The anatomy of violence

In-person observations of Obstetric emergency triage room in a medical college

- Mudit Joshi

Key words: medical college, ethnography, referral system

A medical college can be an overwhelming space, especially for someone who has had no prior exposure to formal training in medicine or very limited interaction with the medical fraternity. At first, the place can seem to be filled with its own set of idiosyncrasies, which can be quite insular from the outside world, but on a more careful examination one would appreciate the inherent interconnectedness of the place with the outside world. As an intern/researcher, while pursuing a post graduate degree in public health, I had an opportunity to sit near an emergency triage room of Obstetrics and Gynaecology department in a medical college for more than a month, and observe its day - to - day ebbs and flows. The main objective of the internship/research was to study and understand the patterns of referred-in cases coming to the medical college. What followed on the side lines were frequent encounters with violence, sometimes explicit and mostly implicit, in its varied forms (physical, social, psychological and structural).

The emergency triage room and the attendants' waiting area surrounding it can be described in a variety of ways where patients (pregnant women) keep coming in and doctors (usually junior residents) along with paramedical staff, in shifts, work around the clock to take care of the incoming patients. It's a place where a new life takes birth, however, the place itself can sometimes get extremely tense, dark and grim. Once in a while, residents and nurses could be seen rushing to save a life of a woman who comes to the triage room in a very critical condition. The tension, stress and anxiety during these times felt almost palpable. It was during these times one could see doctors loose their cool, and reprimand their juniors for the little mistakes that they would commit. Residents scolding, shouting and behaving rudely with patient attendants was a common sight. This was prevalent to such an extent that it was almost normalized and completely acceptable within the doctors' community and among patient attendants as well. Moreover, the behavior of nurses towards patient attendants was no different. However, occasionally few attendants would protest against this kind of behavior, but such instances were very few and the intensity of the protest was negligible. It must be mentioned that not all resident doctors behaved in this manner, some were quite gentle in their interaction with patients and their attendants, but majority of them were harsh and ruthless in their approach. This form of psychological violence was common, and normal for insiders, but quite disturbing for an outsider. However, it will be a mistake to blame the actors without looking at the environmental factors which compels them to act in a certain way. It must also be recognized that this violence is not always unidirectional that is, flowing from doctors to patients. It is now becoming a common experience, across hospitals and medical colleges in India, of doctors facing violence from the caretakers of the patients or even from patients themselves. The medical college where I was placed was no different. Although I never witnessed such acts of violence taking place, the hospital staff would talk about such instances occasionally among themselves. They would describe the brutality of physical assaults inflicted upon doctors and how gory these acts were. From their vivid descriptions, it appeared that the violence directed from patients' side towards the hospital staff was more explicit and physical in nature.

A medical college functions with its own set of distinctive hierarchies, among which some are more visible than others. For instance, there is a clear visible hierarchy between teaching faculty, senior residents and junior residents. This hierarchy often translates into certain power positions with those at the top of the hierarchy commanding undisputed authority by virtue of their position. These powerful positions are often misused to extract unfair advantages and have been internalized by the community of doctors working in a medical college setting. An example of this can be seen in the way workload is distributed among residents and teaching

faculty. Junior residents do most of the work in the triage room, thus becoming overworked and overburdened, tired, sleep deprived and frustrated. This has become a norm and is a form of systemic violence with those at the bottom of the hierarchy as its end victims. While doctors, having formal clinical authority, occupy the top position in the grand hierarchy of things in a medical college, security guards stationed near the triage room operated with informal power towards the patients and their attendants. Having being placed there to control the crowd in the waiting area, and to make sure that things near the triage room proceeds smoothly, they left no opportunity to berate patient attendants whenever they fell even slightly out of line. At the bottom of the hierarchy, were patients and their attendants: helpless, in pain and in need of care – navigating through humiliation and indignity. However, it will be a mistake to look at patients as a homogenous category; the socio – economic stratification within them needs to be acknowledged. Those belonging to lower socio - economic strata (often from the tribal communities and coming from far flung districts) were subjected to much harsher treatment from the hospital staff which can be attributed to the stigmatization of these people in-general based on their identity and living conditions.

As Shahaduz Zaman (2005), eloquently portrays in his famous medical ethnography "Broken Limbs, Broken Lives: ethnography of a hospital ward in Bangladesh", based on his fieldwork in an orthopedic ward of a government teaching hospital in Bangladesh, that there is no one standard 'universal' way in which biomedicine is practiced, that medical care is not purely 'scientific'; these are shaped by the broader social, economic, political, and cultural forces. For him the hospital ward is a microcosm of Bangladeshi society itself. Therefore, prevailing power hierarchies, resource constraints and structural violence, which are typical features of the social and economic fabric of a developing country, are reflected in the day - to - day functioning of the hospital ward as well. A similar lens can be used to understand the violent episodes taking place in the triage room. Many of the patients referred to the Obstetric emergency triage room of the medical college were referred there because of resource constraints at the peripheral facilities.

Common resource constraints were: shortage of human resources (Obstetricians not available and/or anesthetist not available, at all or at night), infrastructure related issues (operation theatre not functional and/or ICU not functional) and logistics related issues (blood/blood components not available). These resource constraints resulted in denial of care at peripheral facilities, hence, forcing the patients to come to the medical college. The issue of resource constraint is systemic and structural in nature. It forces patients to travel long distances from remote villages and towns to seek good care which should otherwise have been available close to them. This increases the burden of cases at the medical college with even mild cases landing there which could have been easily dealt with at the peripheral facilities. This results in staff working in the medical college being overworked and overstretched - adding to their frustration and pressure. Inside the medical college, structural constraints create another form of violence — where suffering is compounded by systemic neglect and bureaucratic indifference.

A critical and thorough examination of the Indian public health system would yield the conclusion that systemic and structural violence are embedded within the health system at all levels. Inter facility referral mechanism or referral system reflects and reproduces the embedded violence within the health system. Both the parties, patients with their caretakers and actors in the health system, are at risk of being exposed to this violence with very little to no safeguards. Occasionally there would be selective public outrage and media scrutiny against this violence, but that usually reduces the discourse to blaming individuals or parties involved rather than looking at the root causes behind the phenomenon. The remedial measures taken, thus, are mostly curative in nature and not preventive – trying to do quick fixes rather than addressing systemic and structural issues. This is where our collective failure lies, and if we wish to make serious progress on the issue of curbing violence (in its varied forms) in the Indian public health system then we must look beyond quick fixes and address the root causes issue.

Mudit is a public health professional who is interested in health systems research and policy action. He has a master's degree in public health from Azim Premji University, Bhopal (mudit.joshi23_mph@apu.edu.in).

References and notes:

1. Zaman, Shahaduz. Broken Limbs, Broken Lives: Ethnography of a Hospital Ward in Bangladesh. Het Spinhuis, 2005.

Activist by Name, Frontline Worker by Role, Exploited Women Caregiver in Reality

A Nationwide Analysis of ASHAs Reality

- V R Raman and Colleagues

Key words: community health, CHWs, ASHAs, front line workers, human resource for health, India

Context

The ASHA programme is marked by its continued and irreplaceable centrality to primary health care service delivery and community representation in health in India. Recognised globally by the World Health Organisation for their significant contributions during the pandemic, close to a million ASHAs in India are struggling, nationally, provincially, and locally, to receive the recognition they are due for wages and social protection benefits. We witnessed the intense contestation that they had to do over pay, workload, and status, with major mobilisations and partial gains for these important frontline workers in several Indian states. From both a front-line worker and a human resource for health perspective, ASHAs remain indispensable for the health systems across the country, yet continue to be structurally and societally precarious.

While the acronym ASHA stands for Accredited Social Health 'Activist', these workers are called ASHA 'Workers' these days by most the state and societal constituencies; however, for all official purposes, they are still treated as "volunteers" despite their workload becoming heavy, and multiple analyses suggest that they are performing at the level of full-time workers (Khandre et al., 2022). Their long-standing demands for worker status, regular wages, and social protection remain unmet.

At the end of 2025, the ASHA programme in India stands at a paradoxical juncture: it is structurally indispensable to primary health care and listed as the most critical frontline force, yet sustained through systematically undervalued, exploited, and feminised labour. Front-line narratives and labour struggles across states reveal how ASHAs bridge systemic gaps in human resources for health (HRH), even as their own status, income security, and career prospects remain precarious (Saha, 2025).
In this context, we conducted this situation analysis to inform the ongoing debate on the ASHA programme in the country, drawing on reported facts and ground-level experiences.

Methods

This situation analysis has covered:

- National-level policy and parliamentary documents on ASHA incentives and HRH planning under NHM.
- Press, Trade Union and civil society reports on ASHAs during 2025.
- Recent research papers on the ASHA programme.
- Perplexity AI has been used for preparing state-level summaries of a few states.

While the focus is on the year 2025, we have tried to cover the longer trajectory of mobilisation and reform, organised around their complex role of front-line (boundary) workers, the HRH implications, and state-level case studies. It is important to note that one of the authors is among the founders of the Mitanin Community Health Volunteer Programme in Chhattisgarh and among the system builders of the Sahiyya Community Health Volunteer Programme in Jharkhand. Both programmes are pre-NRHM initiatives, and the Mitanin Programme, especially, is seen as a pioneer programme that influenced the concept and design of the ASHA programme at the national level. The second author has also spent considerable time supporting the Mitanin Programme in Chhattisgarh. Hence, it is essential to note that the authors' first-hand experience would also have influenced the analysis.