COMMENTS

Aruna Shanbaug and workplace safety for women: the real issue sidestepped

SREELEKHA NAIR

Introduction

Aruna Shanbaug (born 1948) passed away on May 18, 2015 and the coverage that the news got on the front pages and the primetime news slots surprised everyone. One wonders whether this news would have got so much coverage had it not involved the sensational euthanasia debate. That Aruna should have been projected as the face of the euthanasia debate in India disturbs those who have been following her "story". The fact remains that it was a debate set off by Pinki Virani – for people like Aruna – with due respect to the former's earnest intentions and efforts. That Aruna was subjected to violence in November 1973 was nothing but the potential experience of every working woman in India. Aruna should be remembered for that reason – a cause much more bitter than passive euthanasia. She has been and will remain the face of working women in India against whom male prejudice has remained unabated even 42 years after Aruna became a victim. How many Arunas were assaulted, murdered and violated physically, emotionally and mentally during this period? To a substantial number of Indians, women still belong to the hearth and the harem, and the rapist of the Delhi girl whom we nicknamed Nirbhaya told us this impudently from within the Tihar jail in Delhi (1)[i]. India as a society seems to refuse to recognise the ethical issues associated with denying women their right to be safe at their workplaces.

Newspaper reports were eloquent on the relentless care that generations of nurses provided with devotion to Aruna; they, however, did not talk about the medical treatments that she received. There were a few reports on how she was not taken out of the hospital for some diagnosis because she was uncomfortable being taken out of the familiar environment[ii]. The details of Aruna's service as a nurse in the hospital are not known and as of May 21, 2015, we know that the hospital does not have any records that can be placed before the public (2).

Author: Sreelekha Nair (writetosree@gmail.com), Independent Researcher, Gender, Development and Sociology of Profession, TC 27/1109(1), Athiyara Madom Devi Temple Lane, Vanchiyoor, Thiruvananthapuram, Kerala-695 035, INDIA.

To cite: Nair S. Aruna Shanbaug and workplace safety for women: the real issue sidestepped. *Indian J Med Ethics*. 2016 Jan-Mar; NS1(1): 47-52.

Published online on December 10, 2015.

For every known Aruna assaulted in the workplace whose story becomes known, there are thousands who are unknown. The public space of every woman in India is subject to violence of some sort; it is just that there is disagreement on what constitutes violence. When it is physical assault amounting to rape and murder, there is some acknowledgement that there was violence. While men's crimes are often excused as "their unavoidable biological tendency" or as a product of their "playful nature", the responsibility for "being at the wrong place at the wrong time" is thrust upon the women who are subjected to violence. It has been so very convenient for all of us – the media, the government, the judiciary, us women who go to work every day and make sure we return before it gets dangerous, and the general public – to evade the real issue. Is it because there is no solution? Or is it that we do not want to face the reality as it is too harsh?

Women's safety at the workplace: the real issue

As mentioned earlier, the safety of women at the workplace is a difficult issue and yet so easy to sidestep. Physical and sexual violence are definitely imminent threats for every working woman[iii]. Women in workplaces like hospitals, where they work in proximity to men in various capacities, such as colleagues, patients and the companions of patients, face issues that result from the nature of their work and the widely prevalent norms on gender roles. When it comes to women workers, violence of a sexual nature is the predominant form of crime. The sexual nature of the violence discourages women from reporting the crime as they fear that their reputation will be tarnished, given the importance of women's "sexual purity" in our society. In a study on health workers in the private and public sector hospitals of Kolkata, conducted over the last decade, Chaudhuri (3) identified a cross-section of men as perpetrators of violence, of which sexual harassment was a significant form. The men included doctors, patients, non-medical staff who were assistants to the medical staff, administrative staff and outsiders.

It has also been observed that the organisational structure and hierarchy of a workplace like a hospital play an important role in the way a crime such as sexual harassment is identified and reported. Seeking redress and finding solutions to the issue also depend on the position, status and power of the perpetrator, rather than that of the harassed person[iv]. It has been found that when male doctors are the perpetrators,

harassment is far less likely to be reported than when other male staff members harass women (3: p 230). Similarly, actions taken on complaints of harassment depend on the hierarchy and the power of the perpetrators. Interestingly, gender is an important factor that mediates the processes of the act of violence, reporting and redress. Gender becomes the greatest deciding factor when there is educational and occupational equivalence between the harassed and the perpetrator. That is why women doctors, especially juniors, and nurses often find themselves experiencing the same kind of harassment despite their occupational and social differences.

Nurses, as a group of professionals, are the greatest sufferers when it comes to violence, especially of a sexual nature, within the hospital space. Nair and Healey (4) found that the history of the development of nursing as a profession in India contributed towards the low status of the profession and the way its practitioners are mistreated. Another study in the context of Delhi found that the perceptions of patients and others regarding power and hierarchy are very important in their dealings with nurses (5). It was found that while doctors were seen as professionals who kept a social distance from the patients due to their language and class, nurses shared the same language and social location with a majority of patients and hence, it did not come naturally for the latter to respect nurses (5: p 87).

Evidence found by the committee[v] appointed to look into the problems in the nursing sector in Kerala reveals that even after an acceptance by the wider society that hospitals as workplaces are not always safe for women, the conditions have not improved much. The committee (6), therefore, recommended that "adequate basic facilities such as changing room with dining and toilet facilities for male and female staff, sick room, transportation at odd hours of duty shifts, quarters and canteen facility shall be ensured for nursing staff"(6:p 29).

Hospitals as workplaces and sexual violence: some observations

It has been widely reported that women workers in hospitals experience sexual harassment on a daily basis. Interviews with women of diverse social standing – whether they are highly qualified professionals or simply eking out a living with few opportunities for professional growth – reveal an insecurity regarding their physical safety at their workplaces that their male colleagues do not share. Hospitals have been one of my fieldwork sites for more than a decade. They illustrate the daily connotations of gendered living at a workplace. A hospital, a public place like all workplaces, is distinct from the others in various respects. It is a place characterised by a sense of urgency among the patients as well as workers, regardless of their working hours and personal circumstances. In the latter category, nurses care for patients even when other medical staff members are not available. They are, therefore, supposed to command immense power at their workplaces. They are in a majority in any hospital. A numerical majority should rid one of some degree of insecurity, but despite all this, nurses experience a sense of insecurity at their workplaces. On the contrary, the omnipresence demanded of them by the nature of their work seems to devalue their work and dehumanise their persona. This makes it important to analyse hospitals as workplaces for nurses in the context of the frequent occurrence of sexual violence.

Often, the lack of a sense of safety and security is due to the structural powerlessness that nurses feel within hospitals. As workplaces, hospitals are supposed to provide them with adequate comfort within the physical environment. Staff nurses working in Delhi and Kerala disclosed that certain physical and material circumstances of their work encouraged misbehaviour by men and, therefore, such conditions inhibited them. In most cases, changing rooms are not available for nurses and the individual nurse is forced to find the privacy to change her uniform. Often, store rooms and toilets are used for changing clothes before and after duty. In many cases, it is not possible to lock doors from the inside. Some reported that the male staff deliberately damaged the locks. Toilets may not have lights and enough space to manoeuvre while dressing and undressing without the clothes getting soiled. Just to avoid getting into embarrassing and sometimes fatal situations, many travel to and from the hospital in their uniforms, making a mockery of the high standards of hygiene that are supposed to be maintained in hospitals.

Nursing is an extremely gendered job, but the care aspect of the work is considered feminine and devalued and those who do nursing work are deprived of the qualities of a "worker". Numerous nurses who reported violation of the physical body or attempts at such violation – whether of their own body or those of other nurses known to them – pointed out that the attack occurred merely because they are female. The numerous cases that I came to know of through interviews point, without doubt, towards the fact that sexual violence is a manifestation of power. And the attackers range from representatives of managements, superior or subordinate colleagues, patients and their companions to contract employees who come for electrical or plumbing jobs. When men of a low professional status attack a woman of a higher designation, it is intolerance towards her official superiority and affirmation of their male supremacy. The claim of Sohanlal Walmiki, the criminal who attacked Aruna, that he did not assault her sexually is irrelevant; he was filled with vengeance because she had shouted at him. It is clear that he would not have dared to attack a male colleague under such circumstances. As argued elsewhere, sexual harassment is often an extreme manifestation of low status and the dehumanisation and devaluation of women in our society (7).

Chaudhuri (8) found that even when sexual harassment is reported, it does not always take the shape of a formal complaint. There are many informal obstacles in the way of filing complaints. Women file complaints if they think that they are going to be heard without any prejudice and that they will not be misunderstood. Inaction on the part of the authorities is an important obstacle, but such inaction is not always due to

sympathy for the harasser; it is that the authorities simply do not want to get involved in what they see as a time-consuming matter. It is easier, instead, to ask women to show restraint, dress "properly" and behave in a way that does not attract the "unwanted attention" of men. Thus, the onus of the harasser's act is placed on the harassed. Described below are two cases to which I was a witness, and which illustrate the ways in which the process of redress is sought and managed.

Case 1: I had gone to the female ward of a Delhi government hospital much before regular office hours to interview nurses. As I entered, I noticed that there was a commotion. The nurse who had been on duty at night was waiting to complain about a drunken electrician who had attempted to harass her and misbehave with her. She was bent on speaking to the senior representative of the nurses' union. Here are some important facts that I learnt of subsequently.

1. The nurse was confident that she would be heard and understood without having to give explanations. She believed that union leader would not be dismissive about her experience.
2. The nurse said she decided to complain because she did not have to deal with the administrative authorities directly.
3. She was sure that the Medical Superintendent (MS) and other authorities would respond differently to the union representative than to the "harassed", that is, herself.

Later, the union representative called the MS directly. The latter was polite and responded positively, promising immediate action. The action taken in this case was a "win–win" situation for everyone for the following reasons.

1. The allegation was against a worker who was on contract and had no formal affiliation with the hospital.
2. It was easy to take action: the company which had contracted the worker was asked not to send the worker to work in the hospital again.
3. It did not create any trouble for the hospital hierarchy as an outsider was the perpetrator.
4. If the perpetrator had been an outsider who happened to be a patient or a patient's relative, the authorities would have been hesitant to take action. In this case, no one was going to question the decision as it was not really going to hurt anyone. It would most probably not hurt even the harasser, who would simply be barred from working in the hospital and face no further action.

Case 2: A female nurse in a well-known charitable hospital in Delhi was sexually harassed by a senior physician. After the incident, the woman learnt that the perpetrator was a habitual offender and no action had been taken against him in the past. By then, she had already complained verbally to the Nursing Superintendent (NS). The NS assured her that her complaint would be considered seriously and asked her to give a written complaint through her ward in-charge. Meanwhile, the nurse shared the incident with her friends among her colleagues. They advised her against lodging a formal complaint as the doctor was an "indispensable" member of the hospital staff; the best "solution" would be to ignore it and avoid the person. However, our respondent felt that she had to "do something" if she had to continue working there. She wrote a formal complaint and went to her immediate superior. The lady in charge appeared surprised by her allegation and said that the doctor was a senior person who had been working there for several years. When the "harassed" insisted that she wanted to file a formal complaint, she was asked to come the next day.

The next morning, judging by the seemingly "casual and innocent" chat with some senior colleagues, it was clear that the news had reached everyone and that no one was in favour of anyone creating a problem in that "peaceful" workplace. The fact that it was an atmosphere in which a harasser ruled the roost did not seem to disturb anyone. The threatening body language of the perpetrator showed that he had come to know about the nurse's complaint. When she went to file the complaint, the in-charge was unusually busy and made her wait for hours. When they finally met, her superior literally refused to accept her complaint. In a matter of one month, she was asked to leave the hospital for dereliction of duty, the details of which were never specified. She was told that it would be better for her if she resigned as this would leave her career record intact; on the other hand, she would be given a suspension letter if she resisted. By one month after the incident, she had lost all confidence in herself and in the system. All the while, she tried to avoid the perpetrator and act meek so as to prove that she was nice and not a "troublemaker".

During the fieldwork conducted among health professionals in Kerala during 2012–2013, I tried to explore the differences between the situations of the nurses and other female hospital staff. My research revealed that nurses are more vulnerable than the others to the gender prejudices of men (predominantly) as they are often closeted with men due to their work. Nurses are direct and first points of contact for patients, their associates and other health professionals during cure and care. The other women professionals in hospitals are doctors, pharmacists, laboratory technicians, receptionists and technicians, none of whom visits patients alone. They see patients mostly in their own work rooms, mostly in the daytime. Even when night pharmacies in hospitals employ women, they are often locked in their rooms and the pharmacies are situated in more open spaces. Women doctors visit patients either as a part of their routine visits or rounds, and are accompanied by junior doctors and the nurses in charge of the patients. When they visit them in emergency situations, they never go alone. It has been reported that in England and Australia, women doctors face fewer sexual advances from other doctors and patients than do nurses and their presence acts as a deterrent for nurses (9). Nurses in charge of wards often have to handle patients' associates, canteen workers, electricians, plumbers and other such workers, especially at night. They express relief when the non-medical staff takes charge of administrative and housekeeping duties. Such comforts are becoming scarce due to cutbacks in staffing and budgets. There is a new pattern of employment of

contracting private security agencies to cut down the number of hospital staff on the permanent payroll, and this has resulted in inadequate security arrangements, which have no relation with the rest of the hospital staff and leave much to be desired in terms of moral obligation. The security personnel take on the role of "bouncers" who would make sure that the hospital is run as a business, without any disturbance from any source, especially aggrieved patients.

There are some formal obstacles that prevent women from filing complaints. Despite the Supreme Court order, the service rules have not been amended to spell out the procedures to be followed in the aftermath of sexual harassment. The Complaints Committee has not been constituted in most workplaces. Where it has been constituted, it has not been done so as per the guidelines in the *Vishaka v The State of Rajasthan* case of 1997. Where it has been constituted as per the guidelines, meetings are not held regularly. Most importantly, the members of the committee selected from civil society organisations may not be favourably disposed towards women in cases of harassment, contrary to the general perception.

It has been reported that a search for the keyword "nursing" in the literature and newspapers brings forth reports on sensational events, such as protests and violence (10). The image of nurses still carries a sexual flavour and the images thrown up by the media seem to have contributed to this. Over the last decade, I have observed that caricatures of nurses with overblown lower lips and breasts, in tight tops and short frocks, appear alongside news items which are unrelated to nurses and/or are remotely related to health issues – such as a rise in drug prices or waste management in hospitals. There have been positive changes in the portrayal of nurses in serials and movies, but as Mrs Khurana, the founder GS of DNU stated: "In our country, no woman can say with a sense of pride that she is a nurse by profession" (7: p 80).

Questions on sexual harassment elicited an interesting response from a handful of young women nurses during my fieldwork. They argued that emphasising the sexual nature of violence against nurses would only make them look more like sexualised objects. They felt that this focus would detract from the other issues that needed urgent attention. This clearly shows that sexual assault and fear of sexual violence are not the only threats that women nurses face in their workplaces. This view was expressed by young, articulate nurses. These women also stressed individual responsibility in raising their status, as well as the need to maintain the dignity of nurses and their profession. For many of them, the nature of the work of nurses is part of the issue! They feel that doing "menial jobs" such as cleaning and washing patients only adds to the perception that "these women will do anything to make a living"[vi].

Discussion: is there a way forward?

Experience elsewhere in the world shows that collective action is the best method to combat the problem (11)[vii]. The problem of violence against nurses is not confined only to India. According to a study by the International Council of Nurses (2004), as many as 72% of nurses do not feel safe from assault at work (12). A report by the United States Occupational Safety and Health Administration in1998 showed that healthcare workers in the USA were assaulted more frequently than workers in any other occupation, including law enforcement officers (12). Most northern countries have adopted measures intended to prevent and redress violence at work. Considerably stringent implementation of the rules and measures against violence in these countries has ensured that the crimes against healthcare workers have become less atrocious in terms of severity and nature, if they have not been eliminated altogether. India can, therefore, learn from these examples to adopt useful strategies to tackle such violence.

Most of the hospital communities in these countries have adopted a policy of "zero-tolerance" of violence at the workplace as the standard (13). This means that they have addressed the contributing factors to violence, such as allowing female personnel to work in isolated units, inadequate staff coverage, lack of staff training, a poor work environment, such as one characterised by lack of empathy on the part of superiors, and the presence of drunk people or those who take drugs, workers or patients in states of mental or emotional duress, and violent or revengeful people. Should violence occur, countries like the USA and Canada put the potential liability on the employers (14) and in my opinion, this seems to be acting as an important deterrent in countries such as Canada. Employers are expected, without fail, to have policies on workplace violence and harassment and on prevention and redress in place. If the employer has more than five employees, the policies must be exhibited in writing at an open place at the workplace. In the USA, the gravity of the problem is recognised to such an extent that 30 States have made violence against emergency nurses a felony; convicted violators have to spend up to three years in prison (14).

More than legislations, it is social attitudes towards and perceptions of the issue of harassment that have undergone a significant transformation in these societies. An important aspect of the change in attitude has been the acceptance of nursing as an essential service by the governments and civil society, and the subsequent recognition of nurses' right to equality and dignity at the workplace as an ethical matter. Moreover, the acceptance of women as first citizens, just like men, and their freedom has to become more universal. The fight against violence in healthcare organisations has become part of a broader work culture that encourages gender equality as a moral principle. Such a culture includes policies that eliminate all forms of discrimination and exploitation, especially in terms of the participation of traditionally underrepresented groups in civic life and their occupying non-traditional positions, thus demonstrating that prejudices against women and other marginalised sections are unfounded and illogical. Professional development opportunities that include formal or informal networking and mentoring programmes for women at all levels, including

women working in non-traditional fields, have been found to be successful in countries like Australia (15). Violence has been seen as a work hazard and, therefore, a focus on its prevention as an ethical duty has yielded results.

In India, the Sexual Harassment at Workplace (Prevention, Prohibition and Redressal) Act 2013 (16) has provided considerably clear guidelines on the prevention of violence and redress for victims in workplaces. The role of the employers and district officers has been outlined quite explicitly. What is distressing is that even after the Act has come into force, women employees are neither aware of the law, nor of the options for redress. Even when they seek redress, they encounter the formal and informal obstructions discussed earlier. Discussions on the Vishaka judgment had brought the issue to the fore among activists and lawyers. That judgment was an important milestone as it was for the first time that sexual harassment was institutionally recognised as the violation of a woman's right to equality rather than a simple personal harm. Nevertheless, my research indicates that we require measures that go beyond legislations and judgments; stricter enforcement of the existing laws is what has made some of the northern countries a better place for nurses to work in.

Policy statements such as the health policy should contain provisions aimed at making the workplace safe and optimal for women. The Draft National Health Policy, 2015 did make a beginning. It states:

"4.2.6.5. Nirbhaya Nari – Action against gender violence ranging from sex determination, to sexual violence would be addressed through a combination of legal measures, implementation and enforcement of such laws, timely and sensitive health sector responses, and working with young men."(17)

Concrete and systematic measures are needed to put an end to violence against women in the workplace, as it is a systemic issue. The role of professional councils, such as the Nursing Council, is underestimated and they have been underutilised until now, even if one accepts the argument that their role is limited to the education and training of professionals. Interventions in the clinical settings become the area of activity more of the states' department of labour. Even with such limitations, training programmes and awareness campaigns can be conducted during the registration process every five years, now that the pattern of "once-in-a-lifetime" membership has been changed in the cases of nurses. The councils can network with the respective state governments, especially the department of labour, to make sure that all hospitals constitute the mandatory complaints committee in a manner that is intended to function effectively and ethically. We have seen that the government and civil society insist on the enforcement of nurses' duties even in adverse conditions of work and nurses are asked to forego their right to protest and strike, citing ethical issues (18), However, the same conviction about ethical issues is somehow not in evidence when they are mistreated at their workplaces.

Nurses themselves have suggested some measures very specific to Indian settings. These include reducing the non-medical burden on them by appointing non-medical staff to take charge of administration and housekeeping. Administrative mechanisms to ensure adequate staffing patterns and security measures are essential. Programmes that train workers to recognise and manage potential assaults, safety training that may include martial arts, alertness and precise reporting are important. Travel to work for night shifts has been an area of concern and poses much risk for women as reported in newspapers. Ensuring safe transport for professionals who travel for night shifts should become the employers' responsibility[viii]. Factors like poor lighting and inadequate facilities should be identified by the administrators. Countries such as Canada have adopted measures like assigning more security staff to psychiatric units, making provision for personal alarm pendants and security cameras, and carrying out risk assessment of potentially violent patients and co-workers. These could mitigate the risk of violence against nurses to some extent. Given the lifelong physical and emotional scars that result from violence, the need for providing counselling to the victim cannot be overemphasised. Societal attitudes, as well as the mass media's portrayal of nurses as "loose" and "sexually oriented", will have to change to create safer workplaces for nurses.

Our duty to Aruna's memory lies not just in allowing humans who are in a vegetative state to die with dignity, but in ensuring that women are safe in their workplaces. We can no longer sidestep the issue, be it with reference to public sector institutions such as the one where tragedy befell Aruna or private sector institutions, where such matters are hushed up even more vehemently. The only way forward is to cultivate a culture in which workers are treated ethically, with dignity and equality. In the present era, in which the health sector is market-oriented, ethical issues are reportedly being relegated to the background; however, unless all the stakeholders take an ethical stand, many more Arunas will be lost to our society. Last but not the least, drawing a distinction between women's honour and their sexual identity and purity may help matters farther than we imagine at present.

Acknowledgement

This comment is dedicated to all the working women of India, who in spite of the many abuses inflicted on them, struggle on from strength to strength, and from whom our society benefits and learns much. The author would like to thank the anonymous peer reviewers for their help in improving the article.

Notes

[i] "A decent girl will not roam around at nine o'clock at night. A girl is far more responsible for rape than a boy," Mukesh Singh, one of the killers of the woman whom we nicknamed Nirbhaya, told the interviewer.

[ii] Since she was attacked in November 1973, she had been cared for in the King Edward Memorial Hospital, where she worked as a nurse.

[iii] In no way is it an argument that those who just move around idly deserve to be assaulted; everyone has a right to be safe in our public space, whatever their reason for being there.

[iv] The word "victim" is consciously avoided in order to indicate that an

act like sexual harassment should not be the burden of the woman but that of the perpetrator. The concept of so-called sexual "purity" should be debunked. Every woman should be reminded that after sexual harassment, she has many options and the ultimate aim of the employers and the immediate society should be to help women exercise these options.

[v] The committee for studying the problems being faced by Nurses in Private Hospitals of the State of Kerala, chaired by the late Dr S Balaraman, the former acting chairman of the Kerala State Human Rights Commission. This committee was appointed by the Department of Health and Family Welfare in response to the state-wide strikes by nurses in private hospitals.

[vi] Interview with a 23-year-old Delhi-born Malayali nurse working in a private hospital in Delhi,

[vii] Unionisation is an important factor as far as collective bargaining and action are concerned. As affirmed by Ms Molly OS, a member of the Indian Nursing Council and General Secretary of the Kerala Government Nurses Association, it is the absence of a forum for collective action that makes the private sector nurses much more vulnerable in comparison to their counterparts in the public sector.

[viii] Hospitals sometimes use ambulances to transport nurses, but this can be a control mechanism that restricts their movement. Moreover, when there are shortages of nurses in some shifts, especially at night, an ambulance is sent without any prior notice to fetch nurses for duty

References

1. BBC News. Delhi rapist says victim shouldn't have fought back. 2015 Mar 3 [Accessed 2015 Aug 21]. Available from: http://www.bbc.com/news/magazine-31698154
2. Times of India. Hospitals clueless of Aruna's job records. p 7. 2015 May 21[Accessed 2015 Aug 21]. Available from: http://timesofindia.indiatimes.com/city/mumbai/Hospital-clueless-of-Arunas-service-records/articleshow/47356164.cms
3. Chaudhuri, P. Sexual harassment of women health workers. In: George A, Sheikh K (eds). *Health providers in India on the frontlines of change.* New Delhi: Routledge; 2010:223–41.
4. Nair S, Healey M. A profession on the margins status issues in Indian nursing, Occasional paper, New Delhi: Centre for Women's Development Studies; 2006.
5. Minocha A. *Perceptions and interactions in a medical setting: a sociological study of women's hospital*. New Delhi: Hindustan Publishers; 1996.
6. Unpublished Report. Committee for studying the problems being faced by nurses in private hospitals of state of Kerala, chaired by Dr S Balaraman; 2012.
7. Nair S. *Moving with the times: gender, status and migration of nurses in India*. New Delhi and London: Routledge; 2012.
8. Chaudhuri P. Sexual harassment in the workplace, experiences of women in the health sector. Working paper 1, Health Policy Innovation Fellowship Programme, Population Council, New Delhi; 2006.
9. Pringle R. *Sex and medicine: gender, power and authority in the medical profession.* Cambridge: Cambridge University Press; 1998.
10. Vyas A. Researching nurses and nursing: some observations. Paper presented at the national seminar 'Indian Nursing in the New Era of Healthcare' organised by Sreelekha Nair with the support of the Indian Council of Social Science Research, New Delhi, 2–3 December 2010.
11. Kergoat D, Imbert F, Doare HL, Senotier D (eds). *Les infirmiers et leur coordination* [The nurses and their coordination] 1988–1989. Paris: Lamarre; 1998. French.
12. Violence: a worldwide epidemic. 2009 [Accessed on 20 August 2015]. Available at http://www.icn.ch/images/stories/documents/publications/fact_sheets/19k_FS-Violence.pdf
13. American Psychiatric Nurses' Association. Position Statement 2008[Accessed 2015 Aug 21]. Available from:http://www.apna.org/files/public/apna_workplace_violence_position_paper.pdf
14. Nordal R. Workplace violence. 2010 Nov 26-27 [Accessed 2015 Aug 21]. Available from: http://www.cba.org/cba/cle/PDF/adm10_nordal_paper.pdf
15. Zimlich, Rachael. Preventing violence against nurses will take more than legislation, 2014 Apr 30 [Accessed 2015 Aug 21]. Available from: http://healthcaretraveler.modernmedicine.com/healthcare-traveler/content/tags/emergency-department/preventing-violence-against
16. Government of India. The Sexual Harassment of Women at the Workplace (Prevention, Prohibition and Redressal) Act, 2013 [Accessed 2015 Aug 21]. Available from: http://india.gov.in/sexual-harassment-women-workplace-prevention-prohibition-and-redressal-act-2013
17. Government of India. National Health Policy Draft, 2015[Accessed 2015 Aug 21]. Available from: http://mohfw.gov.in/showfile.php?lid=3014.
18. Nair S, Timmons S, Evans C. Nurses in the private health sector in Kerala: any lessons learnt from their strikes in recent years? *Indian J Gender Studies*, Special Issue (23:1), Women and commercialisation of healthcare. Expected date of publication: January 2016.

The Allied and Healthcare Professional's Central Council Bill, 2015: more of the same

GEORGE THOMAS

The Medical Council of India (MCI) is a statutory body established in February 1934 under the Indian Medical Act, 1933. This act was repealed in 1956 and replaced by the Indian Medical Council Act, 1956. The objectives of the MCI are:

1. Maintenance of uniform standards of medical education, both undergraduate and postgraduate.
2. Recommendation for recognition/de-recognition of medical qualifications of medical institutions of India or foreign countries.
3. Permanent registration/provisional registration of doctors with recognised medical qualifications.
4. Reciprocity with foreign countries in the matter of mutual recognition of medical qualifications.

The main task of the MCI is to oversee the standards of medical education in India. The council has performed this task fairly well, though there are constraints. Health being a state subject, the council has to work with state governments. It has no mechanism to ensure compliance with its directives other than not recognising degrees. Besides it has an unwieldy

Author: **St Isabel's Hospital,** Mylapore, Chennai 600 004 INDIA – George S Thomas (george.s.thomas@gmail.com), Chief Orthopaedic Surgeon.

To cite: Thomas G. The Allied and Healthcare Professional's Central Council Bill, 2015: more of the same. *Indian J Med Ethics*. 2016 Jan-Mar; NS1(1): 52-3.