Violence Against Resident Doctors in Maharashtra:
Their Perspective on Occurrence, Consequences and Redressal Mechanisms

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In collaboration with

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And

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Foreword

The study, "Violence Against Resident Doctors in Maharashtra: Their Perspective on Occurrence, Consequences and Redressal Mechanisms", comes at crucial time when such violence is on the rise and there is a need to address it in an informed and decisive manner. A collaborative effort by the Centre for Enquiry into Health and Allied Themes (CEHAT), King Edward Memorial (KEM) hospital and the Maharashtra Association of Resident Doctors (MARD); the study presents this complex issue in a holistic and balanced manner.

The report highlights the pervasive nature of such violence and the impact it has on the residents. While underlining the strategic and supportive role that hospital administrations and seniors need to play in preventing and addressing the issue; it also advocates for changes to address the systemic and infrastructural issues. At the same time, residents have also highlighted the need for improved communication and empathy with patients and relatives. The study brings forth the reflection that such violence is an indicator of a deeper crisis in the health sector.

I would urge my fellow administrators to engage with this report to develop an informed approach in developing comprehensive policies and protocols to respond to such violence. Residents are at the forefront of our health system and it is imperative that thay be provided a safe working environment. As a medical community we need to ensure strategic participation of all stakeholders and policymakers.

I congratulate the CEHAT, KEM and MARD team for bringing out this crucial and timely report on the issue.

(Dr. Hemant Deshmukh)
Dean, Seth G.S. Medical College & K.E.M. Hospital

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CEHAT, KEM and MARD

Preface

Reports on the issue of violence against doctors has been in news for some time. The World Health Organisation has estimated between 8 per cent to 38 per cent health providers across the world as being subjected to physical violence in their careers. Little is known about forms and consequences of violence against doctors. Even lesser is known about perspectives of doctors towards the phenomenon of violence faced by them.

CEHAT undertook such a study to understand causes for violence, its exact nature as well as recommendations from doctors to create a comprehensive response towards such occurrences. The study report "Violence Against Resident Doctors in Maharashtra: Their Perspective on Occurrence, Consequences and Redressal Mechanisms", focuses on resident medical doctors as they are often the first point of contact with patients, care givers and general public; they are therefore at the receiving end of violence directed against the medical system.

The report brings forth different forms of violence ranging from being threatened and humiliated to being slapped, pushed and assaulted with objects. Cause for such violence was attributed to the department being over crowed, death of a patient and dissatisfaction about the medical services offered. The report highlights strong impact of such violence on the resident doctors and documents specific recommendations to deal with it. It also highlights lacunae in current management of episodes of violence. Resident doctors in this report call for implementation of procedures such as availability of senior doctors in cases of death of patient, stringent gate pass system for entry to OPDs / wards and encouragement from administration to report instances of violence. We sincerely hope that policy makers and hospital administrators will bring about the necessary changes to make hospitals a safe work place for all its health personnel

Sangeeta Rege
Coordinator, CEHAT

Contents

Foreword iii
Acknowledgements v
Preface vii
List of tables xi
List of abbreviations xiii
Executive Summary and key findings 1
Chapter I: Introduction, Rationale and Definitions 5
Chapter II: Literature review 7
Chapter III: Methodology 21
Chapter IV: Findings 27
General profile of respondents 37
Section A
A.1. Sex of respondents 28
A.2. Work profile of respondents 29
A.3. Violence faced by resident doctors 30
- Incidents of violence exposed to 30
- Forms of violence / abuse exposed to 30
- Perpetrators of violence 31
- Common sites of incidents 32
- Most common time of incidents 33
- Cases found to be more commonly associated with incidents of abuse 33
- Sex of patient in the context of the incident 33

Section B
B.1. Responses of resident doctors in the context of the incident 35
- Immediate response / action taken by resident doctors at the time of the incident 35
- Post incident response of resident doctors 35
- Why no formal action? 36
- Help provided by colleagues 38

B.2. Impact of violence on resident doctors 38
- How worried are residents about the phenomenon of violence against resident doctors? 38
- How did the incident of violence affect the resident doctors? 39

Section C
C.1. Factors leading to violence against resident doctors 41
- Resident's perspective 41
- Reasons voiced by perpetrators 42

Section D
D.1. Perspectives of respondents who had not been exposed to violence 44

Section E
E.1. The response of the hospital administration towards the incident 48
E.2. What the hospital administration could have done better 49
E.3. Encouragement to report violence 50
E.4. Do the residents think the incident of violence could be prevented? If yes, then how? 50
E.5. Preventing, responding and addressing the issue of violence against resident doctors 51
- Procedures of reporting violence at the workplace 51
- Mechanisms that could help prevent or respond to violence against resident doctor's versus mechanisms currently in place 51
- Perspective on triage and its role in prevention of violence 53
- Perspective of resident doctors about long term strategies that can help prevent violence 54
- Specific policies at the workplace in the context of violence against resident doctors 55

E.6. Recommendations by residents on how to prevent and control violence against resident doctors from patients/relatives/escorts 56
Chapter V: Discussion 63
Chapter VI: Recommendations 69
References 73
Annexure 1: Who are Resident Doctors? 83
Annexure 2: Some of the documented cases of attacks on doctors in the media 85
Annexure 3: The Maharashtra Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage or Loss to Property) Act, 2009; case laws and other actions 89
Annexure 4: Some resources for the prevention and management of workplace violence 93

Tables

Table 1:	Structure of the tool	23
Table 2:	Profile of respondents	28
Table 3:	Categories of respondents	28
Table 4:	Sex of the respondents	29
Table 5a.	Duration of each shift	29
Table 5b.	Double shifts / per week	29
Table 5c.	Night shifts / per week	29
Table 6.	Incidents of violence exposed to	30
Table 7:	Forms of abuse exposed to	31
Table 8a:	Perpetrators	31
Table 8b:	Violence inflicted by	32
Table 9a:	Place of incident	32
Table 9b:	Most common time of incident	33
Table 9c:	Case under treatment at the time of the incident	33
Table 10:	Sex of the patient	34
Table 11:	Immediate response to incident	35
Table 12:	Post incident response by residents	36
Table 13:	Reasons for no formal action	37
Table 14:	Help provided by colleagues	38
Table 15:	Percentage of residents who were worried	39
Table 16:	Impact of violence on residents	39
Table 17:	Factors leading to the incident	41
Table 18:	Responses as voiced by perpetrators	53
Table 19:	Profile of respondents	44
Table 20:	Perceptions about common forms of violence	44
Table 21:	Perceptions about common perpetrators of violence	45
Table 22:	Factors contributing to such violence	45
Table 23:	Opinion of resident doctors who had not been exposed to violence about the impact of such violence	47
Table 24:	Response of the hospital administration towards the incident	48
Table 25:	Encouragement to report violence by	50
Table 26:	If the violence could have been prevented	50
Table 27:	Procedures to report violence	51

Table 28:	Perspectives on what mechanisms can prevent violence versus those that presently exist	52
Table 29a:	About triage	53
Table 29b:	Triage system	54
Table 30:	Long term strategies that can help prevent violence	54
Table 31:	Presence of specific policies at the workplace	55

Abbreviations

AMO	Assistant Medical Officer
CCTV Camera	Closed Circuit Television Camera
CEHAT	Centre for Enquiry into Health and Allied Themes
DJ	Double J stent
EMS	Emergency medical services
ENT	Ear nose throat
EPR	Emergency pediatrics Room
ESR	Emergency Surgery room or Enhanced surgical recovery
FIR	First Information Report
HO	House officer
ICN	International Council of Nurses
ICU	Intensive Care Unit
ILO	International Labor Organization
IPD	In - patient department
KEM	King Edward Memorial Hospital
MARD	Maharashtra Association of Resident Doctors
MLC	Medico legal case
MO	Medical officer
MS	Master of Surgery
OPD	Out - patient department
OSHA	Occupational Safety and Health Administration
OTST	Orthopedic trauma and surgical theatre
PG	Post - graduate
PSI	Public Services International
RMO	Resident medical officer
UG	Under graduate
WHO	World Health Organization
WPV	Work Place Violence

Executive Summary

Violence against health care providers has been recognized as an issue ailing the health sector for long. Health workers are recognized as being particularly at risk with almost one quarter of all violent incidents at work occurring in this sector (di Martino, 2002). This report, "Violence Against Resident Doctors in Maharashtra: Their Perspective on Occurrence, Consequences and Redressal Mechanisms", looks at the phenomenon from the perspective of the residents[1] taking into account their experiences. The study was based on data from an online survey across public hospitals in Maharashtra, conducted by the Centre for Enquiry into Health and Allied Themes (CEHAT), in collaboration with King Edward Memorial (KEM) Hospital and the Maharashtra Association of Resident Doctors (MARD). The need to understand this phenomenon emerged from our discussion with residents in the course of our work with public hospitals and in the context of the several attacks on doctors in recent times (See Annexure 2). Literature review further strengthened the rationale to undertake such a study and helped in identifying factors that needed further exploration.

The objectives of the study were as follows: to understand the violence faced by doctors at their workplace from patients and/or relatives; how such violence affects them and their practice and how they dealt with it. It is important to know the views of doctors about what led to such violence; to document existing mechanisms for preventing, reporting and responding at the hospital level, and to seek suggestions from doctors about responding to such violence and preventing such occurrences.

The study showed that violence against resident doctors was widespread across public hospitals in Maharashtra.

Key Findings

- Of the 193 respondents, 61.7 per cent of them had been exposed (faced and witnessed) to violence by patients and/or relatives and/or escorts. Of these, 76.5 per cent of them had been exposed to more than one incident of violence as a resident doctor working in a public hospital in Maharashtra.

[1] Resident doctors are students who are doing their post graduate studies (junior residents) or super specialization (senior residents). They are the frontline workers, the first point of contact between the people and the health system. See Annexure 1 for further details.

- Majority of the residents reported doing double shifts and nights shifts 1 - 3 times a week; the duration of each shift often being 12 hours or more. About 20 per cent of them have also reported doing double shifts and night shifts more than 3 times a week. Importantly, 87 per cent reported double shifts and 91 per cent had night shifts more than once in a week (n = 193).

- An incident of violence comprised of several forms of abuse. Threatening (76.5 per cent), humiliation (57.1 per cent) and pushing / shoving (57.1 per cent) were the most commonly reported. Assault was reported in 17.6 per cent of the incidents.

- Relatives and escorts of patients were responsible for most incidents of violence; and the attacks were usually by those present in groups (in 73.9 per cent of the incidents).

- The Emergency department/Casualty (31.1 per cent), followed by General Medicine (12.6) and Paediatrics (10.9 per cent), were the commonest site of incidents.

- More than half the incidents were reported to have occurred at the time of night duty (59.71 per cent).

- In 36.1 per cent of the incidents of violence, the patient was seriously ill. However, several respondents had reported that the case under treatment at the time of the incident was in fact a routine medical case (21.8 per cent).

- Residents responded in multiple ways at the time of an incident. Predominantly, they had called the security detail on duty (74.8 per cent); called a colleague (52.9 per cent) and also tried to talk or reason with the perpetrator/s indicating an effort made to de-escalate the situation (40.3 per cent). Calling a senior was not a common occurrence (28.6 per cent).

- Colleagues were found to have largely helped by calling the security detail on duty (68.9 per cent) and/or intervening and telling the perpetrators to stop the violence (62.2 per cent). None of the residents shared that colleagues did not help at the time of an incident.

- Post-incident action/s largely comprised reporting the matter to the hospital administration (as shared by more than half the respondents) and/or seeking legal action - MLC (reported by a third of the respondents). Seeking counselling, compensation or a transfer was not a common course of action.

- A total of 44 respondents (37 per cent) reported that they had not taken any formal action for various reasons: It was of no use to report such an incident (56.8 per cent); there were no procedures available in the hospital to formally report such violence (29.5 per cent), and/or did not know about procedures to report such violence (27.3 per cent). None of the residents reported that they felt guilty about the incident.

- Exposure to violence affects a resident in several different ways. Predominantly, at a professional level, 39.5 per cent of the residents have more commonly reported that they started avoiding giving proactive advice to patients and relatives and 34.5 per cent reported having lost the motivation at work. They were affected at a personal level with 35.3 per cent of the residents reporting that they had developed anxieties about coming to work and 36.1 per cent, that they were afraid to come to work.

- Residents had also reported becoming vocal about such violence against resident doctors (37.0 per cent) and 31.9 per cent reported they had taken part in protests.

- Both organizational and patient-related factors were found to have together contributed to the context that led to the incidents of violence. The most commonly identified reasons were overcrowding of patients and relatives (43.7 per cent); death of a patient (32.8 per cent); lack of equipment and drugs (31.9 per cent), and dissatisfaction with medical care provided (31.9 per cent).

- Cost of care (3.4 per cent), denial of admission (6.7 per cent) and commercialization of medical sector (7.6 per cent) were not commonly perceived to have contributed to the context of violence against residents, although lack of trust in doctors was identified as a contributing factor by 27.7 per cent of residents.

- Only 13.4 per cent of residents in the present survey reported that various hospital administrations encouraged the reporting of violence.

- Triage is used largely in case of major incidents. Almost three-fourths of the respondents felt it could help prevent violence. About 53.4 per cent of them said that triage could help manage crowds and 52.3 per cent that they are could help in more effective patient treatment.

- Hardly any of the measures and mechanisms that the residents felt could mitigate or prevent violence were reported to exist in hospitals. Nor were there formal institutional policies in place to prevent and manage violence.

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[2] Triage is the process of screening patients to determine their relative priority for treatment and referral.

CHAPTER I: Introduction, Rationale and Definitions

While the health sector accounts for almost a quarter of all violence at work, occupations in this sector are also high on the list of those with serious stress levels (di Martino, 2003). One study estimates that health-care workers face 16 times the risk of violence from patients/clients, than other service workers (Elliot 1997 in Cooper and Swanson 2002).[3] Such violence comes at a huge cost at the individual level; at the level of health sector institutions; for communities, and for people (Cooper and Swanson, 2002).

In the Indian context, the public health sector has been under much strain over the decades largely as a direct consequence of the chronic issue of low resource allocation and weak political will to see health as a public good and right. This negatively affects conditions of work, availability of drugs and diagnostics, doctor patient ratio, services and infrastructure. This leads to high out of pocket expenditures for users of the public care system and impacts accessibility and ease of seeking health care. A weak primary health care system and a poorly implemented continuum of care approach worsens the situation; and also leads to overcrowding at secondary and tertiary care levels. It is under these structural and organizational stressors and conditions that health care providers, including residents as young students, are managing these services and attending to thousands.[4]

CEHAT works closely with the public health sector. It seeks to study and address issues of pertinence for the health of the marginalized population and developing sustained partnerships with the public health sector is one of its core strategies. During the course of its work, several resident doctors had suggested that CEHAT, in addition to addressing the problems faced by the poor ought also to examine the issues affecting health care providers. They began discussions with CEHAT on the rising incidents of violence against the medical community by patients and their relatives. In 2017, there occurred an incident of violence against a resident occurred at the Shree Bhausaheb Hire Government Medical College and Hospital, Dhule, Maharashtra. This incident, along with several other

[3] Across all three sources of violence, Type I, Type II and Type III. Type I, where the assailant has no legitimate relationship to the workplace and the main object of the attack is cash or some other valuable commodity. Type II, which involve some form of assault by a person who is either the recipient or the object of a service provided by the affected workplace or the victim. Type III, where an assault is perpetrated by another employee, a supervisor, or an acquaintance of the worker (Cooper and Swanson, 2002).

[4] In KEM, for instance, for the year 2009, the average number of patients at the new outpatient department (OPD) were 1,920 and that for the old OPD the figure was 3,364 patients daily, making the average daily OPD attendance at 5,238. The total yearly attendance in the casualty was 1,99,231 and there were 237 new in-patient admissions every day and the daily average bed occupancy is 86 per cent (which is 1543 of 1800 total beds). https://www.kem.edu/hospital-statistics/

documented attacks (Annexure 2), prompted us to systematically study the phenomenon of workplace violence inflicted by patients and their relatives in the public health sector, particularly from the perspective of resident doctors. Resident doctors[5] are the backbone of the Indian public health system (Wakchaure in Gupta 2014). They are the on the ground functionaries; and also, the first point of contact for patients and their relatives.

Workplace violence is defined as "incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health" (Wynne, Clarkin, Cox, & Griffiths 1997 in di Martino 2002), or "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" (WHO 1995). For the present study, violence has been identified as physical, psychological or verbal and sexual (ILO, 2013). According to the World Health Organization (WHO 2002), physical violence includes the use of physical force against another person or group, and can include slapping, pushing, punching, assaulting (with an object), etc. Psychological violence includes threatening as well as other forms verbal abuse including humiliation and bullying that indicates a lack of respect for the dignity and worth of an individual. Sexual violence includes unwanted sexual comments or advances, unwanted sexual or lewd remarks, behaviours or gestures that attack an individual's dignity and security.

For the purpose of the present study, we have looked at "client-initiated" violence (Mayhew, and Chappell 2001). This the kind of violence is inflicted by patients and / or their relatives and / or their escorts on health care providers (in this case resident doctors), at their workplace. "Client initiated" violence, also referred to as "Type II" violence, is amongst the most commonly inflicted violence in the workplace (Peek-Asa and Howard 1999 in Cooper and Swanson 2002; McPhaul and Lipscomb 2004).[6]

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[5] Resident doctors are students who are doing their post graduate studies (junior residents) or super specialization (senior residents). They are the frontline workers, the first point of contact between the people and the health system. See Annexure 1 for further details.

[6] Type I, where the assailant has no legitimate relationship to the workplace and the main object of the attack is cash or some other valuable commodity. Type II, which involve some form of assault by a person who is either the recipient or the object of a service provided by the affected workplace or the victim. Type III, where an assault is perpetrated by another employee, a supervisor, or an acquaintance of the worker (Cooper and Swanson, 2002).

CHAPTER II: Literature Review

Violence against health care workers has been recognized as an issue ailing the health sector for long. Some early literature looked at such violence in the context of psychiatric patients and facilities (Brailsford and Stevenson 1973 in Schnieden 1993; Armond 1982; and Bouras et al. 1982). In 1987, the Health Services Advisory Committee recognized medical sites as being amongst the most vulnerable to verbal abuse (HSAC 1987 in Hobbs and Keane 1996); and the WHO estimated that between 8 per cent to 38 per cent of health workers would be subjected to physical abuse at some point in their career (WHO, undated). The majority of health care workers were found likely to experience workplace violence at least once in their professional careers (Blair and New 1991; in di Martino 2002); and one-quarter of all violent incidents at work were found to occur in the health sector (di Martino 2002).

Studies in both developed and developing countries have been carried out across different health sector settings, methodologies and health care providers including doctors, nurses, ambulance workers, etc.[7] This is particularly the case with the ILO/ICN/WHO/PSI studies.[8] What is evident is that the phenomenon is widespread across countries, irrespective of their development status.

Prevalence and forms of abuse

One of the earliest studies in a developed country on the issue was a retrospective survey of 1093 family practitioners of the West Midlands Regional Health Authority in England. The reported verbal abuse was 91.3 per cent of all abuse with one incident of verbal abuse occurring each day (Hobbs, 1991). Prevalence of abuse was reported much lower in another a population-based survey of 380 general practitioners' study in Northern England (Ness House and Ness 2000). Verbal abuse was reported to be 54 per cent, and 6 per cent respondents reported physical incidents. In an American study by Benham et al. (2011), a cross-sectional online survey of Emergency Medicine (EM) residents and

[7] For the literature review, studies were included till such point where it was felt that no new information was being added. Most studies had a reference period of 12 months prior to the survey, unless stated otherwise in the review.
[8] In the year 2000, the International Labor Office (ILO), the International Council of Nurses (ICN), the World Health Organization (WHO) and Public Services International (PSI) initiated a joint programme on workplace violence in the health sector in order to evolve policies to address such violence. Country case studies were undertaken in Brazil, Bulgaria, Lebanon, Portugal, South Africa and Thailand to fill in the gaps in information need for such policies (di Martino, 2002). In the present literature review, these ILO/ICN/WHO/PSI studies have been presented along with several other studies across countries. All of these studies look at Type II and Type III violence across health sector settings and health care providers using both quantitative and qualitative tools.

attending physicians, verbal threats were reported by 75 per cent of the respondents and physical assaults by 21 per cent of them. Confrontations outside the workplace and stalking were also reported (5 per cent and 2 per cent respectively).

In an ILO/ICN/WHO/PSI study in Australia, verbal abuse was reported by 67 per cent of the 400 interviewees; 10.5 per cent reported bullying, and 12 per cent assaults (Mayhew and Chappell 2003). In similar ILO/ICN/WHO/PSI studies from Bulgaria (Tomev et al. 2003) and Portugal (Ferrinho et al. 2004), abuse reported was lower than in the Australian study. In Bulgaria, verbal abuse was reported by 37.2 per cent of the respondents; whereas unarmed physical assaults reported were reported by 7.5 per cent of them. In Portugal verbal abuse was reported by 27.4 per cent of the participants in the study and physical violence by 2.6 per cent.

In a retrospective cross-sectional study of employees in the German healthcare and welfare system that included hospitals, facilities for the disabled and outpatient as well as inpatient geriatric care facilities; the reported physical abuse was higher than in the above studies. However, it continued to follow the general trend, as it was less than the verbal abuse reported in the same study. Of the 1973 employees, 56 per cent of the respondents had reported experiencing physical violence and 78 per cent reported verbal abuse. The highest frequency of physical violence was found in inpatient geriatric care (63 per cent) and the lowest in outpatient care (40 per cent) (Schablon et al., 2012). In a longitudinal study in Finland, with physicians using a web based /postal survey to respond; physical abuse was reported higher than psychological abuse with 61 per cent of 1515 physicians reporting physical violence and 19 per cent reported having experienced bullying(Heponiemi et al, 2014).

Studies in developing countries too report higher psychological abuse than physical. The three African countries; Morocco, Mozambique and South Africa reported similar trends of verbal and physical abuse, with studies in Mozambique and South Africa being a part of the ILO/ICN/WHO/PSI studies. The verbal abuse rates were 47 per cent, 38 per cent and 49.5 per cent; and physical violence was reported lower; by 8.3 per cent, 6.7 per cent and 13.2 per cent of respondents in the respective country studies (Belayachi et al., 2010; Eduardo et al., 2003; and Steinman 2003).

In the Brazilian and Lebanon chapters of ILO/ICN/WHO/PSI studies, the most common violence was again psychological. In Brazil, verbal aggression was reported by 39.5 per cent of the respondents and physical by 6.4 per cent (Pal·cios et al 2003). About 41 per cent respondents in the Lebanon study reported verbal abuse followed by bullying /

mobbing (22.4 per cent) and physical attacks (6 per cent) (Deeb 2003).

In a cross-sectional study in two hospitals in Istanbul, Turkey using face to face interviews, the most common form of abuse was verbal, reported by 86.8 per cent of the respondents whereas physical abuse was reported by 2.1 per cent of respondents (Eker et al. 2012). In another cross-sectional study in Turkey (Pinar et al. 2015) covering 11,437 respondents across primary and secondary care health workers including doctors, nurses, paramedics 43.2 per cent reported verbal abuse and 6.8 per cent reported physical violence. A study amongst emergency department residents in Iran found that more than 90 per cent residents had faced some form of abuse (Hedayati et al. 2018).

In a mixed methods study in Peshawar (Khan and ul Haq, 2018), more than half the participants had faced or witnessed violence in the preceding 12 months with verbal abuse (49.9 per cent) being more common than physical abuse (23.7 per cent).

Studies from China were also found to follow the global trend. In a cross-sectional study with doctors as respondents through an online survey across 30 provinces in China in primary, secondary and tertiary care settings; of the 2617 participants, 76.2 per cent reported experiencing verbal violence within the last 12 months. Other incidence rates reported were 'made difficulties'[9] (58.3 per cent), smear reputation (40.8 per cent), mobbing behaviour (40.2 per cent), intimidation behaviour (27.6 per cent), physical violence (24.1 per cent) and sexual harassment (7.8 per cent) (Sun, et al. 2017). Zhao et al. (2016), in their cross-sectional survey amongst 448 GPs and 412 general nurses from 90 township hospitals located in Heilongjiang province, China reported lower rates: psychological violence was reported by 27.2 per cent respondents and physical violence by 1.3 per cent.

Two studies in different tertiary hospitals in Delhi, India, found high verbal abuse and comparatively lower physical abuse faced by health care providers. In the study by Kumar et al. (2016), of the 151 physicians, 87.3 per cent of them reported verbal violence; while 8.6 per cent reported physical violence. In the other study, by Anand et al. (2016), verbal abuse was reported by 75.4 per cent of the respondents and 11.6 per cent of them reported physical violence.

A cross-sectional study of post graduate students at the Regional Institute of Medical Sciences (RIMS) in Imphal, Manipur by Ori et al. (2014) found that out of 230 respondents, verbal abuse was the commonest form of abuse faced (91.1 per cent). Another study in

[9] As in nit-picking demands, unreasonable requests, non-compliance, heckling and so on by patients.

Manipur, at the same institute, but with junior doctors found that the prevalence of verbal violence in the last 12 months was 47.4 per cent and for physical violence it was 2.9 per cent (Vanlalduhsaki et al. 2018). The study by Ori, et. al. (2014) had a longer duration of reference period in as it spanned the period of post graduate training; as against 12 months in the study by Vanlalduhsaki et al. 2018.

In a two-country study through a prospective online survey by Grundmann et al. in 2017 involving emergency department physicians, the US chapter reported higher verbal and physical abuse than the Indian study. In the US, 92.9 per cent of respondents had reported verbal abuse and 38.8 per cent had reported, physical abuse. In India, the researchers found that verbal abuse was experienced by 70 per cent and physical abuse by 4 per cent.

Prevalence of violence varied widely across countries and contexts. Studies in England, US and Australia have reported higher psychological abuse than other developed countries. Physical abuse was in a similar range across most studies in developed as well as developing countries and lower than the reported psychological abuse. However, two studies stood out. In the Finland study, physical abuse was reported higher than psychological abuse. While the researchers have not explored the reason for this, a factor to note was that it was a longitudinal study done over a four-year period (Heponiemi et al. 2014). The German study had reported physical abuse higher than most studies. However, it was less than the psychological abuse reported in the same study (Schablon et al. 2012). Studies in emergency departments were generally found to report higher abuse. Such studies include the American study by Benham et al. 2011; the US chapter of the two-country prospective study done in the US and India (Grundmann, et al. 2017); and the study in the emergency department in Iran (Hedayati et al. 2018).

These studies establish the pervasive nature of workplace violence in the health sector the world around with psychological violence (verbal abuse, threats, bullying / mobbing, etc.), being the predominant form of violence experienced.

Perpetrators and causes of violence

In the study by Hobbs in England (1991), 56.9 per cent of the perpetrators were reported to be patients and 37.6 per cent were reported to be relatives of patients. This was the first ever study that identified patients' anxiety as a cause for violence. Bereavement, however, was identified as a precipitating factor only in 5.1 per cent of the cases. Mental illness was an important cause for 38.1 per cent of assaults and injuries, but not implicated significantly in case of verbal abuse. Patients were responsible for three-quarters of all incidents in an

Australian study by ILO/ICN/WHO/PSI. Such violence was most common when patients had suffered injury, illness, dementia or a semi-comatose state, while recovering from anesthesia, suffering from mental health problems, or even affected by drugs or alcohol. Relatives, who were secondary abusers, were found abusive largely in the context of organizational factors such as long waiting time or poor attention; or even in high stress situations (Mayhew and Chappell 2003).

In the Bulgarian chapter of the by ILO/ICN/WHO/PSI country studies, of those who had faced verbal abuse, the patient was the perpetrator 43.4 per cent of the times and relatives were perpetrators 11.1 per cent of the times. Every third respondent perceives the patient's individual characteristics as a factor leading to violence at the workplace. These included patients who were angry, distraught or even alcohol or drug affected, mentally deranged, senile and terminally ill. In case of physical violence, it was found to occur mostly between doctor and patient. The comparative share of violence by relatives or friends of patients; or even by other staff, was insignificant.

In a cross-sectional survey of family physicians in Canada (Miedema et al. 2010), 78 per cent of the abusers were patients and the rest were family members. However, only one-third of abusive patients had mental health issues or were intoxicated. In a German study, where the respondents were primary care physicians, the perpetrator was the patient 73 per cent of the time. Alcohol, drugs, mental illness or a combination of these factors were thought to have played a role in 51 per cent of the incidents (Vorderwülbecke et al. 2015). In the German study by Schablon et al. (2012) that had high physical violence as noted in the previous section, dementia in patients was noted as a key precipitating factor.

Several studies in developing countries have reported relatives as the more common perpetrator. These include studies in Turkey (Pinar et al. 2015 and Eker et al. 2012) and Israel (Carmi-Iluzet al 2005). A study conducted in Egypt with 134 physicians also found that relatives were responsible for 89.7 per cent cases of verbal abuse and 90.5 per cent cases of physical abuse (Abdellah & Salama 2017). Studies from India too have reported relatives and escorts to be common perpetrators (Ori et al. 2014; Anand et al. 2016 and Madhiwala & Roy 2006). In fact, in the study by Pinar et al. 2015 in Turkey found a direct link between number of relatives and violence - the greater the number of relatives that come with patients, the more likely it is for violence incidents to occur.

Relatives were also found to be the more regular perpetrators of violence in studies from China (Hu et al. 2017; Xing et al. 2015). In a retrospective cross-sectional survey of general practitioners and nurses, respondents had also reported having faced something

that was very peculiar to China called "Yi Nao" reported by 14.9 per cent of the doctors. Yi Nao is any medical or hospital disturbance created by a group of people against health care providers. This group can include relatives of patients, Yi Nao gang members hired by patients or their families and sometimes patients themselves. They gather at hospitals involved in disputes with patients for actual or perceived medical malpractice. While they refrain from using physical violence as it is punishable under the law; they do engage in verbal abuse with the aim of forcing the hospital to meet the demands which could be in the form of financial compensation or reduction of costs (Li et al. 2018). In another study in China by Liu et al. (2015), shift work, high out-of-pocket expenses and overwork were identified as some of the risk factors. Moreover, staff with higher levels of anxiety about workplace violence was reported to be more vulnerable to violence.

Poor workplace surroundings, working conditions, dissatisfaction with care and shortage of staff and resources were also some of the common organizational issues across several studies contributing to violence in studies fromThailand, Lebanon and Brazil (Sripichyakan et al. 2003; Deeb 2003; and Pal·cios et al. 2003).

Over-crowding, long waiting time, staff shortage, poor management of the facility, lack of patient screening for alcohol and drug abuse by patients were factors identified in the South African study (Steinman 2003). In the Moroccan study, besides organizational factors, the exposure of physicians to some form of violence was greater among doctors with an anxiety trait (Belayachi et al. 2010). This finding was in line with the German study by Schablon et al. (2012) and Liu et al. (2015).

A study from Israel reported additional factors that precipitated violence, besides organizational conditions. Shafran-Tikva and colleagues (2017) found that 39 per cent of the respondents referred to staff behaviour, 26 per cent to patient/visitor behaviour, 17 per cent to organizational conditions, and 10 per cent to waiting times as factors leading to violence. Patient dissatisfaction with the quality of service, the degree of staff professionalism, or an unacceptable comment of a staff member were also identified as key precipitators; along with lack of understanding of the hospital system on the part of patients, together with poor communication between patients and providers and expectations gaps. Eker et al. (2012) in their study in Turkey also reported that staff behavior, manifested in the form of disrespect towards patients, was an important factor contributing to violence. Poor security and not protecting the rights of patients was also amongst factors identified.

Studies from South Asia too predominantly identified organizational issues as factors contributing to violence. In a mixed methods study in Pakistan, while participants felt that there were multiple reasons that led to the violence, 71 per cent of the participants had shared that communication failure had led to the incident (Khan and ul Haq, 2018).

Long waiting periods (73.5 per cent), delayed medical provision (45.6 per cent), violation of visiting hours and dissatisfaction with nursing care (41 per cent), psychological stress (38.4 per cent) and denial of hospital admission due to limited availability of beds in the wards (31.1 per cent) were pointed out to be possible causes of violence identified in the study in a tertiary care hospital in Delhi by Kumar, et. al. (2016). In another study in Delhi by Anand et al. (2016) death of the patient and delay in initiation of treatment were two of the commonest causes shared by respondents leading to violence. Poor communication skills and conflict resolution skills were also noted as risk factors. In terms of organizational issues, the respondents felt that over-crowding (77.5 per cent), shortage of medical supplies (73.4 per cent) and poor living conditions of the doctors are also significant risk factors. In a community-based study in Aurangabad district of Maharashtra, communication gap (32.93 per cent) was the most commonly perceived reason for the violence against doctors. This was followed by the patient related reasons (such as poor education) which accounted for 26.84 per cent of the responses. The reason of social pathology (such as bad attitude of relatives and patients) was attributed in 23.18 per cent of cases (Pund et. al., 2017).

What is evident is that patients are the more common perpetrators of violence against health care providers in most studies from developed countries. It was also observed that the reasons perceived to have led to violence by patients were often sourced in individual patient related characteristics such as their mental state, intoxication, dementia, etc. Family members were largely secondary perpetrators in developed countries, and the perceived reasons for violence by them were often sourced in organizational factors.

In developing countries, on the other hand, family members were the more common perpetrators and the reasons were sourced in organizational issues. Patients were most often found to be the secondary perpatrators and the factors were largely soured in individual patient related issues such as intoxication, mental health, etc. Therefore, while the common perpetrators in developed and developing countries were different (or interchanged); the factors associated with each that were perceived to have led to violence against health care providers is similar across developed and developing countries.

Common or vulnerable sites identified

In the study by Hobbs in England (1991) with general practitioners, while most incidents took place in surgery[10] itself, serious violence was also reported on domiciliary visits particularly at night. In the Australian chapter of the ILO/ICN/WHO/PSI (Mayhew and Chappell 2003), emergency departments, drug and alcohol clinics and mental health department and other sites that involved high stress such as maternity / delivery wards, ICU, CCU etc. were also identified. In the German study by Schablon et al. (2012) the highest prevalence of physical violence was found in inpatient geriatric care.

The study in Bulgaria too found that dispensaries for mental disorders, hospital emergency departments and intensive care units were at particular risk (Tomev et al. 2003). Researchers in the Portuguese study (Ferrino et al. 2003) found that violence was frequent in consulting rooms when it came to health centres; and in case of hospitals it was the emergency care departments. In the study by Liu et al. (2015) in China, it was found that medical units were at a higher risk of non-physical violence whereas the surgical units were at a higher risk of physical violence. In the Indian study by Kumar et al. (2016) most reported cases of violence were from Obstetrics and Gynecology; followed by Surgery, Medicine and other departments. The study in Manipur, India, by Ori et al. (2014) reported maximum incidents in the emergency.

Clearly, across various studies, different sites were identified to be more vulnerable to violence than others. In general, high pressure and high distress zones are particularly vulnerable. These include the emergency departments, ICUs, surgical departments, etc. Moreover, in developed country studies where patients were more likely responsible for the violence and patient-related factors were commonly identified as risk factors, mental health departments, geriatric departments, etc., were also found to be the key vulnerable sites.

Impact of violence, post incident action and support

Among the developed country studies, the Portuguese study by Ferrinho et al. (2004), found that victims of verbal abuse have shared being super-alert or vigilant or watchful and on guard. Workplace violence was also reported to affect the efficiency and performance of the institution, staff absenteeism; and led to lowered motivation and professional dissatisfaction. There was also a tendency to become overcautious. Increase in cost on security was also noted as a consequence of violence.

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[10] In England, a surgery is the consulting room of the doctor.

In the study by Tomev et al. (2003) in Bulgaria, in case of physical violence, both physical and verbal abuse were found to generate anxiety and disturbing memories post abuse. About 44.4 per cent men and 59.1 per cent women shared that they occasionally had repeated memories of the incident and felt anxiety. Verbal abuse generated disturbing memories and thoughts in 56 per cent of the men and 67 per cent of the women. The study revealed absence of any special reporting procedures. There were also no individual or institutional strategies and policies that dealt with workplace violence.

Mayhew and Chappell (2003) in their study in Australia found that the emotional impact of violence faced was not related to the physical severity of the event. The stress levels were found to increase with the increase in the number of violent events experienced. Reporting of an event was not linked to how severe the violence was, as many assaults had not been reported. At least 50 per cent of the perpetrators experienced no negative consequences following their behavior.

Two studies in Germany lead to very divergent findings in terms of impact. The study by Schablon et al. (2012) found that a third of the respondents reported being seriously stressed as a result of the abuse. Respondents also reported anger, rage, anxiety, self - doubt and helplessness. Training was found to help in better management of stress as well as reduce the risk of facing violence. However, in the study by Vorderwülbecke, et. al. (2015), with a little over half the participating doctors having been exposed to some aggression in the previous 12 months; only 3 per cent of the respondents had any psychological impact of the abuse faced, though 18 per cent of the primary care doctors reported a change in behaviour towards patients. The reasons for the low psychological impact were not explored in the study.

The specific aim of the Finland study that had reported higher physical violence than psychological, was to examine the associations of work-related violence with turnover intentions and job satisfaction in a four-year follow-up among Finnish physicians. Doctors had reported modified behaviour towards patients and violence was found to be associated with increased turnover and decreased job satisfaction (Heponiemi et al., 2014).

The impact of violence reported from developing countries was in line with that reported in the developed countries. In the Thailand chapter of the ILO/ICN/WHO/PSI studies (Sripichyakan 2003), 27.5 per cent of those who had faced physical assaults had suffered injuries. Victims of violence in general had admitted to having bad memories of the incident and being super alert. They were found to generally talk to their colleagues about the incidents with (41.4 per cent) and pretend that the incident never happened (38.5 per

cent). Only 22.7 per cent sought counselling post incident. While 28 per cent of the victims said that they had reported the incident to a senior staff member, less than 10 per cent had filled-in an incident form. This was because reporting procedures were predominantly pro-patient and focused on incidents such as how patients were victimized by staff or errors committed by staff. These perceptions of respondents were supported by the fact that the incident form of one of the hospitals was found to have incidents of patients/clients and of the health personnel on the same form but almost all details were related to the patient/client incidents. In addition, there was no particular authority responsible for such cases. Occasionally, an ad hoc committee would be formed to investigate into an incident.

The staff in the public facilities in the South African chapter of the ILO/ICN/WHO/PSI studies, registered higher anxiety than those in private facilities. This could be a reflection of the fact that public facilities had reported higher abuse. It was also found that policies, including post- violence response policies, reduced anxiety levels. Symptoms of post-traumatic stress disorders were common amongst victims of both physical and psychological violence. Less than half the victims of physical abuse reported the incident to a senior staff, and of these 18 per cent were offered counselling. About two-thirds of the victims of verbal abuse reported that no action was taken (Steinman 2003). In Mozambique, in a study by Eduardo et al. (2003) most respondents reported that they had taken no action post the incident as they were simply unaware of what they could do.

In Lebanon, most of the respondents who had faced physical abuse and psychological abuse had reported being super alert and having had repeated memories of the incident. About 40 per cent of respondents shared that there were some institutional policies in place for physical and verbal abuse. Respondents found approaches such as security measures; efforts to improve surroundings and restrict public access; patient screening; increasing the number of staff members, training of staff, etc. useful, but not actually implemented. The commonest type of support given by the employer was the opportunity to speak. Most of the victims were dissatisfied with the way incidents were handled. Respondents mostly noted that it was 'useless' or 'it was not important' to report the violence. Respondents were mostly unaware of support mechanisms and they felt that this was largely because authorities did not acknowledge the problem as also because of underreporting.

Eker et al. (2012) in their study in Turkey found that about half the health care providers felt that their exposure to the violence had negatively affected their behaviour towards

patients. A little over 90 per cent of the health care providers exposed to violence at work stated that the applicable current laws do not protect the staff against violence and 88.3 per cent of the respondents felt that they were not supported by their institutions at the time of the incident. About 88 per cent of them also said that they had not received adequate support from the authorities.

A Chinese study by Zhao et al. (2016) found that those professionals exposed to violence had a strong opinion about improving diagnosis/treatment competence, developing violence prevention guidelines and plans, reinforcing staff by providing back-up support, etc. Those who had faced anxiety post the incident had suggested improving doctor-patient communication skills; installing cameras in wards; keeping work areas bright; improvements in violence reporting, statistics, and interventions; security patrols in the key departments; reinforcing staff, and correcting inaccurate media perspectives and reports.

The study by Sun et al. (2017) found that violence against doctors led to psychological stress, affected their health, sleep quality as well as their relationship with the patients. Of the 840 respondents in the study by Liu et al. (2018) in China, more than half of the respondents thought the incident could be prevented. Around 47.6 per cent of respondents reported that their workplace did not have reporting procedures. A total of 54 per cent respondents reported that there were no specific measures for dealing with psychological violence in their workplace.

More than half the respondents who had faced physical violence had an injury and 45.4 per cent of respondents took two or three days of sick leave in the study by Xing et al. (2015) indicating the intensity of the physical violence. Reporting workplace violence in hospitals to superiors or authorities was low (9.4 per cent) and most respondents (62.8 per cent) did not receive training on how to prevent violence. Of those who did not report the events, 69.8 per cent thought it was useless and 41.5 per cent "felt ashamed". More than half the respondents said that there was no encouragement to report workplace violence.

In the Israeli study by Carmi-Iluz et al. (2005) 13 per cent of the 170 respondents said that they felt that their health had been endangered as a result of the verbal violence and 22.4 per cent said the same for physical violence. Only 9.4 per cent of the physicians said that legal options were pursued post the incident. Most times there was no action or the security guard would simply send the perpetrator off.

In a study by Anand, et al in 2016 in a tertiary care hospital in Delhi, all of those who had been physically assaulted felt angry, fearful, frustrated, irritable and sad. Half of them reported that it affected their self-esteem. Reporting of the abuse to higher authorities or seniors was largely verbal. A cross sectional Study at the Regional Institute of Medical Sciences by Vanlalduhsaki et al. (2018), reported that doctors who had faced verbal violence had repeated memories of the incident, avoided thinking and talking about the attack and became watchful and on guard. Even though the prevalence of physical violence was low, it was found that none of these were investigated and majority of those who had faced abuse were dissatisfied with the way the attacks were handled by the administration. Respondents most commonly suggested security system should be strengthened and better infrastructure be put in place together with counselling for patients to prevent violence against doctors.

In a two-country study in US and India by Grundmann et al in 2017 involving emergency department physicians, found no difference in the impact of the abuse faced by doctors in the two countries despite differences in reported verbal and physical violence. The researchers were of the opinion that the effects of violence (such as self-reported sleep, missed days of work, or fear of going to the workplace) were statistically indistinguishable which suggested a threshold effect of workplace violence.

Impact of violence was explored at personal and professional levels across studies. Research evidence from a range of studies, both in developed and developing countries found significant psychological impact and professional consequences of both psychological and physical violence on health care providers. Irrespective of their development status, studies from across countries have also reported poor reporting procedures, lack of formal support and policies and absence of training to deal with violence.

Besides the above, there are three qualitative studies from India that explored the phenomenon. In a study in a public hospital of Mumbai by Madhiwala and Roy (2006), sudden death of a patient was a significant cause leading to violence. Other factors include, denial of admission, delay in providing care, rude behaviour from health care providers and unavailability of essential drugs and diagnostic equipment in the hospital. Resident doctors were often found to have been given responsibilities that they were not equipped to handle, such as communication of death to a relative, leading to misunderstandings and friction. Rampant absenteeism and shortage of staff led to doctors undertaking tasks such as escorting patients, pushing trolleys, etc. This was reported to affect their interaction

with patients.

A study by Deosthali and Rege (2012) in two public hospitals in Mumbai found that women health workers, including doctors, nurses and class IV employees, experienced sexual harassment from patients and relatives as well as other staff. This was usually in the form of inappropriate touching staring or making sexually coloured comments. Male patients were also reported to have started undressing deliberately in front of female nurses. Relatives were often found intoxicated and abusive. Several female doctors felt that patients and relatives taken seriously because they were women.

In another qualitative study in a medical college in Ujjain involving junior doctors and young teachers, respondents reported loss of morale, fear, anxiety, depression as well as a negative change in attitude towards patients as a result of the violence faced. Doctors preferred to refer the patients to other practitioners as they did not wish to risk further abuse. Both male and female respondents had commented on the lack of support from the hospital administration, government, judiciary, etc. Lack of security provisions was also an important concern (Joshi SC and Joshi R 2018).

Key recommendations across studies and findings pertaining to their implementation

The Portuguese research study (Ferrino et al. 2003) recommended the setting up of a legal framework to deal with violence for a long-term impact. Guidelines and improving management competencies at the level of the institution, generating awareness, etc. were also recommended. Respondents in Bulgaria (Tomev et al. 2003) recommended security measures, improved surroundings, reduced periods of working alone and restricted public access. Staff training was recommended for those working in high risk situations to be better able to deal with aggressive behaviour. Putting in place reporting procedures as well as medical and psychological support post incident were found essential. Making available security guards was an important measure, and the importance of ensuring security was highlighted in the Australian study by Mayhew and Chappell (2003), where many health workers reported feeling relatively safe when security officers were accessible particularly at high risk time and in high risk wards. Improved communication with patients and relatives was noted as being important, particularly when there were lengthy waiting times and when other patients needed to be prioritized. Respondents believed that aggression minimization training was essential and that it would help with the development of de-escalation skills. Researchers have noted that the administration needs to recognize the existence and impact of the problem of violence against health care professionals and provide impetus to initiatives to prevent the violence, including a zero-tolerance policy.

There was also a need to publicize these initiatives. The study by Schablon in Germany (2012) found that those who were trained to deal with aggressive behaviour by patients and relatives faced less risk of facing both verbal or physical aggression. Such training was also found to have a positive effect on stress. Zhao et al (2016) in their study in China noted that respondents had a strong opinion about the need to improve health care provider competence and to develop violence prevention guidelines. Other strategies include training in doctor-patient communication, installation of cameras, having proper lighting, improving reporting procedures, etc. Participants in the study from Pakistan felt that need to improve health care services and increasing number of health personnel as two of the key recommendations (Khan and ul Haq, 2018). In the Indian study by Ori et al. (2014) it was suggested that there needs to be written policy against violence in the emergency rooms and this should be displayed. There needs to be a designated authority to whom complaints can be reported. Madhiwala and Roy in their study in Mumbai (2006), noted that most respondents expressed an urgent need to improve conditions in the hospital particularly in terms of human resources. There was also a felt need to communicate more sensitively with patients and relatives and employing more social workers and frontline staff to give more time and attention to patients and relatives.

These international studies, and studies done in India, establish the pervasive nature of the violence faced by health care providers. The extensive literature review has helped in grounding the primary research study and has also highlighted the need to comprehensively understand the phenomenon in the local context.

CHAPTER III: Methodology

The present study was initiated to understand client - initiated violence against resident doctors in public hospitals by patients and / or relatives and / or escorts (or caretakers) from the resident doctors' experiences and perspective in Maharashtra. It sought to identify the context of such incidents, understand risk factors, response of residents as well as the impact of such violence on the residents. There is a need to understand what are the preventive and addressing mechanisms presently in place and identify way forward.

Research Questions

1. What is the kind of violence faced by doctors and how does it affect them and their practice?
2. What is the understanding of doctors about what leads to / precipitates such violence against doctors from patients and / or relatives?
3. What are various systems and protocols in place to help prevent report and respond to such violence?
4. In the opinion of doctors, what needs to be done to prevent and respond to such violence?

Objectives

1. To identify the kind of violence faced by doctors at their workplace from patients and / or relatives.
2. To understand views of doctors about the cause of such violence.
3. To find out how it affects them and their practice and how they dealt with it.
4. To document existing mechanisms for preventing, reporting and responding to such violence.
5. To document the suggestions by doctors about preventing and responding to such violence.

The tool was a semi structured self-administered online survey with scope for qualitative responses at select places. Residents were requested to share about the abuse faced during

the entire duration of their residency at public hospitals, whether as a senior resident or as a junior resident. Prevalence was not intended as an outcome of the study. Our focus was on the context, responses and impact in the prevalence of the violence.

Study tool

The study tool was designed using the Workplace Violence in the Health Sector Country Case Study - Questionnaire (ILO/ICN/WHO/PSI, 2003) as a model and was modified to suit the objectives of the present study as well as address the gaps that were identified through literature review:

- The present study looked only at client-initiated or type II violence; whereas the ILO/ICN/WHO/PSI survey also included violence amongst co - workers.
- The focus of the present study was only resident doctors in public hospitals of Maharashtra; whereas ILO/ICN/WHO/PSI survey included doctors, nurses, pharmacists and other support staff.
- In the ILO/ICN/WHO/PSI questionnaire, the main respondents were those who have faced violence. We were keen on understanding the experiences (where relevant) and perspectives of three categories of respondents - residents who have faced and witnessed violence (i.e. exposed to violence), and those who have neither faced nor witnessed.
- Further contextualization and addressing of gaps in literature review was done by introducing topics that were not a part of the ILO/ICN/WHO/PSI tool. The purpose was to understand the local milieu better. Thus, aspects such as residents' immediate responses, help received from colleagues, post incident responses and policies, opinion on triage in the context of such violence, what the hospital administration could have done better, etc; were included in the tool. It was also pertinent to understand the mechanisms and policies that in the resident's perspective could help address such violence; and of these what was presently in place at the level of public hospitals.

The tool was reviewed by CEHATs Programme Development Committee (PDC) that monitors and advises work being done at CEHAT. The survey tool was revised based on the feedback from the PDC and from the pilot.

The online survey approach was selected as resident doctors are usually busy and also work in shifts. They are also juggling their work responsibilities with their academic

demands. It was felt that it may be easier for them to fill out an online questionnaire, which they could do in their own time.

The survey was designed in such a way that once informed consent and profile related questions were completed, respondents needed to answer whether they had faced or witnessed violence by patients and/or relatives and/or escorts (hitherto being referred to as 'violence') and depending on the response, they would be automatically directed to the relevant section of the survey. Only completed questionnaires could be submitted by hitting the "submit" option.

Accordingly, the online survey tool comprised the following five parts:

Table 1: Structure of the tool

1. Informed consent form	Filled by those resident doctors who had read the details of the survey. The form included the assurance of anonymity. At the end of the page, there were two questions. One confirmed that the respondent was a resident doctor in Maharashtra; and two, that he or she has understood the study and gives consent. Only after these two were clicked in the affirmative, were residents guided to the questionnaire. The consent form also shared information about the relevant Act[11] and names, email and contact details of the IEC members of both KEM and Anusandhan Trust ethics committees.[12]
2. General work profile	Filled by all resident doctors who have responded to the survey
3. Section for doctors who were exposed to violence	Filled by resident doctors who had either faced or witnessed violence
4. Section for doctors who were not exposed to violence	Filled by resident doctors who had neither faced nor witnessed violence

[11] Maharashtra Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage or Loss to Property) Act, 2009. http://www.lawsofindia.org/pdf/maharashtra/2010/2010MH11.pdf
[12] CEHAT is the research centre of Anushandhan Trust.

5.	Recommendations for prevention and management of violence against doctors	Filled by all resident doctors who have responded to the survey (exposed + neither faced nor witnessed)

An important aspect of the study is the CEHAT collaboration with the King Edward Memorial Hospital (KEM) and Seth Govardhandas Sunderdas Medical College, Mumbai; and the Maharashtra Association of Resident Doctors (MARD). KEM, founded in 1926, is one of the foremost institutions for teaching and provision of medical care in the country. The MARD looks after the welfare of resident doctors in Maharashtra.[13] The CEHAT - KEM - MARD collaboration gave the strategic base for planning and implementing the study and helped in streamlining the tools. Engaging in discussions at various stages also helped in clarification and contextualizing of issues. MARD facilitated in pilot testing of the tools. Both KEM and MARD acted as units for the snow balling technique to reach out to residents in Maharashtra and facilitated the process of propagating the survey link. The MARD letterhead was used to forward the link to the survey with a covering note drafted on the with a request to residents to participate in the survey. CEHAT took upon the role of the primary research partner and contributed by developing the tools, analysing the findings and writing of the study report. Discussions with KEM and MARD helped in providing insights into the findings.

Respondents

As stated above (Table 1), the sample had two main categories of respondents: those who were exposed to violence and those who were not. We felt that those resident doctors, who were witness to such incidents would be able to share information about the incident as they were present at the time. Therefore, the category of respondents exposed to violence includes those who had faced violence as well as those who had witnessed violence. We felt that it was also important to understand perspectives and seek recommendations on some aspects from those residents who had neither faced nor witnessed violence (not exposed) since they belong to the same professional group and help us understand the general perception on the issue. Recommendations about policies of prevention and management were sought from all the respondents. Resident doctors in public hospitals

[13] MARD looks after the welfare of all resident doctors. There is a basic registration fee to be paid and the funds thus collected are used for various purposes such as outreach services (e.g. blood donation camps), supporting a resident who is in need of funds, pursuing litigations, and other issues that may come up. Advocacy efforts are also made by MARD; such as to revise the salaries of resident doctors or efforts to ensure maternity leaves and the issue of poor availability of medicines and other hospital supplies.

of Maharashtra involved in providing direct services to the patients formed the sample for the study.

Since we needed to reach out to the residents across Maharashtra a snowballing technique was used. There are 4500 residents in the state working in public hospitals. We do not know how many of these had received the link to the survey on WhatsApp (see "data collection" below). It was likely that despite concerted efforts and reminders (to fill the survey as well as forward the link), many residents in Maharashtra might not have received it. Some residents might also have missed seeing the forward, despite having received it; and others might simply not have been keen to be a part of the study. Therefore, we could not determine the response rate. Nevertheless, having received 193 responses, the study reflects and represents the experiences, perceptions and opinions of 4.3 per cent of the resident doctors in public hospitals in Maharashtra.

Of the 193 respondents, 119 had been exposed to violence (26 had reported having faced violence, 93 had witnessed violence); and 74 had neither faced nor witnessed. The questions answered by the respondents who had faced violence and those who had witnessed violence were the same (see Table 1). Further, they are both providing information on incidents of violence that they had been exposed to and the findings were also in line. Therefore, for the purpose of analysis, the two categories were merged.

Data collection

The link to the Google form survey along with a covering note specially drafted on the MARD letter head requesting residents to participate was sent as a WhatsApp message. Complete anonymity was ensured. The link was sent to WhatsApp groups of residents as well as to presidents and vice-presidents of hospital level MARD committees. They further forwarded these messages to their respective colleagues in other MARD groups as well as to residents in other colleges. Initially, the plan was to have the survey open for a month. However, since it was close to the medical college examination and based on the feedback received from some residents regarding the same, the survey was kept open for about two months.[14]

The responses recorded were entered into SPSS (Statistical Package for the Social Sciences) Version 20 and analysed. Qualitative responses were analysed for emerging themes. Descriptive statistics were employed in interpreting the quantitative data.

[14] 20th March 2018 to 28th May 2018.

Review by ethics committees

Ethics clearance was received from both the KEM Ethics Committee and the Anusandhan Trust's Institutional Ethics Committee.

CHAPTER IV: Findings

The study sought to understand the perceptions and experiences of resident doctors in public hospitals in Maharashtra in the context of client-initiated violence against them. Each of these were operationalized through the survey tool. Thus, for instance, in order to study the kind of violence faced by resident doctors; the survey questions were operationalized to cover acts of violence faced, by whom it was inflicted, when and where the incident took place, and so on. There was space provided for qualitative responses at strategic points in the tool. The findings of the study are presented here along these domains of enquiry.

The chapter is divided into six sections. The "General Profile of Respondents" is followed by:

- **Section A:** Looks into the work profile of respondents who have been exposed to violence, followed by identifying the kind of violence faced by doctors at their workplace from patients and / or relatives and the context of this violence in terms of the nature of perpetrators, the common sites and time for incidents, sex of the patients and so on.
- **Section B:** Looks at how such violence affects residents, and how they dealt with it. This section looks at their immediate and post incident responses and experiences.
- **Section C:** Shares the perspectives of respondents about what factors led to the incident.
- **Section D:** Documents the views of respondents who have not been exposed to violence, but have an opinion to share.
- **Section E:** This section notes the responses by the hospital administration and gaps therein. Besides these, it also documents perspectives and existing mechanisms for preventing, reporting and responding to such violence from the experiences and perspectives of resident doctors; as well as their opinion of using triage in this context. It also documents the recommendations shared by residents.

General profile of respondents

Across Maharashtra, 193 resident doctors responded to the survey. Table 2 presents a general profile of the respondents in terms of sex and designation.

Table 2: Profile of respondents

Sex of the respondents	Frequency	Per cent
Male	129	66.8
Female	64	33.2
Total respondents	193	100.0
Current designation of the respondents		
Junior Residents	154	79.9
Senior Residents	39	20.1
Total Residents (respondents)	193	100.0

Table 3 presents number of respondents across each category. Of the total 193 respondents, 13.5 per cent of the respondents said that they had faced violence (n=26) and 48.2 per cent had witnessed violence (n=93) from patients and / or their relatives and / or companions. Thus, there were 119 respondents (61.7 per cent) who had been exposed to violence (n = 26 + 93). The remaining 38.3 per cent of the respondents had neither faced nor witnessed violence, but had an opinion to share (n =74).

Table 3: Categories of respondents

Those who had been exposed to violence (faced + witnessed)		
Residents who had faced violence	n = 26	13.5 per cent
Residents who had witnessed violence	n = 93	48.2 per cent
Total	n = 119	61.7 per cent
Those who had not been exposed to violence		
Residents who had neither faced not witnessed violence	n = 74	38.3 per cent
Total (All residents)	n = 193	100 per cent

Section A

This section looks at responses of residents who had been exposed to violence (faced + witnessed) (n = 119).

A.1. Sex of respondents

Of the respondents who had been exposed to violence, 76.5 per cent were males and the rest females (Table 4).

Table 4: Sex of the respondents (n =119)

	Frequency	Per cent
Male	91	76.5
Female	28	23.5
Total	119	100.0

A.2. Profile of respondents

Residents work in shifts and a profile of shifts according to its general duration as shared by respondents has been presented in Table 5a. Further profiling of the respondent's shifts has been shared in Table 5b (double shifts) and 5c (night shifts).

Table 5a: Duration of each shift (n = 119)

	Per cent of respondents	Frequency
8 hours	10.9	13
8 - 12 hours	26.9	32
More than 12 hours	62.2	74
Total	100.0	119

Table 5b: Double shifts / per week (n = 119)

	Per cent of respondents	Frequency
Never	14.3	17
1 - 3 times a week	66.7	77
More than 3 times a week	20.2	24
Missing response	0.8	1
Total	100.0	119

Table 5c: Night shifts / per week (n = 119)

	Per cent of respondents	Frequency
1 - 3 times a week	71.4	85
More than 3 times a week	19.4	23
Missing response	-	-
Total	100.0	119

One - fifth of the respondents have reported working in double shifts more than three times a week and about the same have also reported working night shifts more than three times a week. Importantly, 87 per cent reported double shifts and 91 per cent had night shifts more than once in a week. With each shift commonly extending to more than 12 hours each (Table 5a, 62.2 per cent) it is not uncommon for them to have worked continuously for 24 hours, if not more.

Resident doctors have duties across departments and wards with most of them working in the outpatient department (OPD), in patient department (IPD) and emergency / casualty services.

A.3. Violence faced by resident doctors

- *Incidents of violence exposed to*

  For the present study, respondents were asked to share their perspectives and experiences with respect to only a single incident of violence. It was found during their period of residency, most residents (76.5 per cent) had been exposed to more than one such incident (Table 6).

Table 6: Incidents of violence exposed to

	per cent of respondents (n = 119)	Frequency
More than once incident of violence	76.5	91
Only one incident of violence	23.5	28
Total	100.0	119

- *Forms of violence / abuse exposed to*

  Violence was categorized as physical, psychological and sexual (Table 7). Physical violence was further categorized as slapping, pushing/shoving and assault by an object; psychological violence included bullying, threatening and humiliation and sexual violence in the form of lewd/sexually offensive comments. An incident of violence can comprise of multiple forms of abuse simultaneously.

Table 7: Forms of abuse exposed to*

	Frequency	Per cent of respondents reporting the form of abuse (n = 119)
Physical abuse		
Pushing / shoving	68	57.1
Slapping	47	39.5
Assault by an object	21	17.6
Psychological abuse		
Threatening	91	76.5
Humiliation	68	57.1
Bullying	55	46.2
Sexual abuse		
Lewd / sexually offensive comment	33	27.7

*this was a multiple response question.

Accordingly, threatening, humiliation, pushing / shoving and slapping have been the most commonly reported forms of abuse to have occurred against resident doctors. Assaults were reported as part of 17.6 per cent of the incidents.

- *The perpetrators of violence*

  Respondents have shared that most commonly abuse was perpetrated by groups of people accompanying patients who are very likely to be relatives of patients and other people accompanying the patients, i.e. escorts (Table 8a and 8b).

Table 8a: Perpetrators were -

	Frequency	Per cent of respondents
Group of people	88	73.9
Single person	21	17.6
Two people	10	8.4
Total	119	100.0

Table 8b: Violence inflicted by? *

	Frequency	Per cent of respondents who shared this
Relatives of patient	109	91.6
Escorts of patients	48	40.3
Patient	18	15.1
General public	11	9.2
Missing response	1	0.8

*this was a multiple response question.

- *Common sites of incidents*

  The Emergency/Casualty, Pediatrics and the General Medicine departments were reported as the more common sites of violence (Table 9a).

Table 9a: Place of incident (commonest select sites)

	Frequency	As per cent of total incidents (n = 119)
Emergency / Casualty	37	31.1
General medicine	15	12.6
Pediatrics	13	10.9
General surgery	9	7.6
Intensive Care Unit (ICU)	8	6.7
Outside the department but within the hospital premises	6	5.0
Gynecology and Obstetrics	5	4.2
In waiting area	4	3.4
Orthopedics	3	2.5
Outside the hospital campus (to / from work)	3	2.5
Psychiatry	1	0.8
Others[16]	15	12.6
Total	119	100.0

[16] Some of the "other" departments reported by residents in the survey include the operation theater and ophthalmology.

- *Most common time of incidents*

  Most incidents of violence were reported at the time of night duty followed by incidents taking place after OPD hours (Table 9b).

Table 9b: Most common time of incidents -

	Frequency	As per cent of incidents reported (n=119)
At the time of night duty	71	59.7
After OPD hours	23	19.3
During OPD hours	18	15.1
Before OPD hours	7	5.9
Total (per cent)	119	100.0

- *Cases found to be more commonly associated with incidents of abuse*

  While 36.1 per cent of the reported incidents of violence against resident doctors involved a severely ill patient, 21.8 per cent of them were also routine cases (Table 9c) as well as cases such as dog bites, removal of a double J stent[17] and putting a plaster for a fracture ("other cases").

Table 9c: Case under treatment at the time of the incident

	Frequency	per cent of total cases (n = 119)
Severely ill patient	43	36.1
Routine case	6	21.8
Accident case	20	16.8
Other	14	11.8
Case of physical assault	10	8.4
Woman in labor	5	4.2
Missing response	1	0.8
Total	119	100.0

- *Sex of patient under treatment in the context of the incident*

  The patient was a male in 63.9 per cent of the cases (Table 10).

[17] Removal of a Double J stents is a routine procedure. They are commonly used to manage urinary obstruction.

Table 10: Sex of the patient

	Frequency	Per cent
Male	76	63.9
Female	37	31.1
Other	1	0.8
Missing response	5	4.2
Total	119	100.0

Section B

This section looks at the responses of resident doctor at the time of the incident, post the incident and the impact of such violence on them.

B.1. Responses of resident doctors in the context of the incident

- *Immediate response / action taken by resident doctors at the time of the incident*

  The data show that residents had most commonly responded by calling security on duty (74.8 per cent), calling a colleague (52.9 per cent) and trying to talk or reason with the perpetrator/s (40.3 per cent). Calling a senior was not common (28.6 per cent) and rarely had residents reported taking no immediate action (5.9 per cent), or having reprimanded / scolded the perpetrators (7.6 per cent) (Table 11).

Table 11: Immediate response to incident*

	Frequency	per cent of residents who reported this (n = 119)
Called for security on duty	89	74.8
Called a colleague for help	63	52.9
Tried to talk or reason with the perpetrator/s	48	40.3
Told the person/s to stop	44	37.0
Called a senior staff member to the spot	34	28.6
Called police on duty	32	26.9
Warned perpetrator that you would report the incident	14	11.7
Reprimanded/scolded the perpetrators	9	7.6
Took no immediate action	7	5.8
Tried to pretend it never happened	2	1.7

*This was a multiple response question.

- *Post incident response of resident doctors*

  After the incident of violence had occurred, residents were asked what they did after the incident. These responses have been presented in Table 12.

Table 12: Post incident response by residents*

	Responses by residents (n = 119)	
	Frequency	Per cent of respondents
Reported it to hospital administration	61	51.3
Sought help from MARD	47	39.5
Took no formal action taken	44	37.0
Pursued/ helped to pursue legal prosecution of attackers (MLC)	36	30.3
Sought/helped to seek transfer to another department/hospital/town or city	3	2.5
Sought/helped to seek compensation claim from hospital administration	2	1.7
Sought/helped seek counselling	2	1.7
Sought/helped to seek compensation from insurance company	0	0

*This was a multiple response question.

More than half the respondents reported the matter to the hospital administration and 39.5 per cent sought help from the MARD. Seeking counselling, compensation or transfer was not a common course of action. In their qualitative responses, some of the residents also shared 'other' actions that they had taken post - incident. One resident reported having gone to the head of security and another informed a senior staff about the incident.

- *Reasons for not taking formal action*

  No action was taken by 44 residents (37 per cent) (Table 12). We sought to explore the reasons behind this. Table 13 shares these perspectives.

Table 13: Reasons for no formal action *

	Frequency	Per cent of residents who said no formal action was taken (n = 44) and given the following reason/s -
It is of no use to report such an incident	25	56.8
There are no procedures available in the hospital to formally report violence	13	29.5
Did not know about the procedures in place for reporting such violence	12	27.3
It is a part and parcel of our profession	9	20.5
Afraid of negative consequences from patient/ relatives/ escorts	6	13.6
Afraid of negative consequences from hospital administration	3	6.8
Felt ashamed about the incident	1	2.3
Felt guilty about the incident	0	0

*This was a multiple response question.

A resident may have more than one reason for not doing so, the most common of which being: It was of no use to report such an incident; there were no reporting procedures in the hospital, and/or did not know of procedures in place.

Besides these, through their qualitative responses, residents have also pointed to the hospital administration's lack of interest and its negative attitude on these issues. Security personnel were also reported to be disinterested in the context of such incidents. Another reason was fear of retaliation by perpetrator. A sample of responses is as below:

> *"The person was accused of murder and he threatened to kill me. He was drunk. I was little afraid and wanted to close that matter there only." - Junior resident, male*

> *"Residents are frowned upon if they complain against unruly patients/relatives" -Junior resident, male*

- *Help provided by colleagues*

  Table 14 presents information on the various ways in which colleagues contributed in the context of an incident of abuse.

Table 14: Help provided by colleagues*

	Frequency (n = 119)	**Per cent of respondents who shared nature of help provided -**
Called security guard/s on duty	82	68.9
Intervened and told perpetrator/s to stop	74	62.2
Tried to talk to the person/s	55	46.2
Called police on duty	36	30.3
Formally reported it to hospital administration	25	21.0
Raised emergency alarm	20	16.8
Reprimanded/scolded the perpetrator/s	12	10.1
Did not help	0	0

*This was a multiple response question.

Largely, colleagues have helped by calling security on duty (68.9 per cent) and by intervening and telling the perpetrators to stop (62.2 per cent). None of the residents shared that colleagues did not help.

B. 2. Impact of violence on resident doctors

- *How worried are residents about the phenomenon of violence against resident doctors?*

  In terms of impact of violence, this was one common question for all the respondents of the survey (including those who had neither faced nor witnessed but have an opinion to share, therefore n = 193) (Table 15).

Table 15: Per centage of residents who are worried

	Per cent of residents who had been exposed to violence (n=119) and were -	Per cent of residents who had not been exposed to violence (n=74) and were -	Per cent of all residents (n = 193)
Very worried	84.9	81.1	83.4
Moderately worried	15.1	17.6	16.1
Not worried	0	1.4	0.5
Total	100.0	100.0	100.0

Thus, irrespective of whether residents have been exposed to incidents of violence, most are very worried about such abuse.

- *How did the incident of violence affect the resident doctors?*

  The impact of exposure to violence from patients/relatives/caretakers on residents was categorized across three fronts: on the professional front and on the personal front; and thirdly, post incident coping.

Table 16: Impact of violence on residents *

	Frequency (n=119)	Per cent of residents who reported (n=119) -
Impact at a professional level post the incident		
Started avoiding giving proactive advice to patients after that incident	47	39.5
Lost motivation at work	41	34.5
Started avoiding one on one interaction with patients and relatives	27	22.7
Impact at a personal level		
Became fearful	43	36.1
Developed anxiety about coming to work	42	35.3
Started to feel sad	32	26.9
Avoided thinking about the incident	27	22.7
Repeated memories of the incident	24	20.2
Lost self-worth	23	19.3

(Table 16 continued)	**Frequency (n=119)**	**Per cent of residents who reported (n=119) -**
Felt chronic fatigue post incident	11	9.2
Post incident coping		
Became vocal about violence against resident doctors	44	37.0
Participated in protests/ solidarity campaigns	38	31.9

*This was a multiple response question.

A resident could be affected by the violence in several different ways at the same time. At a professional level, 39.5 per cent of the residents had reported that they had begun to avoid giving proactive advice to patients and relatives. Violence had also resulted in them losing motivation at work (34.5 per cent). At a personal level, 35.3 per cent of the residents have said that they had developed anxiety symptoms and 36.1 per cent also said that they had become fearful. Several residents also reported about becoming more vocal about the issue (37 per cent) and participating in protests (31.9 per cent).

In their qualitative responses, residents have shared the psychological consequences of violence as well as changes in their perspectives leading to professional outcomes, both negative and positive. These include making an effort to understand the needs of patients and relatives better and explaining the treatment to them in order to reduce their anxiety; or, on the other hand, choosing to keep their distance from patients and their families and limiting their interaction. A resident was also reported to have left medicine as a profession as a result of the trauma.

Section C

C.1. Factors leading to violence against resident doctors

- *Resident's perspective*

  There may be several factors that constitute the context that led to the incident. From the residents' perspective, the most commonly reported ones were overcrowding, death of the patient, lack of equipment and drugs and dissatisfaction with medical care provided (Table 17).

Table 17: Factors leading to the incident*

	Frequency	Per cent of residents who shared the factors (n=119) -
Patient / relatives / escorts related factors		
Death of a patient	39	32.8
Dissatisfaction with medical care provided	38	31.9
Patient was brought in critical condition leading to stress for patient's relatives and / or escorts	36	30.3
Patients/relatives/escorts of patients not understanding / following required procedures	33	27.7
Intoxication of patients/relatives/escorts of patients	28	23.5
Communication gap with patients/relatives/escorts of patients	22	18.5
Psychological problem with the perpetrator/attacker	15	12.6
Prohibiting certain behavior of patient or relative-eating tobacco, hygiene in hospital, etc.	14	11.8
System level factors		
Overcrowding of patients and relatives	52	43.7
Lack of equipment and drugs	38	31.9
Being stressed and tired due to work at the hospital	13	30.9
Long waiting time for patients and relatives	36	30.3
Lack of trust in doctors among patients	33	27.7
Referral of the patient to another hospital	20	16.8

(Table 17 continued)	**Frequency**	**Per cent of residents who shared the factors (n=119) -**
Delay in providing care (by doctor)	19	16.0
Lack of an emergency response plan	10	12.1
Lack of referral mechanism (ambulances, protocols, etc.)	12	10.1
Commercialization of medical sector	9	7.6
Denial of admission in hospital	8	6.7
Cost of care for the patient and relatives	4	3.4

*This was a multiple response question.

Qualitative responses have highlighted the inter-connectedness of various factors such as lack of equipment, a poor doctor-patient ratio, overcrowding, etc. Residents have also noted the impatience of relatives on the one hand; and lack of sensitivity of residents, on the other. Some of these responses include:

"Relatives were drunk and not in condition to understand the critical condition of patient."- Junior resident, female

"Patience from side of relatives when they can see doctors are less, workload and patients are more." - Senior resident, female

"It is very unfortunate to say but many times it is the resident doctor who talks very rudely with the relatives of a critical patient. One such incident was reported to me by the security in charge about a 2nd year resident of medicine who was slapped by the relatives as he said to them that, 'your patient is anyhow going to die, why should I look at him again' when he was asked by one of the relatives about the condition of his patient...I would not blame the relatives always for such incidences. If you go in depth of the matter in many cases where the wrong attitude of a resident doctor lands him in such situation." - Senior resident, male

- *Responses voiced by perpetrators*

  Residents have reported that delay in providing care, dissatisfaction with medical care, doctors' negligence and worsening condition of patient were some of the

commonest reasons vocalized by the perpetrators (patients/relatives/escorts) at the time of an incident of violence (Table 18).

Table 18: Responses as voiced by perpetrators*

	Frequency	Per cent of respondents sharing the response/s
System related factors		
Delay in providing care (by doctor)	53	54.5
Lack of equipment and drugs	29	24.4
Not happy that patient had to be referred	16	13.4
Doctor related factors		
Dissatisfaction with the patient's medical care provided	53	44.5
Doctor worsened patient's condition	41	34.5
Doctor was negligent	41	34.5
Doctor was rude/misbehaved with patient/ relatives/escorts	22	18.5
Patient and relatives related		
Stressed by the hospital procedures	19	13.4

*This was a multiple response question.

Section D

The present survey had an option where resident doctors who had not been exposed to violence (neither faced nor witnessed), could also share their opinion on the phenomenon of violence; what they think leads to it; and what impact that they think violence has. This is also an important category of respondents as it helps understand the general perceptions amongst resident doctors.

D.1. Perspectives of respondents who had not been exposed to violence

Of the 193 respondents to the survey, there were 74 such respondents, of which there were 38 males and 36 females.

Table 19: Profile of respondents

	Frequency	Per cent
Male	38	51.4
Female	36	48.6
Total respondents	74	100
Current designation of the respondents		
Junior Residents	67	90.5
Senior Residents	7	9.5
Total Residents	74	100.0

In the opinion of those who had not been exposed to violence; physical abuse was perceived to be the very common, almost as common as verbal abuse (Table 20).

Table 20: Perceptions about common forms of violence*

	Per centage of respondents (n = 74)
Verbal	95.9
Physical	93.2
Sexual	29.7

*This was a multiple response question.

Most felt that, violence on resident doctors, was most commonly inflicted by group of persons (97.3 per cent of respondents) and by relatives or escorts of patients (95.9 per cent of respondents) (Table 21).

Table 21: Perceptions about common perpetrators of violence*

	Per cent
Relative/s of patient	95.9
Escort/s of patient	78.4
Patient	12.2

*This was a multiple response question.

Most resident doctors felt that violence mostly took place outside the emergency (94.6 per cent) and the ICU (77 per cent); and is most likely to take place at the time of night duty (90.5 per cent).

Resident doctors opined that several factors could contribute to violence against residents. The death of a patient; patient being brought to the hospital in critical a condition, dissatisfaction around medical care provided, communication gap with patients/relatives or escorts, long waiting time and delay in providing care were strongly perceived to be contributing towards violence against residents (Table 22).

Table 22: Factors contributing to such violence*

	Responses received from those who have neither faced and witnessed, but have an opinion to share on the issue (number of respondents = 74) (Per cent)
Patient / relatives / escorts related factors	
Death of a patient	87.8
Dissatisfaction with medical care provided	78.4
Patient was brought in critical condition leading to stress for patient's relatives and / or escorts	74.3
Communication gap with patients/relatives/escorts of patients	62.2
Patients/relatives/escorts of patients not understanding / following required procedures	59.5
Intoxication of patients/relatives/escorts of patients	54.1

(Table 22 continued)	**Responses received from those who have neither faced and witnessed, but have an opinion to share on the issue (number of respondents = 74) (Per cent)**
Psychological problem with the perpetrator/ attacker	21.6
Prohibiting certain behavior of patient or relative- eating tobacco, hygiene in hospital, etc.	20.3
System level factors	
Delay in providing care	74.3
Long waiting time	68.9
Overcrowding	59.4
Lack of equipment and drugs	55.4
Referral of patient to another hospital	52.7
Lack of trust in doctors	51.4
Denial of admission in hospital	47.3
Being stressed and tired due to work at the hospital	43.2
Commercialization of the medical sector	36.5
Lack of referral mechanisms (ambulances, protocols, etc.)	35.1
Lack of an emergency response plan	32.4
Cost of care for the patient	23.0

*This was a multiple response question.

Residents who have not been exposed to violence also shared their views on the impact that such violence can have on resident doctors. These opinions may have been based either on what they may have observed; on what was discussed with other residents, or even perceived to be the case. Most of them feel that these incidents of violence cause a loss of motivation at work (68.9 per cent) and they are anxious when reporting to work (60.8 per cent). These have been presented in Table 23.

Table 23: Opinion of resident doctors who had not been exposed to violence about the impact of such violence*

	Per cent of residents who shared the opinion (n = 74)
Impact at a professional level	
Lost motivation at work	68.9
Started avoiding one on one interaction with patients and relatives	54.1
Started avoiding giving proactive advice to patients after that incident	54.0
Impact at a psychological level	
Developed anxiety about coming to work	60.8
Became fearful	56.7
Lost self-worth	50
Repeated memories of the incident	43.2
Started to feel sad	33.7
Felt chronic fatigue post incident	29.7
Avoided thinking about the incident	16.2
Coping post incident	
Participated in protests/ solidarity campaigns	55.4
Became vocal about violence against resident doctors	51.3

*This was a multiple response question.

Section E

This section notes the responses of the hospital administration towards the incident. It also documents residents' views on mechanisms that can help prevent violence as well as seeks to understand from them, the existing mechanisms for preventing, reporting and responding to such violence. In this context, the section also documents their opinion of using triage.

Subsections E.1 to E.4 are responses of those residents who have been exposed to violence (faced + witnessed; n = 119). All residents (exposed + not exposed) responded to subsections E.5 and E.6 (n = 193).

E.1. The response of the hospital administration towards the incident

In the event of an incident of violence against the resident doctors, it was important to understand the response of the hospital administration and what it could have done better; from the resident doctors' experience and perspective.

The administration displays a limited role in the case of an incident of violence. More than half the residents (58 per cent) said that the hospital administration had taken no action, 16.8 per cent reported that they were in fact blamed for the violence, 22.7 per cent also said that the hospital administration took the trouble to understand the incident in detail and 17.6 per cent acknowledged that they were also provided assistance in reporting the violence to the police. Hardly anyone reported any offer by the administration to provide counselling.

Table 24: The response of the hospital administration towards the incident*

	Frequency	Per cent of resident doctors who and shared the response (n = 119)
No action taken	69	58.0
Took initiative to understand the incident in detail	27	22.7
Provided assistance in reporting violence to police	21	17.6
Blamed you for violence	20	16.8
Offered to provide counselling	6	5.0

(Table 24 continued)	**Frequency**	**Per cent of resident doctors who and shared the response (n = 119)**
Gave paid leave for period when undergoing treatment/ recovery	3	2.5
Transferred you to another department as requested	3	2.5
Transferred you to other hospital, as requested	1	0.8

*This was a multiple response question.

E.2. Suggestions related to improving hospital administration responses

An analysis of the qualitative data shows that residents feel that they are the ones that often bear the brunt of infrastructure and administrative lapses. Notwithstanding this, neither the administration nor the seniors support the residents who are often blamed for the incident. Immediate response and stringent action against the perpetrators of violence by the administration was also found lacking. Several residents have opined that they should receive support in filing FIRs and be provided help in pursuing legal action. The administration needs to ensure better security and address security lapses. Residents also recommended the setting up of patient-friendly services and recognized the distress of the patients in difficult times compounded by poor organizational factors. Overall, residents have suggested that the hospital administration needs to take responsibility for the residents and support and trust them. Some responses:

> *"There should be a proper response from administration regarding what facility is available and what's not available especially ventilators and advanced life support equipment.....there should be a proper system in place for critical patient where they're given all the necessary care at one place including CT scanners and ultrasound, they shouldn't be made to roam around the hospital looking for various departments." - Senior Resident, Male*

> *"Prompt intervention at a senior level would have helped immensely. Unfortunately, in most departments it's the residents who are always portrayed as bad people[19]" - Junior Resident, Male*

[19] i.e. by seniors

E.3. Encouragement to report violence

Most residents felt that it was mainly the Maharashtra Association of Resident Doctors (MARD) and colleagues who encouraged them to report violence. The hospital administration, it was felt, provides the least encouragement.

Table 25: Encouragement to report violence by*

	Per cent of Resident doctors who have been exposed to violence (n = 119)
Maharashtra Association of Resident Doctors (MARD)	69.7
Colleagues	37.0
Family members	24.4
There is no encouragement to report violence	17.6
The hospital administration	13.4

*This was a multiple response question.

E. 4. Do the residents think the incident of violence could be prevented? If yes, then how?

Resident doctors feel that incidents of violence against them can be prevented.

Table 26: If the violence could have been prevented

	Per cent of resident's doctors (n = 119)
Yes	86.6
No	13.4

Through their qualitative responses, residents expressed that often patients and relatives come to hospitals with expectations of quick recovery and results, which are in practice, not possible. A better understanding between doctors and patients and their families, better communication by doctors and counseling of patients and relatives can go a long way in preventing violence.

Resident doctors also said that there was a lack of support from seniors. They needed better supervision and support from them.

Reasonable hours of duty, improved staffing and infrastructure are not just important to prevent violence and for the benefit of patients; but it would also motivate the residents to work hard for the patients. There is a need to increase awareness of the consequences of attacking doctors and the government needs to ensure the implementation of the law in order to prevent violence.

E.5. Preventing, responding and addressing the issue of violence against resident doctors

- *Procedures of reporting violence at the workplace*

  Most resident doctors have said that there are either no procedures to report violence or they do not know of such procedures (Table 27).

Table 27. Procedures to report violence

	Per cent responses by resident doctors who were exposed to violence (n = 119)	Per cent Responses by resident doctors who were not exposed to violence, but have an opinion to share (n = 74)
Yes	28.6	35.1
No	40.3	28.4
Do not know	31.1	36.5
Total	100.0	100.0

- *Mechanisms that could help prevent or respond to violence against resident doctor's versus mechanisms currently in place*

  Resident doctors have been emphatic in suggesting several measures: having security guards in place, CCTV cameras, restriction of public to certain areas of the hospital, having a gate pass system, effective hospital supplies and management system, human resource management duty allotment system to ensure allocation need based supply of human resource as and when needed (Phlebotomist, nurses, MPWs, ward-boys) and having emergency alarms.

  We also requested them to identify which of these systems are currently in place in the hospitals. Except for security guards and CCTV cameras, hardly any of the other systems existed; though a gate pass system seems to be present at some hospitals.

Table 28: Perspectives on what mechanisms can prevent violence versus those that presently exist*

	Mechanisms that that resident doctor's think can help to prevent / respond to violence against resident doctors (per cent) (n = 193)	Of these, mechanisms that presently exist at their hospitals (per cent) (n = 193)
Prevention strategies		
Gate pass system for patients for entry	86.0	42.5
Restriction of public access to certain hospital areas	82.9	15.5
CCTV cameras[20]	79.3	64.8
Human resource management duty allotment system to ensure allocation need based supply of human resource as and when needed (Phlebotomist, nurses, MPWs, ward-boys)	65.3	7.3
Patient help desk	62.7	11.4
Hospital supplies management system to ensure regular supplies to the hospital	61.1	5.7
Reduced periods of working alone	56.5	1.6
Counselling services for patients	56.5	3.1
Patient grievance redressal system	53.9	5.2
Adequate functional emergency medical response	53.5	4.7
Emergency preparedness plan (for mass casualties)	53.4	10.9
Training for violence prevention for residents (e.g. coping strategies, communication skills, conflict resolution)	50.8	4.7
Changed shifts or rotas (i.e. working times)	46.1	5.7
Staff grievance redressal system	43.5	5.2

[20] Could act as a deterrent

(Table 28 continued)	**Mechanisms that that resident doctor's think can help to prevent / respond to violence against resident doctors (per cent) (n = 193)**	**Of these, mechanisms that presently exist at their hospitals (per cent) (n = 193)**
Counselling services for doctors	42.5	3.1
Check-in procedures for staff (especially for home care)	36.3	5.2
Addressing once incident as occurred		
Security guards[21]	83.9	87.6
Emergency alarms	72.5	20.2
Regular presence of police personnel	65.3	15.0

*This was a multiple response question.

- *Perspective on triage and its role in prevention of violence*

  Triage is the process of screening patients to determine their relative priority for treatment and referral. It was found that the triage system was largely followed only during emergencies and major events.

Table 29a: About triage

	Per cent (n = 193)
At times of emergencies and major events	67.4
Not followed in the hospital anytime	23.8
Throughout the year as a formal system	8.8
Total	100

Only 28 per cent of residents felt that a formal triage system would be ineffective in preventing violence, and more than 50 per cent opined that the system can help manage crowds and enable more effective patient treatment (Table 29b).

[21] These could also act as a deterrent. As a prevention mechanism, security guards could prevent a potential incident if called in time or is alert to signs and risk factors. They can also intervene and help prevent escalation or intervene to stop the violent incident.

Table 29b: Triage system*

	Per cent of responses (n = 193)
Can help manage large crowds	53.4 per cent
Can help with more effective patient treatment	52.3 per cent
is in - effective in preventing violence against resident doctors	28 per cent

*This was a multiple response question.

The qualitative responses of residents helped us understand their experiences and perspectives on triage as a system. Relatives and patients did not understand the system and generally think that their patient's problem is more serious than those of others. Relatives want their patient to be treated out of turn and this can lead to friction as it can be seen as favouring some patients over others. Another concern was about the hindrance to the triage system when politically influential people demand that their kin be prioritised.

- *Perspective of resident doctors about long term strategies that can help prevent violence*

  Resident doctors' opinions were sought on policies that could help prevent violence.

Table 30: Long term strategies that can help prevent violence*

	Policies that can help prevent violence against resident's (per cent) (n = 193)
Protocols for protection of resident doctors	75.6
Making doctors aware about the legal aspects of such violence and their rights	72.0
Orientation of doctors towards the ethics of doctor-patient relationship	51.2
Palliative care for end of life patients and their families for better coping	35.2
Sensitization of doctors towards social determinants of health	34.1
None of the above	2.5

*This was a multiple response question.

Making doctors aware of the legal aspects of such violence and of their rights and protocols for protection were initiatives that responding doctors thought would be effective in preventing the violence. Sensitization of doctors on the social determinants of health and palliative care for end of life patients and their families for better coping were thought to be mechanisms that would be least effective in preventing violence.

- *Specific policies at the workplace in the context of violence against resident doctors*

  There were hardly any specific policies addressing violence at the workplace and in fact most residents were unaware of such policies.

Table 31: Presence of specific policies at the workplace*

	Per cent Responses by resident doctors who have been exposed to violence (n = 119)	**Per cent Responses by resident doctors who have neither faced nor witnessed, but have an opinion to share (n=74)**
I am not aware on any such policies	79.8	77.0
Policies for prevention		
Safety protocol for prevention of violence against resident doctors	12.6	18.9
Human resources training and capacity building for resident doctors	4.2	5.4
Post incident policies		
Policy to deal with violence faced by resident doctors once it has occurred	13.4	9.4
State sponsored mandatory health insurance scheme for resident doctors	2.5	1.3
Legal assistance system for resident doctors	2.5	5.4
Paid compensatory leave policy for treatment and rehabilitation of resident doctor who have faced violence on duty	1.7	1.3

(Table 31 continued)	**Per cent Responses by resident doctors who have been exposed to violence (n = 119)**	**Per cent Responses by resident doctors who have neither faced nor witnessed, but have an opinion to share (n=74)**
Institutional policy for free treatment and rehabilitation of resident doctor who face violence on duty	0.8	6.7
Institutional policy for financial compensation to resident doctor who faces violence on duty	0.8	2.7

*This was a multiple response question.

E. 6. Recommendations by residents on how to prevent violence against resident doctors from patients/relatives/escorts

We sought recommendations from resident doctors in the form of qualitative responses on how to prevent violence against resident doctors. A total of 93 resident doctors shared their opinion on the matter. The responses were analyzed thematically and grouped together across domains of recommendations.

1. *Earn respect again*

Residents recognized the need for increasing the accountability of the doctors towards patients and their relatives and for better care for patients. A senior resident doctor put it succinctly that there was a need to "earn respect again". This view was echoed by several residents who were keen to change the public's impressions of doctors in government hospitals. They were keen on working efficiently and encouraging people to see their good work. They also felt that keeping the relatives of the patients well-informed about the patient's condition and prognosis can go a long way in addressing their anxiety. Better communication skills, politeness and compassion were recognized as important. Training for better communication skills was also required, particularly in communicating bad news to relatives. Some responses of doctors:

"...The lack of training of doctor in handling relatives or the way in which he should declare death or communicate with relatives." - Senior resident, male.

"Proper communication skills... more patient centric attitude of doctors and other staffs.... helping patients than sending them from one OPD to another.... making them aware about their problem and its solution... listening to each patient... giving time to patients than to only achieve zero waiting time in the hospital and disposing off patient (as expected by hospital administration).... try to build up trust in doctor from OPD itself or primary care centers so that their frustration will not be shown on the night duty doctor in case of emergency...... doctors should not show tantrums or bad attitude to patients at any point of meeting... patients are poor and in pain... one should attend patient with empathy... out of all the most important is better communication..." Junior resident, female

2. *Role of seniors*

Some resident doctors felt strongly about the role of senior doctors in preventing violence and for being role models. The presence of senior doctors and their mentoring was recommended. Resident doctors also felt that often they are reprimanded in front of patients and that creates a bad public image of resident doctors.

"First of all, resident doctors should be respected by seniors especially in front of patients. This attitude of patients is mainly because they see senior doctors treating residents as shit worthless human beings.Even if they have done some mistake they should be reprimanded in privacy and not in front of patients." - Junior resident, female.

"Make a role model for them, if a junior doctor doesn't see senior doctor working or communicating to patients, how are they going to learn...." -Junior resident, female.

3. *Better public awareness*

Residents felt that there was a need to increase awareness among people about the work that they do and the conditions that they work under. Often, they feel that people fail to understand that there are limitations to what doctors can do and that patients do not trust doctors. This perception needs to change. There was also a need for patients to follow basic etiquette while in the hospital. For instance, tobacco chewing and alcohol consumption should be strictly prohibited.

"Awareness among the general public that doctors can't guarantee complete cure and cannot prevent unavoidable death, doctors try their best to cure the patient and the relatives should also co - operate for the same." - Junior resident, male.

"People coming to hospitals want instant effects of medication received or instant relief. They fail to understand that there is nothing instant with body, Healing takes time. Reduction of pain takes time and patience. People want everything instant like Maggi noodles. People need to understand this concept." - Junior resident, male.

4. *Accountability of media*

Several resident doctors felt that there was an unfair image about them, delivered by the media that often portrays a negative image of the medical sector and professionals. They are of the opinion that positive stories and their conditions of work should be highlighted as well.

5. *Adequate staff, equipment and infrastructure*

Residents have opined that there was a need to improve services and infrastructure at public hospitals. In emergencies, when there are several patients in serious need of care, arriving at the same time or when a piece of equipment is unavailable or out-of-order the situation can become grave. The lack of available doctors, nurses and other staff as well as of services, equipment and infrastructure increases residents' workload and leads to stress and frustration for relatives. Residents also opined that the condition of government hospitals (compared to private sector hospitals) may prompt people to take government doctors for granted.

"Government hospitals always lack even basic emergency drugs, many a times we find that we don't have basic anticonvulsant in LR (labor room) *when patient actually has one convulsion, and relatives are forced to buy it from medical store due to unavailability. If government hospitals are provided with proper supply of drugs, instruments, diagnostic facilities and infrastructure; distress of doctors, nursing staff and ultimately patients will be reduced. ...Adding to number of doctors and nursing staff will definitely help in management." - Junior resident, female*

6. *Role of the state government in monitoring on the ground situation*

Resident doctors are of the opinion that the government plays an important role preventing violence. This includes monitoring the situation on the ground. There is a need to meet

with the staff and residents of these hospitals in order to get an accurate picture.

"…hospital management and state health sector of government should understand the grassroot level conditions…not on paper that we have that much MRI machine and that much facilities available...we are working here 24 by 7.… we know technical issues… they should take periodic meeting at hospital spot to know about conditions of hospitals…superiors most of the time tell everything is going well where fact is not same.…I suggest a single minister or any intellectual person should come to hospital hiding identity and go through all procedures asking what are issues ..then they will understand it's not always a doctor who is responsible for such assault." - Senior resident, male

7. *Reducing overcrowding and restricting flow of relatives*

As in case of the quantitative responses, qualitative responses of resident doctors have identified overcrowding as a factor leading to violence. They have recommended strengthening of primary care services and effective referrals, which would reduce the burden on tertiary care hospitals. Other ways of reducing overcrowding, from their perspective, includes use of triage, restricting entry of relatives, streamlining patient services and crowd management facilities.

"1st strengthening of PHC, RH, AND SDH[22] so patient load distributes evenly." - Junior resident, male.

"There should be restricted entry of relatives to places like emergency unit, ICUs, etc., where high risk procedures are being done and where there is high risk of the patient deteriorating, as the relatives may see and misinterpret the treatment which is being done with good intentions. Only a maximum of 2 relatives to be allowed, as more the bystanders, more will be the difficulty in controlling them. Proper counsel and informed consent before starting any treatment/procedure is essential." - Junior resident, female.

8. *Training to prevent violence*

Residents understand that they need to be alert to potential situations of violence against them and be aware of what can be done in such situations. Several doctors advocated training for this.

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[22] Primary health center, rural hospitals and secondary district hospitals

"Meanwhile a doctor must analyze quickly and become alert if during the admission of a patient, the relatives are violent or talking rudely with the staff or they are present in crowd. In such scenario he must inform the security either personally or seek help from colleagues or staff or any person of hospital authority in the vicinity." - Senior resident, male.

9. *Need to address corruption and unethical practices in medicine*

Residents recognized the corruption and unethical practices prevalent in the medical profession. They were aware that this led to a lack of trust in doctors. Some of the doctors who were corrupt and engaged in unethical practices were creating a bad image for the profession. They should be pulled up and reported. Such doctors should not be allowed to practice.

"…Of course, the field has some persons who are corrupt and are spoiling the name of the entire profession. We have to watch over them, if the person is a close friend then we can counsel them. But yes, if something is blatantly immoral, unethical then it needs to be brought to the notice of law so that such persons are thrown out of the system..." - Senior resident, male.

10. *Better living conditions and working hours*

Resident doctors felt that better working hours, along with better working and living conditions could help in bringing down stress levels of the doctors, especially since they are faced with large patient load in public hospitals. They also linked better working hours to better communication with patients.

"….reduce working hours of residents. Working 16-18 hours a day is inhuman.…treat residents as human beings. Provide better facilities, accommodation so that they are relaxed while communicating with patients." - Senior resident, male

11. *Laws to be made more stringent*

Residents felt the need for stringent laws along with greater general awareness of such laws.

"...legislation to make doctor protection act stricter…it is useless in current form and not followed by police. Fast track such cases. There is no commitment by government towards this problem and most of the times politicians are the assaulters...patient

awareness about consequences of assaulting doctors ... media should highlight these issues rather than spreading hatred towards doctors." - Senior resident, male.

12. *Better security*

Security systems in hospitals need to be robust and supportive. These include guards, emergency alarms and CCTVs. Guards need to be trained and alert and available outside all departments with special focus on the more vulnerable departments. They should due their duty diligently.

"Security should be vigilant. Most of security guards are lying around purposelessly. They don't have a sense of responsibility." - Senior resident, male.

"Security requested not to report and solve amongst ourselves." -Senior resident, female.

13. *Patient help desk and patient counselling*

Residents felt that there was a need to counsel patients and relatives; particularly relatives of patients who are critical. However, they felt that doctors only had a limited scope to do this since time was a constraint. There should be special counsellors or patient kiosks to assist with the same. An information desk to help and guide patients around the hospital and provide information about services available, diagnostic tests and other aspects of the hospital was also essential.

"Effective communication by doctors goes a long way in preventing mishaps but this is limited by lack of time and extremely increased work load on doctors so a kiosk where all patients and their relatives are properly counselled at all times may be useful." - Junior resident, female.

CHAPTER V: Discussion

This study highlights the fact that violence against resident doctors is widespread and occurs routinely in public hospitals across Maharashtra. It provides an understanding of the nature of such violence, circumstances surrounding it, the response of various stakeholders and perspectives and experiences on various aspects of such violence.

Incidents of violence reported in our study most commonly comprised psychological abuse in the form of issuing threats and subjecting doctors to humiliation. Physical violence was noted in the form of pushing / shoving and slapping. The study also found that violence was most commonly perpetrated by 'groups' and these were chiefly family members and acquaintances accompanying the patient. Psychological violence has been found to be the more prevalent form of abuse reported in India and across the world. Several studies from developing countries have reported relatives as the primary perpetrators (Tomev et al 2003; Pinar et al. 2015; Abdellah and Salama 2017; Hu et al. 2017, Xing et al. 2015; Ori et al. 2014; Anand et al. 2016 and Madhiwala & Roy 2006). In fact, in the study by Pinar et al. (2015) in Turkey; there was a direct link between the incidence of violence and the number of relatives accompanying the patient.

Incidents of violence were most reported at the time of night duty. The emergency/casualty had the highest reported incidents of violence (31.1 per cent). Emergency department as a risk site was also identified in the study by Mayhew and Chapel (2003) and in Eker et al. (2012). In fact, in a study by Steinman (2003) it was found that the presence of a casualty/ trauma unit influences the level of violence at a facility. The present study also found that death of patients, and patients being brought to the hospital in critical condition leading to stress for relatives, were some of the key contributors to the context of an incident of violence. The emergency is not just a high stress area, but also a space where there are high emotions and patient volume, making it vulnerable to violence (Bukowski 2012; OSHA 2016).

However, it was also found that these episodes of violence were not restricted to just night duties, the emergency department or for critical emergencies and bereavement. In our study, 21.8 per cent of the residents had reported that the case under treatment at the time of violence was a routine or a regular medical case. Thus, it is not only critical cases or death of a patient that can lead to violence. This is an important and a worrying finding of this study.

System related and organizational factors were also found to contribute to violence. Thus, an interplay of several factors was believed to have come together in the context of the incident. System related factors more commonly identified as having led to violence were overcrowding, long waiting time for patients and relatives, lack of equipment and drugs, and lack of trust in doctors. This is true for routine cases as well, and not just high distress cases. Organizational factors contributing to violence were also commonly reported in various studies, particularly in situations where families and acquaintances (as is the case in our study) were the perpetrators of violence (Mayhew and Chappell 2003; Tomev et al. 2003; Sripichyakan et al. 2003; Deeb 2003; Pal·cios et al. 2003; Steinman 2003; Anand et al. 2016).

Given the several risk factors identified, the resident's opinion about triage and its use are important. The majority of the residents have opined that triage can help prevent violence and about half of them have also said that it could help manage crowds and contribute to effective patient treatment. This way, to some extent, it can also address the above system level factors that, in the resident's perspective, had contributed to violence. However, only 8.8 per cent of the residents have reported that triage is followed the whole year around as a formal system. Most residents (67.4 per cent) said that it was only followed at the time of major events or emergencies; and 23.8 per cent that it is not followed at any time in their hospital. The limited use of triage in public hospitals is a matter of concern particularly in the context of overcrowded emergency departments and shortage of drugs, equipment and staff.

Further, as a result of the public health sector facing acute and chronic shortage of medicines and equipment, the cost of care at public hospitals as a result of the rise in out-of-pocket expenses is high (Selvaraj, Farooqui & Karan 2017). In this context, while 32 per cent of the respondents have identified lack of equipment and drugs as one of the factors leading to violence, cost of care has not been identified commonly as a contributing factor (3.4 per cent).

Besides working under infrastructural constraints, the working hours of residents are also long. Majority of the residents had shared doing double shifts and nights shifts 1 - 3 times a week with the duration of each shift more often being 12 hours or more. Importantly, 87 per cent reported double shifts and 91 per cent had night shifts more than once in a week.

Despite long hours of work, colleagues were found to be supportive at the time of incidents of violence and calling a colleague was an important immediate response of the residents.

Colleagues have largely helped by contacting security on duty and intervening in the incident by telling the perpetrator to stop. This also clearly reflects what has emerged from the present survey. In the absence of violence prevention protocols and policies, and the limited response of the administration in the context of violence; calling a colleague comes across as a more reliable option.

Calling a senior, on the other hand, was not so common with just over one-fourth of residents choosing to do so. With residents reporting bias of seniors against them in the context of incidents of violence; as well as in terms of the fact of the lack of actual availability of seniors at night, when most incidents were found to have taken place. Residents have also opined that hospital administrations too need to respond to their needs. Moreover, 58 per cent of the residents have reported that the hospital administration took no action, 16.8 per cent said that they were in fact blamed for the incident and only 13.4 per cent reported that the hospital administration encouraged them to report the incident. The lack of action by the hospital administration towards such incidents and their lack of interest is a matter of concern as inaction contributes to condoning of such incidents.

It is a matter of concern that more than half the residents have said that it is of no use reporting such incidents indicating that they feel nothing would change and nor do they expect the hospital to take action. Residents have shared that they are often blamed for such incidents and are looked down upon by seniors and hospital administration when they complain about patients. In a study in Lebanon (Sripichyakan et al. 2003), a similar context was found to have led to very low reporting of incidents of violence. An unsupportive administration in this context, as reported in the study, further creates a difficult working environment for the residents. Moreover, nearly 30 per cent of the residents have also shared that there were no procedures to report violence and / or that they were not aware of such procedures. There were no safety protocols for prevention and addressing of violence against resident doctors; no specific insurance schemes, nor institutional policies for free treatment and rehabilitation of resident doctor who face violence on duty or for financial compensation. There were also no policies in place for legal support for resident doctors. Identification and formulation of policies and procedures require accurate incident reporting to begin with (Campbell, et al. 2015). Reporting of incidents, in turn, are linked to conducive environments, particularly marked by trust and encouragement to report violence along with policies and procedures specifically for the purpose. One without the other, therefore, is difficult to achieve. The role of the hospital administrations and of seniors is thus pivotal in preventing and addressing such

abuse and absence of supportive environment, policies and protocols are an important organizational risk factor in itself leading to violence (OSHA, 2016).

In terms of impact of violence on the residents, findings of the present study were in line with evidence at the international and national levels. Violence directed at health care providers results in psychological impact and professional outcomes (WHO 2014; Hobbs & Keane 1996; Schnieden 1993; Morrison et al. 1998; di Martino 2002; Vanlalduhsaki et al. 2018 and Anand et al. 2016). Residents have reported having felt anxious and afraid. It also affects the doctor-patient relationship as residents have reported loss of motivation at work and even to distancing themselves from patients and refraining from offering proactive advice to patients and relatives. A large number of residents have reported participating in protests against such violence.

As noted, the study points to a critical gap, viz., the absence of formal mechanisms and policies to prevent and address violence directed at residents. The importance of having policies in place to deal with workplace violence cannot be better underlined than by its requirement in new ILO treaty of 21st June 2019 (HRW, 2019) (See Annexure 3). Countries that ratify the treaty, will be obligated to not just promulgate such laws, but also take preventive measures such as information campaigns and ensure institutions have workplace violence policies in place, undertake risk assessment and training. In terms of mechanisms, residents have identified having security guards, CCTV cameras, restriction of public to certain areas of the hospital, having a gate pass system, effective hospital supplies and management system, better human resource management, emergency alarms; etc. About half the residents were also of the opinion that reduced periods of working alone, having a functional emergency medical response in place, training for violence prevention for residents, emergency preparedness plan (for mass casualties), patient grievance redressal system as well counselling services and the same for doctors; would help prevent violence. However, what the study revealed was that except for security guards and CCTV cameras, and to some extent, a gate pass system; the rest were reported to be almost non-existent across public hospitals in Maharashtra.

In this context, an important finding of the study was also the ineffectiveness of limited measures, particularly if implemented inadequately, in preventing violence. Specifically, these include security guards and CCTV cameras. In this study, 87.6 per cent of all residents who had responded to the survey had reported that security guards were present in the public hospital where they worked and 74.8 per cent of the residents who had been exposed to violence had reported calling out security guards at the time of an incident. However,

violent incidents had not really been prevented and presence of security was also not a deterrent. Moreover, of all residents who had responded to the survey, 83.9 per cent of them also felt that the system of deploying security guards is one of the many mechanisms (the most identified one) that could help prevent and manage violence. While more evidence is needed to understand the effectiveness of security guards for prevention and management of violence, it is a fact that generally, security is an ad hoc affair in many hospitals. The guards may not have had adequate training in either physical or interpersonal skills; and inept handling could worsen the situation. The adoption of any system, even of CCTV cameras and emergency alarms, also need training and monitoring for most effective use (Richards, 2003). Moreover, security system by themselves cannot prevent violence. So, while security guards, CCTVs and alarm systems are useful, they should be part of a package comprehensive measures (Richards, 2003).

Residents have also highlighted the need for better communication, empathy, time and patience for patients and their relatives. This is particularly relevant as lack of trust in doctors was identified by more than a quarter of the residents as a factor leading to violence. As Dr Supe (2017) had noted, "The number of guards at hospitals will increase. Security measures will be beefed up. However, unless mistrust, miscommunication and misperceptions are taken care of, attacks on doctors, will not stop completely. The medical profession needs to look at itself to bridge the social disconnect between society and medical profession. That is the need of the hour". This too is an important dimension of the issue and is reflected in the perspectives of the residents of study.

The present study provides critical information through the reported perspectives and experiences of resident doctors about the context and characteristics of the phenomenon of violence directed at them by patients and/or relatives and/or escorts in public hospitals in Maharashtra. The study defines several essential components towards building a response to address the issue. It highlights the need for comprehensive deliberation to prevent violence and address the issue in a manner that is holistic and as well as sustainable in its approach.

CHAPTER VI: Recommendations

A complex interplay of factors was found to have led to incidents of violence by patients and relatives against the resident doctors working in the public sector. With incidents of violence against doctors continuing unabated, such incidents reflect a deeper crisis in the health sector; and a consequence of a policy climate that directly affects the state of the sector, its functioning and the consistently poor resources made available for it. The violence itself exacerbates the crisis, with the residents at the centre of it. Residents are the ones at the forefront, working in highly deficient and difficult contexts, making them most vulnerable. A positive and safe working environment for them is critical to the well-functioning of the medicare system. Incidents of violence against resident doctors have to be dealt with seriously and comprehensively for effective prevention, response and impact mitigation. It requires using a systemic approach and eschewing an ad hoc one that renders the residents even more vulnerable, caught as they are between the patients and a non-responsive administrative system.

Violence prevention strategies and protocols as well as post incident responses need to be evolved contextually and comprehensively. All impediments that prevent implementation should be dealt with. The role of the hospital administration and the state is critical on this front. We highlight below some of the elements of a comprehensive policy to prevent such violence.

Strategies to address overcrowding: A gate pass system and restricted patient entry to specific areas of the hospitals should be implemented and no more than two relatives should be allowed to be with the patient at any time. Strengthening of the public health sector, primary health care and referral systems are also essential.

Triage as a regular protocol in hospitals: A triage system is a standardized way of determining the relative seriousness of the patient's condition and his/her most critical needs and prioritizing patients based on these. As the resident doctors have pointed out, if applied systematically the system will be effective in managing crowds, ensuring efficient and better patient care and in so doing mitigates the conditions that may be leading to violence. It is imperative that the system is followed routinely in all hospitals.

Security measures: Security measures such as guards, CCTV cameras, emergency alarms, etc., need to be put in place. However, these should be a part of comprehensive strategies and policies to deal with violence in the heath sector and be accompanied with relevant

training and response protocols.

Special measures for high risk zones: The Emergency / Casualty, Pediatrics and General Medicine departments have been identified as common sites of violence against resident doctors. It is essential that special efforts are made to introduce measures to address the risk factors in these departments. These could include additional security and consistent presence of seniors along with strict implementation of gate pass system and restriction of movement of relatives in these areas.

An effective and well implemented hospital supplies management system: There should be an effective procurement and management system to make available an uninterrupted supply of medicines and essentials.

Training for residents: Residents need to be made aware and trained in using violence prevention strategies and protocols as well as post incident response and protocols in order to facilitate their optimal and effective use. These could include, but are not limited to, training in empathetic and improved communication, ethics of medical practice and conflict resolution skills. Residents agree that they need to deal with patients and their families with patience and empathy and that the families and attendants should be kept informed about the patient's condition and prognosis. Details and options regarding treatment need to be shared so that they are able to take a well-informed decision on the way forward.

Better working hours and living conditions: Better working hours, along with better working and living conditions for residents could help them manage work-related stress, consequent upon the huge patient loads in public hospitals, better.

Availability and presence of seniors at critical and sensitive times: A senior doctor, trained to disclose sensitive news and information, should be present at thetime of declaration of death of a patient as well at times of critical communication of prognosis. Residents should also be mentored by seniors on communication skills at critical times and offered relevant training. Moreover, as a majority incident have occurred at the time of night duty, the availability of seniors at this hour is pertinent.

Provision of post-violence counselling and treatment to residents: Post incident policies and protocols need to include counselling, treatment and rehabilitation of residents. Service rules need to be amended suitably, such as granting additional leave for recovery (these should not be cut from the residents existing official leave), etc.

Institutional environment to encourage support for residents at times of violence: The hospital administration should encourage residents to report violence and ensure that every resident is provided support and each incident of violence reported by them is investigated. Even investigation of incidents that could have turned violent can contribute to understanding what led to and prevented a potential situation from escalating (OSHA, 2016).

Hospitals should be declared as violence free zones : This involves putting in place clear messages across the premises that announce that violence will not be tolerated in the premises and the consequences of such violence to those who perpetrated it. There should also be messages pertaining to the Maharashtra Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage or Loss to Property) Act, 2009 displayed across the premises.

Amendment and strategic implementation of the Maharashtra Medicare Services Persons and Medicare Service Institution (Prevention of Violence and Damage or Loss to Property) 2009: In the United States, several state legislations around workplace violence require employers to have comprehensive workplace violence prevention programmes (McPhaul et al. 2013). This is not the case in India, and therefore the above Act needs to be amended across states so that it becomes the hospital administrations legal responsibility for provision of such policies. Moreover, the hospital administration is responsible for the safety and security of the residents for any violence that might have occurred on their premises and associated with their work. Therefore there should be a move towards filing an institutional first information report (FIR) rather than leaving it to the individual doctor (See Annexure 3). These provisions should also be made a part of the central Act, which is presently in its draft form.

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Annexure 1

Who are Resident Doctors?

Resident doctors are students who are doing their post graduate studies (junior residents) or super specialization (senior residents). They are the frontline workers, the first point of contact between the people and the health system. The graduate course for medicine spans across four and a half years followed by one year of internship. This marks the end of graduate studies for students from private medical colleges. However, for those graduating from government medical colleges, they are further required to serve a bond for a year in rural areas. If they do not wish to serve this bond, they need to pay the bond amount. Following this, they get their Bachelor of Medicine and Bachelor of Surgery (MBBS) degree or Bachelor of Dental Surgery degree (BDS). For the purpose of their post graduate studies (degree and diploma), they need to give the National Eligibility cum Entrance Test (NEET), which also needs to be given to seek admission even at the graduate as well super specialty stage. Once a student enters the post graduate degree or diploma course, she/he is called a Junior Resident (JR) Doctor. The degree course spans a period of three years; and the diploma course, two years. The resident hence holds the ranks of JR1, JR2, and JR3. They may also be called Resident Medical Officers (RMO) or House Officers (HO). Once this is complete, there is another one year of compulsory bond on completion of which, the students receive a Doctor of Medicine (M.D) or Master of Surgery (M.S) degree; and those who have completed diploma obtain a PG Medical Diploma. Students from private colleges do not have such a requirement of fulfilling a bond period. However, from academic year 2019 - 20 in the state of Maharashtra, post-graduates from government institute have to complete their Post PG bond first before joining to super specialty. No such criteria for private post graduate students and other state students.

Some of the courses at PG level are terminal branches, e.g. community medicine, radiology, or obstetrics and gynecology. If students from these courses wish to study further, they can pursue fellowships, e.g. fellowship in Preventive Radiology, preventive oncology, etc. However, some can opt for super-specialties such as D.M. Medicine in Medical Gastroenterology, or M.Ch. (Magister Chirurgiae; Master of Surgery) e.g. M.Ch. in Plastic and Reconstructive Surgery. These courses span three years. In these three years, students hold the title of Senior Resident, and hence are SR1, SR2, and SR3; in the first, second, and third years of post-graduate studies respectively. Following this, doctors

from government colleges are required to complete a period of bonded service for two years in a government college; this bond is valued at Rs 2 crore. Doctors from private colleges do not have this requirement.

Annexure 2

Some cases of attacks on doctors documented in the media

25 September 2015, Pediatric ward, KEM Hospital, Mumbai: Relatives of a three-year-old attacked three doctors beating them with wooden sticks and hospital chairs at the death of a child due to dengue.[23]

6 April 2015, Lifeline Hospital, Panvel: Woman died after receiving treatment and relatives of a the 75-year-old patient broke doctors' nose and he had to be admitted to the intensive care unit (ICU).[24]

Date unknown, Rajawadi General Hospital in Ghatkopar, Mumbai: An auto driver who was brought in late at night with a head injury died. Relatives and friends threw chairs on doctors. Family had to run to look for a stretcher.[25]

18th March 2017 Nashik General Hospital: Mob attacks doctors and nurses after death of patient brought in critical condition suffering from swine flu.[26]

June 2017 Relatives Dhule Civil hospital, Maharashtra: A patient was referred to another hospital due to unavailability of the specialty at Dhule. Patient subsequently died and his furious relatives returned to the Dhule hospital and attacked doctor accusing him of fatally delaying treatment. He was punched and kicked and suffered several fractures including damage to his eye socket that threatened his vision.[27]

March 18, 2017. Rajiv Gandhi Government General Hospital, Chennai: House surgeon allegedly roughed up by relatives of a student when they were asked to come meet him one by one rather than crowding the ward.[28]

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January, 2017 Gandacherra sub-divisional hospital: Attacked by people of MLA. Doctor had received a call for an ambulance which was sent. However, it was alleged that it was not sent.[29]

March 2018 DY Patil, Pimpri, Maharashtra: Relatives alleged negligence resulting in death of patient. A resident doctor was assaulted with a scalpel and a few paramedics were roughed up by 30 - 40 relatives.[30]

April, 2018 Indira Gandhi Government Medical College and Hospital, Nagpur: Relatives of a 6-year-old patient who had died in the ICU had attacked with knives. Security guards were hurt and hospital equipment was damaged.[31]

20th May 2018 JJ Hospital, Mumbai: 3 - 4 relatives vandalized the female ward and assaulted two doctors at the death of a patient claiming they were not satisfied with medical care provided.[32]

June 2018 Government Stanley Medical College Hospital, TN: Patient found it painful as doctor tried to insert an intravenous line for which he was assaulted by relative.[33]

March 13, 2019 Sawai Mansingh Medical College, Jaipur: A female resident doctor was attacked by attendants of patients. She was kicked and her hair was pulled, she hid in the bathroom traumatized. The 80-year-old patient was referred from another hospital, and the female resident was finishing the formalities of the transfer when the attendants began abusing.[34]

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[33] Rao, M. (June 19, 2018). Fear among doctors in Chennai Hospital after patient slaps house surgeon. The News Minute. https://www.thenewsminute.com/article/fear-among-doctors-chennai-hospital-after-patient-slaps-house-surgeon-83301

[34] Garima. (March 13, 2019). Patient attendant attacks female doctor, pull her hair: 2500 resident doctors go on strike. Medical Dialogues.https://medicaldialogues.in/patient-attendants-attack-female-doctor-pull-her-hair-2500-resident-doctors-go-on-strike/

June 2019. NRS Hospital, Kolkata: The family of the deceased patient attacked an intern leading to serious injuries.[35]

July 15, 2015 Nair Hospital, Mumbai: The incident took place in the medicine ward when about 15 relatives of a patient who had died attacked three residents by pushing and slapping them.[36]

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[35] Scroll Staff. June 11, 2019. West Bengal: Junior doctors in state - run hospitals go on strike after alleged attack on colleague. Scroll.in. https://scroll.in/latest/926675/junior-doctors-at-a-kolkata-hospital-on-strike-after-family-of-deceased-patient-attacks-a-colleague

[36] Debroy, S. (July 15, 2019). Three Nair Hospital Doctors attacked by kin of patient. The Times of India.https://timesofindia.indiatimes.com/city/mumbai/3-nair-hosp-docs-attacked-by-kin-of-patient/articleshow/70220257.cms

Annexure 3

The Maharashtra Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage or Loss to Property) Act, 2009; case laws and other actions

Maharashtra was the first state to enact this landmark legislation. This was following the lead taken by the then Dean of JJ Hospital, Dr T. P. Lahane to prevent attacks on health care providers and institutions.

The Act aims to provide for -

- Prevention of violence against medicare service persons
- Prevention of damage or loss of property for medicare service institutions

Medicare service institution includes both public and private health care services as well as mobile units and camps. It also includes mental health care institutions and homes for convalescents. Property can be movable or immovable, owned by the Medicare institution or in possession of the medicare institution.

A medicare service person includes a registered medical practioner, registered nurse, medical student, nursing student and paramedical worker. It also includes any other worker employed by a medicare service institution.

The Act defines violence as any Act which "causes or may cause any harm, injury and endangering the life of, or intimidation, obstruction or hindrance to, any Medicare service person in discharging his duty in a Medicare service institution or causing damage or loss to the property in a Medicare Service Institution.

Penalty and compensation: imprisonment that may extend up to 3 years and fine that may extend up to fifty thousand rupees. Is also liable to pay compensation twice the amount of damage or loss caused to property.

It is a cognizable offence (police officer has the authority to make an arrest without a warrant and to start an investigation with or without the permission of a court) and a non - bailable offence. This means that the arrested person has to make an application for bail before a magistrate or court. Bail is a matter of right if the offence is bailable and is a matter of discretion if the offence is non-bailable.

It is triable by Judicial Magistrate first class. The Act also authorizes the state government to set up an authority to look into grievances of medical negligence.

Case laws and other actions:

Convictions under the Act: Till date there has been only one conviction under the Act. In December 2018, relatives of a patient who had attacked a doctor and vandalized the Talasari primary health center, were sentenced to one-year rigorous imprisonment and a fine of Rs. 500 each.[37]

Institutional FIRs: In April 2019, a circular was issued by the Government of National Capital Territory of Delhi, where in it directed all Heads of Departments of hospitals and medical institutions that in case of any incident involving abuse or violence by patients or their attendants, an FIR / complaint needs to be filed by the concerned hospitals / institutions. It strongly stated that these no doctor or staff that has been abused should be asked to lodge a First Information Report (FIR) on an individual basis.[38]

Under the Uttarakhand Medicare Service Persons and Institutions (Prevention of Violence and Damage to Property Act, 2013, the Honorable High Court had ruled that it is the responsibility of the state government to protect the lives of doctors on duty: Dr. Kumar, a pediatrician, was killed in the April of 2016 at a Combined Health Center, Jaspur, Uttarakhand; by relatives of a patient. The High Court ruled[39] that the state government was "remiss in implementing the provisions of the Uttarakhand Medicare Service Persons and Institutions (Prevention of Violence and Damage to Property Act, 2013. It is the duty cast upon the State Government to protect the Medicare Service Persons and Institutions throughout the State of Uttarakhand." The High Court also ruled that it was the duty of the state government to protect the lives of the doctors on duty as per the law, failing which, would amount to negation of the rule of law and negligence. The state government was asked to compensate the wife of the late doctor an amount of Rs 2 crores, along with pension and a government job for the elder child. Importantly, the state government was directed to enforce the Act in letter and in spirit and was found negligent in having done so in the context of the case.

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[37] The Times of India. December 2018. Mumbai: 13 get 1-year rigorous imprisonment for assault on doctor in public hospital. https://timesofindia.indiatimes.com/city/mumbai/mumbai-13-get-1-year-rigorous-imprisonment-for-assault-on-doctor-in-public-hospital/articleshow/67201827.cms

[38] Hindustan Times. April 2019. Hospitals told to register Institutional FIRs over violence against docs, staff. https://www.hindustantimes.com/delhi-news/hospitals-told-to-register-institutional-firs-over-violence-against-docs-staff/story-pQUpyDSxdhd7s4uBQD6aOP.html

[39] *Sarita Singh vs State & Others* on 12 September, 2018. Writ Petition (S/B) No.284 of 2017. Reserved on: 08.08.2018. Delivered on: 12.09.2018. https://indiankanoon.org/doc/60733795/

Giving necessary police protection: In *Dr. Uma Sundari. N vs State* on 14 August, 2015 (Madras High Court), the court ruled that in the situation where in there may be the possibility of a threat from disgruntled relatives of a patient, "necessary Police protection may also be afforded to the petitioner's hospital, so that no untoward incident takes place."[40]

The purpose of the Act was to check incidents of violence against doctors: in *Rakesh Makkar vs State of Haryana* on 15 July, 2011 the court noted that the purpose of the act was to check incidents of violence against doctors and damage to property. Further, considering the seriousness of the allegations (window panes were smashed and doctors and staff were threatened with dire consequences); the case was not considered fit for granting pre - arrest bail.[41]

Suo Motto action by the Bombay High Court, 2014: In 2014, the Bombay High Court in a suo motto action and asked the state government to issue a circular that leading to sensitization of the police on the Act and invoke the same in case of assault on doctors. Moreover, it also asked the government departments concerned to issue the notification for setting up of a committee for redressal of grievances of victims of medical negligence by March 31 of that year.[42]

IMA demand

In 2017, the Indian Medical Association (Maharashtra) demanded that the Act should be made a part of police training as police were not aware of the same.[43]

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[40] *Dr.Uma Sundari.N vs State* By on 14 August, 2015. Crl.OP No.20431 & 20362 of 2015 14.08.2015https://indiankanoon.org/doc/9693121/

[41] *Rakesh Makkar vs State Of Haryana* on 15 July, 2011. In The Punjab And Haryana High Court At Chandigarh. Crl. Misc. No. M-12112 of 2011 (O&M). https://indiankanoon.org/doc/191255447/

[42] Indian Express. 2014. Assault on doctors: Ask cops to use special Act, HC tells govt. https://indianexpress.com/article/cities/mumbai/assault-on-doctors-ask-cops-to-use-special-act-hc-tells-govt/

[43] Deshpande, M. 2017. Include Doctor's Protection Act in Police Syllabus, says IMA president of Maharashtra. May 23. 2017. My Medical Mantra.
http://www.mymedicalmantra.com/include-doctors-protection-act-in-police-syllabus-says-ima-president-of-maharashtra-unit/

[44] Marapakwar, P. Maharashtra govt set to slap anti-strike law on medical colleges. 2018. http://timesofindia.indiatimes.com/articleshow/66047212.cms?utm_source=contentofinterest&utm_medium=text&utm_campaign=cppst
https://timesofindia.indiatimes.com/city/mumbai/maharashtra-govt-set-to-slap-anti-strike-law-on-medical-colleges/articleshow/66047212.cms

[45] DNA correspondent. 2018. Maharashtra Essential Services Maintenance Act unfair to us, pleads MARD. October 17. 2018. https://www.dnaindia.com/mumbai/report-maharashtra-essential-services-maintenance-act-unfair-to-us-pleads-mard-2672448

MESMA, 2011

In October 2018, there was a move by the Maharashtra states medical education department to bring medical teachers and officers, resident medical officers and nursing staff under the purview of the Maharashtra Essential Services Maintenance Act (MESMA), 2011. However, it has been argued by resident doctors that applying MESMA to their mass leaves is not right as they are doing so in demand for a safe working environment in the context of the attacks that have been happening with some regularity. Without the government fulfilling its promises, such an imposition was not fair. MESMA is applied for six months, and when the stipulated time period is over, a fresh proposal is sent to the government. MESMA is invoked to protect the common man's rights. And to ensure that essential services are not affected. These services cover public health. However, there is an ongoing appeal against the application of MESMA on resident doctors.

Security audit

Following the attack on the resident doctor in Dhule in March 2017, the government proposed that security audits of all public hospitals will be conducted by an expert within fifteen days. To start with; 1,100 new armed guards were to be posted at public hospitals across the state. Measures like CCTV monitoring, restriction on number of visitors, special security measures at sensitive places like the Intensive Care Unit, Operation Theatre, Emergency Care or Casualty department etc., were to be put in place immediately. Some of these measures have been undertaken.

ILO Treaty, 2019

On the 21st of June, 2019; the International Labor Organization (ILO) adopted a ground breaking global treaty aimed at improving protection for workers facing violence and harassment at the workplace and it includes violence by third parties such as clients. If India, which is a founder member of the ILO, ratifies this treaty, it will be obligated to not just have laws; but also take preventive measures such as information campaigns and ensure institutions have workplace violence policies in place, undertake risk assessment and training (HRW, 2019).

Annexure 4

Resources for the prevention and management of workplace violence

1. Occupational Safety and Health Administration (OSHA). 2016. Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers. U.S. Department of Labor Occupational Safety and Health Administration. https://www.osha.gov/Publications/osha3148.pdf

2. Occupational Safety and Health Administration (OSHA). 2015. Workplace violence in health care. Understanding the challenge. https://www.osha.gov/Publications/OSHA3826.pdf

3. Occupational Safety and Health Administration (OSHA). 2015. Caring for our caregivers. Preventing Workplace Violence: A Road Map for Healthcare Facilities. https://www.osha.gov/Publications/OSHA3827.pdf

4. Occupational Safety and Health Administration (OSHA). 2015. Workplace violence prevention and related goals. The Big picture. https://www.osha.gov/Publications/OSHA3828.pdf

5. Crisis Prevention Institute. 2016. CPIs top 10 de-escalation tips. https://www.jointcommission.org/assets/1/6/CPI-s-Top-10-De-Escalation-Tips_revised-01-18-17.pdf

6. The Joint Commission. Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation. Oakbrook Terrace, IL: The Joint Commission, Nov 2012. http://www.jointcommission.org/.

7. Department of Health and Human Services. Centers for Disease Control and Prevention National Institute for Occupational Safety and Health. 2004. Workplace Violence Prevention Strategies and Research Needs Report from the Conference Partnering in Workplace Violence Prevention: Translating Research to Practice November 17-19, 2004, Baltimore, Maryland. https://www.cdc.gov/niosh/docs/2006-144/pdfs/2006-144.pdf?id=10.26616/NIOSHPUB2006144

8. The Workplace Violence Toolkit by the Emergency Nurses Association (2010). https://www.ena.org/docs/default-source/resource-library/practice-resources/toolkits/workplaceviolencetoolkit.pdf?sfvrsn=6785bc04_28

9. CUPE Research JULY 2018. ON GUARD FOR PUBLIC HEALTH SECURITY. CUPE Local 5430 Submission to Saskatchewan Health Authority regarding the Review of Health Security Services. https://www.cupe5430.ca/images/news/2018/Submission_Review_Health_Security_Services_2018_06_27.pdf

10. International Labour Office/International Council of Nurses/ World Health Organization/Public Services International. 2002. Framework Guidelines for Addressing Workplace Violence in the Health Sector. Geneva, International Labour Office, 2002 ISBN 92-2-113446-6 https://www.who.int/violence_injury_prevention/violence/interpersonal/en/WVguidelinesEN.pdf

11. American Federation of State, County and Municipal Employees. 2006.Workplace Violence: A union Issue. Second edition. https://www.afscme.org/news-publications/publications/for-leaders/pdf/Preventing_Workplace_Violence.pdf

Centre for Enquiry Into Health And Allied Themes

CEHAT is the research centre of Anusandhan Trust, conducting research, action, service and advocacy on a variety of public health issues. Socially relevant and rigorous academic health research and action at CEHAT is for the well-being of the disadvantaged masses, for strengthening people's health movements and for realizing the right to health care. CEHAT's objectives are to undertake socially relevant research and advocacy projects on various socio-political aspects of health; establish direct services and programmes to demonstrate how health services can be made accessible equitably and ethically; disseminate information through databases and relevant publications, supported by a well-stocked and specialised library and a documentation centre.

CEHAT's projects are based on its ideological commitments and priorities, and are focused on four broad themes, (1) Health Services and Financing (2) Health Legislation, and Patients' Rights, (3) Women and Health, (4) Violence and Health.

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