Position Paper

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The 2017 Academic College of Emergency Experts and Academy of Family Physicians of India position statement on preventing violence against health-care workers and vandalization of health-care facilities in India

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ABSTRACT

There have been multiple incidents where doctors have been assaulted by patient relatives and hospital facilities have been vandalized. This has led to mass agitations by Physicians across India. Violence and vandalism against health-care workers (HCWs) is one of the biggest public health and patient care challenge in India. The sheer intensity of emotional hijack and the stress levels in both practicing HCWs and patient relative's needs immediate and detail attention. The suffering of HCWs who are hurt, the damage to hospital facilities and the reactionary agitation which affects patients who need care are all together doing everything to damage the delivery of health care and relationship between a doctor and a patient. This is detrimental to India where illnesses and Injuries continue to be the biggest challenge to its growth curve. The expert group set by The Academic College of Emergency Experts and The Academy of Family Physicians of India makes an effort to study this Public Health and Patient Care Challenge and provide recommendations to solve it.

Key Words: Doctors, healthcare professionals, violence

INTRODUCTION

Recently, an orthopedics resident in Maharashtra was brutally assaulted by a mob for allegedly telling the attendants to shift an accident victim with a head injury to some other hospital since the hospital did not have a neurosurgeon. The police took action and arrested the person who assaulted the doctor and the accused later committed suicide in the police custody.[1] There have been multiple incidents such as the above in the past few years. There have been protests, and these have made headlines too.

BACKGROUND

Workplace violence is defined by the World Health Organization (WHO) 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.[2]

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With the modernization of medicine and growth of corporate culture in India, the fabric of patient–doctor relationship has become weak. We must note that the incidents of violence against health-care workers (HCWs) have rarely been reported from the corporate hospitals. The prominent factors responsible for low rates of violence in the corporate sector include the restricted access of public to the treatment rooms and wards, high nurse to patient ratios, security personnel and processes, step-up care systems, round the clock availability of senior doctors, fixed working hours for HCW and staff, better communication systems, and availability of counseling and grievance redressal services. We know that the patient treatment protocols are not very different in the corporate hospitals than the government hospitals. The environmental and administrative issues play a major role in the prevention of violence in corporate hospitals.

The government hospitals, on the other hand, are run mainly by junior postgraduate/MBBS doctors who work continuously without sleep and rest for 24–36 h in the absence of assured backup from senior doctors, dealing with the neglected patients, their frustrated relatives, inefficient hospital staff, poor nurse/patient ratios, lack of beds, poor laboratory and radiology services, delays in treatment, lack of hospital supplies, medicolegal aspects, and lack of security arrangements. Such a working environment is like a haystack waiting to be lit up by a minor incident.

Like every other incident, even this one has multiple perspectives, which need to be studied and the solutions should be clear and easily implementable. Workplace violence is not an isolated, individual problem but a structural, strategic problem rooted in social, economic, organizational, and cultural factors. An approach should consequently be developed and promoted which would attack the problem at its roots, involve all parties concerned and take into account the special cultural and gender dimension of the problem.[2]

CHALLENGES AND SOLUTIONS

According to the WHO, the organizational attributes that predispose to violence include hospitals working with insufficient resources, including inappropriate equipment, functioning in a culture of tolerance or acceptance of violence, working with a style of management based on intimidation, and noted for poor communication and interpersonal relationships.[2]

As shown by the Indian Medical Association study, most violence was faced by the Indian doctors while providing emergency services.[3] Still, the rudimentary casualty system exists across India, while rest of the world has developed advanced nationwide prehospital emergency medical service systems integrated with Emergency Medicine (EM) Departments in their hospitals to deal with the emergencies.

Patients are the same across the world so are the relatives. EM and emergency situations are adrenaline charged scenarios.

THE EMERGENCY SCENARIOS IN PATIENT CARE

Despite the nod by the Medical Council of India in 2009 to develop EM as a standalone specialty in Indian medical colleges, only few States in India have shown interest to develop this specialty till date. We know that EM will not bring an end to the assaults on HCW, but it will surely improve the delivery of care to the patients in an emergency in a scientific manner to reduce the substrate for such reactions. As shown by the Indian Medical Association study, most violence was faced by the Indian HCW while providing emergency services in the age old casualty system of Indian hospitals that is a nightmare for the HCW, patients, and public.[3] Most hospitals in India lack the processes and people who are committed and capable of emergency service delivery. The senior doctors with skills and experience are hard to find, in most Indian hospitals, during the emergency hours. Our emergency departments (EDs), run by nonspecialized casualty medical officers and interns, run as mere postal service shuttling patients from one specialty to the other till someone claims them.

Patients need private areas of emergent intense care. Departments need providers who can communicate and counsel the charged relatives. Departments and providers should be capable of facing any emergency and provide immediate clinical interventions to manage airway breathing circulation and provide high-intensity resuscitation. Having transfer agreements and protocols in place and having blood, resuscitation drugs, ambulances, and infrastructure available is another important aspect. Most important factor is having physicians who are trained in EM and by that also having all skills of communication and skills to contain emotionally hostile situations. Such skills also should be provided to all graduating doctors and nurses.

NATIONAL EMERGENCY LIFE SUPPORT EDUCATION

The Ministry of Health, Government of India, has also rolled out the first phase of National Emergency Life Support Skills Centres in six states recently that will

work to provide the necessary skills to the HCW dealing with emergencies. This is a highly appreciable step by the government and needs to be implemented at a large scale in all States of India.

TEACHING CRITICAL COMMUNICATION SKILLS

We need massive nationwide efforts to develop our clinical responsiveness in critical situations. Mere development of trauma centers and hospitals is not going to be enough and a comprehensive approach focusing on all emergencies that endanger lives, organs, or limbs of humans has to be the basis for future emergency care in India. This includes training of all family physicians, MBBS doctors in smaller hospitals in emergency care as well as the development of large number of super-specialists to provide specialized care in district level hospitals.

In our medical schools, we need to teach medical students how to break the bad news to the relatives. The junior doctors are often assaulted just because they consider death as a routine matter, but for the laymen who assault them, it is usually their first experience in life. Therefore, careful choice of words and actions in such situations makes all the difference.

MEDIA AND ITS EFFECTS ON MEDICINE

Media has also played its role in maligning the image of the HCW.[4] Stories of over-prescription, abuse of laboratory investigations, cut-backs, foreign trips, acceptance of gifts and cash keep appearing in the media regularly. The assaults on HCW have increased in the recent times because of the negative media marketing and intolerance among the public.[4]

LEGISLATIVE AND LEGAL PERSPECTIVES

A petition directed at the Prime Minister of India has been signed by 81,938 people demanding that "people assaulting HCW should be punished like terrorists."[5] This is more of an emotional reaction of the helpless HCW than being a solution to the menace of violence-against-HCW the two main issues responsible for violence, not addressed by the petition include:

1. Lack of quality emergency care for public
2. Unsafe working environment for HCW in the government hospitals where 1 in 2 doctors have faced violence while working.[6]

HCW, all over India, are demanding legislation for making violence-against-HCW a nonbailable offense. However, it is unlikely that assaults are going to be over with the legislation. Even in a country like the US, a survey done in 2010 showed that one in four nurses reported being assaulted more than twenty times over the past 3 years.[7] A collaborative survey which looked into emergency physicians in India and US concluded that ED workplace violence is common internationally, underreported, and results in poor job satisfaction, workplace fear, and loss of sleep.[8]

The HCW working in EDs face another challenge in India. These workers cannot stop emergency services even in the scenario of an assault by someone as the emergency services maintenance act comes into force, by which, they are liable for disciplinary action. At the same time, there is no act to safeguard HCWs working in an emergency from the brutal assaults and are left to fend for themselves against the public in the heated and hostile environments of Indian ERs.

A diagrammatic analysis is shown in Figures 1 and 2. As shown in Figure 1, the existing (in blue) and the proposed (in red) actions for the hospitals that can be implemented to reduce the chances of violence in the hospitals.

There are many factors which are involved in incidents against HCW, especially those working in emergency services across India as shown in Table 1 and the proposed solution to tackle these factors as shown in Table 2.

Table 1: Factors promoting violence against health-care worker in India

- The absence of the postgraduation training in EM in medical colleges
- Poor quality of emergency care in hospitals
- Untrained medical officers/fake EM degree holders working in emergency
- Untrained staff nurses working in emergency
- Poor grievance redressal mechanisms in the hospitals
- Poor prehospital emergency care network
- Poor communication skills of HCW and staff
- Lack of emergency resources such as blood, laboratory services, emergency drugs, workforce, etc.
- No mechanism to assess, display and notify the emergency intake capacity of hospitals
- Nursing homes running emergency services without proper training
- Wrong belief of public that hospitals charging more money provide better medical care
- Increasing education, demands, intolerance, fearlessness, and anxiety among the youth
- High workload in government hospitals
- Lack of civic sense and responsibility in the public
- Political interference in the hospital affairs
- Non-NABH certified hospitals dealing with emergencies
- Absence of legislation to curb violence against HCW
- Negative image of HCW portrayed in the public by the media
- Unrestricted public access to the premises of the government hospitals without identification
- Lack of security, surveillance, and mob prevention capabilities in hospitals

HCW: Health-care worker, EM: Emergency medicine, NABH: National Accreditation Board for Hospital

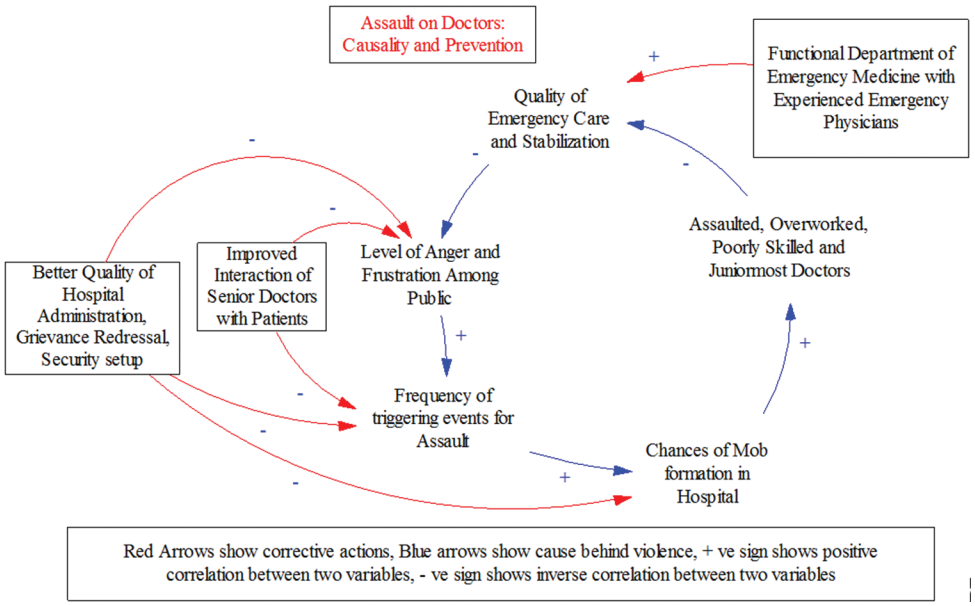

Figure 1: Causality diagram for violence-against-healthcare worker in India

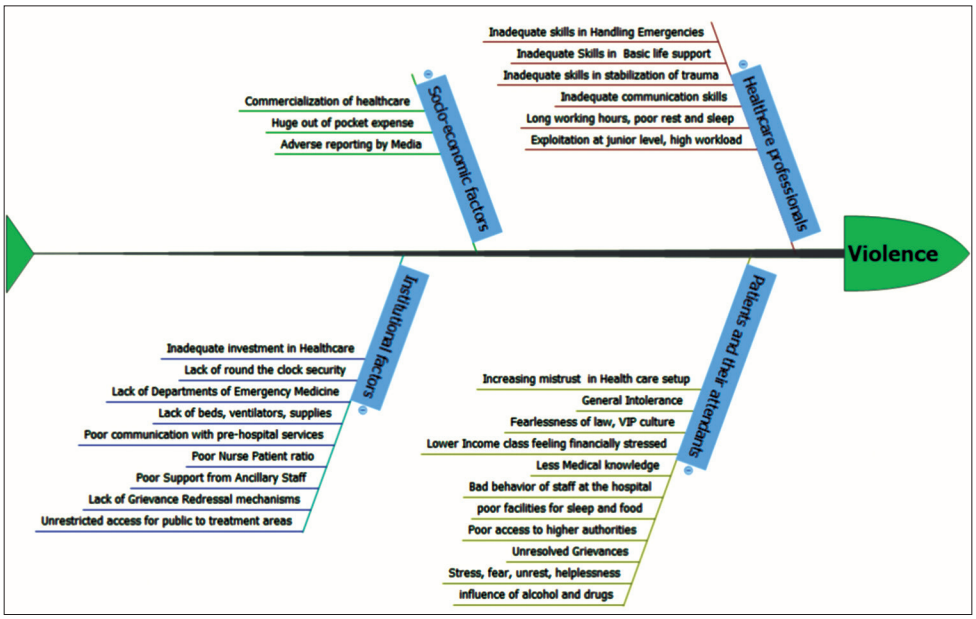

Figure 2: A fish bone diagram to identify the probable causes of violence against health-care professionals

CONCLUSION

If we can have the proposed systems in place then we will surely minimize the chances of violence-against-HCW in India. The prehospital system will deliver the patients to the appropriate National Accreditation Board for Hospital certified hospitals that will be equipped with trained emergency physicians, nurses, and technicians to deal with all kinds of emergencies. The capacity of hospitals to accept a particular number of emergency patients will be displayed live to the prehospital services so that no patient is brought in when the hospital is not ready to receive more patients. The HCW in the hospital will have advance information to receive a particular emergency, and the staff will be ready to receive and stabilize the patient at the door of the hospital. The patient will be provided the airway, breathing, cervical stabilization, and circulatory support by the prehospital teams with a clear flow of information, quick assessments, and decisions in consultation with the emergency rooms (ERs). A complete survey of injuries and diseases will be done in the ERs, and appropriate steps for stabilization will be undertaken. There will be restricted access to a limited number of attendants with the patient. The prognosis will be discussed with the attendants, and the treatment options decided mutually. Disruptive behavior will be identified and reported in a timely manner followed by

Table 2: The recommendations of the expert group to address the major problems

Variables	Agent (public)	Host (HCW)	Environmental (hospitals)
Regulation	Strict laws prohibiting people from assaulting HCW on duty making it a nonbailable offence Keeping a check on the VIP culture	Enroll more doctors in MCI/NBE EM training programs in all States of India Relax the MCI norms of 2 years training for faculty from medicine, surgery, orthopedics, anesthesia, or pulmonary medicine who are willing to join EM Extend the relaxation period for non-EM faculty to join EM till 2025. Discourage non-EM/non-MCI/NBE programs in EM from working in emergency departments	Laws and rules for taking care of every emergency patient arriving at any hospital NABH quality certificate mandatory for emergency medical services
Education	Dissemination of law against violence using displays, social media, pamphlets, etc.	Mandatory life support certification courses for HCW and staff in EM Mandatory continued medical education and workshops for all in EM Training of all HCWs in team work in providing emergency care in emotionally charged setting	Efforts at national level and through medial to change the mindset of people toward government hospitals, HCW, and public property
Administration	Easily accessible grievance redressal systems Proper nurse/patient and doctor patient ratios	Mandatory training in patient privacy, care confidentiality, breaking bad news/death to relatives, counseling Mandatory resuscitation training to all staff providing healthcare Leadership grooming to take charge of difficult situations	Prevent overcrowding Security arrangements Camera installations Restricted access
Communication	Periodic counseling of emotionally charged attendants by allied health-care providers	Maintenance of appropriate body language (verbal and nonverbal gestures in conflict situations) Having empathy and use of appropriate words while breaking bad news	Creating strict transfer protocols for pre- and inter-hospital transfers

HCW: Health-care worker, EM: Emergency management, MCI: Medical Council of India, NABH: National Accreditation Board for Hospital, NBE: National board of examinations, VIP: Very important person

immediate appropriate steps to prevent violence. These steps have been known to work in other countries toward improvement in emergency care that does reduce the chances of violence against HCW.

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Conflicts of interest

There are no conflicts of interest.

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