

Workplace Violence Against Healthcare Providers: Medico-Legal Perspectives, Administrative Challenges, and Policy Solutions in South AsiaDr Jaspinder Pratap Singh¹, Dr Yashpal Sharma²

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Abstract

Workplace violence against healthcare providers is an escalating global crisis with profound medico-legal, ethical, and administrative implications. South Asia is disproportionately affected, with overcrowded facilities, fragile health systems, high patient expectations, and socio-political tensions driving incidents that range from verbal abuse to mob assaults. Consequences include psychological trauma, compromised patient care, attrition of skilled professionals, and erosion of trust in healthcare institutions. Medico-legal documentation remains inadequate, limiting judicial accountability and epidemiological insight. Hospital administrators face escalating challenges in ensuring provider safety while balancing patient rights and continuity of care. Comparative models from high-income countries demonstrate the effectiveness of integrated frameworks that combine legislation, zero-tolerance policies, institutional preparedness, and public awareness. This review synthesizes epidemiological trends, medico-legal dimensions, administrative challenges, and policy solutions for workplace violence in South Asia, situating the issue within a global framework. Recommendations emphasize the need for harmonized legislation, strengthened medico-legal protocols, hospital-level security reforms, conflict resolution training, and community engagement. By addressing structural, legal, and ethical gaps, South Asia can advance toward safer healthcare environments and align with international standards of occupational health and justice.

Keyword: Healthcare workers, Workplace Violence, OSHA, Mob Violence.

Introduction

Workplace violence in healthcare is defined as physical, verbal, and psychological aggression in the course of the professional duties of healthcare personnel. WHO and

ILO have listed healthcare professionals in the highest risk category of occupations, and violence has been established to impact individual well-being and healthcare systems [1]. Globally, 8-38% of healthcare personnel are exposed to physical violence

at some point in their careers, and verbal aggression and threats are even more common [2].

South Asia is a critical epicentre of the problem. India, Pakistan, Bangladesh, Nepal, and Sri Lanka face crowded facilities in healthcare, poor staffing numbers, and limited medico-legal regulation. According to a systematic review in 2018, an estimated 63% of doctors in India had been exposed to violence in their professional environment, overwhelmingly in emergency units [3]. Similar figures have been reported in Pakistan (77%) [4] and Bangladesh (74%) [5], again highlighting built-in systemic vulnerabilities.

These consequences are even bigger than patient harm. Violence leads to burnout, moral injury, poor clinical judgment, and decreasing numbers of young professionals entering high-risk specialties. From the perspective of forensic medicine, violence at workplaces necessitates diligent medico-legal recording, categorizing injuries and preserving evidence, but frequent failure to report and poor medico-legal procedures undermine accountability. For hospital administrators, it is a matter of walking the tightrope between patient access and security infrastructure, establishing effective grievance redressal systems, and gaining community trust.

Despite the recognition of healthcare facilities as protected spaces in international treaty law, the legal frameworks in South Asia are marked by non-coherent application and fragmentation. This analysis comprehensively examines violence in the Workplace perpetrated against healthcare providers from medico-legal, bureaucratic, and policy perspectives in the context of South Asia, in light of global experiences,

and suggests reforms that are both regionally viable and globally consistent.

Epidemiology & Patterns in South Asia

Epidemiological evidence suggests a high prevalence and characteristic features of violence in the Workplace in South Asia. Prevalence rates in India are reported to vary from 50% to 75%, and verbal abuse is the most prevalent form, followed by threat and physical attacks [3,6]. The emergency and intensive care units are the most affected areas. Violence cases often occur owing to treatment delays, unexpected deaths, or dissatisfaction with communication.

In Pakistan, a multicentre survey cited that 77% of healthcare providers were exposed to violence in the preceding year, 51% to verbal abuse, and 12% to physical assault [4]. Mob violence in response to adverse outcomes is a frequent occurrence and an index of poor hospital security and socio-political activism.

Trends are similar in Bangladesh; a hospital-based survey identified 74% of doctors having faced some forms of violence at workplaces, and male doctors in emergency units in urban areas were at highest risk [5]. Nepal and Sri Lanka report lower but equally alarming figures, which are often associated with limited resources and the absence of systematic grievance mechanisms [7,8]. Countries with high income show low levels of physical violence but considerable verbal abuse. The difference is not merely in terms of prevalence, but also in institutional responsiveness and judicial sensitivity. Underreporting is prevalent in the case of South Asia due to fear of revenge, mistrust in the legal system, and the non-availability of formal reporting systems. A comparative summary is presented in **Table 1**.

Table 1: Prevalence of Workplace Violence in South Asia

| Country | Reported Prevalence | Common Settings | Key Triggers | Source |
|------------|---------------------|--------------------------|---|--------|
| India | 50–75% | Emergency, ICU | Delay, death, and communication failures | [3,6] |
| Pakistan | 77% | Emergency, OPD | Adverse outcomes, mob action | [4] |
| Bangladesh | 74% | Urban hospitals | Patient dissatisfaction, poor communication | [5] |
| Nepal | 40–55% | Emergency, rural centers | Scarcity of resources | [7] |
| Sri Lanka | ~30–40% | General wards | System delays | [8] |

Medical-Legal Consider

From a forensic perspective, workplace violence necessitates the proper documentation of injuries, the collection of forensic evidence, and reporting to the relevant law enforcement authorities. However, in South Asia, systemic failures frustrate these requisites.

Some of the Indian states promulgated laws on healthcare protection, criminalizing assaults on providers, but enforcement is inconsistent [9]. The absence of a uniform central law weakens medico-legal deterrents. Reporting systems are typically inadequate, with many hospitals lacking a

standardized injury reporting protocol. Pakistan and Bangladesh have their penal codes addressing assault, but effective specialized laws on healthcare protection are hardly present or absent, and their judicial outcomes are therefore limited [10-11].

Medico-legal officers are usually overworked and hence poorly documented. Injury certificates are often poorly completed and therefore inadmissible in court. Threats and intimidation are additional deterrents to providers taking legal action.

Globally, in America, the Occupational Safety and Health Administration (OSHA) imposes liability on employers to mitigate violence in the Workplace, with standardised reporting systems and medico-legal accountability [12]. The European Union has comparable occupational safety directives. The sub-region of South Asia lags in consolidating medico-legal protocols and international standards.

Ethically, health professionals are entitled to their safe workplaces, as incorporated in the ILO Convention on Safety and Health at the Workplace. Non-enforcement of medico-legal protections amounts to systemic negligence and a sustained reign of violence and impunity.

Hospital Management Concerns

Hospital administrators sit on the front line of violence mitigation, but they face numerous challenges. Budgetary limitations restrict spending on violence prevention infrastructure, such as CCTV cameras, panic alarms, and swift response teams. Overcrowding and unfavorable patient-provider ratios escalate hostilities.

De-escalation training and conflict communication skills are often

inadequately developed in medical curricula. Fewer than 20% in Bangladesh and India have formal training in how to de-escalate aggression [13]. Deficient grievance redressal mechanisms foster mistrust and escalate issues outside the hospital setup.

Administrative challenges include reconciling the need for open care with security. Closing wards to visitors might enhance safety, but it will also isolate society. Furthermore, bureaucratic inertia typically postpones the implementation of policies, even in the face of repeated violence.

Comparatively speaking, high-income countries adopt zero-tolerance strategies, formalized staff education, and adaptations in hospital design (e.g., protected access areas). These strategies are largely absent in South Asia due to financing gaps and prioritization issues.

Comparative World Perspective

The United States, the United Kingdom, and Australia have adopted broad-based approaches to combat healthcare workplace violence. OSHA requires violence prevention programs, while zero-tolerance programs backed by criminal prosecution are ingrained in the UK National Health Service (NHS) [12,14]. Australia blends occupational safety and health legislation with mandated training. WHO and ILO recommend multi-sector approaches with particular emphasis on legislation, hospital preparation, and community awareness [1]. The gap in South Asia is not one of insufficient recognition, but rather one of piecemeal coverage and intersectoral non-coordination.

Policy Solutions & Recommendations

Addressing workplace violence in South Asia requires multi-pronged strategies:

1. **Legislative Reforms:** Enact and enforce uniform national laws criminalizing violence against healthcare providers across South Asia.
2. **Strengthening Medico-Legal Systems:** Standardize injury documentation, introduce electronic medico-legal reporting, and protect providers pursuing legal remedies.
3. **Hospital-Level Interventions:** Security audits, panic buttons, rapid response teams, and visitor management systems must become mandatory.
4. **Training and Capacity Building:** Integrate de-escalation and communication modules into medical and nursing curricula.
5. **Community Engagement:** Public awareness campaigns to recalibrate patient expectations and rebuild trust.
6. **Regional Collaboration:** Develop a South Asian framework under SAARC or WHO-SEARO to harmonize policies.

Prospective Directions

Longitudinal investigations to track violence trends in workplaces, as well as real-time tracking by digital video devices and computer-learned systems to identify risk incidents in their formative stages, are areas of future research. Comparative medico-legal investigations in various jurisdictions will be employed to inform the development of harmonized legislation.

There is a need for inter-country collaboration to develop a regional consensus.

Conclusion

Workplace violence among healthcare professionals in South Asia is a multifaceted emergency whose causes are entrenched in systemic inefficiencies, weak enforcement of law, and a lack of administrative preparedness. Documentation and prosecution of cases through forensic medicine is essential, but justice is impeded by gaps in the system. Administrators of hospitals are constantly faced with the added difficulty of aligning patient treatment with professional safety. Comparative international experiences indicate that interlinked frameworks of legal reforms, institutional preparation, and community participation are effective.

South Asia must prioritize the conformance of medico-legal protections, enhance security infrastructure in hospitals, and integrate communication training into medical curricula. Action in this regard requires coordinated policy actions, a strong ethical commitment to workplace safety, and international cooperation. Through these alone, healthcare professionals can be assured of safe workplaces essential to delivering excellence in patient care.

References (Vancouver style)

1. World Health Organization. Framework guidelines for addressing workplace violence in the health sector. WHO, 2002. Available from: <https://apps.who.int/iris/handle/10665/42617>
2. Liu J, Gan Y, Jiang H, et al. Prevalence of workplace violence against healthcare workers: A systematic review and meta-analysis. *Occup Environ Med.* 2019;76(12):927–937. doi:10.1136/oemed-2019-105849
3. Sharma S, Shrestha S, Dutta A. Workplace violence among health care professionals in India: A systematic review. *Indian J Community Med.* 2019;44(3):197–201. doi:10.4103/ijcm.IJCM_175_19
4. Kumar R, Khan AM, Inder D, et al. Violence against doctors: A study of violence-prone areas and their prevention. *J Family Med Prim Care.* 2017;6(2):199–202. doi:10.4103/2249-4863.219992
5. Hossain MM, Sultana A, Mazumder H. Workplace violence in healthcare settings in Bangladesh: A cross-sectional study. *BMJ Open.* 2018;8:e021616. doi:10.1136/bmjopen-2018-021616
6. Nagpal N. Incidents of violence against doctors in India: Can these be prevented? *Natl Med J India.* 2017;30(2):97–100. doi:10.4103/0970-258X.213957
7. Paudel S, Subedi R, Ghimire S. Violence against health care workers in Nepal: A cross-sectional study. *BMC Public Health.* 2020;20:1–8. doi:10.1186/s12889-020-09359-9
8. Wickramasinghe ND, et al. Workplace violence against nurses in Sri Lanka: A survey. *J Nurs*

- Manag. 2021;29(4):679–686.
doi:10.1111/jonm.13170
9. Ministry of Health and Family Welfare, Government of India. Draft legislation for protection of doctors and healthcare professionals. 2020.
10. Malik S, Farooqi M. Violence against healthcare professionals in Pakistan: Challenges and solutions. *J Pak Med Assoc.* 2020;70(9):1505–1507.
doi:10.5455/JPMA.35539
11. Yasmin R, et al. Legal responses to violence against healthcare professionals in Bangladesh. *Health Policy Plan.* 2022;37(1):79–87.
doi:10.1093/heapol/czab119
12. Occupational Safety and Health Administration. Guidelines for preventing workplace violence for healthcare and social service workers. OSHA 2016. Available from: <https://www.osha.gov>
13. Ambesh P. Violence against doctors in the Indian subcontinent: A rising bane. *Indian Heart J.* 2016;68(5):749–750.
doi:10.1016/j.ihj.2016.07.023
14. NHS England. Violence prevention and reduction standard. NHS; 2021. Available from: <https://www.england.nhs.uk>
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