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Assaults on public hospital staff by patients and their relatives: an inquiry

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Abstract

Open-ended interviews with providers, administrative staff and patients in one teaching hospital and two peripheral hospitals in Mumbai were conducted to investigate the triggers to violence against hospital staff, the underlying conditions that give rise to such conflicts, the structural and organisational factors that contribute to these conditions, the steps taken to reduce the hostility towards the public health system and what needs to be done. Our findings indicate that the violent incidents are usually triggered by sudden deaths. Patients are frustrated by rude health providers and a lack of essential drugs and diagnostic equipment. On their part, resident doctors must provide life-saving treatment while also handling agitated crowds. They live and work in conditions that put them under pressure and keep them demoralised. Bad working conditions, overcrowding and inadequate facilities are responsible for the increased friction between patients and providers.

Introduction

Attacks on doctors and hospitals in Indian cities are on the increase. At least seven such incidents were reported in Mumbai between June 2005 and March 2006, all in public hospitals. In February 2006, an assault on resident doctors even led to a strike by resident doctors from government hospitals in Mumbai.

We conducted interviews with administrative staff, senior doctors, nurses, resident doctors, class IV employees, police stationed in the hospitals and patients in one teaching hospital and two peripheral hospitals in Mumbai. We sought their opinions to answer the following questions:

What are the triggers to such violence and what are the underlying conditions that give rise to these patient-provider conflicts? What are the structural and organisational factors that contribute to these conditions? What steps have been taken to reduce the current hostility towards the public health delivery system and what needs to be done?

The following summary of the respondents' perceptions provides insights into the problems of public health services in teaching hospitals.

What triggers attacks on doctors?

Hospital staff said that the most common trigger of such incidents is a sudden death. This perception is borne out by a review of news reports. Other triggers are denial of admission, a delay in providing care, an absence of equipment and drugs during emergencies, and abuse or negligence by hospital staff.

Senior doctors noted that resident medical officers (RMOs) are usually entrusted with delicate tasks such as communicating the news of a relative's death, negotiating for permission to do a post-mortem and explaining what has happened inside the operating theatre or emergency room. This practice continues even though the public believes that RMOs are young and inexperienced and therefore even responsible for the patient's death. The presence of senior doctors can defuse the situation, but when sudden deaths occur after office hours few senior doctors are available for support. Nor are there social workers or counsellors who might be better equipped to deal with such situations and address the relatives' anxieties and queries. Juniors must cope as best as they can.

Sudden deaths are most common following an accident. Crowds of people who interfere with the emergency treatment often accompany accident victims. The doctor must resuscitate the patient while also managing the crowd and worrying about mob psychology. The attacks are often started by people, at times by a local leader, who are unrelated to the patient. When a relative starts an argument, others join in the fray.

Hospital staff also felt that relatives have a limited understanding of the patient's critical illness. They expect the medical staff to save the life of their loved one, regardless of the patient's condition. "A woman who goes for delivery is seen as basically healthy," said a resident of obstetrics and gynaecology. "Relatives cannot understand how she could become seriously ill all of a sudden, let alone die. The same applies to infants."

Many patients come to public hospitals desperate for help. A casualty officer noted that patients are often referred to a government service after having spent most of their money in private hospitals. Private hospitals wishing to rid themselves of a bankrupt patient may have told the relatives that the patient is critically ill and should be rushed to a teaching hospital. This is their last resort and they want something done immediately. They may not be convinced by a casualty medical officer's opinion that there is no emergency.

Overall deterioration of public health services

Respondents spoke at length about the underlying tensions and structural problems responsible for creating such situations.

Shortages of drugs, linen and other items are a major concern. Many staff reported that patients and their relatives are often angry about having to pay for services that are supposed to be

free. Several doctors mentioned that even life-saving drugs like adrenaline are often missing in emergency rooms and operating theatres. Sometimes the drugs are just not available; at other times, adequate stocks may not be maintained in each ward or outpatient department. Doctors complained about having to do the administrative work of stock maintenance at the cost of providing medical care.

A senior doctor illustrated how problems of supply irritate patients. The list of drugs in stock, displayed in the hospital out patient department (OPD), is not regularly updated and doctors in the OPD prescribe drugs based on the outdated list. At the dispensary patients are told that the drugs are out of stock; either they must be purchased from outside at their own expense or they must get the prescription changed, which means going back to the crowded OPD.

Further, diagnostic equipment such as ultrasound and X-ray machines are routinely out of order, forcing patients to get these investigations done at private centres for a fee.

Residents noted that staff shortages also force relatives to take on substantial responsibility for nursing the patient. They are required to be present almost round the clock in the hospital. Yet there are no bathing, resting or food facilities for them.

Doctors under pressure

Almost all respondents mentioned a shortage of personnel – either because of under-staffing or because of rampant absenteeism among the support staff. Several doctors mentioned that orderlies and *ayah*s are often on leave. Nurses and doctors are compelled to do jobs like crowd management, pushing trolleys, getting drugs and equipment and escorting patients between departments. This affects their interaction with patients. They also feel that such work reduces their status in the eyes of the relatives. It does not help that residents are bullied by ward staff who view them as novices.

The stress is compounded by the environment of the outpatient department, where crowds of patients, each pushing case papers to get the doctor's attention, surround doctors and nurses. If Class IV staff is absent there is no system to manage the stream of patients.

Residents reported that absenteeism is common among senior doctors (lecturers, assistant professors and professors) who may make cursory rounds of the wards and are often missing during duty hours when they are required. This affects the quality of care and dampens the residents' morale. "There are not enough role models among the senior staff," said one resident. "The government's recent decision to allow full-time professors and associate professors to practise privately has made the situation worse. Teachers rush to leave the teaching hospital and compensate their pay packets with a private nursing home attachment." Several doctors felt that senior doctors are not committed to patients in public hospital. A number of academic posts remain vacant and this overburdens the existing cadre of doctors.

Doctors feel they are under constant pressure to give special treatment to patients who have connections with politicians, senior government officials or senior doctors and administrators. It is common for patients to proffer a 'note' or letter of reference from an influential person. It is not rare to have politicians demand preferential treatment for certain patients.

Administrations were also criticised for succumbing to pressure from politicians, local leaders and patients instead of standing up for doctors. The recent incidents of violence by patients have led doctors to practise a kind of defensive medicine – doctors focus on avoiding an "incident" even if it is at the cost of victimising innocent colleagues. Seniors may berate residents in front of patients, humiliating and demoralising them.

The conditions of medical students

Many of the demands of the residents are related to their working and living conditions. "Resident doctors do not have regular duty hours. They are not even assured of a day off following a night on call. They may work all day and attend calls through the night. So patients coming in through the night assume that the doctor on duty is sleeping and get angry," said an associate professor. They may not even get a break to eat. All this takes a toll. Many residents are not from Mumbai and cannot go home even on holidays. Several have problems adjusting to the culture and the work environment of Mumbai.

Residents also resent the meagre stipends they receive. Although medicine is a lucrative profession in the long term, residents resent that their peers in engineering and management already earn a lot more. Many view the three years of residency as something to survive before they can start their practice. They feel that they are being made scapegoats for all the problems at the hospital.

A senior administrator pointed out that residents are at a stage in life when they have many other personal preoccupations and no support system. Many of them start with the belief that medicine is an exalted profession and they, as doctors, should be treated as important people. They become disillusioned when their colleagues or patients don't reciprocate this belief.

Class, culture and medical education

"There is a class difference between doctors and the patient community they serve," noted a professor. "By the very nature of the medical entrance system, it is the elite upper middle class which makes it to medical colleges, either through merit driven by tuition classes and intensive coaching or simply by way of capitation. The usual fees in medical education have been hiked, even in state-run medical colleges." Those waiting for a post-graduate seat are likely to prefer studying for competitive exams rather than take a house post. Hence, when they start working as residents, they have very little practical experience and knowledge about the background of patients, their problems and their expectations.

"Today's doctors do not connect with patients who are the indigent poor and live in slums," said a senior doctor. "Patients are routinely subjected to comments about their character,

community, religion, education and upbringing. Doctors are unaware of the conditions in which their patients live, their social problems, and the kind of difficulties they face in accessing care. This affects their communication and interaction with patients."

Both patients and doctors have stereotypes about regions and religious communities. At least three respondents claimed that Muslim patients were more aggressive and more likely to assault. This is contradicted by a review of incidents as reported in the press. Such prejudices may affect the doctor-patient interaction. If the patient's religious identity influences the attitude and behaviour of staff, it could well mean that Muslim patients would actually feel more discriminated against and, ironically, get into more altercations.

Similarly, the doctors interviewed blamed such incidents, including the providers' bad behaviour, on non-local students. Some contended that students from the North were more aggressive and abusive with patients. Most insisted that "uneducated" patients and relatives were responsible for the violence. If that were true, such incidents should be occurring daily because most of the public system's patients are poor and uneducated.

Public opinion about government health services

To understand patients' views on the causes of violence in hospitals we interviewed patients in the wards and OPDs of three hospitals. Patients were angry that doctors had gone on strike. They felt that the behaviour of a few patients should not become the reason to inconvenience so many others.

The most common grievance of patients was the hospital staff's rude behaviour. Very few providers were polite and they did not treat patients with respect. Patients said they were violent only under severe provocation. "Under normal circumstances one would not dare to raise a hand against 'big people' (doctors)," one person said.

Patients were also angry about the constant demands to pay for services or to purchase materials from outside. Other major grievances were delays, being shuttled from department to department and poor communication about the patient's condition. Patients were not too concerned about the lack of nursing care; they were more upset about the constant demands to buy drugs and supplies from private pharmacies. In general, patients and their relatives felt helpless. They felt that the system is not responsive to their needs and they cannot exert any control on their own treatment. One common complaint was that doctors and nurses did not respond to calls from patients.

The almost complete disjuncture between the versions of patients and providers is worth noting. Each group claimed that the other had no understanding of their problems. Doctors seemed unaware of their patients' social conditions. Patients had no understanding of the complexities of the hospital system. They just wanted to be examined and treated by a senior, experienced doctor, not by "novice" doctors (residents and interns).

Views about the measures taken to prevent such incidents

Hospital managements respond to a violent incident by temporarily enhancing security, usually with the help of the police and by constructing a few barricades. One municipal councillor has even suggested that doctors carry pistols to protect themselves.

Almost all respondents were sceptical about whether the presence of more security personnel would solve the problem. A patient noted that the doctor-patient relationship is delicate and involves a lot of intimacy. The presence of security personnel would inhibit patients from speaking freely with their doctors. Doctors noted that since the attacks were largely spontaneous, there was little that security personnel could do. Moreover, in many instances, the security personnel were often missing from their post or unwilling to intervene when called upon to do so.

What should be done?

Almost everyone expressed the urgent need to improve conditions in hospitals and to communicate tactfully with patients. Many noted that there should be more staff on the frontline to give more attention to patients and relatives. Several residents felt that more social workers should be posted in the wards.

Junior doctors believe the primary problem is a high patient load and adverse working conditions, which make it impossible for residents to provide adequate care and also communicate with patients and their relatives.

Senior doctors felt the need for more than one doctor – especially a senior doctor – to communicate with aggrieved relatives. There may still be heated exchanges but the situation may not turn violent. When a patient dies the relatives often blame junior doctors for their "inexperience". But they are likely to accept the same explanation if given by a senior colleague.

A senior administrator felt that aggrieved patients would at times be satisfied if the senior publicly reprimanded staff; they would feel that action had been taken. However, seniors should be supportive of their unit staff and ensure that they are able to deal with such situations. Often seniors are unfairly harsh on their juniors, who then vent their frustration on patients.

Many residents suggested that counsellors or social workers should talk to the relatives while the doctors dealt with the medical aspects of care. They also felt that seniors should deal with serious issues, such as breaking news about death and seeking permission for post-mortem.

Trouble-shooting must focus on the one or two troublemakers in the crowd to defuse the situation. A senior administrator suggested that in such an altercation, the doctor must address the patient's immediate relatives and separate them from other people in the crowd. It is important to build a bond with them, give them time to reflect on the problem and allow for the real reasons for the conflict to emerge.

"Usually, getting security to the scene serves as a deterrent," said a senior doctor. "The nurse or doctor is quickly able to

separate the medical problem from the administrative problem and hand over the situation to a more competent authority. Doctors have no training in handling crowds and aggression." Doctors felt that stringent punishment to those who assaulted them would be a deterrent against such attacks. They welcomed the government's announcement that assaulting a healthcare worker would be made a non-bailable offence.

A few doctors and almost all the patients felt that many problems would be resolved if patients were treated with more respect. A senior doctor felt that doctors should make an effort to befriend patients' relatives and pay attention to repeated complaints from a particular patient or relative. A casualty officer noted that doctors who are given lessons in communication could manage most potentially violent situations. However some situations may always arise where the advice and strategies suggested would not be useful.

Several suggestions emerged in terms of hospital management. Senior doctors said that the current atmosphere of fear and distrust must be addressed. The management gives in to political pressures from municipal corporators and its own deans and bullies staff into compliance. This should change.

Shortages and planning issues need to be addressed to ensure better efficiency. Doctors should not have to run around to collect equipment and drugs. Ward staff and casualty staff who are responsible for maintaining stocks and ensuring their availability should be made more accountable. One orderly suggested that the design of the hospital could be altered to ensure that patients don't have to walk a lot and wait for long periods, which adds to their frustration and suffering.

Suggestions were made about improving the conditions in which residents live and work. These included providing them with better accommodation, ensuring that they get breaks for eating and resting, and providing counselling for residents with personal problems or difficulties in adjusting to a new city and environment.

Acknowledgements for interviews*: Sushma Gamre (CEHAT), Staff of SAHYOG, Ann Kuruvilla, Amita Mukhopadhyay.*