

**Kapil Babu Dahal**

## **MEDICAL VIOLENCE IN NEPALI HOSPITALS: SOME ETHNOGRAPHIC EXPLORATIONS**

### ***Abstract***

*Conflicts are inevitable by-products of human interactions, however, violence is not. This article analyzes the factors and context in which conflict and confrontations take place between the health seekers and the Nepali health institutions and health workers serving there. The prevailing reality of confrontations and medical violence in both the government and private hospitals show us that they may occur in any hospitals regardless of their ownership. Though medicine is not an objective and perfect science, nevertheless, its accuracy and efficacy has been projected in such a way that it has escalated expectations of patients. With esoteric nature of medicine, there is always communication gap between the service providers and the patient party. Such differential explanatory model also provides fertile ground to flourish conflict and violence against the service providers. The increasing confrontation also reflects falling trust between the service providers and the health seekers.*

**Keywords:** *Service Providers-Patient Relation, Medical Violence, Expectations of Patients, Medical Trust*

### **Introduction**

In Nepal, referral level health facilities and specialized health professionals are concentrated in few urban areas. Amidst this reality, when we look at their operation and relations with health seekers, a gloomy picture appears. The contentions between the health seekers and the service providers are emerging here as common phenomena; sometimes erupting even as confrontations and violence. In case of death or deteriorating health of a patient in the hospital, often, doctors are blamed for committing negligence. Sometimes, family members, friends and relatives of the “victim” go for physical attack on the hospitals and/or health workers. In response to such activities, severely affecting the health care system, health professionals have also gone to strikes, such as a three day long one during December 27-29, 2006, Mishra

**KAPIL BABU DAHAL**, Lecturer, Central Department of Anthropology, Faculty of Humanities and Social Sciences, Tribhuvan University Kirtipur, Kathmandu, Nepal, Email: kapil.dahal@cda.tu.edu.np

(2006) presents, in which all health facilities in Nepal were closed except for the “emergency services”.

With the aim of understanding this kind of inharmonious relations, this paper examines the dynamics of major facets, which have contributed in the emergence and perpetuation of confrontations between health service providers and the health seekers in Nepal. It sheds light on the pattern of confrontations between these two sides and the factors responsible for such situation. The central research question of this paper is why do the family members, relatives and friends, collectively referred here as ‘the significant others’ of the patients, sometimes go for violent actions against the hospital and/or service providers. This paper fills in the gap in Nepali medical anthropology, which has yet focused on the health care system in general and in particular on the context and pattern of relationships between the health professionals and the health seekers (Justice 1986; Harper 2002; Dahal 2017), by focusing on the confrontation between the two sides. Dahal (2020) has interrogated on how far paternalism and commodification has led to the confrontations in Nepali health care settings. This paper is not in line of medical nihilism, as Devanesan (2020) argues, which puts critique without understanding heterogeneity of medicine, rather critiques here are made in particular Nepali context.

Bjorkqvist (1997) argues that conflict emerges due to frustration and aggression. For him, aggression, like hunger, is not an innate drive; rather it is social in nature and can play an instrumental role to fulfill other drives. People learn socially to behave in conflict situations and their learning is essentially shaped by the cultural realm. Bjorkqvist asserts that though conflict is an inevitable part of social life, however, it is possible to avoid violence. Looking at conflict from the normative perspective, Coser (1956: 31) discounts the idea that conflict is always dysfunctional, instead claims that a certain degree of conflict is essential in the formation and persistence of group life. This paper critically examines the context in which Nepali health seekers and sometimes health care providers go for confrontations and their role in forming the group, or at least, the collective actions and approaches.

Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health (NIOSH 1996) have briefly defined workplace violence as violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty. On the other hand, for The U.S. Department of Labor (n.d.), workplace violence is an action which can be verbal, written, or physical aggression but it is intended to control, cause, or is capable of causing, death or serious bodily injury to oneself, others, or damage to property and includes abusive, intimidating or harassing behavior, and threats.

I would like to depart with both of these definitions for denoting “the violence directed towards the service providers” (The Joint Commission 2018)

only and solely implying blames to the health seekers. Principally, it cannot be denied that either side can be victim. I am aware that the most common form of violence in health care settings is from the side of health seekers (Howard 1996) and the workers in health settings are four times more vulnerable to victimization than those working in other sectors (Security Industry Association 2017). These data are from the US, but they are still helpful in comprehending the situation in Nepal.

Conflict arises when people take on antagonistic positions, hold divergent perceptions and ideas. When vital interests are threatened, people, whether in group or as an individual, show aggression, which may result in the form of violence (Bjorkqvist 1997). When the health seekers perceive that their near and dear ones died, got lifelong disability or ailment or are exploited economically and in some other ways, people take this as an attack to either their key interest or even threat to their survival, makes them violent. Therefore, confrontations in health facilities are more than what Ramsay (2001) regards as inability of people to handle the stress of life manifested in the workplace.

Insights from critical medical anthropological perspective, which “understands health issues in light of the larger political and economic forces that pattern human relationships, shape social behavior, and condition collective experiences including forces of institutional, national and global scale” (Singer 1986: 128), is a main theory employed in this paper to look at the pattern of conflicting relationship between the health care providers and the health seekers and the context in which it is interpreted and reproduced.

Health seekers and health workers have distinct notions to look at sickness episode and its treatment. They view ill health in distinct ways within their own healing sub-culture with their specific worldview. Kleinman (1980) is right to put forth that the consultations with the health professionals take place as transactions between the two differing “explanatory models”. In such consultations, enhancing the differences between the two sides, usually the health professionals do not pay adequate attention to the explanatory models of health seekers. Therefore, the naturalized conventional paternalistic relationship creates barrier for effective communications between the two sides. Service providers do not have patience to try to understand idiomatic, metaphorical and analogical expression of patients’ illness narratives (Dahal 2018).

Following this background context of the study and theoretical perspectives employed in the study, the next sections deals briefly on the research methodology and then primarily on the major findings of the study. Initially, the paper highlights some typical cases of confrontations whose analysis provided base for the development of this article. Then, it shows different forms of skirmishes and protests. The next two sub-sections discuss the role of

biomedical knowledge and its promises, as it prevails in Nepal, have raised people's expectations, which propel the hostilities. Then, it portrays how medical procedures adopted in Nepal themselves have become a source of barrier in delivering efficacious health care services which ultimately leads to the medical violence.

### **Research Methodology**

This article is based on a microscopic ethnographic study (Geertz 1973:21-23) not because it did not focus on large-scale interpretation but because it approached meta-narratives and abstract analyses through this approach, staying closer to the ground and focusing on "small places that speak to large issues" (Eriksen 2010). Since this study has focused entirely on the relations taking place within the hospital setting as a topic of study, it is also a form of hospital ethnography (Van der Geest and Finkler 2004). Considering the concentration of health facilities and heterogeneous populace, the study has been conducted primarily in urban settings, in different time in 2018 and 2019, in Bir hospital, Kathmandu and College of Medical Sciences (CMS), Bharatpur, Chitawan. These hospitals have been selected based on the prior incidents of confrontations between the service providers and the patient party.

In both the hospitals, I approached through my social networks. Considering the sensitivity of the topic, research participants from Bir Hospital, where I conducted the study initially, agreed to talk to me only in the form of informal conversations. Nevertheless, I have fully upheld ethical considerations through their informed consent about the conversations topics and accordingly not used their real name and designation while referring them in my writing and study presentations. Fieldwork in Chitawan also began through informal conversations with a medic in January 2018. As per the suggestion and recommendation from my contact, I formally sought permission for the conversations with the service providers. I welcomingly got approval for conversations from the hospital management.

The interactions and conversations for the study were held with members of hospital management team (2), medical doctors (7), nursing staff (4), paramedics (3), administrative staff (2), lab technician (2), and private pharmacist (2) from both the sites. Likewise, this article has also made use of information acquired from the patients and common people (9), mainly about their experience of their medical consultations. Altogether, I talked to 31 persons in their different capacities. The conversations were held at the office nearby emergency ward, out-patient department (OPD) of surgery, medicine, dentistry units, waiting room of the hospitals, and at a pharmacy.

I have also collected data from the online source of some of the selected national dailies and online media. I drew information from there since "the online material can always be considered in the light of our offline knowledge"

(Miller and Sinanan 2017: 4). This strategy of generating information compensated my limitations to reach to the sites of confrontations. I have made use of these online resources to generate information through the content analysis of news reporting and articles mainly in Kantipur, Annapurna Post, Nagarik, myRepublica, Onlinekhabar, and Swasthyakhabar over the last half decade and beyond. I chose only few cases considering their typicality and diversity of incidence. To have relatively fair and balanced information, I looked for the same news reported in more than one newspaper/news portal. Later on, I analyzed data from both the sources thematically. For me, the overall aim of data analysis was to dig out meaning rather than to measure the phenomena.

### **Consultations Leading to the Emergence of Problematic Relation**

The parties of both sides involved in the confrontations have regarded various situations as problematic. This article contains some of the representative cases which show the nature and causes of confrontations.

Mr. Kuldeep Bista, 30, was taken to a private hospital in Kathmandu. His mother had told the doctors that Kuldeep might have heart attack. She informed about that considering his preexisting health condition of hypertension and regular medications. The service providers ignored her. Rather, they were busy on doing treatment for the gastritis, which later on proved non-existent in him. Family members regard that the problem is with doctors who could not cognize ailment on time, which led to his death (Annapurna Post 2016), whereas, the hospital states that doctors have tried their best for his treatment. They confess that had they done patient's angiogram, it would have satisfied late Bista's family members and relatives.

As illustrated in the case of Mr. Bista it is evident that patient parties and the service providers have differential understanding of the incident, portrayed in the form of explanation. They develop differential understanding of the incident not because of their differential "explanatory models" (Kleinman 1980) alone but also because of their conflicting interest on interpretation of the incident. Their interpretation is based on their relation with the deceased and/or what kind of outcome they prefer to seek.

What Trishna K. C. underwent through exemplifies a case of medical negligence. At her early teen age, when Trishna had eye strain and headache, her mother took her to a private hospital in Tripureshwar. The consulting eye specialist referred her to another private hospital, also in the same area. The doctor in the referred hospital provided her some medication, which caused side effects leading to the loss of vision of her left eye, her body became unnecessarily fat, and eventually she suffered from multiple disabilities. For such negligence, with the help of a Non-Governmental Organization (NGO), she filed a case against the doctor. After four years, the Supreme Court of

Nepal came with the verdict to fine the hospital with Rs. 6,17,119.00(Kunwar 2011).

In another incident, a 16 months old infant girl, Helen Acharya was taken to Norvic hospital in Thapathali, Kathmandu for the treatment of her fever. Her father thinks that insertion of unnecessary thick pipe into her lungs caused the bleeding. When the family members suspected and pointed about this, the consulting doctor did not let them to take Helen to Kanti Children's Hospital. By the time, when an ambulance from Kanti Children's Hospital reached at Norvic with family efforts, then, doctors declared that the baby is no more. That made the family to protest against the hospital and the medical doctors involved in the treatment.

At the same private hospital located in Thapathali, assessment of the investigation committee of Nepal Medical Council (NMC) says that Mr. Sami Risal, 47, died because of some medical weaknesses and medical errors in diagnosis and treatment (Mishra 2014). Mr. Risal had been admitted to the hospital for the cure of vomiting, headache, diarrhea and stomachache. The NMC report identified that though Mr. Risal had consulted the hospital for gastroenteritis treatment, the consulting medical doctor could not recognize his neurological problem on time, which ultimately led to his death. The report further adds, when the patient became unconscious, neither was he provided with adequate emergency care nor was he sent for intensive care.

In another incident, Mr. Dinesh Pokharel<sup>1</sup> filed a case at NMC against a medical doctor from Bir Hospital dissatisfying with his neurological operation. He blamed the doctor for unnecessarily dissecting his body that could not improve his situation. He knew about the treatment failure from a senior neurosurgeon from another hospital when he went there for further diagnosis and treatment. The initial failed attempt at Bir Hospital made him to go for expensive treatment at the private hospital and thus had sought for compensation from Bir Hospital and the doctors involved in his treatment.

In an another case filed<sup>2</sup> against a team of medics at a hospital located in Swayambhu, Mr. Shankar Rimal from Kabhre district has complained against the doctors for advising him to go for surgery in the name of taking out kidney stones. His blame is that instead of stones, they took out his left kidney. They did not inform him anything about this but told his wife in privy of him and forced her to sign the contract. He complained against all involved in what he blames as taking out his left kidney without his consent.

The above mentioned cases, represent the different aspects of misunderstanding and confrontations regarding who are responsible for what had happened, how people interpret the incident, involvement of the mediating and regulating institutions in investigations, how the patient party reacted to the emerging situation and where the incident took place; whether at the private hospital or at the government owned health facility. The common theme

one can see in these cases is that contemporary medical practices in Nepal sufficiently lack to respect patient autonomy and they are not at the center of clinical medicine” (Sullivan 2003). These cases provide primary basis for further analysis and development of this article.

### **Various forms of Violence, Confrontations, and Protests**

When significant others of a patient perceive that the patient had undergone through the faulty treatment procedures and that had deteriorated his/her health situation or taken the patient’s life, then they chose to go for various forms of protests and confrontations. Nepali (2018) has illustrated a case of a doctor who was initially beaten by the patient party and later on threatened to sue with fake blaming if he would proceed for the legal action:

A doctor working in a District Hospital was severely beaten by the relatives of a patient on February 19, 2018. The doctors sued against those who attacked him for the attempted murder. In response, they threatened the doctors that they would sue him on the charge of rape attempt during the video x-ray unless he withdraws petition against them.

In their attack, patient parties mainly target the hospital buildings, and their wards, medical equipment and infrastructures (Banu 2017).

In relation to the death of 16 months old girl, her relatives and general people attacked on a hospital in Thapathali, Kathmandu. They smashed windows, doors and some computers of the hospital.

In his article published in a national daily, Budhathoki (2011) links the establishment of democracy in the country with increasing verbal and physical abuse against the doctors. In response, doctors have also called for closure of services several times. A doctor from Chitawan relates growing vandalism in the health facilities with the contemporary political situation. She thinks such vandalizing act reflects the lack of civic sense; otherwise, they would go for legal action. She is not happy that police cannot arrest the hooligans; rather, they arrest the doctors. She has realized that in the last one decade after the establishment of federal republic, people have become anarchic. Her linking of medical violence with the political change shows that “deviance against legitimized agents of social control” (Elston et al. 2002) is increasing.

Only few patients or care givers can find alternative ways to release their angst. Mr. Poudyal (2011) is one of them, who chose writing in a national daily about his bitter experience of being attendant for five days at Patan Hospital. Mentioned as “uncovered evil practices” in his writing, he aimed to shame the doctors and hospital enacting such practices. He reflects that the hospital stay had made him cynical about Nepali health care system and mistrustfulness of hospital and doctors in general, mainly due to the way his

wife was compellingly persuaded to go for cesarean delivery. Moreover, he blames the hospital for being infamous for making money from forced cesarean surgery.

### **Medical Knowledge, Expectations, and Promises**

Christian Missionaries in their way to Tibet and China brought biomedicine in Nepal in the 16<sup>th</sup> century, when it was on its infancy even in the West. Marasini (2003) states that traditional medicine could not develop as an effective health care system despite enjoying the privileges of main health care system of the country for more than a century. When Nepal entered into the democratic era in 1951, the influx of modern Western medicines were increasingly introduced into Nepal as part of the promise of national development. One of the thrusts of this era, Streefland (1985) states, was the expansion of health services through the establishment of health centers in the countryside. By the time hospitals (biomedical institutions) have expanded into Nepal, they have already transformed into an institution of kindness to an institution of professionalism implying great power to the medics (Starr 1982: 148).

Differential understanding of ailment among the doctors and the patients (Kleinman, 1980) leads to divergent explanations of treatment trajectory and its outcome. It is obvious that many patients do not understand biomedical terminologies and jargons. Their understanding of the ailment relies on the symptoms of the disease conditions and alternative ways of knowing health, illness and body. Therefore, patients cannot cognize what doctors really regard for the actual dis-eased condition. A doctor from CMS states:

Patients may visit the hospital with very common symptoms such as fever or stomachache. For them symptoms are the disease, whereas, in reality, they could simply be symptom of some severe disease conditions. For instance, stomachache can happen due to gastritis or because of a perforation in the intestine...so, we need to make treatment decisions not on the basis of what patients want us to do but what we think is right for them.

Nepali (2018) has clearly pointed out that it is not only the lack of proper knowledge about the medical education, rather, illusion and partial knowledge about the medical science is responsible for increasing confrontations. People consider a disease as normal when they keep trying with traditional healers. On the other hand, soon, such as in two days of medical consultation, they create hue and cry when the patient is not recovered. People have illusion that any kinds of ailment can be magically cured in hospitals and medicine is like *Amrit* that can make people immortal.

In my conversations with a medical doctor from Bir Hospital, he also expressed his realization that these days patients' expectations has increased,



whereas, it is not possible to recover from every ailment and diseased situation. He confesses that sometimes doctors have to treat the patients even if they may think that the patient may not recover. They have to do this for the comfort and pain management of patient. They have to follow the principle, which is expressed as- *sas rahunjel aas hunchha* i.e. till the patient is breathing, we have to hope. Echoing with his logic, Dr. Basanta Panta, a renowned neurosurgeon, in Dishanirdesh program at AP1 television (2019), states-

These days, people take their last breathe at hospital in their effort to recovery. With the existing notion of considering hospital as a place of treatment, their expectations naturally increases when the family members take patients to the hospital for reclamation.

Dr. Panta's statement can be extended that medicine cannot cure all the patients and always. Human body has limited life and that also cannot be calculated in advance. A patient's death has to be seen from this angle. This leads to developing understanding about the finitude of human life (Foucault 2003) rather than blaming the doctors for not being able to save the life or taking the life away.

The code of conducts related with medical profession clearly prohibits to advertise and to promise for guaranteed recovery (NMC, 2020). However, there are many instances of violation of such provision, unnecessarily raising people's expectations from medical services (Budhathoki 2011). These advertisements claim to have doctors with national repute, trained abroad, and who can provide guaranteed treatment. Some of the research participants related this kind of medical promise mainly with medical establishment's motive as making money. Mr. Kharel, Bir Hospital states:

Money making is there not only for the doctors serving at the private hospitals but also for those who are working with the government hospitals. The latter cannot make money only by checking the patients. They always want patients to go for excessive diagnosis, medication, and even for the operation. Patients have to pay for this, and this ultimately escalates their anticipations.

Patients' deference to medical authority role is essential for the functioning of paternalistic form of doctor-patient relationships (Parsons 1951). The increasing commodification of medication has contributed to the decline of a long enjoyed status of 'medical paternalism' (Buchanan 1978; Chin 2002) and patients have begun to make demand as per the cost incurred, both in terms of money and health and life of a patient. Declining medical paternalism has made people to be more concerned about the medication process. Health seekers in the process of moving from the stage of *Credat Emptor*, 'let the buyer trust' to the *Caveat Emptor*, 'let the buyer beware' (Potter and McKinlay 2005), amidst the prevailing inadequate legal provisions to address the differences, has been perpetuating the confrontations between the two sides

in Nepal.

Medicine has certain inherent limitations and scope, which places it in typical condition and circumscribes its capacity to address all the expectations of the patients. In his interview at Dishanirdesh program (2019) Dr. Bhagawan Koirala has explained the limitations of medical science in plain words understandable to non-medics as well:

The more lives I save, I further realize that I have less control over other's lives. In this process, I realize that we human beings are weaker. Outcomes beyond expectations make me think in this way. It is not because of poor health care provision, it happens even when we apply the state of the art practice. I realize that we are not the sole player in determining life and death of human being...we know that human brain operates all other organs. The consciousness operates the brain and the science does not know yet where consciousness comes from.

Unexpected outcomes have been identified by other doctors as normal in their efforts to treatment. A doctor from Bir Hospital relates this with the accuracy level of medicine, which is not a mathematical science. Sometimes a patient in hopeless condition may do *baurine*, recovery, whereas, many other times, it may not be possible to cure seemingly a simple ailment. He feels sorry that, in case of recovery, patient party would acknowledge the God, miracle or the doctor, otherwise, the doctor has to solely bear the blame.

Medicine is appreciated more as science in arriving at disease causation and diagnosis (Gordon 1988). Even the performance of a diagnosis may be affected by the level of knowledge, experience and perception of the doctor. A diagnosis trajectory adopted by a medic, thus, can differ with that of another. A medical doctor at CMS pointed:

Medicine is not only a science but also an art. Diagnostic accuracy and treatment depends on the "sensitivity and specificity" of the cases. Even if the best option might have been adopted, still, it may not be hundred percent accurate. Therefore, a procedure considered as the best option in a certain time and context cannot be judged retrospectively from another point...diagnosis report is affected by the timing of the test also. This is why indicators of diagnoses are in range, not in exact figure. Whereas, in case, a report from a lab differs with that of another lab, then the patient party would regard it as unreliable.

Another deductive logic can be drawn from the assumption that medicine is not a perfect science. Medical errors are not equal to medical negligence, they are completely different. A doctor from CMS states his grievances, "often general public and media cannot distinguish between them and present the errors as medical negligence. This can easily lead to the

confrontations". Whereas, another critical scholar (Baskota 2018), a medic by training, points out the prevalence of negligence in the broader health care arena, which could be because of lack of knowledge, inadequate technology, lately approaching to treatment or it could be because of noncompliance to ethical guidelines.

Limitations of medicine sometimes handicap its efficacy to diagnose and identify the problems. This places medicine in precarious condition and the weakness like this is often mistaken as a shortcoming of the doctor or the medical team. A doctor from CMS has pointed out that:

We always prioritize low cost examination of patients. We may not be able to trace out the problem even through the whole body check-up. Sometimes, it is possible to identify the exact problem only upon the death of a patient. Therefore, decisions regarding the diagnostic trajectory also have to focus on the economic condition of the patients.

When diagnosis and treatment of the patient entangle with its cost, then the doctors think that they have to adopt the appropriate treatment trajectory as per the specific situation of a patient. When appropriateness of the treatment trajectory is decided not on the basis of patients' pathological condition but on the basis of patients' economic situation, then, it affects the medical efficacy.

In his interview at Dishanirdesh program of AP1 television, renowned neurologist Dr. Basanta Panta (2018) has linked recovery of patients with his/her will power to retrieval. He pointed out that fighting with the disease is always a primary responsibility of the patient. The job of the doctors and hospitals should be supporting the patients to raise their morale and make them mentally prepared to fight with the disease:

We have seen that people with strong will (power) to live can survive from critical ailment. It is the patient who has to fight the main battle, we are simply the supporters. It is his/her biology and body which has to fight with the disease, and if s/he is not prepared mentally for that...this is why even a patient with the same degree of disease may have different outcomes.

Doctors are not the only one kind of actor involved in and affecting the treatment procedures. Referring to clinico-pathological correlation (Sullivan 1986), a lab technician from Bir Hospital has realized that these days there is pathological supremacy over the medicinal power:

Now, the doctor's job has been confined to *joda milaune*, 'arranging the match' and *khali thaun bharne*, "fill in the blanks". Their job is to look at diagnosis report and decide impact of different factors to the patient and accordingly prescribing the treatment trajectory.

### **Medical Procedure as a Barrier**

Medication needs to follow a certain procedure to arrive at treatment decisions including patient's admissions in the hospital. The procedures in the hospitals, mainly in the government health institutions, are often lengthy, not only because of the inefficiency caused by bureaucratization (Gupta 2012; Kleinman 1995) or unwillingness of the service providers for prompt service but also because of excessive flow of patients. Though the protocol does not say anything about how many patients can a doctor check-up in a day or how much consultation time is required to fully grasp the dis-ease condition of a patient, however, based on my observations in both the hospitals, I can say that everyday doctors check large numbers of patients, always making them in rush.

A lab technician, who worked almost for two decades in Bir Hospital, has observed that actually the procedure at this hospital often becomes obstacle for the patients to get services on time.

Patients have to pass through so many stages that each of them creates obstruction. They get saturated with frustration and irritation by the time they meet the doctor. Sometimes, they have to wait for hours to see the doctor. The doctors meet OPD patients on the alternate day. This makes patients wander for a week to show his/her report to the same doctor whom they consulted initially. Anything can happen to a serious patient during this time. Here, it is almost impossible for the common people to get ICU bed and swift treatment. Family members, relatives and connections of director, doctors, nurse, ministers, and political leaders are the ones who get ICU bed.

Emergency departments are more prone to confrontations with the patient parties. A medical doctor at Bir Hospital states:

Usually, patients come to the emergency department in tense situation. It takes significant time to get admission there. Patients are sent to the concerned department only after confirming their disease. For a patient's admission, a representative of the concerned department has to come in the emergency department, which may take a long time depending upon their workload in their own department. Patients in the emergency department may have to wait, e.g. for a whole day and by the end of the day, the doctors may say sorry to them for the unavailability of bed. In such situation, it is not possible to find a place in other government hospitals. Then, the patient party gets furious and sometimes quarrels with us.

Confrontational situation in government hospitals may arise due to their infrastructural capacity and inadequate sensitivity of their staff. Pandey (2016) has also stated that difficult working conditions, lack of cooperation of other specialties and hospital administrators, as well as rising healthcare costs

have all slowed the development of emergency medicine in Nepal. Based on their research from Chinese public hospitals, He and Qian (2016: 16) add work load of doctors as a contributing factor for creating medical disputes. I would like to emphasize that these factors have also created obstacles to provide on time, adequate and effective services to the patients.

Lack of protocol is common among Nepali hospitals. As NMC investigation committee has mentioned in case of Sami Risal, there is no clear treatment protocol at Norvic Hospital. This report has also pointed out the absence of reliable mechanism at Norvic even for the admitted patients to contact the concerned medical doctor. Compliance to clinical protocols are expected to decrease unwanted variation in care and improve compliance with desirable therapies (Sevransky 2015). Nonexistence of applicable protocol leads to confusion about how many patients can a doctor diagnose in a day and how much time they should give to each patient. This confusion further complicates the situation and deteriorates the quality of consultations.

Perceived sluggishness in consulting the doctor or furthering check-up procedures is not limited to government hospitals. Even in private hospitals, sometimes doctors have to hear such complaints. On the very day I have met Dr. Sharma at CMS, he was referring to a case he encountered at that morning in which he fought with a patient dissatisfied for waiting long time (about an hour). Doctors know patients' expectations from them to be able to turn up to them whenever they want to see the doctors, whereas, even if they are in the hospitals doctors can be busy elsewhere in the operation theater, classes or in the round in wards.

### **Conclusions**

Often conflicting parties interpret the same incident differently, based on their explanatory position (Kleinman 1980) whether they are in the side of patients or with that of the health facility or the service providers. Doctors and patients may have disagreement on what constitutes a health issue and its management (Goodyear-Smith and Buetow 2001: 45). In such situation, conflict can become an inevitable by-product of service providers-patient interactions. Medical conflict is also shaped by people's interpretation of what is good care, and it also reflects manifestations of their frustration and agonies (Bjorkqvist 1997). When there is loss of life, health or deformity, then it is paralleled by violence on the individuals and institutions involved in delivering health care services.

The narratives and information presented above show that service providers, whether they are medics or not, have begun to take medical violence as common phenomena and part of "normal" process of health care delivery. The normalization of confrontations also indicates that there have been inadequate efforts to address grievances of the conflicting parties, mainly the

patient parties. In parallel, there is also a tendency of associating conflicts with typical time, people and situation which helps to *exoticize* conflict as they do not take place in *normal* conditions rather they are the function of such time, place and conditions. Ultimately this kind of characterization has been made instrumental in representing confrontations to save faces of hospital, concerned doctors and the medicine itself. Unlike what Elston et al. (2002) claim from their study on workplace violence against General Physicians in Britain, participants of this research did not link medical violence with that of illness (of the perpetrators) rather they mostly linked it with the situation of lawlessness.

When there is dispute at the hospital, often people see that it is the patient party versus the physicians or doctors. However, the cases discussed in this article show that factors related with confrontations are not solely directly linked with the medical or diagnostic process. Hospital comprises of different entities which form a collectivity and they together contribute for its ultimate aim of medical services. In reality, inability of media and common people to see the differential role of hospital, doctor, lab and other service providers, makes them solely blame doctors for any failures or any dispute emerging at the hospital. Even if there is weakness in the service delivery process, it may not be always true to blame the doctors. This is why I have chosen to use the phrase service providers as generic term to denote this heterogeneity.

The incidences of confrontations in both the government and private hospitals show that it may occur at any hospitals regardless of their ownership. General understanding and perception of common people is that private hospitals run after money and in that course they may compel the patients to have excessive diagnosis and treatment. Along with the commodification of health care services (Henderson and Petersen 2002) even the hospitals which claim themselves as non-profit entity have also been blamed for running after money. On the other hand, often, confrontations associated with the government hospitals are linked with the bureaucratic procedures comprising of delayed diagnosis and treatment, partiality to the common people in favor of those having or who can establish connections with the hospitals, medical negligence, and problematic relations with the service providers.

Medical doctors clearly accept that medicine is not objective and complete science unlike common perception and sometimes even projected by the hospitals and medical colleges to appeal the patients. In addition to informing people about the kinds of services available with them, hospitals do not hesitate to cross the medical ethics and promise beyond the scope of medicine and thereby escalate people's expectations. Moreover, the esoteric nature of medicine and medical profession leads to communication gap between the service providers and the patient party. Amidst this, the increasing trend of confrontations also denotes the crumbling medical paternalism; people are becoming aware of and their knowledge about the appropriate way of administering health care services is also increasing. Commoners are claiming

through the performance of confrontations that they are no more ignorant and thus medicine is also no longer esoteric and people are questioning paternalistic administration. All these factors have collectively contributed to erode patients' paternalistic relation with their doctors.

As per The Public Health Service Act (2018) health institutions can refer patients only in certain conditions. In case, if there is no possibility to provide anymore treatment because of "structure, equipment..., lack of specialist's service or any other appropriate cause", it can refer "to the health institutions which can provide additional treatment to such patient". The practice of defensive medicine clearly goes beyond the permissible level of legal provision of referral. Increasing confrontations in the hospitals have threatened the doctors and made them to look for alternatives to be safe, curtailing their motivation to serve people. As part of this, they may adopt defensive medicine in their efforts to avoid confrontations with the patient parties (Goodyear-Smith and Buetow 2001). To reduce the gap between the two sides, physicians need to respect patient autonomy and produce patient-centered outcomes bringing patient's point of view back into the center of clinical medicine (Sullivan 2003) in their efforts to reduce the differences between the two sides and thus to avoid the confrontations. Health policy reform measures need to pay adequate attention to the restoration of healthy doctor-patient relationship as it is not less important to other aspects of health care reform (He and Qian 2016).

Confrontations and violence in Nepali hospitals can be interpreted as a plural form of manifestation of biomedicine. I would like to relate it with the contemporary situation of weak law enforcement mechanism and reliable apparatus to ensure compensation and reparation. It reflects the existing Nepali socio-cultural context of deepening and widening process of commodification, lack of law enforcement, and declining conventional authority of the social institutions including biomedicine.

### ***Acknowledgements***

I am indebted to the University Grant Commission, Nepal for providing research grant to conduct the ethnographic research based on which this article is developed. I am equally grateful to all the research participants from both the field sites, Bir Hospital, Kathmandu and College of Medical Sciences, Bharatpur, Chitawan. Likewise, my thanks go to all the media, reporters and authors whose articles and reporting have been frequently cited and consulted in developing this article.

### ***Notes***

1. A complaint registered (R.N. 64) at Nepal Medical Council on October 10, 2017.
2. A case registered (R.N. 488) at NMC on July 9, 2017.

### *References*

- Annapurna Post.  
2016. "Upacharma Laparbahi". (Text in Nepali- Negligence in the Treatment). Annapurna Post, 12/10/2016, Kathmandu: Nepal.
- Banu, P. 2017. "Norvic Ma Doctor Ko Laparbahi Le 16 Mahine Sishuko Jyan Gaeko Pariwarko Aarop" (Text in Nepali- Family Blames that 16 Months Old Baby Dies Due to doctor's Negligence at Norvic). Kantipur. 29/08/2017. Kathmandu: Nepal.
- Baskota, D. K.  
2018. "Ajhai Panch Barsha Gunastarhin Doktor Bhitrine Khatara" (Interview in Nepali- Low Quality Doctors may Come in Till Five More Years). Retrieved from <http://swasthyakhabar.com/news-details/14484/2018-01-02>.
- Bjorkqvist, K.  
1997. "The Inevitability of Conflict but not of Violence: Theoretical Considerations on Conflict and Aggression", in D. P. Fry and K. Bjorkqvist (eds) *Cultural Variation in Conflict Resolution: Alternatives to Violenc.* New Jersey: Lawrence Erlbaum Associates, Inc.
- Buchanan, A.  
1978. "Medical Paternalism", *Philosophy and Public Affairs*, Vol 7, No.4, pp 370-390.
- Budhathoki, P.  
2011. "Chikitsak Pani Sudhrinu Parchha" (Text in Nepali- Doctors Need to Correct Themselves). *Kantipur*, 2011-05-11. Kathmandu: Nepal.
- Chin, J. J.  
2002. "Doctor-Patient Relationship: From Medical Paternalism to Enhanced Autonomy", *Singapore Medical Journal*, Vol.43, No.3, pp152-155.
- Coser, L.  
1956. *The Functions of Social Conflict.* New York: The Free Press.
- Dahal, K. B.  
2020. "Why are there Escalating Incidences of Confrontations in Nepali Hospitals? An Anthropological Critique", *Molung Educational Foundation*, Vol. 10, Special Issue, pp 43-55.
- Dahal, K. B.  
2018. "Through the Metaphor: Reflection and Reshaping Selves, Situations and Health", in L. P. Uprety, et al. (eds.) *Contemporary Nepali Social and Cultural Anthropology: A Reader.* Kathmandu, Nepal: Central Department of Anthropology, Tribhuvan University.
- Dahal, K. B.  
2017. *Anthropology of Health Seeking Practices and Consultation with Service Providers: A Study among the Women in Nepal's Tarai.* Ph.D.



- Dissertation submitted to the Faculty of Humanities and Social Sciences (FOHSS), Tribhuvan University (TU), Kathmandu, Nepal.
- Devanesan, A.  
2020. "Medical Nihilism: The Limits of a Decontextualised Critique of Medicine", *Studies in History and Philosophy of Science Part C: Studies in History and Philosophy of Biological and Biomedical Sciences*, Vol. 79, pp 101189.
- Dishanirdesh.  
2019. A Television Episode on Death, broadcasted on August 17, 2019. <https://www.youtube.com/watch?v=9-u8TmGULQk&t=1576s>. Retrieved on August 18, 2019.
- Elston, M. A. et al.  
2002. "Violence Against Doctors: A Medical(ised) Problem? The Case of National Health Service General Practitioners", *Sociology of Health and Illness*, Vol. 24, No. 5, pp 575-598.
- Eriksen, T. H.  
2010. *Small Places, Large Issues: An Introduction to Social and Cultural Anthropology*. London: Pluto Press.
- Foucault, M.  
2003. *The Birth of the Clinic: An Archaeology of Medical Perception*(2<sup>nd</sup> ed.). Milton Park, Abingdon, UK: Routledge.
- Geertz, C.  
1973. *The interpretation of Cultures: Selected Essays*. London: Fontana Press.
- Goodyear-Smith, F. and Buetow, S.  
2001. "Power Issues in Doctor-Patient Relationship", *Health Care Analysis*, Vol. 9, pp 449-462.
- Gordon, D.R.  
1988. "Clinical Science and Clinical Expertise: Changing Boundaries between Art and Science in Medicine" in M. Lock and A. Young (eds.) *Biomedicine Examined*. Dordrecht: Kluwer Academic Publishers.
- Gupta, A.  
2012. *Red Tape: Bureaucracy, Structural Violence and Poverty in India*. Durham: Duke University Press.
- Harper, I.  
2002. "Capsular Promise as Public Health: A Critique of the Nepal National Vitamin A Programme", *Studies in Nepali History and Society*, Vol. 7, No. 1, pp 137-173.
- He, A. J. and Qian, J.  
2016. "Explaining Medical Disputes in Chinese Public Hospitals: The Doctor-

Patient Relationship and its Implications for Health Policy Reforms”, *Health Economics, Policy and Law*, Vol.11, pp 359. doi:10.1017/S1744133116000128.

Henderson, S. and Petersen, A.

2002. “Introduction: Consumerism in Health Care”, in S.Henderson and A. Petersen (eds.) *Consuming Health: Commodification of Health Care*. London: Routledge.

Howard, J.

1996. “State and local regulatory approaches to preventing workplace violence”. *Occupational Medicine*, Vol. 11, No. 2, pp 293-301.

Justice, J.

1986. *Policies, Plans and People: Foreign Aid and Health Development*. Berkeley: University of California Press.

Kleinman, A.

1995. *Writing at the Margin: Discourse between Anthropology and Medicine*. Berkeley: University of California Press.

Kleinman, A.

1980. *Patients and Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine, and Psychiatry*. Berkeley: University of California Press.

Kunwar, S.

2011. “Galat Upacharko Kshyatipurti” (Text in Nepali- Compensation for the Wrong Treatment). *Kantipur*, 2/3/2011, Kathmandu, Nepal.

Marasini, B. R.

2003. “Health and Hospital Development in Nepal: Past and Present”, *Journal of Nepal Medical Association*, Vol, 42, pp 306-311.

Miller, D. and Sinanan, J.

2017. *Visualising Facebook: A Comparative Perspective*. London: UCL Press.

Mishra, A.

2006. “Akasmik Bahek Swasthya Sewa Thappa” (Text in Nepali- Closure of Health Services Except the Emergency Ones). *Kantipur*, 27/12/2006. Kathmandu, Nepal.

Mishra, A.

2014. “Norvic Aspatalle Biramiko Upachar Prakriyama Truti Gareko Thahar” (Text in Nepali- Norvic Hospital Committed Error in the Treatment Process). *Kantipur*, 10/14/2014, Kathmandu, Nepal.

Nepali, P.

2018. “Doctor Le Aba Afnai Tauko Jogaune Ki Upachar Garne?” (Text in Nepali- Whether Doctors have to Save them or Treat the Patients?). <http://swasthyakhabar.com/news-details/21371/2018-02-22>.

NIOSH,

1996. Violence in the Workplace. DHHS (NIOSH). (1996). Publication Number 96-100, Current Intelligence Bulletin 57. Atlanta, GA: DOL, July 1996.

NMC.

2020. "NMC-Code of Ethics". <https://nmc.org.np/nmc-code-of-ethics>. Retrieved on August 8, 2020.

Pandey, N. R.

2016. "Emergency Medicine in Nepal: Present Practice and Direction for Future". *Int J Emerg Med*, Vol. 9, p 20. doi: 10.1186/s12245-016-0118-3.

Parsons, T.

1951. *The Social System*. London: Routledge.

Potter, S. J. and McKinlay, J. B.

2005. "From a Relationship to Encounter: An Examination of Longitudinal and Lateral Dimensions in the Doctor-Patient Relationship", *Social Science & Medicine*, Vol. 61, No. 2, pp 465-479.

Poudyal, S.

2011. "Consented Excesses". Republica Daily, 2011/5/20, Kathmandu, Nepal.

Public Health Service Act.

2018. Nepal Law Commission. <http://www.lawcommission.gov.np/en/wp-content/uploads/2019/07/The-Public-Health-Service-Act-2075-2018.pdf>.

Ramsay, M. A.

2001. "Conflict in the Health Care Workplace", *Proceedings*, Vol. 14, No. 2, pp 138-139.

Security Industry Association.

2017. "Mitigating the Risk of Workplace Violence in Health Care Settings". USA: Security Industry Association.

Sevransky, J. E. et al.

2015. "Protocols and Hospital Mortality in Critically ill Patients: The United States Critical Illness and Injury Trials Group Critical Illness Outcomes Study". *Crit Care Med*, Vol. 43, No. 10, pp 2076–2084. doi: 10.1097/CCM.0000000000001157

Singer, M.

1986. "Developing a Critical Perspective in Medical Anthropology", *Medical Anthropology Quarterly*, Vol. 17, No. 5, pp 128-129.

Starr, P.

1982. *The Social Transformation of American Medicine*. New York: Basic

## Books.

Streefland, P.

1985. "The Frontiers of Western Medicine in Nepal", *Social Science & Medicine*, Vol. 20, No. 11, pp1151-1159.

Sullivan, M.

2003. "The New Subjective Medicine: Taking the Patient's Point of View on Health Care and Health". *Social Science & Medicine*, Vol. 56, No. 7, pp 1595-604. doi: 10.1016/s0277-9536(02)00159-4.

Sullivan, M.

1986. "In What Sense is Contemporary Medicine Dualistic?" *Culture, Medicine and Psychiatry*, Vol. 10, No. 4, pp 331-350.

The Joint Commission.

2018. Sentinel Event Alert 59: Physical and Verbal Violence Against Healthcare Workers. <https://www.jointcommission.org/en/resources/patient-safety-topics/sentinel-event/sentinel-event-alert-newsletters/sentinel-event-alert-59-physical-and-verbal-violence-against-health-care-workers/>. Retrieved on 2020-01-01.

U.S. Department of Labor. n.d. DOL Workplace Violence Program — Appendices. Definitions. Author.

Van der Geest, S. and Finkler, K.

2004. "Hospital Ethnography: Introduction." *Social Science and Medicine*, 59(10), 1995–2001. DOI:10.1016/j.socscimed.2004.03.004.

**RECEIVED: 7<sup>TH</sup> AUG 2020****REVISED: 14<sup>ND</sup> MARCH 2021****ACCEPTED: 27<sup>TH</sup> MARCH 2021**



This document was created with the Win2PDF "print to PDF" printer available at <http://www.win2pdf.com>

This version of Win2PDF 10 is for evaluation and non-commercial use only.

This page will not be added after purchasing Win2PDF.

<http://www.win2pdf.com/purchase/>