

## **RESPONSE OF HEALTH CARE PROFESSIONALS AND SERVICES TO EPIDEMIC OF VIOLENCE IN INDIA - A REVIEW**

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The mainstream social sciences in India have largely ignored the fact that India is a very violent society. Although the investigation and documentation of political violence was started in a systematic manner by many small voluntary groups and the media much earlier (the 19 months of State of Internal Emergency in the mid 1970s provided impetus to it), the mainstream social sciences had not taken sufficient interest in the phenomenon. The other forms of social and political violence, viz. gender, caste, communal etc. were also analysed inadequately.

However, the decade of 1980s has heralded some change. For example, three edited volumes by Prof. A.R. Desai (1986, 1990, 1991) and in his recent study of Gujarat (with D'Costa, 1994) have brought together collection of documents and writings on the political violence and violation of democratic rights which would have otherwise found less recognition in the social science discourse. Similarly, social scientists have also started paying attention to the communal violence and violence against women. For example, the works of Asgharali Engineer, Veena Das (1992), Flavia Agnes (1990, 1992), Chhaya Datar (1992), Vibhuti Patel and many others have done much needed conceptual and empirical work on the subject. Due to their work certain types of violence which suffered from social taboos, such as rape, wife beating, child abuse etc have now found a place in the social science discourse and in the campaigns of concerned organisations. In fact, these concerns have altered the political agendas of many social and political movements. At the same time this has brought in its wake more concern for the victims and survivors of violence.

### **VIOLENCE AS A PUBLIC HEALTH ISSUE**

In this regard, the health care professionals have fared even worse than the social scientists. In the medical discourse in this country the concern for violence is conspicuous by its virtual absence. In much of the medical research, discussion and publications, the mention of the victims and survivors of violence, and their special medical needs and rehabilitation, is rare. Is this because the health care workers do not come in contact with the victims and survivors of violence? Answer is categorical "No". Violence invariably inflicts physical or psychological trauma and in any violence, the victims and many survivors come in contact with the health care workers. Survivors approach or are taken to health care services, for the treatment of their physical injuries and psychosocial trauma suffered. The dead victims of violence are examined for autopsy by the doctors. In fact, the medical record of violence on the survivors and victims constitute one of the important evidences for the police investigations and legal processes for punishing the offenders and compensating victims and survivors.

The figures quoted by the media and social science researchers from the various sources on the incidences of all types of violence and the estimated numbers of sufferers are indeed shocking. What is also shocking for the health care providers is that there is hardly any mention in our scientific journals and in the health policy documents on the implication of such a phenomenon for the health care services. While one doesn't want to sensationalise and exaggerate the phenomenon of increasing violence in our society, one also can't resist saying that for health care services it is a big but ignored epidemic of the present time. Its size needs

to be assessed, but sadly our public health experts have done little in this direction. Information quoted by us in the later part of this document, albeit insufficient, point to an epidemic which is bigger than most of the well-known diseases identified as public health problems. No doubt, therefore, the violence is a public health problem. It is absolutely essential that our health policy makers and the health care providers accept this fact, estimate the health care needs of the sufferers, train health care providers for their treatment and above all, reorient the health care providers in such a way that their work could become an important social instrument for preventing violence, for punishing offenders and for properly rehabilitating victims.

Unfortunately, the conscious response of the health professionals to one of the bigger epidemics of violence in recent times in our country has been grossly inadequate. They have either shown plain indifference or clumsy and adhoc crisis management attitude when faced with the situation of violence. This does not auger well for a profession claiming to have scientific basis for its practice. The implied failing in discharging *social responsibility* raises ethical questions for the profession at large in the country.

### **VIOLENCE AND THE HEALTH CARE PROFESSIONS**

The science of medicine incorporates sociological and epidemiological understanding. The medicine, and for that matter any science, not geared to the real social and epidemiological issues often loses its humanitarian content. As stated earlier, the social scientists have of late started responding to the phenomenon of violence. What is the reaction of health professionals? The violence does not leave the health professionals completely unaffected. After all, doctors also come from the social milieu which has varied and conflicting standpoints on the violence. To what extent is the attitude of doctors to violence shaped by their social positions and ideological orientation in our country? Answer to this question is not easy, as there has been very little empirical research conducted to find out health care providers' attitude on the subject and the extent to which individual biases get reflected in the medical practice. However, some indication on what is happening at the ground level within the profession is available from the investigation reports of various local, national and international groups, and some research studies.

**(a) Autopsy:** The way autopsies are conducted, the reports written, the access to the reports etc have been a bone of contention for long. There have been reports in the press about the pressure exerted by the police on the doctors to give favourable findings. The famous case of police custody death of Dayal Singh made the Resident Doctors' Association of the AIIMS (New Delhi) protest against such pressure is mentioned in the Amnesty International (AI, 1992) report titled "*Torture, Rape and Deaths in Police Custody*" which generated lots of controversy only a couple of years back. Similarly, the autopsy reports of two nuns murdered in a Bombay suburb and doctors' role in unscientific interpretation of its findings created great furor (Solidarity for Justice, 1991). In addition to the autopsy reports of these nuns, I also had an opportunity to go through a sizable number of autopsy reports of the custody deaths and the so called encounter deaths in last few years. In general I found several disturbing issues which have great implication for the ethical behaviour of the doctors involved in conducting autopsies. For instance, autopsies in custody deaths are normally conducted by the police doctors in police hospitals or departments in public hospitals to which lay people and other doctors have no access. An independent medical audit of work being done there is unheard of. This situation is neither conducive for good science nor for good ethics; and should make the profession at large suspicious of the standard of ethics practised, unless such suspicion is disproved by an independent body of the profession. Further, a study of autopsy reports of the violence victims would probably show that normally they have incomplete and often unscientific documentation. It is significant to note that the Supreme Court had to pass an

order in 1989 that all postmortem examinations held at the AIIMS be standardised. However, this High Court order has remained inadequately implemented. This is observation is corroborated by the way autopsy (not once, but three times) was conducted on the charred remains of Naina Sahni in the well known gruesome murder case involving a politician. While legal implications for such autopsy were highlighted, nothing has been written about the doctors involved. (Jesani, 1995).

**(b) Torture and rape:** There have been numerous official denials that the so called third degree methods of interrogation or torture are practiced by our police and security personnel. However, the evidence accumulated so far do not support such a claim. Some of the retired and senior police officers, “reared in the old school of correct policing” have publicly criticised the “new methods of policing” which are “supposed to be firm, unorthodox, effective and harsh, and they condone the use of torture, illegal detention and tempering with records, and in worst cases even condone execution by police officers of hard core criminals” (Rustamji, 1992).

The above-mentioned 1992 report of the AI cites 13 cases of custody deaths due to torture in the period 1985-89 in Maharashtra. However, a Bombay newspaper (*The Independent*, 1991) reported a study by the prestigious Karve Institute of Social Work, Pune giving the toll of custody deaths in Maharashtra to 155 in 1980-89 period. On inquiry, I (Jesani, 1995) found that of these 155 deaths, 102 (20.4 per annum) had taken place in the five year period of 1985-89 for which the AI had reported only 13. On analysing the causes of the 155 custody deaths, I found that only 9.7% (15) were admitted as due to police action, 44.5% (69) were attributed to suicide or acts of the accused, 7% (11) to acts of the public, 22.6% (35) to disease and illness, 13.6% (21) were termed natural deaths and in 2.6% (4) the cause was not known or record not available. I was further astonished to learn about some specific causes mentioned, viz. alcohol consumption (9 cases), hanging (45), jumped in well (3), jumped under the train (2), jumped under the autorickshaw (3), jumped under the bus (1), fell from the coat or bed (1), skin disease (1), giddiness (1), unconsciousness (1) and so on. Given the norm that every death in the custody ought to be investigated and proper autopsy done, such causes are not only incomprehensible but they create suspicion that a larger proportion of them were due to torture. The role of doctors doing such autopsies therefore need to be investigated by researchers and the media.

In one of the investigations (CPDR, 1990) of the police custody death in Bombay (of which I was a member of the investigation team along with two journalists and a lawyer), we found that the young victim accused of a petty theft was, in the course of interrogation, brought to a public hospital in serious health condition which included (as per hospital records), typical torture inflicted injuries on his wrists and thighs, bloody vomiting, pain in the region around kidney etc. He was given routine treatment and asked to go back to his torture cell by the doctor. It was also found that the doctor had taken case history and done medical examination in the presence of the police officer who had accompanied the victim. The doctor did not consider presence of the police in the doctor patient relationship unusual but termed it as routine and yet insisted that he did not suspect torture, as the victim never reported it to him. The victim went back and later died. Similar thing was found by us in an investigation (YUVA, MFC et al, 1990) of a gang rape wherein, inspite of the visible signs of injuries in regions which could make any medical person suspicious of rape, the male doctor turned away the patient with routine treatment of injuries simply because the woman could not tell him that she was raped. In this particular case the woman had reported rape to the nurse on duty but could not communicate the same to the male doctor. In another case of custodial gang rape and torture of a tribal woman by police in Gujarat (AI 1988), the commission of inquiry constituted by the Supreme Court found that two doctors at the government hospital were guilty of shielding the policemen and also for issuing a false certificate.

These examples, I have reasons to believe, only represent a tip of the iceberg. It is not that the doctors who often come into contact with the survivors and victims are always conscious accomplices in covering up the cases. A section of doctors involved are plainly ignorant about this aspect of medical work. Another section is indifferent to the plight of sufferer due to their own social biases against the victims and survivors. Such indifference is also produced by social pressure to conform to the dominant belief. Thus for instance, in cases of torture inflicted on persons labeled as terrorists, doctors often faithfully treat the injuries but show great reluctance in mentioning torture due to the fear of being seen as opposed to state's efforts at fighting terrorism, separatism etc. Besides, the psychosocial trauma inflicted by torture is completely ignored, often because there is no training imparted to them for managing such trauma and also due to low commercial value of such medical work. A third section simply believes that being in the employment of the government, the police department or the prison, they are bound by the orders of their superiors and the code of their service did not allow them to "blow the whistle". Another reason for doctors' apathy to these issues is that they consider themselves as mere technicians (as some doctors have often remarked, "we are doctors, we treat illness, we are not interested in torture or rape") and therefore they do not make necessary efforts to explore the causes and history. This is both inadequate science as well as inadequate understanding of medical ethics.

**(c) Family Violence:** The great surge of women's movement in the 1980s brought issue of violence against women on the political agenda of the country. Yet, a survey of violence against women in the less developed countries has shown that it is a grossly neglected public health issue (Heise, Raike et al, 1994). The family violence involves violence against women and children.

The violence against women and children is the most common form of family violence and it has social, cultural and religious sanctions. The studies done by Flavia Agnes in the 1980s in Bombay and other studies have shown that it cuts across the class and class barriers. These social variables only change the form of violence, not the high prevalence of it. In a study of 120 families done at the NIMHANS, Bangalore, Bhatti (undated) found that some form of violence against women was prevalent in all families, the physical and verbal violence being the highest (88%) in the low income families while in the middle income (43%) and high income (35%) families those forms were less prevalent. However in the latter groups, there was higher prevalence of social and emotional violence. In a large study of 230 women from urban middle and upper classes, Sathyanarayan Rao and his colleagues (1994) from the department of psychiatry in the Medical College at Mysore, studied the pattern and causes of psychological violence against women in the family and came to the conclusion that psychological and emotional torture are highly prevalent in the middle class families. In a study by Mahajan A, Madhurima (1995) of 115 women in the lower caste households in one village at the outskirts of Chandigarh in Punjab, it was found that as many as 87 (75.7%) women reported physical violence against them by their husbands. Further, of these 87 women, 58 (66.7%) said that they were beaten regularly. Similarly, the dowry deaths and their increasing numbers despite changes in law, point to the pernicious prevalence of family violence.

While women's movement has brought the family violence out of the closet and made it a social and political issue, the violence against children in the family and outside is still not properly recognised, except in the campaigns against child labour and the problems faced by street children. The studies on child abuse in India are difficult to find although our experiences suggest that the violence against girl child, including sexual violence, is as highly prevalent as the wife beating.

The role of health care professionals is highly ambiguous in cases of family violence. Although battered baby syndrome as a cluster of signs and symptoms for battered children was

medically recognised in the early 1960s, very little work on it by health professionals in India is available. Similarly, the battered wife syndrome is almost unheard of in the medical discourse in our country. A practical implication of such indifference of health professionals is felt by women's groups in their cases in the family court. In our discussion with women activists we were repeatedly told that in the cases filed in the Family Courts though the cruelty by husband is the biggest reason given by women for separation and divorce, they normally do not have any documentary evidence in the form of medical records to support their claims. This does not mean that such battered women never approached doctors for treatment when severely beaten up, but the medical record invariably showed the injuries as accidental. In many cases women had not reported correct cause of injuries due to social fears, in some cases when such reporting was done they had found the doctors uncooperative. The studies done so far on this problem have normally not paid much attention to the response of health professionals and health services. For instance, in the study by Mahajan and Madhurima (Ibid, 1995) neither in the survey conducted nor in the case studies, the response of health professionals and health services to whom many of these battered women must have approached from time to time for treatment is even explored. The child abuse while being a health problem in itself, it is also a public health problem in the adult life. For the abused children suffer from multitude of psychological problems crippling some parts of their lives when they grow to be adult.

**(d) Communal and Caste violence:** Most of the sociological studies have shown that the doctors hail from upper caste and class strata of the society (Ommen T.K., 1978, Venkatratnam R., 1979). With the phenomenal increase in the number of private medical colleges, the dominance of these strata is on the increase. It is interesting to note that in the anti-reservation agitations of 1980s, particularly of Gujarat in mid 1980s, the medical students played a very prominent role. For that matter, in the communal and caste mobilisations, a significant support has come from the professional classes, which include doctors. Our personal experiences with doctors at professional level and in our interaction with them in several health service studies in urban and rural Maharashtra, we have found the health professionals highly coloured by the caste and communal ideologies.

While day to day discrimination against women and lower castes in the provision of health care is prevalent and unethical, the role of health professionals during the large scale caste and communal violence has remained unexplored. During the communal violence in Bombay in 1992-3, we came across many doctors in public and private hospitals who justified the violence against minorities, but we also came across some who showed heroism at that time to take care of victims, although the number of the latter was much less as compared to the former. To what extent the caste and communal biases amongst doctors get manifested into overt discrimination in the treatment? This subject needs more exploration and research.

## **TREATMENT, REHABILITATION AND DOCUMENTATION**

All types of violence produce traumatic effect on the victims. The trauma could be on the body or on the mind. In a famous case of mass torture of villagers by the security forces in Manipur, although there were official denials, a team of doctors which also included psychiatrists visited and examined 104 survivors in that area after 22 months of the incident. They found that a very high number of them were suffering from the post-torture traumatic stress. They found that 36.6% were suffering from recurrent dreams of torture, 66.3% of disturbed sleep, 54.4% were not able to enjoy village festivals, food, sex and even friendship, 37.6% showed loss of self confidence, developed a sense of foreshortened future, etc. (Biswas, Das et al, 1990),

There is extensive work done on the treatment and rehabilitation of survivors of violence in many countries, it is conspicuous by its absence in India. The survivors of violence are special types of patients, and they would be missed, continue to suffer if not treated. While there is no

doubt about their individual sufferings, they also add into the socio-political problem. Their rehabilitation also has a socio-political dimension as the medical documentation could be a formidable evidence to get justice for them. An independent, conscious and trained health professional thus while treating cases of violence can also become a source of deterrence and prevention of violence.

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