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Workplace violence against medical practitioners in India before and during the COVID-19 Pandemic

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WATER FOOD ***DIABETES*** AYURVEDA ***GENETICS*** POVERTY ***YOGA*** STDS ***HISTORY*** SEX ***SOCIETY*** FAMILY PLANNING ***CASTE*** GENDER ***RIOTS*** RELIGION ***HEALTH*** DEMOCRACY ***FLOODING*** WASTE-MANAGEMENT ***UNANI*** PSYCHOLOGY ***FOLK MEDICINE*** AFFIRMATIVE ACTION ***GLOBALISATION*** BIOCHEMISTRY ***OLD AGE*** REPRODUCTIVE HEALTH ***MALARIA*** POLICY ***HIV AIDS*** WHO ***MEDICOSCAPES*** COLONIALISM ***PHARMACY*** RELIGION ***LEPROSY*** BOTOX ***DEHYDRATION*** NGOs ***AYUSH…***

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Master's thesis

Workplace violence against medical practitioners in India before and during the COVID-19 Pandemic:

Influence of their experiences, coping processes and the media on doctor patient relationships

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Note on transliterations

For this interview, I have translated Marathi & Hindi in a simple way. I have presented the interviews verbatim without any grammatical corrections.

Chapter 1. Introduction

A safe workspace is a fundamental human right (UN High Commissioner for Human Rights, 2003). The topic of Workplace Violence (hereafter WPV) is becoming more and more important in the past two decades, and it is a major safety concern for healthcare (Chauhan & Campbell, 2020) as the risk of WPV against people working in healthcare is graver than in other sectors (World Health Organization et al., 2002). Although WPV in healthcare is positioned as a grave problem to its victims globally, it quietly continues to be broadly noticed but neglected as a public health concern (Gilai, 2020; Pandey, 2020). World Health Organization (WHO) defines WPV as:

> the situations where staffs are ill-treated, intimidated, or attacked in conditions linked to their workplace, including commuting to and from the workplace, involving an explicit or implicit challenge to their safety, well-being, or health … Verbal, physical and psychological all come under the umbrella of WPV (World Health Organization et al., 2002, p. 3).

Tiruneh et al. (2016) mention that the hospital setups are predisposed to WPV. The healthcare provider is vulnerable and easily accessible, thus, healthcare professionals catering to emergency, geriatric, or psychiatric services are known to be more prone to such events from patients and their relatives in hospitals (Occupational Safety and Health Administration [OSHA], 2016). A study in the New England Journal of Medicine reported that “there are 4 types of WPV” (Phillips, 2016). The major wrongdoers are of the second type, who are either patients, their kith and kin or sympathizers (Ferri et al., 2016; Hobbs & Keane, 1996; Phillips, 2016).

The occurrence of verbal violence was regular in healthcare setups and nowadays, it’s deliberated as a workplace hazard (di Martino, 2002). The economic standing of a person and a nation both play a significant part in influencing WPV (di Martino, 2002). A study in the

New England Journal of Medicine stated: “Health care workplace violence is an underreported, ubiquitous, and persistent problem that has been tolerated and largely ignored” (Phillips, 2016, p. 1661). This underreporting of WPV (Farrell & Cubit, 2005) and even more scarce reporting of psychological violence raises concerns in a workplace scenario (di Martino, 2002). The offenders probably consider it to be a WPV with no repercussions (Adedokun, 2020). No acts of violence at a work setting can be ignored. Lanza et al. (2006) mention that when a person suffers verbal assault, their risk of being physically assaulted increases. This resonates with Kelling and Wilson’s (1982) *Broken Windows theory* which mentions that if a minor crime is overlooked and unchecked in a community, then there is a greater possibility of it becoming a serious crime in the future and affecting the same community. This applies to violence in healthcare as well; when the nonphysical violence is tolerated, other grim forms of WPV are attracted (McPhaul & Lipscomb, 2004). In addition, the lack of training and education of medical personnel to handle WPV and the lack of processes to tackle WPV, in a way, leads to impunity of violence (OSHA, 2016). Research has shown that WPV has a negative influence on the victims, which leads to absenteeism, anxiety, and various other health problems (Anand et al., 2016; Joa & Morken, 2012; di Martino, 2002). Any WPV in healthcare setups causes a health burden on institutions in the form of paying for cost of treatments for the healthcare provider and infrastructure damage (Speroni et al., 2014), decline of performance quality (Dubb, 2015; Joa & Morken, 2012), leaving jobs by employees (Dubb, 2015), loss of morale and mistrust between the doctor and the healthcare institute (see in Jenkins et al., 1998; World Health Organization et al., 2002). Such events might have grim repercussions on the country’s healthcare burden too. Kidder (2009) describing Paul Farmer’s practice makes some important points on healthcare in developing nations. He states that health inequality in emerging nations between the rich and the poor is obvious. He also mentions that people are devoid of essentials like “food”,

"water" and "sanitation" (p.126-127). Ranjan et al. (2018) resonating with Kidder mentioned that the public hospitals in developing countries are ill equipped and mainly cater to the poor.

During the COVID-19 pandemic too, the incidence of WPV against doctors was frequently reported in India. These topics were reported frequently by the media too. The WPV in healthcare was so profound that the Government of India added an Ordinance to amend the 100-year-old Epidemic Diseases Act in April 2020:

> The Epidemic Diseases (Amendment) Ordinance provides for the prevention of the spread of dangerous epidemic diseases. The Ordinance amends the Act to include protections for healthcare personnel combatting epidemic diseases and expands the powers of the central government to prevent the spread of such diseases… imprisonment between three months and five years, and a fine between Rs. 50,000 and two lakh rupees (PRS Legislative Research, 2020, para. 1 - 5).

Even then, these cases of WPV have been reported (Saha, 2021). Although, there has been an extensive amount of research on WPV in the public health domain, there is a void in research on WPV in anthropology and the social sciences in general. The anthropological view on WPV from a healthcare sector perspective is missing. The study presented in this thesis helps in filling the gap by seeking to understand the experiences and coping process of medical practitioners who have faced WPV caused by patients, their family or sympathizers and whether it influences the Doctor Patient Relationship (here after DPR). Through this study, I will also attempt to understand the visual media's influence on the DPR, as I hypothesized that the media plays an important role in shaping the DPR and influencing WPV. I also hypothesized that the experiences and coping post WPV influences the future of the DPR. I hope this study will be of value to the future researchers, policy makers as well as the doctors and public.

After introducing the topic in the first chapter, I will move on to the methodology where I explain about the process in which this study was conducted. In chapter three, I shall attempt to understand the doctor patient relationship through various viewpoints, here I will also investigate the DPR through visual media anthropological lens in attempt to inspect its influence. Chapters four and five will showcase the finding of this study which I shall discuss and conclude in chapter six.

Workplace violence in India before and during covid

A quote in a decade old edition of The Journal of the American Medical Association (JAMA) specified:

No physician, however conscientious or careful, can tell what day or hour he may, may not be the object of some undeserved attack, malicious accusation, blackmail or suit for damages . . . for sufferance is the badge of all our race (as published in JAMA, 1967, pp. 25-26).

Indian Medical Association, a Non-Government Organization (NGO) that works for the rights of doctors in India conducted a pan-India study and reported that over seventy percent of Indian doctors have suffered some WPV (as mentioned in Dey, 2015). Ranjan et al. (2018) studied the Epidemiology of violence against medical practitioners in a developing country and their research showed that WPV was most seen in government healthcare setups as these places were not well equipped with facilities. In addition to this, a poor doctor patient ratio of less than 1:1000 (Central Bureau of Health Intelligence [CBHI], 2018) leads to poor manpower in public hospitals. Rural Health Statistics report by the Union Ministry of Health and Family Welfare stated that the Community Health Centers (CHC) have a shortage of specialist doctors of over 70 percent (Sheriff, 2021). The same report mentions overall shortage of allopathy doctors for Primary Health Centers (PHC) is over six percent. The World Bank's report of 1998 states that over one third of the primary care load in India is

managed by unqualified practitioners (as cited in Iles, 2019). Many of these government hospitals that are functional are devoid of proper infrastructure and due to the scarcity of medicines, the patients had to go to a private diagnostic examination center, or to a chemist to buy the medicines (Ranjan et al., 2018). It is imperative to note that most of the times, these government medical centers are the only functional centers in remote places in India and cater to people from economically poor backgrounds and a doctor on duty may consult hundreds of patients a day (Ambesh, 2016), hence the doctors and other healthcare workers are always working for long hours and many a times, in ill-equipped setups (Ranjan et al., 2018). The delays in examining cases are inevitable, which could also lead to briefer consultation periods (Ambesh, 2016). Thus, the treatment by unqualified medical practitioners is usually the first mode of treatment (Iles, 2019; Sharma, 2020) and hence, the cases that reach higher centers are usually the ones that are complicated. This delay of a case reaching the hospital, in addition to the long waiting process for the consultations, could lead to aggression of the patients and their families and result in WPV against doctors (Ambesh, 2016).

Although, it is a commonly known fact that infrastructure and hiring is not in the hands of the doctor, the study by Ranjan et al. (2018) showed that if any negative incidents happened, it was always against the doctors responding on the first line. They also note that such acts of violence have shown to result in grievous injury and sometimes death of the treating physician. A senior citizen doctor working in a Tea estate was lynched by a mob of over two hundred people in Johrat, Assam (Choudhury & Achom, 2019). The mob alleged that the doctor delayed the treatment due to which the patient died and thus assaulted the doctor (Das, 2019). The article also mentions that the mob had beaten the doctor with sticks, cut him with glass and pelted stones. The NDTV news channel showed the horrific site of the doctor trying to find a place to lean on to when he was bleeding profusely and gasping for

breath (Choudhury & Achom, 2019). The healthcare setups are devoid or scarce of properly trained security (Ranjan et al., 2018), something which was seen in this case as well. The police had to intervene and rescue the doctor who later succumbed to his injuries (Choudhury & Achom, 2019).

The COVID-19 pandemic reached India comparatively later than rest of the world. The United Nations report on 31 January 2022 noted that by 30 April 2020, it had claimed over two hundred thousand deaths in India ("Putting an end to India's oxygen crises," 2022). The same conveyed that there was a dearth in facilities including lifesaving oxygen. This panic and anxiety among people resulted in aggressiveness and assaults on healthcare personnel during pandemic. The failure in preparedness also led to venerating martyrdom and pushing doctors and staff to choose work over their safety and life (Patil & Taneja, 2021).

Bereavement is a traumatic episode for everyone. It can affect a person's wellbeing (Stroebe et al., 2007). *Dual process model* notes that in such a process, one needs to work on 'both loss and restoration' (Schut, 1999). The author says, it is difficult for a person to adjust to a sudden loss, and can result in immense stress, hence it is important that such events are handled with utmost care as they can easily turn violent. In Assam, a doctor at a COVID-19 treatment center was beaten with metal instruments by a patient's family after declaring the death of a patient (Saha, 2021). Similarly, The Guardian reported that a government hospital center for COVID in the state of Uttar Pradesh faced multiple episodes of WPV. As the hospital had a shortage, a patient's family were asked if they could procure oxygen cylinders through a private source. Upon hearing this, the attenders stormed into the Intensive Care Unit (ICU) and attacked the treating doctor and destroyed the property (Baloch et al., 2021). The same report also wrote that a few days later, another family of a different patient broke into the ICU and threatened the doctor with dire consequences if the medicines they had got

from a private chemist were not used, as they believed the medicines in government hospitals were spurious and would not cure their patient. This situation went on to get worse with the coming of the next waves of the pandemic, as it brought some rare superinfections like the Mucormycosis, also called ‘Black fungus’ (DHNS, 2021). The lack of anti-fungal dugs led to increase in the anxieties and aggression assaults over doctors across India (DHNS, 2021). As we already saw, the occurrence of WPV against doctors is noted both before and during the pandemic, hence at this stage I wanted to understand how the doctors view such events. For this study, I will deal with following questions:

Research question

1. What are the experiences and coping processes of a medical practitioners in India who have faced WPV, caused by patient or patient family/sympathizer, before and during the COVID-19 pandemic?
2. Does mass media projection of doctors have any effect on Doctor Patient Relationship and in turn on WPV?
3. Do these experiences and coping processes have an influence on the Doctor Patient Relationship?

Chapter 2. Methodology

Research methods

The main aim of this thesis is to describe the experiences of the medical practitioners and look at their coping systems and I leveraged qualitative research supported by a quantitative survey to achieve this objective. The quantitative data was necessary to comprehend the prevalence of WPV. It was important as it delivers a strong reasoning of concrete occurrence of the problem. The qualitative research intends to understand the respective situation by examining the actions of the medical practitioners. It reflects upon how they view the situation and act in and after WPV has occurred. The acquired qualitative data to help in showcasing the deeper understanding of the doctors and WPV. The data is collected mainly with the help of interviews and secondary literature, which are then collectively analyzed.

Primary data research

Semi structured interviews

As my research question suggests, my study participants were doctors i.e., registered medical practitioners. I chose to draw on my ties from my medical college where I obtained my MBBS degree and reached out to my collegemates and acquaintances from my clinical practice. My status of a registered medical practitioner in India allowed me easy access to approach the doctors. I found the interviewees by snowball sampling. A semi-structured interview with an open-ended questionnaire was developed based on previous studies of workplace violence against healthcare providers. These studies acted as a guide in fine tuning the outline of the interviews. This research was conducted with the help of doctors who were interested in volunteering for the study. I interviewed medical practitioners from biomedicine

and from AYUSH (AYUSH is an acronym for Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy)

Survey

A survey was conducted with a multiple-choice questionnaire. The questions were structured in such a way that it would help quantify the probability of WPV in healthcare setups (if any).

Secondary data research

Literature research

I relied on research materials from biomedical, anthropology, literature on violence, doctor patient relationship, ethics, WPV, and visual media anthropology. I consulted research articles from renowned journals having a wide view on the topic. There is avid literature on WPV against doctors in the Biomedical stream; this was correlated with anthropological theories to get a comprehensive view on the topic. Some sections of Ayurveda texts that explained the *Charaka Samhita* and *Sushruta Samhita* were consulted to understand the Traditional and Complementary Medicine's (T&CM) view on the topic. I also studied the prevailing literature of descriptive anthropology and nonfiction books. I chose these books with a focus on doctor patient relationships, clinical practice and those which gauged the special status of doctors. I read relevant articles from leading news outlets that were published on the topic of WPV against doctors before and during the COVID-19 pandemic. I scrutinized visual media materials on YouTube of news channels, Hindi movies, Twitter etc., for the projection of doctors and medicolegal cases before and during the COVID-19 pandemic.

Focus group and selection criteria

In this study, I interviewed registered medical practitioners from India. The two criteria for participation were that they must be registered with the state or national medical

councils, which implies that they are officially allowed to practice in India, and that they should have practiced for at least one year in either, or both, public and private healthcare setups. The AYUSH faculties are a part of the National Rural Health Mission due to which AYUSH practitioners are appointed at PHC's along with Biomedical doctors. Hence for this research, doctors from Biomedicine and AYUSH were interviewed that were aged between 30 to 75 years, four of whom were men and two were women. Four Biomedical doctors and two AYUSH doctors were interviewed for this research. The four doctors from biomedicine had studied at least MBBS. The two AYUSH doctors had studied Bachelor of Homoeopathic Medicine and Surgery (BHMS) and Bachelor of Ayurveda Medicine and Surgery (BAMS). Seventy-five doctors across India belonging to both Biomedicine and AYUSH disciplines took the survey as part of my quantitative research. The doctors were chosen by the snowballing method.

Location

I did my research in the months of December 2021 and May - June 2022. Due to the many uncertainties due to the COVID-19 pandemic, I had to keep adjusting my plan and chose to do the field work in December in Pune, Maharashtra. COVID-19 preventive measures were strictly followed. Out of the six doctor interviews, three were done in person i.e., two interviews were carried out in their respective clinics, and one interview was taken at the residence of the doctor. I had procured appointments in advance, so I was able to interview them adequately. Unfortunately, by the mid of December, an even worse Omicron wave affected India and the whole of India went into lockdown, and fieldwork in person was impossible due to the restrictions. The doctors too were unavailable. So, I decided to move to a virtual format. I chose to interview the remaining three participants online. I had to alter the demographics of my study as I could not limit it to one city. The participants were from

Lucknow, Pune, and Bangalore. The quantitative survey was answered by participants across India.

Data collection and management

The participants were contacted through a phone call or WhatsApp, as the participants were either my colleagues, acquaintances, or their acquaintances. They were explained the process of the interviews and a verbal, informed consent was taken. The informed consent highlighted the reasoning of the study, length of interviews, processes, benefits, and discomforts that the participants could expect from the interview. The interviews were recorded using the audio recorder app on the phone. The participants who agreed on recording were requested to give consent when the audio recording was started. The data post the interviews was stored on cloud and the access to these files was available only to me. The participant identities were kept anonymous in this research. They were given pseudonyms as Doctor 1- Doctor 6. I transcribed the audios files of the English interviews on a word processor application with the help of accessibility function and dictation app on my MacBook and proofread them. For the non-English parts of my interviews, I transcribed and translated them to English. My proficiency in the language appeared sufficient to translate them.

The same process of data processing and storing was done for surveys too. The Google form was sent to the participants primarily by WhatsApp. The form had an informed consent and also provided information about me and my thesis.

Ethical considerations

No participants were pressurized to take part in the study. They could discontinue their participation whenever they chose without any ramifications. I had asked the participants if they wanted to read the transcripts, but neither did they want to nor did they have time. I had to ensure that the participants felt safe in sharing their experiences. I think

my medical education was both a benefit and a drawback. It was a benefit, as I could approach the participants easily, but the medical practitioners would address me as ‘doctor’ and while explaining the process, they would say things like “you already know this” or this is part of “our” job. I also felt that they hesitated when they criticized the doctors. I had to encourage them to be comfortable and remind them that my role in this research was only of a researcher. Although distancing oneself in these situations is difficult, I had to underline my role to others and to myself, to strictly adhere to my role of a medical anthropology researcher. I believe that I was successfully able to achieve this. There were no expected dangers to the participants undertaking this study. However, as it is based on WPV, there was a possibility that some of them might have apprehension in reliving those situations. Hence, before the start of the interview, they were informed extensively that there was no obligation expected from them, and they can ask to stop or take a break from the interview at any time. For the survey, the participants were informed beforehand that their names would be kept anonymous, and they had a choice to fill the survey or decline it.

Chapter 3. Literature review

Doctor patient relationship

Dr. Joseph Murray's book *Surgery of the Soul* says, "Any form of medical treatment is a balance between intended good and potential adverse effect" (Murray, 2004, p. 76). And so, a good DPR is needed to achieve this balance. Brody (1987) mentions that this DPR is thus the first step in comprehending medical ethics, and therefore, is one of the most important parts of healthcare. He adds that it is a very complex, humanistic relationship. The author also says that this relationship is ever evolving and that changes in patient care pattern are now seen. Earlier, the treatment was provided by one doctor, but has now moved to a team handling cases (Brody, 1987). The DPR has many ethical elements like informed consent, legalities, truth, etc. that a physician needs to learn (Brody, 1987). While elaborating on similar aspects, Kleinman et al. (1978) highlighted that with the change in care pattern, many aspects are now tallied by the patient to ascertain whether the DPR is efficient.

Wenegrat (2001) in his book *Theater of Disorder: Patients, Doctors, and the Construction of Illness* reveals a "theatrical model of social relations in medicine" (p. 4), which he says has rarely been explored. The clinical setting, just like the theater, has common elements like actors, props etc. As per the author, the 'roles' of a physician and patient are predetermined and taught to a young student. Something similar was noted in an Indian context too. The old texts by sages "Sushruta, the surgeon and Charaka, the physician" confirm the medicinal practices that were used then (Paul & Bhatia, 2016, p. 4) and provide instructions for the DPR and ethics (Tomar & Kumar, 2020). Kanishka's royal physician was Charaka. In *Charaka Samhita* (his book), he explains philosophical and ethical guidelines for the physician, or *Vaidya*, and patients along with the kind of qualities and roles they should hold (Tomar & Kumar, 2020).

The Vaidya's of ancient India, who were provided a high social standing in the Indian society and courts, also followed the ayurvedic ethical guidelines (Gopinath, 2001; Lavekar, 1996). Lavekar's (1996) book on *Doctor Patient relationships in ancient Indian medicine (Ayurveda)* is an analysis of ancient texts elaborating on how the DPR was in ancient India. He mentions that a *bhikshak* or *medicine man* which means a Physician, like medicine, is timeless. He notes that every person who aided others in times of health-related needs, was a philanthropist and had to be akin to the rules in Ayurveda, of not working for monetary gains. In a DPR, not just the physician, but also the patient has prerequisite "qualities". "The patient should be tolerant, should believe in the doctor, should have an adequate life span and finally, should have a curable disease; a physician is not a *Master of Life"* (Lavekar, 1996). The author says that the physician can provide services in healing of rare diseases, but it is irrational to anticipate miraculous outcomes. Probably, this idea of expecting miracles is seated in the space between magic and healing from the history of medicine. Nevertheless, even in the formative days during postcolonial times in India, there was an eliteness and privilege noted in the medical profession. There was also an element of caste and gender attached to this profession too. Broomfield and Seal (1968) pointed that all the educated Hindus were always given affluent jobs. There has been a domination of Brahmins (an upper caste in India) since a long time (Suntharalingam, 1974). Even the women who joined this profession in the formative years of pre- and post-independence India were from privileged backgrounds (Forbes, 2005). There has thus, been an inequality in education, gender and society (Rege, 2015), a "class-based hierarchy" (Khare, 1962) in medicine, that has influenced the attitude of the people over the years and caused imbalances in the DPR (Kumbhar, 2022). However, in the current times, there is a difference in medical education seat allotments. Here I investigate Karnataka state seat distribution as an example. The medical seats for MBBS are divided into All India Quota (AIQ) comprised of 15%, via the

National Eligibility cum Entrance Test (NEET) and state quota comprised of 85%. Of the 15% in AIQ, the reservation category for schedule caste (SC), schedule tribes (ST), and other backward classes (OBC) amounts to over 40 percent (MBBSCouncil, n.d.). The same article also notes that even in state quota, the reservation category is similar. Caste based reservations for medical seats is seen in all states. The pre and early postcolonial studies have shown a gender and caste disparity (Alavi, 2008; Venkatesh, 2019) but as noted earlier, due to caste and economics reservation category established by the Government of India, this inequality has significantly diminished. However, even though this change is implemented, the image of an early post-colonial "dominance of privileged upper-class and caste Indians in medical profession" (Kumbhar, 2022, p. 3) still overshadows the image and people's perception of the current doctors, and this is probably why it is still investigated by some studies (see, e.g., Kumbhar, 2022; Venkatesh, 2019). This points to fact that even this credence affects the DPR.

Pappas (1990) studied the doctor patient models of Arthur Kleinman and Howard Waitzkin and speaks about its subtleties. He mentions it is "autonomy" and "dependency" that decides who gets what position in a DPR, as it is interchangeable. Szasz and Hollender (1956), in their unique way point out that the DPR is "novel", and as in any relationship, there is a joint participation. The authors go on to describe three models of a DPR: First - the model of Activity-Passivity, where both play different roles: a physician being active does something to the patient, who receives it passively e.g., that which is seen in emergencies. Second - the model of Guidance-Cooperation, where the physician guides the patient, and the patient obliges, as he is able to comprehend. There is a transfer of power (although temporary), and third - the model of Mutual Participation, where both participate equally. The first and second models are both paternalistic and widely followed. Similarity is seen in the text by Lavekar (1996) where he notes that the DPR in ancient times was paternalistic. He

says a *Vaidya* (a practitioner of Ayurvedic medicine) donned many hats in the DPR, like "friend, philosopher, advisor and counselor" and emphasized that this was an ideal model to follow in practice for future generations too (pp. 7-8).

So, the doctor's behavior with the patient always plays an important role for the patient to assess the result outcome, as the patient builds positive or negative biases (Ben-Sira, 1980). The *doctor as a friend* model by Emanuel and Emanuel (1992) claims that it is better for the DPR as it is compatible with the Hippocratic oath, but Szasz and Hollender (1956) do not agree and support a more paternalistic model. They say such paternalistic models are necessary when the patient is not able to contribute to a relationship, may that be during an emergency or a psychiatric illness. Charaka stresses "A good physician nurtures affection for his patients exactly like a mother, father or brother… The physician having such qualities gives life to the patients and cures their diseases" (as cited in Paul & Bhatia, 2016, p. 1). Hence the doctor's roles are seen to be more dominant even in ancient medical practices, so there are certain positions of power seen in this relationship.

Power relations in a Doctor Patient Relationship

Francis Bacon's book *Meditationes Sacrae* published in the late fifteen-hundreds states *ipsa scientia potestas est* or "knowledge itself is power" (Azamfirei, 2016, para. 1). The author says Bacon mentions this because "having and sharing knowledge is the cornerstone of reputation and influence, and therefore power". The healthcare systems are grounded on hierarchy and power (Foucault, 2003). These cause asymmetrical relationships that are going on from ages (Halford & Leonard, 2003) and can be viewed in the context of a DPR (Foucault, 2003). Power of knowledge has shown to claim dominance in a relationship (Foucault, 1972) and is probably why the relationship is still paternalist (Szasz & Hollender, 1956) and so the medical knowledge and its practitioners have an upper hand (Leventhal et al., 2005; Lindsey, 1997). Some might say it forms the basis of the God syndrome, which

means “having a reputation for thinking that they are Gods” (Ghaemi, 2008), that is sometimes observed in medical practitioners, especially as doctors being given a stature next to God is not unknown in an Indian scenario (Jaiswal & Bahatnagar, 2013).

Foucault (2003) says that the person with less power plays the role of a “second fiddle”. In a DPR that would be a patient. This is unlike the Marxist view. This hierarchy as per Marxist followers, oppresses the people with less power (Maner & Mead, 2010; Tew, 2006). The dichotomy between the two positions in a DPR is so normalized that one seldom interrogates it. In his book *The Birth of the Clinic*, Foucault (2003) mentions that the medical knowledge provided the practitioners with a power. He says that this gave the practitioners power to differentiate “normal” and “deviant”. Thus, a doctor is given a power to put patients and processes as normal or abnormal. He adds “Power and knowledge directly imply one another” (Foucault, 1979, p. 27). It is not wrong to say scientific knowledge gives the practitioners an upper hand and a position of power in a DPR. This is because, the scientific knowledge is given more prominence than a patient’s expertise (Leventhal et al., 2005; Lindsey, 1997). Nimmon and Stenfors-Hayes (2016) while correlating “Bourdieu’s concept of doxa” help in “understanding how physicians subconsciously accept and internalize attitudes, knowledge, beliefs … without knowing they are doing so”. The authors say that this internalization puts a doctor in “positions of power”. The physicians become the expert on whom the patient is relying upon (Bending, 2014). This places them in a nearly autocratic position (Goold & Lipkin, 1999). Foucault does not state power to be linear because he believes that power from the top receives defiance from below (Foucault, 1972). He emphasizes further that no one is “passive” and has the possibility to defy oppression. So, in a way everybody is in a place of power and can claim it, but as roles, especially in a DPR are so well defined, that this goes unnoticed until something disrupts the “power relations”.

The book *Discipline and Punish* showcases that violence can create power (Foucault, 1979). He noted that, one can use violence to bring social order. This goes without saying that the one constituting the violence can thus change or control the dynamics of the positions of power. If we see this in the context of a DPR then WPV has the possibility of changing the power dynamics of the relationship. Applying Fiorenza's (2001) "Kyriarchy" to a DPR would mean both the participants, from time to time can be oppressed and oppressors. A violent act, in this case a workplace violence, then can help one party gain power over another and oppress.

In rural setups in India, there was a scarcity of doctors, so people who became doctors stayed back in their hometowns aiding their and nearby towns (Tripathi et al., 2019), due to which they became an integral and important part of families, and the community, and were rarely questioned about the treatment decisions (Hellenberg et al., 2018; Varma & Gupta, 2009). A better part of the doctor's job is making the patient aware about the illness. But with the advent of technology, a part of the physician's job was filled by technology that was aided by the Internet. The Internet provides a lot of free knowledge (Akerkar & Bichile, 2004), both credible and otherwise, as do other forms of media. Even this knowledge can provide power. The basis and credibility of information that helped gain knowledge is also important as one acts on the knowledge gained. So, the "Blind trust" is being replaced by "Informed trust" in a DPR by questioning and resisting the medical advice, thereby influencing it (Akerkar & Bichile, 2004; Tripathi et al., 2019), probably (unknowingly) in the quest of gaining a prominent position in a DPR. When this equality becomes hard to achieve, it is met with resistance. "Power is strongest when it is able to mask itself" and "can also be disguised as resistance" (Pylypa, 1998, p. 24). Resistance can fracture ties and disrupt societies (Foucault, 1979). When violence is used as an aid to depict resistance, the changes in the power positions seem inevitable. What probably causes this is the need to change the

power relations through WPV, which can be due to many reasons like lack of trust advancement in medical technology, and treatment costs. I will delve into this in the next sections.

Medical technologies and costs

Scientific advances have given the foreseeability of diseases with the help of new instruments and tests. The Foucauldian terms help us see that medical technologies are not just instruments but also various medical practices, may those be "technologies of bodily governance" like surveillance for population, disease, tests etc. "or technologies of self" used by oneself on one's own self like meditation and other cultural habits. An implicit conjecture rooted in both these technologies is that "material artifacts are things - in - themselves, and therefore ethically and morally neutral" (Lock & Nichter, 2003, p. 245). Shockingly, both have a lot of power to disrupt a DPR. A physician who is unaware of importance of culture in the patient's life might not pay attention to it and the patient might not be contented with his/her treatment process. It is important to know the patient's culture for a better treatment outcome (Kleinman, 1980). Dube (2022) resonates the same in his book *Indian Village* that in the early days, the villagers used to go to doctors only if the herbal medicines and "Divination, protective magic and spells" did not heal them and the health problem persisted for a long time. He adds that there have been changes in health seeking behaviors, as the people now believe in usage of injectable technologies. This happened because the access to cities became more easier (Dube, 2022) and the trust in medical technologies increased (Harrison, 2015). The western medications and health goods were marketed even by non-medically trained individuals (Harrison, 2015). The book *Anthropology of biomedicine* examines the biomedical technologies and their usage in medical care and elsewhere (Lock & Nguyen, 2010). The authors noted that the technologies are influenced by prevailing health, political benefits, and socio-cultural models. They say technologies are portrayed to be

essential and a part of denoting progress. Technologies are always supported by stating their importance for development of healthcare (Lock & Nguyen, 2010), something which we see in the Indian scenario too. The boom of private sector in healthcare of India is significant. The health sector in India is mainly dominated by the private institutions, yet rural India is mostly devoid of it, so people usually go to government PHC's (Kasthuri, 2018). The role of private health care system in India gives a good idea about the burden. It is responsible for 'eighty percent of the total healthcare expenditure' as compared to 'twenty percent by government sector' (Garg, n.d.; Jain et al., 2015). With the healthcare GDP among one of the lowest in the world (Khanna, 2022), it demonstrates how poorly funded and limited the public sector is, and probably why government hospitals lack facilities and trained staff (Iyengar et al., 2022). With lesser than the WHO advised 1:1000 doctor-patient ratio (CBHI, 2018; Garg, n.d.), lack of PHC's (Sethi, 2022), about one tenth of PHCs lack doctors and staff, basic instruments like stethoscope among others (Kasthuri, 2018), and are based far from rural areas with the cost of commute being equivalent to a day's wage (Singh & Badaya, 2014). This is supported by the National Sample Survey Office's (NSSO) report, which uncovered that people prefer private hospitals even though they have access to PHCs (Jain et al., 2015), probably as they consider them superior, modern, and developed as compared to PHCs. Balarajan et al. (2011) in their research mention that in both the health sectors, a long-term burden of treatment of a family member could lead a household to poverty. In turn, poverty also affects the individual's reach in accessing healthcare, especially in lower- and middle-income countries (Das, 2018).

Expenditures due to medical technologies directly affects and burdens the DPR. The advent of biomedical advances brought with it its regulating laws too. Consumer Protection Act (CPA) articulated in 1986 brought the medical systems under its umbrella in 1995 (Barapatre & Joglekar, 2016). They report that the patient has thus, become a consumer now

and expects to be provided with services that are worth his/her money. van Maanen writes that "*Quality health care*, from the patient's point of view, therefore may most simply be seen in the framework of patient's expectations versus actual experiences" (as cited in Sitzia & Wood, 1997, p. 1831). Thus, the patient might not always be satisfied, and they might consider certain outcomes as 'good 'or 'bad' when in reality, the outcome achieved might be the best possible scenario, and 'good' or 'bad' medicine might just be a personal understanding (Mallia, 2012).

Another expectation in a DPR thus is that a certain level of professionalism is needed in practice. In his comprehensive study, Kleinman et al. (1978) notes that professionalism actually distances the patient and the doctor, a doctor is more fixated on medical aspects like anatomy, physiology etc. of the disease than the actual relationship. The shift of the patient to a client is also due to the "Consumer organizations" who "influenced the consumerist approach to health care" (Sitzia & Wood, 1997, p. 1829). This has also made the physician observe services through the patient's lens (Armstrong, 1991; Meredith et al., 1993), shifting focus to patient's satisfaction. The sole purpose of the DPR then shifts on to avoid dissatisfaction of the "client" (the patient). This has also initiated a shift from paternalist or friend like relation to a "buyer" and "seller" (Beisecker & Beisecker, 1993, p. 50). They point out the irony that, when we discuss about who has the autonomy in a DPR, we get to know that none of these two players do. They also state that it is the insurance agencies and corporate health setups who have an upper hand in the DPR. With the shift in focus towards the patient's i.e., the client and their satisfaction, in came the corporate hospitals. They became the forerunners and dedicatedly attempted to be more 'hospitable' for the patients (Kabat-Zinn, 2020). The evaluation and quality assurance of a DPR became important. It is not that easy as it is in any other consumer client relationship, as it relies on many factors. On the jobs front, they provide lucrative salaries to health professionals thus, are more preferred

by doctors over a government job in remote cities and rural places where there is lack of infrastructure and poor pay (Marathe et al., 2020). The author also throws light on medical education system, stating that there are more private medical colleges in India that charge heavy fees so that by the time a medical student becomes a doctor, he/she has a big burden to pay off their fees, while in addition the quest of specialization over burdens them. The fee disparity between medical seats is significant, where the private college fees are nearly double that of a government seat (MBBSCouncil, n.d.). There are some accounts where the authors say that with this burden of educational loan, the doctors prefer to work in private hospitals. However, authors also claim that this is the reason why some doctors are exploited by setting monthly targets on revenue generation which could lead to prescribing unnecessary tests in fear of losing their jobs (Marathe et al., 2020). According to them, this is the harsh reality of practicing in the private sector, and the advent of corporate clinics makes it nearly impossible for smaller private setups to sustain as in no way can they compete with the financial backing that the corporate setups have. They also note that the public sector on the other hand is massively understaffed with poor infrastructure and technologies. In both these setups, over prescribing or under prescribing can strain the DPR. The repercussion of over prescribing due to above stated facts or under prescribing due to lack of infrastructure, and targets can both lead to the lack of trust in the doctor.

Lies and trust in a doctor patient relationship

Clinical diagnosis is very important in treatment, and this can be achieved only by honest information exchange during the two-way communication in a DPR. Bok's (1999) book *Lying Moral Choice in Public and Private Life* analyzes the moral dilemma in truth telling in professional relationships likes the DPR. She goes on to say that both parties seem to withhold information and what is withheld or disclosed matters deeply to the person being treated. Not just the truth but lies too can be devastating. Ekman (2009) defined "*lie or deceit*

as when one person intends to mislead another, doing so deliberately, without prior notification of this purpose, and without having been explicitly asked to do so by the target" (p. 28). The author says it is done in two ways, by concealing or by falsifying. Both these ways have a different intent behind them. On one hand, the gravity of the cases influences why a doctor would or should conceal the truth (Korsch & Harding, 1998), while on the other hand, a patient lying could have serious repercussions on treatment régimes (Kernberg, 1995). Fainzang (2016) establishes that both the actors in a DPR lie; one does to prevent retribution and awkwardness while explaining diagnosis, while the sick lie to hide their symptoms to avoid shame and rejection. Dutton (1987) notes Hippocrates's advice to the doctors:

> Perform your medical duties calmly and adroitly, concealing most things from the patient while you are attending to him. Give necessary orders with cheerfulness and sincerity, turning his attention away from what is being done to him; . . . revealing nothing of the patient's future or present condition, for many patients through this course have taken a turn for the worse (p. 48).

The advice does not prohibit lying (here concealing) but is shown to be used as a skill for the welfare of the patient, as he listed *primum non nocere*, first do no harm as the primary crux of medicine (Wenegrat, 2001). A physician's lie is contemplated as a *white lie* as these lies have a protective connotation, and hence are befitting even ethically (Fainzang, 2016).

As per Charaka in Ayurveda, lying or deception are essential armors of a doctor (Wujastyk, 2012). A Physician should use it with discretion (Wujastyk, 2012). Sushruta's teachings resonate with the same point:

> A patient may mistrust even his mother, father, children or relatives but places trust in the doctor. He himself gives himself over and he does not distrust him. Because of

that, the physician ought to protect that patient like a son (as cited in Wujastyk, 2012, p. 125).

Wujastyk (2012) emphasizes that Sushruta pays a lot of importance to the patient's trust. He says that this makes a physician become worthy and to upkeep this worthiness, the physician needs to remain noble in their act. Every patient evaluates and 'tests' before trusting a practice (Skirbekk et al., 2011). They add that, even after this, a DPR can be of an "open or limited mandate of trust" (pp.1184 - 1185) as a lot of factors then play a role. Every patient analyzes a lot of parameters before deciding to consult a doctor (Chauhan & Campbell, 2020). They say it's the trust on the clinician, or clinical setup, that helps one pick whom to consult. Scambler (2001) notes that in a DPR, the doctors "paternalistic form of, I am a doctor I know best" (Graham and Oakley, 1981, as cited in Scambler, 2001, pp. 53-54) and a 'conscious deception' of using medical terminology is a means of getting control and consent. The author says the doctors also unknowingly use 'unconscious deception' that is a methodically distorted communication which ultimately culminates into trust. The caginess by the doctor can sometimes (not always) lead to mistrust too (Hall et al., 2001).

A patient's vulnerability plays a role in trust in a DPR. The graver the ailment, the more vulnerable the sick person is, and this increases the probability in trusting the physician (Hall et al., 2001). Patients who have trust in their doctors tend to "develop effectiveness in treatment and activating self-healing mechanisms" (p. 617). They mention, it is only when an adverse reaction happens, do they reevaluate the trust by talking to their friends and family, and sometimes they give their clinicians the benefit of doubt. The authors also point out that in a DPR, both are vulnerable (patients more than physician) and two-way trust is important for effective treatments.

Another element in this trust is also based on which stream of medicine is practiced by the doctor and the hospital. India has many systems of medicine; Biomedicine comes under the Ministry of Health and Family Welfare. The T&CM have a separate ministry called the Ministry of AYUSH. Of late, there is a newfound attractiveness to T&CM in India as it's believed to be safer and more effective (Cant & Sharma, 1999). It is not uncommon for people to use T&CM as first remedies (WHO, 2014) and also use Biomedicine as an ad-hoc option to cure ailments (Chatterjee et al., 2012; Spudich & Menon, 2014). It is singularly preferred only during emergencies (Ahmad & Sharma, 2020). Today, with the standardization, commercialization and professionalization of Ayurveda practice, this knowledge and understanding seems to have been lost (Mathpati et al., 2020). Similarly, in biomedicine, commercialization and consumerism has seeped in since coming under the purview of consumer laws. Thus, Pellegrino (2012) laments that "professional competition, profit, honor, and prestige" (p. 22) have become a hurdle in the DPR and trust. This commercialization of the DPR is also portrayed in visual cultures and open to interpretation to the public, hence it is in need to be assessed.

Intertextuality and politics of representation of media generated image of doctors

"They need us during this pandemic so they will never show doctors in bad light" (Doctor 3).

In our visually saturated surroundings, we are constantly flooded with texts (Werner, 2004). The texts have become a part of our everyday life. They can be in any form. They may be written, spoken, in the form of images or language etc. The main approach that intertextuality operates with is that all these texts are interrelated (Werner, 2004). He further says that it "operates through the eye of the beholder", the audiences who derive the meaning based on "what they see in light of what surrounds or is referenced" (p. 64). Intertextuality is

a core concept in the world of visual media anthropology. The viewer's vision is an important part of this process where he/she decodes the texts. By vision it doesn't mean actual sight, but the way a text is decoded by the person. The meaning of the text here can be different for different people. In literary studies, 'texts' is a broad term. Not just the actual written and spoken texts, but it also includes visual and audio media (Werner, 2004). A commercial released by First Games (2020) in September, showcased images of violence and power. This commercial was about a boy being slapped by his coach. He is questioned by the coach, *life mai khelna hai? ya cheer karna hai* (in *Hindi,* it loosely translates to do you want to play or just keep cheering for others). Seeing the boy hurt, his friend suggests that the boy should join a different coaching center. The abused boy agrees, but the next day he chooses to go back to his coach. The other half of this commercial shows the young boy learning a 'straight drive'. It is a signature style of an Indian cricketer Sachin Tendulkar. The advertisement ends with Tendulkar reminiscing his straight drive and encouraging everyone to make the right choice, in a way hinting the boy made the right choice of going back to the coach who assaulted him. The commercial generated a lot of hate on social media for attempting to normalize the violence and assault of a child (afaqs! news bureau, 2020), while some media applauded the struggles of the boy (presumably young Tendulkar) in the advertisement. According to Hall, a greater part of people's understanding of the world relies on meaning created by the media producer (Bishop, 2021). When violence is naturalized, it gets culturally ingrained as a way of life (Vyas, 2021). The same article also stresses that violence in entertainment surges violent behaviors in people. Similarly, the normalizing of workplace violence against doctors and healthcare setups by the media is also a possibility. Mirzoeff (2016) explains how people see their environments. The author mentions the "invisible gorilla test" while highlighting "inattentional blindness" (pp. 85-87). In simple terms, if people are asked to focus on a certain aspect of an image, they completely ignore and miss

out on the other intricacies. “Our judgment corrects the perception of sight” and ignores what is in front (Mirzoeff, 2016, pp. 70-71). This “inattentional blindness” is the basic core of various magical illusions, shows and media reportages (Mirzoeff, 2016).

It is not uncommon to find a stereotypical doctor in Indian cinema who is depicted as a privileged, greedy, materialist/capitalist person, may that be in print media or in new age Indian cinema. Enlightening about Hindi cinema, Dwyer (2010) says: “that Hindi cinema deserves our attention … This does not mean that film reflects Indian society; rather that it shows us how life should or could be” (p. 381). Many movies like The Doctor released in 1940, Najma in 1943, Anand in 1971 etc. have depicted a doctor in a hegemonic role. In all these movies, the doctors are shown affluent, entitled, having cars and being well-groomed and well presented, so as to display them as elite, and are hence addressed as *Doctor Sahab*. This address of *Sahab*, which means ‘Sir’, is a term used since colonial times to address someone in an elite societal position in India. It is interesting to note that this phrase is still used to address doctors in India (Kumbhar, 2022). In a movie of 1980s named Clerk, the male protagonist (a yesteryear film actor of Hindi cinema named Manoj Kumar) asks his brother to get a doctor for a home visit to cure his ailing father, but his brother is unsuccessful (Chandaver, 2018). He asks, why didn’t the doctor come to which his brother replies *kehne laga ki mai mandir ka pujari nahi jo daan aur chadave ke paise se prashad batu* i.e., the doctor said he is not a priest, who gives free offerings (to people) from the donations that the temple receives (Jay Hind!, 2010). Similarly, a movie named Gabbar is Back released in 2015 where the male protagonist (an Indian actor Akshay Kumar) plans to sue the capitalist doctors and gain money. He takes a dead man to the hospital, whom the doctor admits in ICU in an attempt to make money (Viacom 18 Studios, 2020). Finally, when the doctors declare the person dead, the male protagonist reveals that the man was already dead, and that the hospital should pay the deceased family a compensation to avoid a medical negligence case.

He later slaps one of the hospital staff, smirks and says, “good shot”. The IMA released an official statement asking the actor to apologize for defaming the profession (Press Trust of India [PTI], 2015). In another similar case, Amir Khan (a Hindi film actor) aired an episode in his show titled *Satyamevajayate* (translates to truth will prevail) showcasing the same stereotype about doctors and refused to apologize to the IMA (PTI, 2012). Through both these examples, we observe a propagation of a stereotype through prefixed ideologies. Hall says that meanings of text can be set through ideologies (Bishop, 2021). The representation theory states that stereotypes fix meaning to the images which in turn produce knowledge. “Stereotyping reduces people to a few, simple, essential characteristics, which are represented as fixed by nature, it naturalizes and fixes difference” (Hall, 1997, p. 257). One can also note that in these media examples, the phrase of Doctor Sahab is used every time while addressing the doctor politely but then the Sahab is eliminated when the difference of opinion initiates. Stereotyping, in a way leads to othering, a separation of “us” form “them” (Derrida, 1972). The author argues that “between binary oppositions like us/them, we are not dealing with ...peaceful coexistence ... but rather with a violent hierarchy. One of the two terms governs the other or has the upper hand” (p. 41). Thus, the media that generates these texts is in a position of power and can influence audience by building narratives.

A Para Social Relationship (PSR), as mentioned by Horton and Wohl (1956), is when the audience has a one-sided relation with actors. The authors say that the audience believes and perceives the relation with media actors to be as that of friends and family, and hence trust them. The media tries to fix a dominant meaning to the texts and when this meaning is repeatedly presented to the viewer, it can lead to narrowing of a society’s perspectives of the topic. The PSR can thus, help in forwarding the fixed meaning.

Tuchman (1978) mentions that media producers set frames that the viewers decode, and this hegemonic media offers limited, and agenda driven information (Bishop, 2021;

Scheufele, 1999). When they show these texts repeatedly to the audience, it fixes a meaning, and leads to naturalization of the texts (Hall, 1997). Although scarce, a good doctor stereotype is also presented by some texts. Hall argues that the people's reaction to the media produced texts is based on 'reception theory' (Bishop, 2021). Hall says there are 3 ways of reading a text 1) dominant, 2) negotiated, and finally 3) oppositional (Bishop, 2021). So, as, and how people decode the text, and find their meaning, that is how they will react. He adds further that the meaning arises from "shared conceptual maps", which are heavily influenced by the culture and society one lives in.

The coming of the pandemic saw various assaults on healthcare personnel. The doctors were saluted for risking their life and demonized every time a new COVID -19 wave arrived. The mass panic due to the unknown disease and home quarantines led to lesser in-person appointments. Hall emphasizes that when technology replaces face to face contact between people, the technology gains power (Bishop, 2021). Frequent assaults on doctors were regularly reported by the media. The texts about doctors being verbally and physically abused were so commonly reported that the Indian government had to bring in an Ordinance to amendment the Epidemic Diseases Act. These texts were available for interpretations and correlations. These intertextualities help the people generate their own meaning and read them as per their cultural background (Hall, 1997). Conflicts too are grounded on cultural background and 'social memory' (Schmidt & Schroeder, 2001). If certain acts are accepted and normalized in society then these images could probably encourage the people to act violently - something, that was seen during the pandemic. The New York Post on March 21, 2020, reported that doctors in Delhi were forcibly evicted from their homes for the fear of them spreading COVID-19. No action was taken against the landlords who manhandled them (Reuters, 2020), and following this, such events were seen in Pune (Scroll Staff, 2020) &

Bangalore (Kulkarni, 2020) too. When such acts go unpunished, their images are permanently available for some other audience who can gain meaning out of them. The media produced texts are generally made by keeping the user's opinions and curiosities in mind and these in turn influence the audience's views too (van Bekkum & Hilton, 2013). This would mean the projection of healthcare personnel is heavily subjective to people's perceptions (Hoyle et al., 2018)

A Business Standard article mentions a Deloitte study that has concluded that there will be around "1 billion smartphone users by 2026, . . . with rural areas driving the sale of internet-enabled phones" (as cited in PTI, 2022). The same article mentions that with over a billion mobile users, the demand for internet is at its peak. The foremost familiarity or understanding of internet to a user in India is generally on the mobile phone (IANS, 2021). Dip in the cost of data plans paired with extensive usage of phones makes producing and distributing media fairly easy and usual (Farooq, 2018). Over one fifth of the global WhatsApp users are Indians, as this is the highest downloaded application (Farooq, 2018).

> In *Empowering Visions: The Politics of Representation…* (2005), Christiane Brosius says, This dynamic development of the Indian media landscape heightened the transformation of the public domain, affecting … fields of power and representation. When such mass exchange of more and more texts and similar images are made available for the user, it leads to meaning generation based on their conceptual maps (as seen in Farooq, 2018, pp. 108-109).

Something similar was seen in a case where fake WhatsApp videos showcasing Muslims being purposely infected with COVID-19 by healthcare workers, resulted in an assault on the healthcare team doing surveillance in other Muslim dominated areas (Ghatwai, 2020). These shared conceptual maps probably influenced people to resort to violence. A

study done by Hoyle et al. (2018) on media projection of WPV against healthcare workers noted that:

> Although, media stories highlight that WPV is not acceptable, the reporting does not appear to adequately address the causes of WPV… The regular reporting of WPV and the lack of attention to reduction and prevention may lead to the continued normalization of WPV (p. 69).

The routine showcasing of violence by media leads to its normalization (Monteiro, 2005). Although, intertextuality and workplace violence have seldom been read together, it is not incorrect to say that intertextuality has a significant influence on WPV especially as engagement with intertextuality enriches meanings by helping the viewer position themselves in the text and act on it based on their conceptual maps.

Chapter 4. Fieldwork findings

Quantitative research findings

The survey was undertaken by seventy-five doctors across India who were having more than one year of experience as registered medical practitioner. The findings supported the hypothesis that WPV is prevalent and all of the doctors in this study have encountered, either as a victim or as a witness, some form of workplace violence. From all 75 doctors surveyed, 72 (96%) responded that WPV is mainly caused by patient attenders, 55 (73.3%) believe that the visual media's projection of doctors is mostly negative and 61 (81.3%) suffered anxiety while seeing the next case after encountering WPV.

Day to day experiences

In this study, I was able to find some themes in the topic and elaborated herewith. The themes will also showcase responses before and during the pandemic (note - the grammatical composition of the interlocuters has not been changed).

Theme 1- Denial to be associated with WPV

Of the six doctors that were interviewed, four (male doctors) responded by saying they had never experienced WPV but had witnessed it when it happened to their colleagues. The two women doctors seemed to have no problem accepting that they experienced WPV; one said, "it was an indirect incident" and the other "but indirectly" (note that the participants were not quoted to prevent their identity revelation). Based on their interviews, it is important to note that the two women doctors were a witness and not victims. They associated themselves to the WPV but "indirectly".

The WHO definition on WPV was unanimously agreed to be comprehensive, but one of the doctors had an additional remark on this definition. What was seen that at the start of the interview when they were asked about whether they had ever faced a WPV against

doctors, nearly all of them unanimously seemed to be in denial - “I have never faced WPV, but I have seen many colleagues to have gone through WPV” (Doctor 1).

> Actually, I have had no experience of workplace violence . . . Once I was threatened that’s it. The patient family scolded me that if anything happens to our patient, we will do this and that. This was long time back . . .20-25 years ago (Doctor 2).

Another doctor resonates with the same idea.

“I have sort of encountered it once, but it can’t be termed as complete violence. . . He was abusive [verbally] and he was about to hit me, but I was secured by the security personnel at the hospital.” (Doctor 3). The participant then goes on to explain another WPV that he/she faced a few years back but adheres to this notion of not having suffered WPV as in both the instances, it was nonphysical violence. Doctor 6 is surprised that I refer to verbal abuse as WPV.

> You can’t practice in India and think that verbal abuse is WPV. Theoretically, it may be true but hmm . . . it is not WPV, who will report WPV daily? Since the day a doctor starts working you come across patients or attender saying things about you. (Doctor 6).

> Verbal abuse like passing of comments is very common in India, compared to whatever we see in western countries. That almost all 100 percent of the doctors would have gone though it … Whenever WHO defined it, I don’t think they have taken India into consideration; person who did it is a westerner (Doctor 1).

Further explaining this, he tells me that the westerner who defined WPV did not consider the Indian point of view and that is the reason why they have listed verbal abuse as a workplace violence. Otherwise, they would not have done that as verbal WPV regularly occurs in clinics. Another participant had a similar viewpoint while explaining the conditions during the COVID-19 pandemic. “During the pandemic, people were scared of the disease.

They used to run away from hospitals of the fear that we will infect them. Then who will abuse [physically]?" (Doctor 4). "Blaming us and verbal abuse its common even in pandemic, but it's not WPV" (Doctor. 6)

Theme 2 - Unexpected turn of events and politicization

All the participants of this study have worked in both public and private sectors, which includes working in all the departments like outpatient, in patient and emergency department. It is noted in the interviews that none of them were expecting a WPV. Most of the participants faced this in critical care and emergency room.

> I was an intern, patient succumbed to illness, they [attenders] didn't understand why it happened, and how can this happen suddenly, so they started abusing the treating doctor, things escalated quickly . . . The Casualty medical officer came to the location, and he started to calm them, but they [attenders] were so much afire that probably they could not be calmed down. They just slapped him! He was not at all involved in the case! (Doctor 5).

The participants mention that it is hard to determine when a verbal spat changes in to a WPV.

> We were on burns ward night duty, I pushed the patient's attender back, his [attenders] hands were on my friend's neck, he was throttling my friend and I pushed him [attender] and slammed shut the ward door … he [attender] wanted to see his patient at 3 am in the night and my colleague did not allow him … after this my friend was shaking, and I didn't know what happened … it was all too quick (Doctor 6).

On enquiring about procedures before the event, Doctor 5 said, "It is a part of official procedure … Informed consent was taken, and procedure was followed". "The problem is that the patient does not know what treatment the doctor is giving and what is the fault, and if the patient dies, they say that you [doctor] have done the mistake" (Doctor 4). The

participants also frequently reported that patient attenders seem to take matters into their hand. While remembering a case of a rural posting, one participant described

> There is a primary health center, this is nearby to Pune, so what some doctors used to do is that they hardly used to go to the center. There was a delivery case. It was a difficult case… the lady was brought to the PHC, and the doctor was not there. Unfortunately, that child died … The politicians threatened him. They punished him to stand in the sun until he fell down and became unconscious and was then shifted to hospital. The patients asked, *why were you not there? the government is paying you* [emphasis added] (Doctor 2).

> They can't do that! For God's sake we live in a democracy we have laws! It is not jungle raj [rule]. I am not saying doctor is correct all the time, let's say he she was wrong, but how can you just declare a punishment like that? are you a judge? . . . Umm, this happens, you do not expect it, but it does (Doctor 6).

A consensus noted in the interviews is that most of the participants feel that politicization of WPV is possible. They might or might not be related to or just be sympathizers of the patient, but they enter the picture during bereavement process. "In my opinion the patient is not the proper judge who can judge whether the doctor is working or not it is their opinion or outrage that they do this WPV" (Doctor 4). While explaining the same case of the rural PHC doctor, Doctor 2 said, "This is politics. . . they [politicians] want to show the people that *we help you*". According to Doctor 5, the political influences are regularly seen in private hospitals in urban cities too:

> I won't name him, he was corporator [elected representative] and his mother was admitted in the ICU. He was standing out. The doorkeeper was not allowing him inside. Obviously, because it is an ICU, nobody is going to allow that right! You

> don't know who I am, I am a corporator here . . . he started yelling [at the staff and doctors].

During the pandemic, Doctor 4 says the events were unexpected too, as they happened even during basic disease surveillance. "I saw this [WPV] on news, they are doing the surveillance, and educating about COVID and the whole lane came out in a mob … What will the health care personnel do?"

Theme 3 - Self-doubt and anxiety

Even though everyone went through different incidents at different times, they appear to share a common reaction of being on guard. On the same note Doctor 3 emphasizes, "I had anxiety . . . but has not changed me yet, but there is a fear . . . I have fear of getting beaten up". Doctor 1 added:

> Unfortunately, some of the colleagues as we know have changed their profession the ones who have gone through very horrid situations [of WPV] … it affects the doctor physically and economically … it is more of an emotional thing to the doctor! When so much of care is given and when u get something else in return, and the return is bad, it will definitely affect him [the doctor].

When asked if the WPV affected them, Doctor 5 said,

> Of course, I did, I felt scared, it backfires on your whole morale, … and then you just feel this is not my cup of tea. It is just better to get out of the whole situation and find a good job. Then I got into a non-clinical field… It was not only because of the incident but yes definitely things changed after that incident.

Doctor 2 has a similar experience post facing WPV: "the patient was alright, he went to the bazaar, but I had anxiety for the whole day after that case. I was worried if I should give any one any injection or not!"

WPV affects the doctor very much psychologically… the main damage is psychological. Physical um, . . . you will recover, but whatever psychological trauma you get [due to WPV] you won't recover ever! Your temperament will change (Doctor 4).

Doctor 5 intestinally explained the experience with an analogy, "When one meets with an [road] accident we don't feel like touching vehicle, or we are even scared to starting the engine. Similarly, it [coping with WPV] takes time, we are humans."

Theme 4 - High expectation

While reflecting upon their experiences, the participants emphasize that the patients come with very high expectation. Here this theme would be divided in to two sub themes.

Impossible targets. The participants mention that the expectation of the attenders is very high and to be able to cope with this is very difficult. They say that they are constantly put to test.

> It is mainly the patient attenders from the scene of the incident like a trauma, accident or the patient might have attempted a suicide. They [attenders] think that they got the patient on time to the hospital, and it is the duty of the doctor to get him back [revive the patient] … Umm, in India the patient and all their attenders in a group enter the casualty and they want the treatment to happen in front of them . . . They say he [patient] is not responding now, get him out [revive] it is like ordering a pizza! (Doctor 1)

Another participant states that doctors are expected to treat patients even when there is no support of infrastructure:

> When the patient is on the death bed the doctor can't do anything obviously! But they [attenders] still expect that the patient is brought to normal hood . . . even a slightest deviation from the expected … can result into a physical violence, so you have to

> treat a patient even when you don't have the infrastructure … this patient expectation is too much (Doctor 3).

Lack of doctors and infrastructure. The participants mention that they feel they are overburdened at work. Doctor 3 says that eventually, the skills will be affected when the patient number is so huge:

> After seeing hundreds of patients [in a day] the patience runs out … skills are there, but those skills are not used when you don't have patience". All the participants mentioned that they have seen over 30 cases per day (sometimes the figures are in three digits) in their Outpatient department OPD.
>
> I have seen this myself, I was working in AIIMS, and the patient input [number of cases] is so much, so much! No matter how many doctors you have put on duty, it still is a shortage. There is always a shortage! It is beyond the limit of a doctor. Obviously, if a single doctor [is posted in OPD] then some problem may occur, the patient to doctor ratio is so much [low] that it is beyond the capacity of the doctor to give it a 100% (Doctor 4).
>
> In rural set up the PHC is the nodal hospital where most of the medical cases of the region are referred to. I have seen OPDs run hundred-hundred cases a day and in 8 hours would mean you have around 3-5 min per patient (Doctor 5).

Doctor 6 resonated: "they want you to discuss cases with them when you are trying to save lives … we get tired, tell me how this is physically possible?". "The COVID-19 pandemic revealed the flaws in the medical system pointing out to the deficiencies in the delivery of healthcare. Health infrastructure is very poor in public sector, it's better in private but the cost of healthcare is also high there" (Doctor 3).

Lack of filing of case, punishments, and security. "Security of the hospital plays a major role in support during the WPV. There is always a shortage of security, and the few security guards can't handle a mob" (Doctor 1). "In government we have a police station next to casualty that is still better, as people fear police" (Doctor 6). "All the attenders enter the casualty and the number of security available are minuscule 1 or 2, and most of this [WPV] is seen in night" (Doctor 1). Security may or may not be a problem as per Doctor 5, but people's lack of fear of laws and punishment is. Further states that "there are no strict punishments, so people don't fear to do WPV". On the legal case filling topic, Doctor 4 notes that doctors hardly file cases after a WPV. "We think, patient has just died and they [attenders] are in shock". Doctor 2 says even the authorities also discourage from filing. They say "tumchatach mitva" [solve it personally]. After the event, "He (doctor) is scared, there is a law to protect the doctor, but they [authorities] don't take you [doctor] seriously … that is why the doctors don't go to [file cases] you don't get the right verdict" (Doctor 2).

> During the corona times government had given proper security to our hospital a battalion of police force was posted in front of hospital, because ...cases [of WPV] were occurring, patients were dying, so intense security was given after a case [WPV]… probably why WPV decreased ... now they have withdrawn the security" (Doctor 4).

On enquiring about the Ordinance in the Epidemic diseases Act during pandemic, all the doctors revealed that they had heard about it.

Theme 5 - Trust

The theme trust was a common trope in the interviews.

> People they don't realize what is the seriousness of the illness, in spite of telling by the doctor that cases are very difficult to treat, they become very violent because of the thinking …whatever goes wrong is because of the mistake of the doctor… That is

> the main notion in the minds of the people. It is a wrong thing actually, but they don't realize, because at that time, they are in what is called a mob psychology they just go and hit the doctor. . . because they don't trust him (Doctor 2).
>
> WPV in respect of corona (pandemic) was less, everyone knew it was a deadly virus and they feared the virus. They never came to hospitals. If they come and fight with the doctor, they will get infected, so no one came … I think respect for doctors during the pandemic had somewhat increased at that time because people saw they worked so hard and many doctors died, they trusted us (Doctor 4).

On being questioned why did the participant mention 'had', the participant says, "now it is on a decrease, the patients are forgetting the sacrifices of a doctor" (Doctor 4). The participants stated treatment costs heavily influence the trust as a large amount of the population is below the poverty line. They also pointed that the costs of Out of Pocket (OOP) medical aid in India are significant. The participants correlate how these costs and expectations affect trust. Doctor 5 stated:

> There are 2 things that Indian people can't fathom - one is demise of patient and second bill. They expect 5-star treatment, but they should not be charged". The doctor further adds that, if any untoward event happens post treating, the patient, the attenders and the family is furious that it costed them money.

"Nobody wants to go to corporation hospital or because there is a wrong notion, but those people who don't have money; have no option. Only people with yellow cards [Below poverty line card] go there" (Doctor 2). "No middle class or rich would go to a government hospital, it is a social status thing … So, they consciously go to a private hospital knowing that it's expensive" (Doctor 6). "If u go to a 5-star hotel. There u cannot say *give me free food*, then similarly why are you [patient] negotiating with the doctor? If you eat a dosa you don't ask discounts" (Doctor 5). Further added that the patient always has a possibility of

going to a government hospital if he/she requires subsidized treatment. Another participant resonated “we didn’t decide the fees they should ask the government or the hospital, not us” (Doctor 6).

> Private hospitals cost a lot of money … Medical profession has become business. Now a days lot of private hospitals have opened, and they charge so high . . . Private hospital are of two types, one is the corporate, and they, are the ones who are making this a business (Doctor 4).

Doctor 2 states something similar:

> These hospitals decide the fee. . . They import many sophisticated machines, that cost a lot ultimately, they [hospitals] are going to get back money from the patients. We don’t know how much they should charge for this machinery’s test because there is no line of demarcation by the government.

Explaining about the costs and insurance schemes in private and public hospitals, Doctor 4 notes “The government has started Ayushman Bharat scheme that’s good”. Doctor 3 and Doctor 2 also mention the same. But Doctor 3 points out at a crucial point: “For terminal diseases and non-communicable diseases the cost of healthcare is high even in public setups … there are public insurance schemes, but they don’t cover complete population, and the cost”. Doctor 2 mentioned that “The XYZ [names an insurance company] previously they used to give all [money] now they have fixed the prices [reimbursement limits based on diseases].” The participant further adds “There is a limitation of drugs [medicines] also, you get the drugs free from corporation hospital or in government hospitals, but many times the drugs are out of stock so they [doctors] give you prescription to buy medicines outside”. This the doctor states affects trust. “When the infrastructure is bad or insufficient, referrals to higher center or diagnostics is standard procedure, but because they think there are cuts [referral fee] involved, they suspect the doctors” (Doctor 3).

During COVID-19, the cost of healthcare was soring. “It was a complete different ball game” (Doctor 5). “COVID-19 was new, the doctor as well as the patient all were learning” (Doctor 6). Doctor 2 had a similar personal experience:

> It costed a lot, even I was sick with COVID, cost of the treatment was so much that even ABC [names an antiviral medicine] was costing 5,000 to 6,000 rupees … for one week. All these chemists did a lot of black marketing, that is a very bad tendency in our country … Some doctor and chemist had a nexus, but bad elements are in all branches … Doctor’s in pandemic did a good job 70-80 doctors lost their lives.

Doctor 6 mentioned the change in patient health seeking behavior:

> That time people rarely questioned test, when we didn’t write CT’s, they wanted us to write tests, as the names of tests were all over the news. We hardly saw any negotiating as there was a mass panic … ‘*jaan hai to jahan hai’* types [loosely translated as life is more valuable than anything else, if one survives one can have the world] we had to convince people to not do the tests. *Even then they didn’t trust us*!

Mass Media’s influence on the DPR and WPV

The study also aimed to understand the influence of media and projection of doctors in general and when a WPV against them occurs. This section elaborates the finding on the topic, “Media usually hypes ... it will never give a neutral verdict it will be in the favor of patient; they should always give a neutral [view]… by putting up the news from both the people [the patient and doctor]” (Doctor 1). Doctor 3 responded similarly:

> In my opinion, the press, the media shows us [doctors] in bad light! Most of the time media is against the doctor …They try to show that there is no bias. But there is a bias, that doctor had committed something wrong, so he has suffered it [WPV]… due to media… there is some kind of fear [in the people], that there is bribery in the medical profession.

The influence of media on public was discussed and Doctor 1 said, “it does definitely influence, most of the news is going online and it [negative reports] affects the doctor”. Two participants had the exact same response to media influence, “Hundred percent it influences the patient” (Doctor 1; Doctor 4). “It [visual media] influences the patient so much that, they say we will go to someone who has a cheaper fee, as they think you are conning them (Doctor 6). Explaining the same Doctor 3 says, “they have seen this in stories on social media, movies etc. Naa so! [they suspect].” Doctor 5 emphasized that “people forget that medicine is a profession, and they cannot afford to give waivers and discounts to all the patients, and thus when the doctor charges a patient Rs. 50 extra, the patient sees them with suspicion and will so go to someone who treats them for free. The trust has diminished a lot!” (Doctor 5). “The way we are shown in media and movies matters too . . . doctor is always a money-making crook, unless of course it is in movies like Munnabhai (an Indian movie), then again, he was a crook who becomes a doctor” (Doctor 6).

While discussing the media in the context of the pandemic, it was interesting to note the commonality.

> Media was very positive towards the doctors, at least in the COVID-19 pandemic, there is a positive wave in projection for doctors, till when will it last, I don’t know … The media has exposed the poor infrastructure in public sector … At least now they acknowledge that we work in impaired places with poor infrastructure… They will support us now and then they will forget us, when one or two months pass by (Doctor 3).

The participant emphasized “I hope it lasts more, but when they need us, they show us in good light … it will go away when the pandemic goes away” (Doctor 3).

Chapter. 5 Coping with WPV

WPV is a very emotional and personal experience. While mentioning this one doctor said, “I don’t think even my family knows how this has affected me” (Doctor 6). This section showcased six themes.

Be more careful and ask for support

“I always watch over my shoulder; you start reading the facial expressions more. You see a new patient and the ghost of the WPV follows you, no one sees it and only you know it’s there” (Doctor 6). Doctor 4 resonated with the same views adds:

> “You can’t do much… you have to make yourself strong, as you can’t leave your job … be mentally prepared and be cautious for the next time”. Similarly, another participant mentioned “Watch over your shoulder…Don’t take it to heart that’s it!” (Doctor 3).
>
> I have my way of dealing with it, when I used to see a big group entering, I used to call the security or the policeman. I prefer having only one attender, at least you know that people won’t hit a policeman, you just have to ask for help (Doctor 6).

Another participant mentions that “it is not just the physical support, but one should ask for mental support too. Talk to the peers, vent out the frustration… I spoke to my peers, seniors and juniors they helped me a lot … they told me to be on the preventive front than overhelping” (Doctor 3).

Smell the roses

The participants emphasize the need for having a work-life balance.

> Enjoy hobbies… have a work-life balance give more priority to family than work … as we are essential services, we have to provide, but we have to reduce our stress.

> Treat patient as its your work don't get too attached otherwise it will disbalance your life … I don't bring my work home once OPD is over its over! (Doctor 5).

"One should take breaks from work sometime" Doctor 4. "You should smell those roses once in a while, right? I did that" (Doctor 6).

Provide evidence

> Participants mention that evidence-based medicine is now expected by the patient. Say 20 years back if I had told a patient to take medicine, the patient would have taken directly but at present, he says that why is this medicine taken, what is it for so and so, it's good to know the knowledge about it, as evidence-based medicine is expected everywhere. That's good! but if you want evidence-based medicine you should be ready to go through tests … Since the invention of social media, Facebook, internet the knowledge is more. . . *Googelopathy* [see appendix] cases are frequent …The trust has come down, so the solution is they have to spend money for evidence. We have to ask them to get tested, so that they [patients] have the evidence that they [patient] have an issue… so it can be treated (Doctor 1).

I am a XYZ [names his branch] people even from rural areas too want tests. It [medicine] is all evidence based now" (Doctor 4). During the pandemic Doctor 3 says: "Patients used to get their CT and test done on their own and come and show us. That is how much they believe in proof, so it's better to follow the same".

Conversate more

> We take more precautions . . .I see that we have done documentation and talk to the patient diplomatically as much as possible and recommend them the best possible cure. If they are not ok with us, we recommend them some other hospitals also. Keep all their option open, counsel them and only then we go forward (Doctor 3).

Doctor 5 stated, “You have to counsel them more. . . you have to understand who the decision maker for the patient is and talk to him”. Something which Doctor 2 mentioned too. Doctor 4 also stated, “you have to counsel more, explain every detail, they [attender] should feel you have done your duty”.

Spread awareness

Doctor 5 explains that:

> The doctor should know to talk to the patient attender and remind them that the only relation we share is through the patient, and bulling won’t help “*doctor ko todake kya hoga*” [what will you gain by assaulting the doctor] if you [attenders] think something is not correct, we need to tell them there are other ways to do it, violence is not the legal way. *law se jao* [use the legal route].

When an incident happened, Doctor 4 says the victim’s colleagues started spreading the videos and awareness about the WPV as the injured doctor was fighting for his life. “Other doctors should also know this is happening so that it should not happen with them”.

Emphasis on change in policies and laws

> Coping was also noted when all the doctors mention the influence of policy.
>
> Stricter laws to be made, strict punishments should be given who is harming doctor, hospital, or staff … we think who will file a case, patient has already died, the family is crying, nobody files in spite of them assaulting doctor (Doctor 4).

“Security is to be increased in the hospital and policy changes are needed, for immediate punishments for culprits, only then will it [WPV] stop” (Doctor 3). Same was noted by the other participants.

Chapter 6. Discussion Conclusion, Limitation

Discussion

The aim of this study was to understand and interpret the experiences of doctors in India who faced workplace violence caused by patient and patient attenders before and during the COVID-19 pandemic and how they cope after such incidents and their influence on the DPR. In this study, I also assessed the visual media influence on the DPR, and in turn on WPV. Online audio and video interviews with doctors were conducted with the help of a semi structured questionnaire. In these interviews, the participating doctors could openly express their concerns along with their day-to-day problems and disputes that help form their views and understanding of WPV. A survey was undertaken to quantify the problem where 75 doctors across India participated and answered a closed ended questionnaire. The data evaluation revealed five themes showcasing the experiences of the doctors, and six themes in coping after WPV.

The results indicate that they are in sync with the previous epidemiological literature research (as discussed in Chapter 3) on this domain, where lack of infrastructure, manpower and punishments/laws played an important role in influencing WPV against medical practitioners. But as qualitative research on the topic of WPV against doctors was scarce nevertheless, this study made use of theories & studies from medical anthropology, visual media anthropology etc. and investigated it.

One of the dominant themes was trust, where it was interesting to note that all the doctors believed that the trust in the doctor patient relationship had increased during the pandemic, but now is reducing and going back to what it was before the pandemic. This trust in a DPR is influenced by many factors like power relations, costs, media etc.

What this study adds to this topic is that it showcases the visual media's influence on the doctor patient relationships and how the power relations are changed during the act of violence. The participants also associate that the lack of trust is heavily influenced by the visual media and have a strong belief that the doctors are showcased in bad light, other than during the pandemic. As seen in the literature chapter, the separation of a doctor from a patient as two distinct entities is very evident in a DPR (Halford & Leonard, 2003). Derrida's (1972) explanation on "stereotyping" notes that people's notion of separating themselves and others i.e., "us and them", could lead to violent encounters. A stereotype of a doctor, as mentioned by a participant already exists in visual media's depiction of doctors in India. The influence of gender and caste on public perception of current doctors who are perceived as privileged is also noted in literature and fieldwork. It could act as a basis for correlation while reading other similar texts. The influence of gender and class in medicine is no longer the same as it was during the formative years of post-colonial rule. As mentioned in previous chapters, the medical seat allotment and recruitment both have had significant changes from what it was before. However, this trail of older texts of privileged and elite class still influences the image of the doctors today. This was also noted to have been shown in mainstream media. The results also support this, as most of the doctor's mention that the visual media influences the patients, who then shape their (patients') beliefs based on what they have seen. The Reception Theory of Hall furthers this idea, that people gain meaning from a text, based on how they read the text i.e., "dominant, negotiated, or oppositional" (Bishop, 2021). The patients could generate meaning from "texts" in hand and correlate it with other similar "texts". If a visual media text showcases a negative view on a person or event, then the correlation is done with other similar images. The "intertextuality" theory by Hall can be correlated with this finding, where the doctors believe that a "bad" image affects the DPR. All the participants noticed a change in the trust in the DPR during the pandemic

when the doctors were shown in good light by the media as “saviors”. This was noted after the Prime Minister of India asked people to hit plates and spoons to thank the frontline workers (ET Online, 2020). This added a new text for correlation and thus, probably was a reason why a change in people’s behaviors towards doctors was seen. But as Doctor 4 notes that this good or positive portrayal of doctors “will go away when the pandemic goes away”. They even noted that during pandemic, the WPV against them was less as the public trusted the doctors, and due to fear of disease.

Another interesting correlation with literature is where Hall mentions that technology becomes powerful when people use it to communicate than meeting in person (Bishop, 2021). The use of a neologism *Googelopathy* by Doctor 1 is a statement in support of this, where the participants mention that easy access to technology and internet has caused distrust in a doctor as the patients have extensively googled the symptoms and come to a diagnosis. This is not uncommon says Doctor 1, and hence the participants say that evidence-based medicine is encouraged as this trust in the DPR can be withheld mainly by providing proofs. The power that the people gain by accessing the technology reflects in the DPR along with the power of the media producers that control the internet and websites. This supports the hypothesis that the media projection could shape the people’s view, and in turn, the DPR.

It is interesting to note the change in power relations in a DPR due to impact of media and violence. As chapter 3 noted, that the doctor in a DPR is more dominant (Foucault, 2003). The act of WPV puts the doctor (who otherwise is in a dominant role) in a non-dominant role. It is important to note that the patriarchal stature (Szasz & Hollender, 1956) is also lost. Violence can create power (Foucault, 1979), and the WPV against doctors provides a possible change in power positions in a DPR, however temporary might that be. Correlating Fiorenza’s (2001) “Kyriarchy” here would then mean that during the WPV incident, both the

actors are oppressing and being oppressed until one ultimately succeeds to gain the power position.

The victim of violence is always vulnerable and not in the position of power (Foucault, 1979). This can be correlated with two results of my research; firstly, the position of being vulnerable is masked by the obvious 'denial'. All the participants (except two) spoke about being only a witness or indirectly associated with WPV, and only later unknowingly went on to narrate (at least) one incident of WPV that happened to them. The study's findings noted that the doctors unanimously agreed that verbal WPV is very common in day-to-day practice and is part of the job. One of the doctors even stated that the WHO's definition on WPV was extensive, and applicable except for verbal abuse, especially in an Indian context. The doctors attempted to separate themselves from WPV in many instances in my study. They did so by regarding the WHO definition unsatisfactory in an Indian context or saying that the verbal abuse is a day-to-day affair and mentioning that they have not faced any WPV. And the second theme that also correlated with this change in power is that all these WPV incidents mentioned were unexpected and due to sudden change in events, probably due to the changes in the power position. All the participants mentioned that they suffered from anxiety for some time (minutes, hours to days) post the incident. This has supported the finding of earlier research (Kaur et al., 2020; di Martino, 2002) where anxiety among victims of WPV is noted to be common and is also known to affect their future work.

The hypothesis that experiences post facing WPV and coping both influence the DPR, is also supported by results. The coping of doctors after the WPV showcased six themes as a measure which a doctor takes after encountering the WPV. On a personal level, the participants say they are always more careful and on guard and now ensure that they take support from peers. It was noted that they chose to be more distant with the patients now as compared to before and keep the DPR "very professional!" "We are treated as business… so

take it as a business" (Doctor 3), something which Kleinman also noted could lead to an imbalance in the DPR. On the other hand, the participants emphasized that they chose to spend more time with the patient and explain the ailment in more detail and counsel them, which is also in tandem with research (Anand et al., 2016). It is noted that the consultation duration plays a role in the DPR and eventually in WPV. The lack of stricter punishments and laws was noted by all the participants who appear to blame the shortcomings in policy making, as a way to cope after the incident. It was also interesting to note that all the participants knew about the amendment in the Epidemic Diseases Act, but none considered it to be a reason for reduced WPV during the COVID-19 pandemic, but instead noted the increased security and presence of less attenders, to have been the protective cape. Spreading the news of WPV and awareness among peers was seen to be eminent for coping. This awareness exchanged on a community level appears to act as a support system to provide a means of coping, this could have an influence on the DPR as "other doctors should know this is happening" (Doctor 4) shows that they want to keep themselves on guard and could go on to affect the DPR.

Conclusion

The study provides a new insight into how the experiences and coping of Indian medical practitioners, who have faced workplace violence caused by patient and their family/sympathizers during and before the pandemic, influences the DPR. The media's role in influencing the DPR and WPV was also investigated in this research. The quantitative survey acted as a support for the qualitative research by demonstrating that WPV was faced by all the participating doctors. This qualitative research presented that the trust in the DPR plays a role in incidents of WPV, which was shown to be influenced by visual media projection. It can be concluded that change in the power relations was a direct result of WPV that appears to be influenced by the projection of certain stereotypes and the image of a

doctor in visual media. The coping process of doctors showcases how they bring about changes in their day-to-day practice thus probably in a way, influencing the DPR in the long run.

Because the experiences of the medical practitioners who encountered WPV are primarily rooted not only in the DPR, but also in the failures of health systems, I suggest that changes at the policy level (especially after the pandemic, when the Epidemic Diseases Act is no longer applicable), with focus on laws that provide immediate, and strict punishments for WPV offenders could contribute to reducing the WPV in healthcare. On a community level, local hospitals, NGO's, doctors, and healthcare staff could consider taking interest in actively spreading awareness about WPV among public and peers. They can consider establishing better support processes for sufferers of WPV. The mass media, especially the movies and news reports, could attempt to avoid the projection of doctor stereotypes. On a personal level, the doctors could attempt to spend more time and create a stronger DPR. Understanding a socio-cultural background of their patients could help build better ties and equal stature of patients in a DPR. This could then probably lead to get better treatment outcomes and lesser incidents of WPV in future.

Limitations

Although with only 6 participants, this study covered a wide range of doctors from different systems of medicine like biomedicine and AYUSH. It consisted of doctors from family physicians to superspecialists. The sample size, although adequate for qualitative research as it mainly focuses on in depth analysis, could have the limitation that it did not properly represent all the areas adequately. Further research in this domain could consider having participants from either general practice or super specialty or more representation from each system of medicine. Future research could also try to add other qualitative methods like participant observation, which would be interesting to assess, but was beyond the scope

of this study due to the COVID-19 pandemic restrictions. The word count for the master thesis was limited and acted as one of the limitations.

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Chapter 8. Appendix

Googelopathy: The patient believes he knows enough to treat himself and only comes to you to get a written prescription for the medication he saw online. She comes to you just to ask for permission to use this and that because someone online says it works for her condition (as cited in Osunlusi, 2018).

Declaration of authorship

I hereby declare that my thesis with the title:

Workplace violence against medical practitioners in India before and during the COVID-19 Pandemic: Influence of their experiences, coping processes and the media on doctor patient relationships

1. is the result of my own independent work,
2. makes use of no sources or materials other than those referenced,
3. that quotations and paraphrases obtained from the work of others are indicated as such,
4. and that I have followed the rules and recommendations stated in Heidelberg University's guidelines on “Verantwortung in der Wissenschaft (Responsibility in Science)”.

Heidelberg: 26-06-2022 Signature: Aditi Kamat