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# medico friend circle bulletin

February 2026

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# Editors' note

The theme of the 52nd annual meet of the mfc, to be held from 20 to 22 February 2026 at Raipur, is **Understanding and Addressing Systemic Violence in Healthcare.** The meet offers a space for collective reflection, dialogue, and exploration of ways to address these challenges meaningfully.
The following are the sub-themes:

- Concept of 'Violence'
- Violence experienced by Healthcare Workers
- Violence experienced by Healthcare Users
- Reasons underlying Violence in Healthcare
- Initiatives to Mitigate Violence in Healthcare
- Concept of 'Non-violence', 'Dialogue' and 'Justice'

In preparation to the annual meet three webinars were held.

1. Violence against frontline doctors in India: Understanding the structural and systemic factors (21st January 2026)
2. Seeking Healthcare amidst Structural Violence: Experience, Solutions and Way Forward through Community Voices (5th February 2026)
3. Truth, Non-violence and Justice: Reflections on Addressing Violence in Healthcare (11th February 2026)

The recording of these webinars may be accessed on the mfc website (mfcindia.org).

This issue of the bulletin carries the background note and the background papers prepared for the meet. The background note is also available in Hindi (translated by Anil Bamne), Malayalam (translated by P Premnath), and Marathi (translated by Maya Nirmala) and is available on the mfc website (mfcindia.org).

We also note with a saddened heart the passing away of two friends: Anil Pilgaokar and T. Vijayendra. Anil was the mfc convenor from 1990 to 1992 and was instrumental in steering mfc through one of its crisis periods. Mfc remembers them with great fondness and in gratitude for their contribution.

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## *About MFC*

*Medico Friend Circle (MFC) is a nationwide group of socially conscious, secular, pluralist, pro-people, pro-poor health practitioners, scientists, and social activists interested in the health problems of the people of India.*

*Since its inception in 1974, MFC has critically analyzed the existing health care system and has tried to evolve an appropriate approach towards health care that is humane and can meet the needs of the vast majority of the people in our country. It is an organization that has operated as a 'thought current' without allegiance to a specific ideology. Its only commitment has been to intervene in and understand the debates, policies, and practices of health in India. The understanding that our present health service is lopsided and is in the interest of a privileged few prevails as a common conviction. It has critically been analyzing the existing health care system and has tried to evolve an appropriate approach towards health care that is humane, and which can meet the needs of most of the people in our country. It tries the foster among health workers a current that upholds human values and aims at restructuring the health care system.*

*It offers a forum for dialogue/debate and sharing of experiences with the aim of realizing the goal outlined above and for taking up issues of common concern for action. It is a loosely knit group of friends from various backgrounds, medical and non-medical, often differing in their ways of thinking and in their modes of action. But the understanding that our present health service as well as the system of medical education is lopsided and is in the interest of a privileged few, prevails as a common conviction.*

*For more information: https://mfcindia.org*

*science belongs to everyone*

Illustration by Gayatri

than institutional processes. Addressing epistemic violence, therefore, requires not only better communication but structural changes that acknowledge physiotherapy's distinct knowledge base and its central role in improving patient outcomes.

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# Violence as Routine

## How Institutional Conditions Shape Healthcare Workers

***- Sangeeta Rege, Ajinkya Deshmukh, Nancy Angeline, Amruta Bavdekar***

**Key words:** institutional violence, health Systems, medical hierarchies, gender based discrimination

### Introduction

Extreme forms of violence against healthcare workers such as physical violence and attacks by families or relatives on health workers (ToI, 2025) or brutal instances of sexual assault and murder (Singh, 2024) draw significant media and public attention. This compels the state to respond to public outcry following such incidents. They often involve knee jerk reactions such as deployment of police or private security, extending CCTV surveillance and enactment of stringent legislations as public attention fades, these reactions seldom translate into actions and almost never lead to improved redressal or better working conditions for health care workers. While the extreme incidents of violence receive media attention, there is no attention to the routinised "violence" against health workers in the health institutions. The perpetrators are from within the institutions as well as outside.

This article focuses on resident doctors and frontline health workers because, taken together, they capture how violence is produced and sustained across different positions within the health system. Resident doctors occupy a paradoxical location—formally privileged within medical hierarchies yet rendered vulnerable through excessive work hours, weak institutional protection, dependence on seniors, and frequent exposure to patient-facing violence. Frontline health workers, positioned at the lower rungs of the system, experience routine gender-based violence shaped by insecure employment, limited authority, and close engagement with communities. Examining these two groups together demonstrates that violence against health workers is not episodic

or exceptional but systemic, structured by gender, power, and institutional neglect—necessitating prevention and response mechanisms that go beyond reactive, security-driven measures.

Violence against resident doctors has emerged as a critical concern in India in the last two decades but lacks substantive effort to understand underlying causes for it. Though doctors continue to be at the top of the hierarchical health system, resident doctors do not seem to have the same standing. Their roles are characterised by prohibitive work hours, deplorable living conditions, inconsistent and erratic stipends. Several Resident doctors continue to experience harassment as well as incidents of violence by seniors in the health system as well as from the relatives of the patients. Around 40% of the resident doctor work force comprises women. Gendered vulnerabilities of being a woman resident continue to be a peripheral issue (Garg et al., 2024).

Similarly, we also encounter increased feminisation of the health work force at the lower levels of the health care system. These comprise of ASHA, Anganwadi workers, ANM nurses and Community Health Officers. They too continue to experience gender-based violence due to their high vulnerability within the health system as well as outside.

This article seeks to present the experiences of two distinct categories of health workers, one is the front-line health workers and the second group are the resident doctors and argue for an urgent need for a gender sensitive and gender informed prevention and response mechanisms to deal with violence against health workers. In the course of a residential workshop ASHAs and ANMs they spoke of everyday experiences of scolding and humiliation at the hands of senior health care professionals of the formal health system

ABC, 38 years old describes *"As ASHA and ANM nurses we are always out in the field working. but when we attend monthly meetings, being scolded and humiliated for some gaps in documentation is routine. Though we do not get timely salaries for months, we never stop our work. I think higher authorities are unaware of the discrimination we face in the community. Some houses do not even allow us to enter due to our caste. We have to stand outside until the family member comes out, and they will speak to us from the gate. No one looks in to these issues of how we are treated"*

LMN, 28-year-old ASHA pointed out that all the work is being done by women workers in the community, yet the meetings are presided by medical officers who neither make the effort to understand the work undertaken nor acknowledge the hard work put into it.

Many workers noted that the work simply does not end because the data entry is carried out only after returning home or to the health system and without understanding the number of hours spent there is a tendency to keep adding new programs for awareness building and new formats for collection of data.

Most ASHAs or ANMs stated that they refrain from raising these instances of violence with concerned authorities due to fear of losing job or previous experiences of inaction when such issues were raised. Their experiences resonate with findings from multiple research studies across India. A mixed-method study across five Indian cities (Delhi, Guwahati, Kolkata, Jaipur, Hyderabad) was carried out with 601 women healthcare workers. The study found that a whopping 92.2% had experienced sexual harassment in their careers, with 50.7% in the past 12 months. Despite the common occurrence of gender-based harassment only 17.4% reported incidents. Of those 41.9% reported in action. The non reporting category of women disclosed barriers such as fear of retaliation, distrust in systems, and societal stigma (Islam et al., 2025).

Despite glaring evidence of attacks and maltreatment of ASHA workers in COVID-19, the states failed to put mechanisms in place for their protection or improving their work (Garg et al., 2019; Rao & Tewari, 2025). The routine devaluation of front-line workers coupled with instances of humiliation and scolding demonstrate an entrenched environment of overt violence, micro aggression and gender insensitivity embedded in the health system.
This section sought to present routine devaluation of front-line women workers both within and outside the health system. It demonstrated that despite the everyday experiences of humiliation, micro aggression and gender insensitivity, the health system

continued to respond suboptimally to their concerns.

**Plight of Resident Doctors**

A qualitative study of 135 women health workers in four Kolkata hospitals documented similar experiences amongst the women health workers. Of the 128 experiences of harassment incidents among 77 women: verbal harassment (41), psychological harassment (45), sexual gestures/exposure (15) and unwanted touch (27) formed the bulk of violations. Only 27 of 77 harassed women took formal action. But complaints against physicians were a rare occurrence for fear of consequences such as job loss or stigmatization (Chaudhuri, 2007). National statistic indicated that 46.58% of women experience workplace sexual harassment, yet only 3.54% reported to authorities. Consequences include emotional distress, psychosomatic symptoms, and job abandonment (Singh et al., 2014).

Doctors who mustered the courage of recording a complaint with hospital authorities found the procedure to be long, opaque and discouraging. The narratives presented below provide a snapshot of gendered violence experienced by resident doctors.

XYZ, 30-year Doctor narrates, *"As a woman doctor, my focus was having a successful career, I crossed several obstacles to reach here. But the conduct of a senior colleague made me rethink my decision; I wanted to withdraw from my high paying job. He passed comments on everyone's personal lives. Sometimes he would sit so close to me that it would make me uncomfortable. While I was thinking of leaving this job, my colleague advised me against quitting and instead reporting this to a committee in the college. I mustered courage to report only to receive cursory support. I was also told that the process of investigation is long and time consuming. But they at least transferred him to another department which gave me some relief. "*

*STR, 28 years Doctor narrates, "I am a junior doctor. A senior doctor was inappropriately pressing me for a date. I tried to ignore it several times. One day he touched me inappropriately. I was scared. I later told a friend who was supportive. She was the one who asked me to go to the hospital committee. I somehow mustered the courage and provided a written complaint. The enquiry went on for months and took very long. When the entire process ended, nothing came out of it. I was told that I am oversensitive. I just could not believe it. I am now seeking therapy. I wish I had not made a complaint; I hope no one has to go through this."*

In a rapid survey on stipends payments for Resident Doctors in Maharashtra, respondents (besides stating stipend concerns) explicitly expressed concerns about lack of safety and inadequate lighting in hospitals during night shifts due to minimal or no supervisors (CEHAT, 2025). Additionally, they were concerned about lack of security staff during night duty hours adding to their fears in the wake of incidents related to sexual assaults against women doctors. Many expressed apprehensions as well as inhibitions of approaching hospital-based committees for reporting harassment or violence because of lack of information on duties of the committee as well as limited understanding of what constituted harassment and violence. Respondents mentioned relying on their colleagues who would suggest ignoring, tolerating or withdrawing communication with the person harassing them and asking them to focus on their career.

Health institutions encourage a culture of endurance, long working hours, emotional restraint, and adherence to hierarchy. Within this culture, overwork and sleep deprivation are considered unavoidable. Therefore, issues related to gaps in infrastructure, safety and impact on psychological health are often dismissed. The same resident doctors enduring such a work culture may come to view such experiences as inevitable or even formative, thereby reproducing same practices.

**Conclusion**

This article argues that violence against healthcare workers in India is not an isolated problem, but one that is closely linked to how the health system is organised and governed. Repeatedly, serious incidents of violence are met with quick but ineffective responses. While these actions signal concern, they rarely address the everyday conditions that make healthcare workers vulnerable. As a result, violence continues in less visible but deeply harmful ways. Taking cues from scholarship on

symbolic and epistemic violence, particularly the framework outlined by Bunch, 2015, this article examines gendered normalisation of violence against healthcare workers.

By bringing together the experiences of frontline women health workers and women resident doctors, this article shows that violence cuts across different levels of the health system and ways in which gender discrimination is embedded in the health system. Despite differences in status and roles, both groups face challenges: long and demanding work hours, limited control over their working conditions, and grievance mechanisms that are difficult to access or trust. For many women, reporting violence feels risky and futile, leading to silence as a way of protecting one's job, reputation, or future. Over time, this silence becomes normal, allowing violence to persist without challenge.

The article also points to how professional cultures within healthcare—especially in medical training institutions favour values of endurance, obedience, and hierarchy. Gender informed policies and gender sensitive approaches continue to be conspicuously absent in the culture of health systems. Concerns related to safety, mental well-being, or dignity are often seen as secondary or personal issues. This mindset not only discourages reporting but also allows harmful practices to be passed on as "part of the system."

Efforts to address violence against healthcare workers must therefore go beyond reacting to extreme incidents. A gender-sensitive approach requires attention to everyday working and living conditions, timely and fair payments, safe infrastructure, and grievance mechanisms that are independent and credible. Without strengthening institutional accountability and questioning cultures that normalise harm, violence will continue to be accepted as an unavoidable part of healthcare work—at great cost to workers and to the quality of care they provide.

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