurt the medical fraternity) when the hospital presents a "fat bill" on discharge or allegedly over-charges the patient's family.

A Balanced Portrayal

Of late, a common complaint among the public is that hospitals favour patients with insurance as those with insurance cover have no problem clearing the bill. Often, the first question that a patient or his/her family is asked when they enter a hospital is: do you have health insurance? The rest of the process is allegedly determined by the answer to this question. Hospitals

are also accused of administering unnecessary tests simply because the patient has health insurance or he/she is covered for treatment by their employer. Unfortunately in public perception, some hospitals are thought to even hike their charges simply because "the company is paying for the patient." This is another negative perception that hospitals, especially private healthcare centres, have received during the last two decades. Should something untoward happen (either the patient dies in the hospital or the family heckles the hospital over the bill), violence erupts once again putting the healthcare workers in a vulnerable position.

Constant reporting of these sorts of issues over the years has built public opinion in a negative way against the entire health sector, leaving healthcare workers vulnerable to psychological and physical harm. Private hospitals are maligned for "fleecing the public." Thus, a report on vandalism at a private hospital, which should not be justified at all, becomes a general statement on how the hospital is not poor-friendly and serves only the elite. If a doctor has been assaulted because the hospital allegedly charged excess rates, then it is assumed that the fault is indeed with the hospital and, therefore, the doctor! Public/government hospitals are not spared by the media either; the focus there is often on the lack of quality of services, including government doctors' competency, and so on. In some cases, newsrooms do not make an attempt to speak to both parties, providing a one-sided story from the patient without getting any information from the hospital management or doctors involved.

A dip-stick survey by a Delhi-based media/TV house during the peak of the pandemic revealed that 75 per cent of the patients who walked into private hospitals for Covid-19 treatment were "overcharged."[1] Backed up with case studies of patients who struggled to pay hospital bills, the media started generalising that all private hospitals overcharge, eventually leading to this becoming a public perception. This can be combated with transparency on the part of the concerned hospitals, and constant communication between hospitals and media houses to publish some positive "feel-good" stories to show the other side of the coin, such as successful surgeries or excellent crisis-handling. Newspapers and television channels are always deficient in portraying the other side in this situation, so it is crucial that the healthcare industry uses this opportunity (or the vacuum in the media) to showcase when a good job is done. This will go a long way in keeping public perception fair and balanced in case there are any negative outbreaks in the healthcare sector.

1. India, P. T. of. (29 September 2021), 75% Covid-19 patients were overcharged by hospitals, claims survey: Report, NDTV.com. https://www.ndtv.com/india-news/75-covid-19-patients-were-overcharged-by-hospitals-claims-survey-report-2557903 (retrieved 2 July 2022).

Laws Protecting Healthcare Workers

The laws in India to protect doctors when they are assaulted or against any act of violence are not effectively implemented. Prior to Covid-19, the Protection of Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage to Property) Act had been adopted by several States in the country. With health being a State subject, each State has its own Act with its own name while the punishment clauses remain uniform. This is examined in detail in Chapter 1 titled *Protecting Healthcare Professionals in India – An Analysis of Law and Policy*.

The provisions of the Indian Penal Code – Sections 186, 332 and 353 clearly lay down the punishment for anyone who assaults a public servant. However, there is a flaw: a doctor working in a government hospital is defined as a public servant, but not a doctor in a private hospital. Though the jurisdictional police register an FIR (First Information Report) and a case is booked under the said Act, the police cannot book the case under "assault on a public servant" where the punishment for the offender is harsher. It took a pandemic and repeated assault on doctors, who were at the forefront of the battle against the virus, to get the government to amend the Epidemic Diseases Act, 1897, which included penalties for any violence against healthcare workers and provided protection to healthcare personnel and their property against violence during epidemics.[2]

In June 2021 when India witnessed the disastrous second wave of the pandemic, the Centre chose to bring an ordinance where violence against healthcare professionals would be registered as a non-bailable and cognisable offence.[3] The amended Act states that "whoever commits or abets the commission of an act of violence against healthcare service personnel; or causes damage or loss to any property shall be punished with imprisonment and with fine. Such offences are also cognizable and non-bailable."

On weak ground, many cases fall apart and the perpetrators go free after an initial charge sheet is filed. With doctors and healthcare workers leading such hectic lives, they cannot be constantly running for their case updates and court hearings. Often there is a fatigue in fighting the case, and they move on.

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2. News18.com (18 June 2021), As attacks on doctors grow, centre reminds states of law for violence on medical staff, News18. https://www.news18.com/news/india/attack-on-healthcare-professionals-is-non-bailable-offence-health-ministry-to-state-govts-3863672.html (retrieved 2 July 2022).
3. G. Kuppuswamy & U. Warrier. "Covid-19 and violence against doctors – why a law is needed?" *Journal of Family Medicine and Primary Care*, 10(1) (2021): 35–40. doi: 10.4103/jfmpc.jfmpc_912_20. Epub 2021 Jan 30. PMID: 34017700; PMCID: PMC8132815. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8132815/#ref17 (retrieved 2 July 2022).

That the protection is fragile for our healers was exposed when the Health Services Personnel and Clinical Establishment (Prohibition of Violence and Damage to Property) Bill, 2019, which sought to impose a jail term of up to 10 years for assaulting on-duty doctors and other healthcare professionals, faced a hurdle from the Union Home Ministry which said it will not interfere in a State subject (health is a State subject).

The To-Do List for Journalists, the Government and Hospitals

- Non-negotiable guidelines for media houses and journalists on fact checks while reporting every single story of assault on doctors/healthcare workers. Every journalist who reports on health and related issues or covers hospital as a beat for the media house must comply with the fact-check and unbiased reporting policy which is the single guideline before publishing the news report.
- Media trial must be banned by courts. In any case, until both sides are heard and investigated, stringent reporting guidelines must be laid down to ensure fair play for both doctors and patients. These guidelines which should be monitored by an ombudsman (unbiased) can include levying fines for wrong reporting, prejudiced views/opinions and debates in media houses – both print and television.
- The over-arching body which may be known as an exclusive Healthcare Tribunal of India will have powers to investigate medico-legal and any crime against the medical fraternity, will also bring in media houses into its framework/ambit for questioning. If biased reporting is found which resulted in defamation of the doctor, the journalist may be penalised.
- Amend laws to ensure that doctors depose before courts/tribunals against another from his/her fraternity without bias or prejudice. This will ensure a fair justice system.
- Stronger punishment for anyone who engages in emotional reactions, takes law into their own hands and assaults a doctor or healthcare worker.
- The judiciary should treat all medico-legal cases on priority and have a set deadline/timeline to dispose of cases when a doctor or healthcare worker is assaulted. This may end the popular perception that a court case is expensive and time-consuming, encouraging so-called vigilante justice.

Conclusion and Take-Home Messages

The media holds a mirror to the public. While it is crucial for hospitals and doctors to be transparent during the entire healing process, journalists must stay neutral and not get swayed by any vested interest while communicating

with the patient. This chapter has examined the role played by the media in violence against healthcare workers.

1. Journalists should strive to obtain a 360-degree view of every story and report both sides of the story in an unbiased way, leaving readers to come to their own conclusions.
2. Trial by media should be discouraged and even penalised.
3. Media houses should strive to report positive stories from hospitals as well, showcasing the good work done, in order to keep public perception fair and balanced.

APPENDIX

AHPI Legal Advisory Cell
in collaboration with
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- Free first consultation
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Courses and Training Programmes

1. Workshop on Communication in Healthcare (a train-the-trainer programme) by the AHPI Institute of Healthcare Quality
2. Post-Graduate Diploma in Medical Law and Ethics (PGDMLE) by the National Law School of India University (NLSIU), Bangalore
3. One-Year Diploma Programme in Medico-Legal Systems (DMLS) by the Symbiosis School for Online and Digital Learning
4. Certificate Course in Medicine and Law for Doctors by the Institute of Medicine and Law
5. Courses on Healthcare Communication by the Indian Institute of Healthcare Communication
6. Online Certificate Programme in Law and the Medical Profession by ILS Law College, Pune
7. Certificate Course in Medical Law by Medvarsity (Online)
8. Post-Graduate Diploma in Medical Law by the Indian Institute of Skill Development Training

Recommended for Further Reading

Books

1. *Communicate. Care. Cure. A Guide to Healthcare Communication (Third Edition)*, edited by Alexander Thomas and Divya Alexander, Wolters Kluwer, 2019
2. *Essence of Communication for Nurses in India* by Usha Menon, Notion Press, 2018
3. *Nursing Communication and Educational Technology* by Pramilaa R, Jaypee, 2010
4. *Preventing Workplace Violence: Handbook for Healthcare Workers* by Tony York (Reviewer), HCPro (a division of BLR), 2015
5. *Protect Yourself Now! Violence Prevention for Healthcare Workers* by Rae A Stonehouse, Live for Excellence Productions, 2020
6. *Health Law and Ethics: Critical Reflections* by Nandimath Omprakash V, Alexander Thomas and Arpitha H. C., Thomson Reuters, 2022
7. *Textbook on Medicolegal Issues Related to Various Medical Specialties* by Satish Tiwari, Mahesh Baldwa, Mukul Tiwari and Alka Kuthe, Jaypee Medical, 2018
8. *Legal Issues in Medical Practice: Medicolegal Guidelines for Safe Practice (Second Edition)*, edited by V. P. Singh, Jaypee, 2020
9. *Health Law* by Ishita Chatterjee, Central Law Publications, 2019

Articles (Linked on the Open Access Online Version)

- Parliament Passes Bill to Protect Healthcare Workers Against Violence. https://www.ndtv.com/india-news/parliament-passes-bill-to-protect-healthcare-workers-against-violence-2299007
- Orders Issued to Prevent Violence Against Doctors. https://www.thehindu.com/news/national/kerala/orders-issued-to-prevent-violence-against-doctors/article35887720.ece
- Mechanism to Prevent Violence Against Doctors, Press Information Bureau, Government of India. https://pib.gov.in/Pressreleaseshare.aspx?PRID=1806206
- Karnataka High Court Seeks Report on Steps Taken for the Prevention of Violence Against Medical Professionals. https://www.livelaw.in/news-updates/karnataka-high-court-notice-prevention-of-violence-against-medical-professionals-178478
- Rajya Sabha Passes Bill to Punish Those Attacking Healthcare Workers. https://www.thehindu.com/news/national/rajya-sabha-passes-bill-to-punish-those-attacking-healthcare-workers/article32647396.ece

- Centre Asks States, UTs, to Register FIR Against Those Who Assault Doctors, Healthcare Professionals. https://timesofindia.indiatimes.com/india/centre-asks-states-uts-to-register-fir-against-those-who-assault-doctors-healthcare-professionals/articleshow/83668153.cms
- Delhi: Hospitals Must File FIR if Patients' Kin Rough Up Doctor. https://indianexpress.com/article/cities/delhi/hospitals-must-file-fir-if-patients-kin-rough-up-doctor-5679422/
- The Epidemic Diseases (Amendment) Act, 2020. https://egazette.nic.in/WriteReadData/2020/222125.pdf
- Explanation of the Judgement in *Jacob Mathew vs. State of Punjab*. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3579074/
- Delhi Medical Association Moves Supreme Court for Prevention of Violence Against Medical Professionals. https://www.livelaw.in/top-stories/delhi-medical-association-moves-supreme-court-for-prevention-of-violence-against-medical-professionals-176587
- Supreme Court to Hear Plea on Violence Against Doctors. https://www.thehindu.com/news/national/supreme-court-to-hear-plea-on-violence-against-doctors/article30975059.ece
- Ensure Zero Tolerance towards Violence Against Doctors, Says Bombay HC. https://timesofindia.indiatimes.com/city/mumbai/ensure-zero-tolerance-towards-violence-against-docs-says-bombay-hc/articleshow/82617719.cms
- FIR against Doctor for Negligence Cannot be Registered Unless the Police Authorities Obtain an Expert Opinion. https://www.latestlaws.com/latest-news/fir-against-doctor-for-negligence
- Violence against Healthcare: Current Practices to Prevent, Reduce or Mitigate Violence. https://www.icn.ch/system/files/2022-07/Violence%20against%20healthcare%20survey%20report.pdf
- Violence against Healthcare Professionals in India: Recent Legal and Policy Issues. https://vidhilegalpolicy.in/research/violence-against-healthcare-professionals-in-india-recent-legal-policy-issues/

The Dr. Archana Sharma MedLegal Help Desk

A voluntary, free-of-charge initiative by the Institute of Medicine and Law to help doctors who have been threatened with criminal or police action for medical negligence.

https://imlindia.com/initiatives/medlegalhelpdesk

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Justice S. R. Bannurmath, former Chief Justice of Kerala, promoted transparency in judiciary and was the first Chief Justice in the country to declare his assets along with other judges of the Kerala High Court in the public domain. He is the current Chairman of the Law Commission of Karnataka and past Chairperson of the Maharashtra State Human Rights Commission. [srbannurmath@gmail.com]



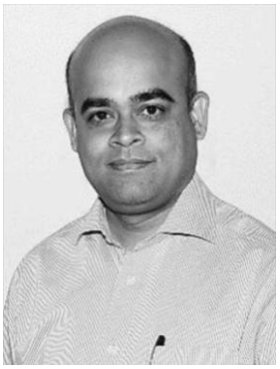
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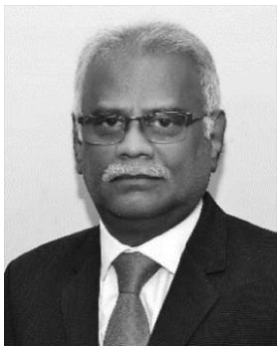
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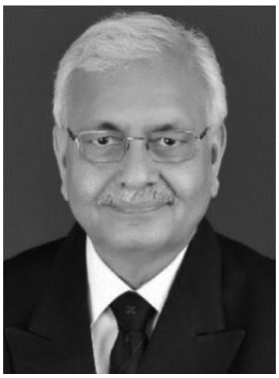
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