EDITORIAL

On violence against patients

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The rape and murder of a trainee doctor in RG Kar Medical College in Kolkata on August 9, 2024, was a brutal crime but had nothing to do with patients or violence by patients or their attendants against health workers. The accused is a civic volunteer who is said to have frequented the hospital as a tout, fleecing patients by promising to get them a bed or help them get tests done for free or at discounted rates [1]. However, following the incident, the protests by doctors, mostly resident doctors' associations across the country, zeroed in on protection for doctors and health workers from violence and attacks by patients through a central law as one of their main demands [2].

While it is true that there are several reports of patients or their attendants attacking health workers, it raises the question — is violence against health workers one-sided or do patients also face violence from health workers? A Google Scholar search did not yield much in terms of studies on violence against patients in India. The help of health researchers with access to repositories of research articles such as PubMed and Scopus was sought and they found almost nothing on violence against patients, barring articles on obstetric violence, described as violence against women by healthcare providers during childbirth, and a few on violence against mentally ill patients.

Why violence in health facilities seems one-sided

"The literature is scarce. Why would perpetrators document their wrongs?" asked a health researcher. "Most healthcare research is done by health providers, and they are unlikely to research their own wrongdoings", remarked another. In short, health researchers have not found it important to study what patients experience when they seek healthcare [4]. In contrast, there is an avalanche of studies on the lack of safety of health workers, especially doctors and nurses, and on patients' or their attendants' violence against health personnel.

With few reports of patients being physically attacked, it is presumed that patients do not face violence. However, beyond gross underreporting, the kinds of violence that patients face also differ substantially. Poor pain management, procedures without anaesthesia, deliberately callous treatment like rough pelvic examination, withholding or not providing water or nutrition for extended periods of time, patients left in their excreta without being cleaned, threatening patients and their families with dire consequences, arrogant, rude and dismissive conduct, financial abuse and torture inflicted on patients and families with limited or no ability to pay, causing financial ruin through overcharging and unnecessary treatment and holding patients or dead bodies of patients hostage are all different forms of violence against patients [3, 5, 6]. Unless these are identified as violence and counted, and are spoken and written about, health personnel and the larger society will continue to believe that only verbal abuse or physical assault count as violence and that they are not commonly faced by patients.

Lack of agency

Patients are the least empowered in a health system and they do not have a lobby or an organised group to take to the streets to protest on their behalf. There are hardly any patient organisations in India at the national or state level that do sustained work on patient rights beyond groups working mostly on access to treatment for specific diseases. Moreover, being a patient is usually a temporary state, and patients and their families move on after the episode of illness and put their bad experiences behind them. They have neither the training nor the wherewithal to do systematic research on the abuse or violence they experience. Physicians might be hailed as advocates of patients, but no doctors' body has taken to the streets on the issue of patient safety or for their basic rights, and neither have other health personnel.

Dictating terminology

In the few studies that exist on the subject, even sexual assault or molestation of patients is described euphemistically as "sexual

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boundary violations" and other kinds of misbehaviour by health workers is referred to as "non-sexual boundary violations" [7, 8, 9]. Medical personnel seem extremely reluctant, even outright hostile, to their abusive behaviour being termed as violence. The hegemonic power of doctors in dictating how their abusive behaviour is viewed by those suffering the abuse can be seen in how they resist even the use of the term "obstetric violence", with a preference for the term "mistreatment" [10, 11, 12].

Senior doctors who are 70-80 years old narrate the obstetric violence they witnessed during medical training in the 1960s and 70s. Yet, no one did anything about it till the concept of obstetric violence emerged from Latin America in the 1990s. In 1993, when the Network for Humanization of Labour and Birth in Brazil in its founding charter recognised "the circumstances of violence and harassment in which care happens", it still did not talk about violence, and instead, favoured terms such as "humanizing childbirth" and "promoting the human rights of women" because it feared a hostile reaction from doctors if it specifically mentioned "violence" [13]. Verbally abusing pregnant women in labour or their attendants, in the foulest language, slapping the women, doing unnecessary episiotomies (surgically cutting the vaginal wall during childbirth to enlarge the vaginal opening), or doing episiotomies and then stitching them up without anaesthesia [14,15], should not, according to doctors, be termed "violence". Doctors dare to dictate that such behaviour should be termed as "mistreatment" not "violence" — even though they do little to change/prevent the "mistreatment". The medical students of today will tell you that little has changed in labour rooms. After over three decades of documenting and researching obstetric violence, occurring across the world, there is no law against such horrific "mistreatment" of pregnant women and hence doctors continue with such practices. This indicates just how powerless patients are to prevent violence upon themselves.

The word/term for its violence towards patients that the medical community seems to be willing to accept is "abuse", as more articles emerge if one searches for the term "patient abuse". Patient abuse refers to the intentional harm of a patient, by a health worker, which can be physical, sexual, psychological, financial, or verbal abuse [4]. The same acts against a health worker would be termed "violence" or "assault, but when it happens to a patient, it is "abuse" [16, 17].

Gaps in research

Even though the World Health Organization (WHO) has documented that rates of abuse of the elderly are high in institutions, with two in three staff reporting that they have committed such abuse in the past year, data on the extent of the problem are scarce [18]. The US-based International Association for Healthcare Security and Safety (IAHSS), mainly concerned with hospital security, also acknowledges in its paper on preventing patient abuse that there is a gap in the literature on the prevalence of elder abuse in hospitals, nursing homes and long-term care facilities. If literature on elder abuse in institutions is scant, IAHSS points out that "estimating the prevalence of patient abuse, as a whole, and among specific groups is difficult because of limited research and data on abuse among groups outside of the elderly population" [4]. In short, there is a glaring gap in research on patient abuse or violence against patients, not just in India, but internationally.

The WHO has a separate section on violence against health workers by patients and "high-risk visitors" but nothing on violence against patients by health workers [19]. The section on violence against health workers states: "Between 8% and 38% of health workers suffer physical violence at some point in their careers. …Most violence is perpetrated by patients and visitors." In the same section, it is stated: "For emergency settings, WHO has also developed methods to systematically collect data on attacks on health facilities, health workers *and patients."* But the focus is on collecting data on attacks on health workers and not patients. Hence, WHO has no data on what percentage of patients face violence, the kinds of violence they face and by whom, compared to the copious data it cites on violence against health workers. The WHO section on "patient safety" has nothing on violence or sexual assaults of patients and it doesn't even contain the word "abuse", despite the availability of research done internationally on abuse or violence against elderly patients and children. It is only about making treatment safe by avoiding surgical errors, medication errors, diagnostic errors and so on [20, 21].

As for sexual abuse or assaults on patients by medical professionals, even though there are no studies in India, internationally, there are several articles [22, 23, 24]. However, researchers note that the studies do not always characterise the nature of sexual assault or the proportion of sexual misconduct that involves patients. This is again in contrast with a huge number of studies on violence against health workers that are quite detailed and list the different kinds of violence, the sites of violence, the triggers and so on. The researchers also admit the possibility of significant underreporting as patients are often consumed by feelings of disbelief, guilt, shame or fear that they will not be believed "due to the significant power imbalance between physicians and their patients". A report found that even in the US, which is highly litigious, only 1.5% of the overall complaints to medical boards reached the formal hearing stage [25].

What needs to be done

To begin with, the violence that patients face has to be acknowledged, for which research and documentation are urgently needed. It would help to have a grievance mechanism like a well-publicised helpline number, such as 1098 for Childline, where

any patient or attendant can lodge their complaints. To encourage people to use it, there have to be extensive and regular public awareness campaigns to help patients, attendants, health workers and ordinary citizens identify the different kinds of violence patients might be subjected to and to educate them about patient rights. Health workers and support staff of a hospital need focused training to recognise the kinds of violence perpetrated on patients, their attendants or staff and on how to report and where to report such instances, with adequate protection for such whistleblowers [26, 27, 28]. Such heightened awareness and measures to facilitate reporting could help make health facilities safer for everyone, including health workers.

Equity in access to safety in healthcare institutions

The absence of studies on the violence patients face also creates a one-sided narrative of health workers, especially doctors, as victims. This prevents the larger society and health workers themselves from acknowledging and addressing the casual everyday violence they unleash on patients and their families. Doctors, who are at the apex of any health system hierarchy, are filled with self-pity as they see themselves as overworked, under-appreciated and under attack. This is best captured in the statement of a young doctor during a group discussion: "The conditions that resident doctors in our country train under are horrible and it's ridiculous to expect compassionate socially sensitive doctors at the end of such a training period". While there is no disputing the poor working conditions of young trainee doctors, they do not seem to realise that the same can be said of patients also — the conditions under which patients get treatment in our country are horrible and it is ridiculous to expect compassionate, understanding and courteous patients in such conditions of care and from those at the receiving end of such misconduct. Yet, health workers hardly ever seem to register the appalling conditions of care that patients have to endure.

The social capital of doctors, who have outsize influence on policymaking compared to any other category of health worker, has ensured that 25 states have a separate law that prohibits violence against "medicare service personnel", but they want a central law [29]. There is no similar law at central or state level to protect patients. All that patients have managed to get, after much wrangling, is a legally non-enforceable charter of rights [30].

The heft of doctors can be gauged from how the national task force constituted by the Supreme Court to look into the safety of medical personnel (doctors and nurses) in a hospital has only senior doctors and no other health personnel, not even nurses [31]. The irony of ensuring safety only for doctors and nurses and no one else in a hospital was lost on the apex court and on the doctors. Though the hegemony of doctors over health policy is not new [32], it seems absurd to seek measures for the safety of only one section. If there is a law or a system to make health facilities safe spaces, it has to be about the safety of everyone within that space, including all health workers, support staff and patients.

The medical community has always opposed any sort of regulation. The lack of interest in having a safety law for health establishments that would cover all, including patients, equally, could stem from doctors being aware that they too could be held accountable under such a law for their (mis)behaviour or (mis)conduct towards nurses, patients and others. As the medical historian Dr Kiran Kumbhar points out, the "unique victim mentality, with the accompanying elitism and entitlement" of doctors has prevented them from taking any steps to curb the pervasive verbal, psychological, physical and sexual violence that patients, especially underprivileged patients, experience every day [33].

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