



Editorial

Violence Against Medical Professionals in India: A System Failure Demanding Institutional Reform

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Violence against physicians in India is no longer an occasional law and order issue. This signals deep-seated failures in health system design, governance, and accountability. Indian commentaries and reviews describe this pattern as an epidemic of violence against doctors, with implications for morale, retention, and care quality.

Burden of Workplace Violence

Across Indian data sets, workplace violence against health care professionals is common and systematic. Reddy et al summarized surveys showing that roughly three-quarters of doctors reported some form of workplace violence during their career.¹ A 2023 narrative review by Gadapati and Shamanna, synthesizing studies from diverse settings, concluded that violence against health care professionals is now a significant occupational hazard.² A recent systematic review pooling hospital-based and community-based data reported high prevalence estimates across states and specialties, reinforcing that these incidents are structurally embedded rather than sporadic.³ Hospital-level studies sharpen this picture: in a tertiary center at Hubballi, more than half of health care personnel surveyed had experienced workplace violence⁴; in Goa, about two-thirds of doctors reported aggression, with government doctors more affected than those in the private sector⁵; and a national mixed method study in *British Medical Journal Public Health* documented high prevalence, pervasive underreporting, and widespread perception that institutional responses were slow or symbolic.⁶ Together, these sources show that violence is neither confined to one region nor restricted to any single cadre, and that both staff and institutions often normalize it.

Structural Drivers, Trust Deficit, and the “Face Value” of Doctors

The geography of violence is closely aligned with structural weaknesses in service delivery. Incidents pile up in emergency rooms, critical care units, labor wards, and congested outpatient departments.^{4,6} Large public hospitals serve as safety nets for those unable to pay for private health care. However, many hospitals function with limited bed availability, restricted diagnostic resources, insufficient nursing support, and poor security infrastructure. When a critically ill patient dies after hours of waiting or treatment with limited resources, the system-level decisions that produced this scenario are often invisible. At that moment, the only visible face of the health system is the doctor.

The face value of the doctor helps explain why comparable dissatisfaction with other public services rarely translates into similar physical assaults. Reddy et al noted that doctors are simultaneously perceived as healers, service providers, and, increasingly, as the personification of a commodified health care system.¹ Hegde argued that in such an environment, every adverse outcome risks being interpreted less as a shared tragedy and more as a personal failure attributable to the individual clinician.⁷ Families come with expectations influenced by media and online content, whereas late-stage presentations, limited intensive care capacity, and the probabilistic nature of outcomes limit physicians. This discrepancy incites frustration, anger, and, in some instances, collective retaliation among the affected groups. Surveys and qualitative work consistently describe limited time for counseling, crowded wards, inadequate spaces for private conversations, and weak grievance redressal mechanisms. Under these conditions, grievances readily spill from formal

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pathways into informal negotiations or, at times, into mob mobilization.^{4,6}

The Bharatiya Nyaya Sanhita, 2023, which supersedes the Indian Penal Code on July 1, 2024, maintains criminal liability for deaths resulting from medical negligence. The law is likely to perpetuate the narrative of the “negligent doctor” potentially emboldening the public to view medical errors as crimes deserving of immediate retribution. In Section 106, deaths from rash or negligent acts remain punishable by imprisonment of up to 5 years and a fine. A separate clause caps punishment for a “registered medical practitioner while performing a medical procedure” at 2 years and a fine, explicitly tied to qualifications recognized by the National Medical Commission and formal registration. This is not decriminalization, the offense remains and the threat of custodial sentences in complex cases also persists.⁸ When complication arise from inadequately trained personnel, the fallout—both reputational and physical—often lands on the fully trained tertiary care doctors who attempt to manage the subsequent emergencies.⁹ Both these developments risk further straining an already fragile doctor–patient relationship unless embedded in a broader, evidence-based reform of health workforce planning and regulation.

Policy Responses, Federal Constraints, and the Monitoring Gap

Policy responses are fragmented. Numerous states have implemented local protective legislation for health care personnel and hospital assets; however, enforcement is inconsistent, and statistics on the number of convictions are minimal. Nair and Zadey argue that while a central law is essential, it is inadequate by itself. Without investment in infrastructure, personnel, communication, and prompt inquiry, the legislation may ultimately be only symbolic.¹⁰ At the Union level, the Ministry of Health and Family Welfare has issued advisories on security deployment, closed-circuit television (CCTV) coverage, and quick reaction teams, and has urged prompt police complaints and institutional support to staff.¹¹ Yet, in our system, where health is a state subject, these measures remain guidance rather than a mandate. There is still no national registry of violence against health care workers or requirement for hospitals to publish anonymized incident data.

Systematic and mixed-methods reviews have repeatedly highlighted underreporting, driven by unclear policies, fear of reprisals, and perceptions that reporting will not lead to meaningful action.^{2,6} Without routine data, violence remains invisible in official documents, even as it shapes career choices, burnout, and willingness to work in high-need settings. Consistent safety audits, including incident assessments and the creation of public dashboards, would establish an institutional memory that persists beyond the current disaster, ensuring a lasting policy effect.

Toward an Institutional Roadmap

International experience provides examples of more structured responses to disasters. In England, the National Health

Service has adopted a Violence Prevention and Reduction Standard that treats workplace safety as a board-level responsibility. This requires incident reporting systems, trend analysis, staff training in deescalation, and structured collaboration with law enforcement agencies. It shifts liability upwards and treats workplace safety not as a security guard's duty but as broad level responsibility. These underlying principles of leadership, ownership, transparent monitoring, and continuous improvement are directly relevant to Indian institutions.¹²

1. For India, a credible roadmap would combine legal clarity, infrastructure standards, and cultural change. A central protection law could define offenses and penalties related to violence in health care settings and set timelines for investigations while allowing states to adapt the operational details.
2. Implement a basic oncology safety bundle: controlled entry, visitor limits per patient, visible security in daycare and intensive care unit (ICU) corridors, functional CCTV coverage, and a rapid response call protocol that staff can activate without hierarchy.
3. Standardize communication for predictable flashpoints: a brief written treatment plan, documented prognosis discussion, consent that explicitly covers complications, and a parallel financial counseling note for expensive regimens and ICU escalation.
4. Run monthly deescalation drills for residents and nurses, including role play for breaking bad news and a scripted escalation pathway to the duty consultant and administration.
5. Create a time-bound grievance mechanism inside the hospital: a patient relations desk, a documented escalation ladder, and a public facing feedback dashboard that tracks complaints and resolutions.
6. Mandate incident reporting and postincident care: immediate documentation, police liaison through a named nodal officer, evidence preservation, and structured debriefing plus mental health support for affected staff.

Any reform agenda must maintain clarity regarding first principles. No logistic delay, diagnostic limitation, or unintended adverse outcome justifies intimidation or assault. Violence against health care professionals is ethically unacceptable and erodes trust, accelerates burnout, and ultimately harms patients by driving clinicians away from high-need environments.

Emerging Indian literature, encompassing commentary, narrative, systematic reviews, hospital-based surveys, and national mixed-method studies, now provides sufficient evidence to treat violence as a measurable and preventable system outcome. Protecting doctors and other health care workers is not an act of benevolence, it is a fundamental requirement for a functional and equitable health care system.

This is not an abstract problem for Indian oncologists. Cancer care entails receiving frequent bad news, unknown results, apparent toxicities, and expensive treatment, all of which increase anguish and the likelihood of confrontation. Oncologists should actively promote institutional safety

standards by requiring proper security and crowd control in clinics and daycare facilities. For high-risk decisions, organized communication, written permission, and collaborative decision-making should be normalized. Embedding psycho-oncology and palliative care early on, using family gatherings for tough talks, participating in event reporting and debriefing, and seeking peer or professional assistance for burnout are all critical to working safely and healthily in this setting.

Ethical Approval

Institutional Review Board approval was not required.

Patient Consent

Patient consent was not required as there were no patients in this study.

Conflict of Interest

None declared.

References

- 1 Reddy IR, Ukrani J, Indla V, Ukrani V. Violence against doctors: a viral epidemic? *Indian J Psychiatry* 2019;61(Suppl 4):S782–S785
- 2 Gadapati S, Shamanna BR. A review on violence against health care professionals in India and its impact. *Natl J Community Med* 2023;14(08):525–533
- 3 Bose A, Gopalakrishnan N, Avula V, et al. Violent behaviours against healthcare professionals in India: a systematic review. *IOSR J Dent Med Sci* 2025;24(03):8–15
- 4 Sushma HR, Nekar MS, Bant DD. Prevalence of violence against health care personnel in a tertiary care centre, Hubballi, India. *Natl J Community Med* 2022;13(02):79–84
- 5 Godinho NNSR, Cacodcar JA. A cross-sectional study on workplace violence against doctors in Goa, a growing threat? *Healthline (Bhavnagar)* 2024;15(04):289–298
- 6 Anil D, Sreena TV, Kindiyode Lakshmi Narayanan D, et al. Workplace violence among healthcare providers in India: a mixed-method study. *BMJ Public Health* 2025;3(02):e002520
- 7 Hegde SN. When healers become targets – The rising violence against medical professionals in India. *APIK Journal of Internal Medicine* 2025;13(01):1–3
- 8 Pai SN, Jeyaraman M, Jeyaraman N, Yadav S. The New Bharatiya Nyaya Sanhita laws: progress or pitfall for doctors? *Cureus* 2024;16(09):e69925
- 9 Bhatt N. Indian doctors threaten strikes as homeopaths approved to practise medicine. *BMJ* 2025;390:r1445
- 10 Nair A, Zadey S. Ending violence against healthcare workers in India: a bill for a billion. *Lancet Reg Health Southeast Asia* 2022;6:100064
- 11 Press Information Bureau. Mechanism to prevent violence against doctors. Ministry of Health and Family Welfare, Government of India; 2022
- 12 NHS England. Violence prevention and reduction standard (updated December 3, 2024). NHS England; 2021