Violence against doctors: a multisystem failure

Gautam Ganguly

The malady of violence against doctors has regrettably become more frequent. The recent incident of two doctors getting brutalized in Kolkata led to a widespread strike paralysing healthcare. There appears a distinct apathy against doctors across the society, including government and judiciary. The deteriorating doctor–patient relationship has become complex with multiple facets: patients, junior doctors, consultants, hospital administration, patient's relatives and the Government. Rising healthcare cost, significant difference in the standard of care between public and private hospitals, lack of an effective central regulatory authority and poor communication skills are contributing towards growing dissatisfaction. The doctors, being the face of the healthcare system, bear the brunt of the patient's ire. A concerted effort by all stakeholders, including the Government, doctors and industry towards modernizing public hospitals, providing universal health coverage and regulating pharmaceutical industry pricing are necessary to rectify the deficiencies in healthcare, which is an essential component of economic development. This assumes more importance as the country has to meet the United Nations' and World Bank's target of eliminating poverty by 2030, and also the vision of the present Government of making India a developed economy.

Keywords. Healthcare, communication skills, doctor–patient relationship, universal health coverage, violence.

'Two roads diverged in a wood, and I,
I took the one less traveled by,
And that has made all the difference'

–Robert Frost

AN oft repeated couplet for the accomplished lot, including doctors who have reached the pinnacle of their profession. But on second thought, have we made the difference that we were entrusted with?

Recently, the malady of mob mentality raised its ugly head again when two young doctors in a public hospital in Kolkata were brutalized by frenzied relatives of a patient. The fallout strike by resident doctors paralysed an already fledging healthcare inviting comments and retorts. Everyone worth one's salt had a viewpoint. One comment which made me go through the Hippocratic Oath once again and also that of Indian defence forces was 'Soldiers and policemen die in line of duty but they don't go on strike'. The soldier's oath says '…I will observe and obey all commands…even to the peril of my life'. The Hippocratic Oath emphasizes 'I will use treatment to help the sick according to my ability and judgement…but never with a view to injury and wrong doing'. Nowhere a doctor is expected to get injured or die in his line of duty. It can be anything but his professional hazard.

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The violence against doctors is not new. Unfortunately, every now and then such incidents occur. I have seen social outrage following crime against children, women and ethnic minority. Sometimes it has changed the course of the society. But I do not remember any such spontaneous protest by society for crime against doctors. Debates in the media are always on 'adverse outcome and high cost of healthcare', but never about crime against healthcare professionals.

The recent Supreme Court comment ('…We cannot protect doctors at the cost of other citizens…') is a word of caution[1]. Though it should be interpreted in the full context, but nevertheless it is a reflection of society's perception about doctors. Why this apathy towards doctors? Why is death/adverse outcome always considered due to negligence? I reiterate the Hippocratic Oath '…to the best of my ability and judgement'. Why would a normal person, least of all a doctor, harm another?

In today's changing social environment, the doctor–patient relationship is at its lowest ebb. It is no more just two sides of a coin, but a complex cube with six facets: patients, junior doctors, consultants/faculty, hospital administration, relatives including onlookers and the Government. Add to this, media – the fourth pillar, as the watchdog. In the past such violent intimidations were reported, condemned according to protocol by lawmakers and medical fraternity, and forgotten. This time however, the outrage amongst our fraternity was more elaborate and cohesive (social media; Amen). Is it the prophecy of Gopal Krishna Gokhale about Bengal coming true, or is it

because an intern who was working under vicarious liability, got assaulted? Was it necessary for an intern to put his life on the line to nudge our conscience? Did we over the years allow the system to degenerate to an extent that we are now facing our own Frankenstein's monster? To answer these questions, we need to take a look at all the facets of the so-called complex cube if we seriously want to make a paradigm shift in society's perception about our 'noble profession'. It is high time that we should become our own devil's advocate, before others decide our professional responsibilities and boundaries.

Problem analysis

The most important and perpetual facet is the 'patient' himself. Whenever a person falls sick, he is not only physically afflicted but also psychologically. His psyche questions 'Oh God, why me? What have I done to get this? Why bad things are happening only to me?' It is with this persecution complex he enters a hospital. He expects sympathy and empathy, both in good measure. We do not know what other stresses he has in life. He feels vulnerable and intimidated at the slightest provocation, however unintentional it may be.

The second facet is the 'residents and junior doctors'. They are the face of the hospital. They are the 'Sherpas' of the medical organization[2]. They work round the clock under constrained environment with the only motivation of climbing up the professional ladder. They are overburdened with patient influx and handicapped by the lack of infrastructure and equipment. Unfortunately, patients view this infrastructure deficiency as the inefficiency of doctors. Moreover, unlike developed countries, these junior doctors do not have time limit of working hours. I remember my mentor telling me, 'I don't care how busy were you last night. Your day starts at 7.30 a.m. daily'.

The third facet is 'consultants/faculty members'. Having been in this profession for 38 years, I consider myself in this group. We were supposed to have been mentors and teachers, but over the years we have put ourselves on a high pedestal and have become unapproachable. It was our responsibility to groom and nurture the juniors, but I think we have failed them. We are supposed to be the umbrella under which the fresh graduates and residents are expected to flourish and hone their skill. But we are more involved in furthering our interest. Why is that we do not stand by our juniors in day-to-day professional activity? Why we do not care to be in the accident and emergency (A&E) department or regular out patient department (OPD) to supervise our residents? Patients rarely get to meet the consultant, except probably in the operation room under anaesthesia. I was appalled to read an incident in social media about how an accomplished consultant was made to apologize to a sitting judge for making him wait in OPD. This by itself is deplorable, but equally inconceivable is the reason given that according to protocol, a patient should first be seen by a resident. Is it our ego? Is it beyond our dignity to sit next to a resident and see patients? Are we not partially responsible for the rising incidents of violence because we have abandoned the A&E and OPD? With our experience and communication skills gained over the years, we can certainly manage patients better and assuage their feelings. If patients get to meet a consultant or senior faculty in the A&E or OPD on arrival, then I think half the battle is won. I know I am stirring a hornet's nest by making these statements and may likely to be ostracized by the medical fraternity, but I think it is high time that we introspect. Surgeons amongst us will agree that during the formative years whenever one was in a difficult situation, a consultant just by standing at the head end made a whole lot of difference and suddenly the difficult situation became manageable. The same holds true even today if we are present next to the resident when the chips are down. One may argue that as part of training, residents have to get used to taking decisions independently and that is baptism by fire. But such unsupervised baptism is deleterious to both patients and young doctors. Presence of a senior faculty infuses confidence amongst junior doctors and they get motivated to give their best. Easy availability of a consultant will not only make him a better leader, but also a more humane doctor and a role model for juniors.

I sometime wonder, why is there a separate Resident Doctors' Association? Why do they have to form a trade union-like organization to look after their interest? Can their basic needs be different from ours? Why have we avoided taking up their issues with the administration? Would not it have been prudent to have a unified Doctors' Association, irrespective of status of the doctor? We have gone through their phase and if we resented that, then why did not we make improvements when we got the opportunity and power to do so? Are we suffering from a sense of insecurity? Do we see the juniors as a potential threat to our survival? Are we not under oath to teach and groom our students?

The fourth facet is the 'hospital administration'. This apex body, with different mandate in a public and corporate hospital, is manned by people with different priorities. Unfortunately, this group as a whole is detached from reality, partly due to compulsion and partly due to economic consideration. The public hospitals, though headed by doctors, have little concern to ensure infrastructure improvement and modernization of hospital services. They being the head of the institution, are also responsible for the welfare of care givers (doctors, nurses, paramedics, etc.) but regrettably this does not figure in their list of priorities. Having been a part of this facet as well, I am convinced that the administration has not only failed the care givers, but also the patients. They can make a huge difference if they seriously want to, as they have the ears of the policy makers in our country.

The kleptocracy and delay involved in modernization and procurement is having a telling effect on healthcare delivery. It is quite common and easy to suspend a junior doctor for negligence (? error of judgement), but how many of us have ensured that he be given modern technological facility to function efficiently and also ensure his continued professional training before making him a scapegoat?

The corporate hospitals are only focused on profit generation as they have invested heavily in modern technological facilities and ambience. Being led by management experts, these hospitals function like a hard-core model of 'business for profit'. Of course, I do agree that they match any good hospital in the West. But I believe clinicians are under pressure to achieve revenue target and remain relevant for the trustees. Only rich or medically insured Indians can afford the steep healthcare cost in these hospitals and hence there has been a boom in medical tourism, wherein at times even foreign transplant recipients get priority over Indian patients. Due to vested interests, the costing system is not apparent and there is no system of supervision by an empowered regulatory authority. The well-publicized world-class treatment and ambience lure the Indian psyche of 'anything costly is better'. Many patients land in corporate hospitals in the hope of getting the best treatment, even if they ill-afford the cost. That is how in cases of adverse outcome the cost factor becomes prime and it leads to commotion and blame game, which get further hyped by the media.

The fifth facet is the 'relatives of patient'. They share similar emotion as that of the patient with the added stress of unforeseen expense and looking after the infirm. They do not want to hear anything negative about the patient's condition. They expect healthcare to function with clockwork precision and believe that good outcome is already preordained. Any deviation from this perception is interpreted as a fault in healthcare delivery. Another unique psychology which has now become prevalent is that because one has paid, so he is entitled to the best outcome. Any complication or death is due to negligence and the guilty should be punished. Moreover, misguided approach that violence will help extracting expense waiver, complicates the situation. Ironically our society also has this notion of why should one pay for death? Even the policy makers tacitly support this misconception.

The sixth facet is 'The Government' – the think-tank responsible for formulating and implementing healthcare system. Unfortunately, taking pre-emptive action with a vision for the future is something we lack. The Government which takes care of the entire country is wilfully blind. I term this attitude as 'Mata Gandhari syndrome' of the *Mahabharata*. It is a paradox that the largest developing economy, with the ability to wage space war, has not invested in its human resources and their basic needs. The Government has to understand that for any economy, healthcare and education are like consumer durables. Investing in them will be long-lasting and will lead to all-round prosperity of the country. We take expedient measures when the situation goes out of hand, instead of having a futuristic plan for comprehensive healthcare. Launching of 'Ayushman Bharat' or Pradhan Mantri Jan ArogyaYojana (PMJAY) as a partial coverage for about 50% of the population who are poor, is a flawed concept. Is Rs 5 lacs per family per year adequate for diseases like cancer and cardiovascular ailments? Majority of Indians resort to distressed financing for specialized treatments, which pushes them into a vicious cycle of debt and poverty[3]. Are the package rates of various treatment procedures under this scheme economically viable for hospitals and also the Government in the long run?

The way forward

Is it all despair? I do not think so. Our greatest strength as a community and also as a nation is resilience and willingness to adapt. From the metaphor of 'doctors are next to God', we have now been devaluated to 'guilty until proven otherwise'. We never bargained for such a situation. I feel fortuitously the circumstances have put the ball in our court. We have to decide whether we set things right or take the easier option of passing the buck. I have no doubt that the senior members of our fraternity can get the healthcare system back on track. We need to work in tandem in making a healthcare system which is patient- and doctor-friendly and also economically viable instead of catering to personal interests under the influence of industry forces. Many senior members of the fraternity are who's who of this country, and are aptly placed and connected to the policy makers. A pragmatic healthcare plan put forward through their collective wisdom will certainly strike the right chord with the Government. I am quite convinced that the present Government with its electoral mandate has the genuine intent of achieving overall prosperity, healthcare being an integral part of the same.

India desperately needs a universal health coverage plan for every citizen without any caste or economic distinction[4]. This plan on the lines of National Health Service (United Kingdom) (NHS (UK)) should be considered with modifications to suit Indian conditions[4]. Australia also has a similar medicare plan.

We must revamp the infrastructure of secondary and tertiary care public hospitals to bring them at par with the private hospitals[4,5]. Treatment protocols should be evidence-based scientific standard of care across all hospitals. Patients cannot and should not be triaged based on economic affordability as far as healthcare delivery is concerned. The public hospitals should be brought up to the standard wherein they become the first preference for majority of the population. Those who can afford and

want to skip the queue may opt for private healthcare through out-of-pocket expense.

PMJAY can be effective only if emphasis is on eliminating distinction between public and private hospitals with respect to the medical facilities as in developed countries. Recently, there have been discussions in world forums whether India should still be called a developing country[6]. The United Nations[7] and World Bank[8], through Sustainable Development Goals, are aiming to eliminate poverty by 2030. Sooner or later world forums will withdraw the privileges of a developing economy from India. The Government needs to work out the modalities to come at par with developed nations. Investing in effective healthcare, where patients and doctors alike do not have to worry about expense and standard of care, is the foremost need of the nation, apart from education, to achieve that goal. 'Health is wealth', as the old adage goes.

The Government's endeavour should be to bring every citizen under UHC through centralized insurance cover to which citizens must also contribute as they do for pension. A fully subsidized free lunch sort of healthcare is neither feasible nor desirable. Any programme to function efficiently has to be self-sustaining and not be a drain on taxpayers' money. Health is a national issue; hence there is no logic of keeping healthcare as a state subject. Healthcare should become Central Government responsibility. This will ensure uniformity and parity. States should be mandated to implement central health policies and schemes instead of having different schemes for political gains. Such state-level schemes have so far not been able to provide standard of care treatment without class and regional bias. Healthcare should ideally be under a central autonomous authority with constitutional powers[4], similar to the Election Commission. Such authority should have the mandate to coordinate with all stakeholders, including Medical Council of India (MCI) and industry for setting guidelines for treatment for every condition which will be the same all over the country. Such uniform healthcare delivery will prevent everyone queueing up at sought after institutions like AIIMS and Tata Memorial Hospital[9]. This will not only reduce patient's logistics and financial hardships, but also overcrowding at these tertiary hospitals.

According to recent reports, India has the requisite number of doctors of modern medicine to meet the World Health Organization (WHO) standard of 1 : 1000 (ref. 4). The problem, however, is of maldistribution with shortage in rural areas and smaller cities[10]. The Government and medical fraternity together will have to devise a policy and infrastructure to make healthcare accessible by all in a systematic manner, wherein doctors should not shy away from giving their services to the rural community instead of organizing only health camps for publicity purposes.

Our society has a deep-rooted belief that medicine is a calling and not a business. Hence all stakeholders have to understand that healthcare cannot be equated with hospitality sector. The society and policy makers resent business-like approach in healthcare and doctors, being the face of the system, become the fall guy despite them having little say on the actual cost of care. The major chunk of healthcare expenditure is controlled by the industry, including pharmaceutical sector, which is in nexus with the hospital administration and the owners[4]. The central regulatory authority, with active participation from senior doctors and industry, will have to regulate the cost of medicines, consumables and disposables transparently with a capping of profit which will be acceptable to the industry. Uniformly standardized healthcare across the country will eliminate the public–private difference and will force the industry to bring down the cost to an acceptable level, because it cannot ignore the Indian healthcare sector due to its sheer volume.

Communication skill, despite being an important part of our profession, remains a soft spot. This is partly due to our diverse social background, possible language barrier and ever-increasing patient load. There have been quite a few incidents of violence because of glaring communication gap. In most such cases, the briefing was left to a junior doctor who probably was not even involved in the management, but took the brunt by being on duty. The treating consultants will have to own the adverse outcomes as they own the successes, if we want to stem this menace of violence against doctors[11].

I might get derided for utopian ideas. However, as I mentioned earlier, we have to introspect and find a solution to this failing healthcare and growing distrust in doctors by keeping the nation's interest ahead of us. The notion that doctors represent the pharmaceutical industry has to be dispelled by ensuring transparency and communication in dealing with patients. It may be an uphill task to bring about a radical change in the perception and break the well-entrenched nexus with industry. To begin with, it might just be 'ekla cholo re' (Rabindranath Tagore) for our fraternity. But I am certain that eventually all stakeholders, including the government and industry will come around. Robert Owen's couplet should not discourage us:

'God and doctor we alike adore; on the brink of danger, not before
The danger passed, both are requited; God is forgotten and the doctor slighted'.

Though Owen advised against expectations but being a diehard optimist, I fervently hope that the society will eventually realize its fallacy through awareness and we will be able to reinstate our 'noble profession' back to its glory.

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