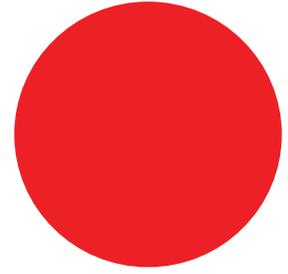


386

medico friend circle bulletin



February 2026

Contents

Perspectives

- | | |
|--|----|
| 1. Understanding and Addressing Systemic Violence in Healthcare: A background note <i>Thematic Group</i> | 4 |
| 2. The Health Care Ecosystem: Vulnerabilities for Violence and Counter-Checks <i>Ritu Priya</i> | 10 |
| 3. When Power Eclipses Caring <i>Abhay Shukla</i> | 17 |
| 4. Whose Health Knowledge Counts: Caste, Power, and Adivasi Healing <i>KV Krishnamurthy</i> | 22 |
| 5. Why India Misunderstands Violence <i>Akshay S Dinesh</i> | 25 |
| 6. Peace-bee or the Most Ultimate Frisbee <i>Sunil Kaul</i> | 27 |

Violence against Patients

- | | |
|--|----|
| 7. Enduring violence against patients in healthcare settings <i>Rema Nagarajan</i> | 28 |
| 8. Violence in Health Care Settings: Experiences of Trans Persons in Gujarat <i>Anagha Pradhan, Kartik Gore, Nilangi Sardeshpande, Renu Khanna</i> | 29 |
| 9. Obstetric Violence and Respectful Maternity Care in India: Reviewing the Evidence <i>Amruta Bavadekar, Jashodhara Dasgupta, Renu Khanna</i> | 35 |
| 10. Labour Room violence in rural Uttar Pradesh <i>Sunita Singh</i> | 41 |
| 11. The anatomy of violence: In-person observations of Obstetric emergency triage room in a medical college <i>Mudit Joshi</i> | 45 |

Violence against Health Workers

- | | |
|--|----|
| 12. Activist by Name, Frontline Worker by Role, Exploited Women Caregiver in Reality: A Nationwide Analysis of ASHAs <i>VR Raman and Colleagues</i> | 47 |
| 13. Epistemic Violence and Physiotherapists' Experiences in Healthcare Teams <i>Shreya Sood</i> | 56 |
| 14. Violence as Routine: How Institutional Conditions Shape Healthcare Workers <i>Sangeeta Rege, Ajinkya Deshmukh, Nancy Angeline, Amruta Bavdekar</i> | 59 |
| 15. Violence in Healthcare in Karnataka <i>Sylvia Karpagam, Akhila Vasana</i> | 63 |
| 16. Shifting gears: Senior-junior relationships in medical college <i>Rizo</i> | 65 |
| 17. Understanding Violence in Medical Training: A Reflection <i>Naveen K</i> | 67 |
| 18. Ragging: Learning Hierarchy Before Learning Medicine <i>Arjun Jaksania</i> | 70 |
| 19. Integrating Gender and Violence in Medical Education: A Pedagogical Intervention <i>Amruta Bavadekar, Ajinkya Deshmukh</i> | 71 |

Obituaries

- | | |
|---|----|
| 20. Remebering Anil Pilgaokar | 75 |
| 21. Books, Bicycles and Broken Myths: Tracing the Path of T. Vijayendra | 77 |

Schedule of 52nd Annual Meet

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.

Editorial Committee: Amit Dhage, C. Sathyamala, CU Thresia, Gajanan P, Mithun Som, Minal Madankar, Mohit P. Gandhi, Randall Sequeira, Ravindra Kurbude.
(email: editormfcbulletin@gmail.com)

Design: Gayatri Sharma

Convenor: Mohit P. Gandhi; **Co-convenors:** Dharendra Arya and Juned Kamal

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 to 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

ragging on paper and start challenging the culture that allows it to continue. This may require a much deeper response than just forming anti-ragging committees — including positive role modelling of how healthcare workers can work as a team, without maintaining toxic hierarchy. Medical education needs to consciously break this mould of hierarchy instead of reproducing it. Many students enter medical colleges already carrying lived experiences of caste, gender, class, language and queer identity. These realities do not disappear at the college gate. When the system ignores these intersectional realities, it ends up harming those who are already vulnerable. Instead of nurturing empathy, reflection and collective

learning, medical education often trains students to follow orders, tolerate abuse and function like robots. In doing so, we may produce technically competent doctors, but we fall short of creating humane healthcare professionals. If violence and hierarchy are not questioned during training, they quietly become part of how care is delivered later. Breaking this cycle is not optional anymore — it is essential for building a health system that is safe, just and compassionate.

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Integrating Gender and Violence in Medical Education

A Pedagogical Intervention

- *Amruta Bavadekar, Ajinkya Deshmukh*

Key words: gender in medical education, medical pedagogy and ethics, gender-sensitive clinical practice

Introduction

Healthcare in India is shaped by social and institutional contexts that influence not only access to services, but also everyday interactions between patients and healthcare providers. In routine clinical practice, experiences such as obstetric violence, coercive medico-legal procedures, and neglect or discrimination are reported by patients. How these experiences are recognised, interpreted, or dismissed is deeply shaped by medical education, which plays a central role in defining what is considered clinically relevant and ethically actionable.

Against this backdrop, the Integrating Gender in Medical Education (GME) initiative, launched by the Centre for Enquiry into Health and Allied Themes (CEHAT) in 2015 in Maharashtra in collaboration with the Directorate of Medical Education and Research (DMER) and the Maharashtra University of Health Sciences (MUHS), emerged as an effort to intervene early within medical training—at a stage when professional identities, ethical orientations, and

clinical reasoning begin to take shape. While initiated over a decade ago, GME continues to inform teaching practices across multiple states, including Gujarat, Karnataka, and Madhya Pradesh, reflecting the continued relevance of its pedagogical approach.

Gender, Violence, and Gaps in Medical Education

For several decades, feminist scholars, public health researchers, and women's health advocates have critiqued medical education in India for its limited engagement with the social realities shaping health outcomes (Qadeer & Nayar, 2005). Reviews of undergraduate medical curricula and textbooks show that gender is commonly treated as a demographic variable or confined to reproductive health and population control, rather than understood as a structural determinant shaping illness, access to care, and clinical outcomes (Gaitonde, 2005; Bhate & Acharya, 2005).

Disciplinary analyses reveal persistent gaps.

Obstetrics and gynaecology texts rarely engage with power relations, coercion, or women's limited decision-making autonomy in reproductive care (Iyengar, 2005). Psychiatry curricula inadequately address the links between social disadvantage, gendered violence, and mental health outcomes (Davar, 2005; Patel, 2005). Forensic medicine has historically reproduced problematic narratives around sexual violence, including undue emphasis on physical markers such as the hymen, while neglecting survivor-centred medico-legal ethics (Agnes, 2005). Even community medicine, where social determinants are expected to be central, has insufficiently engaged with gender, caste, and class as intersecting axes shaping health experiences (Gaitonde, 2005). CEHAT's research with medical educators confirms that gender is often perceived as peripheral to "core" medical knowledge or as external to clinical responsibility (CEHAT, 2015).

These gaps have significant consequences. They contribute to the production of a medical workforce that is technically trained but inadequately prepared to recognise inequities, engage with patients' social realities, or respond ethically to experiences of violence and vulnerability. Although a substantial body of evidence establishes violence against women as a major contributor to adverse physical, mental, sexual, and reproductive health outcomes (WHO, 2013; Sen & Östlin, 2008), violence continues to be framed within medical education as a legal or social issue rather than a legitimate health concern requiring clinical engagement.

CEHAT's long-standing experience through the Dilaasa initiative—which focuses on strengthening health system responses to domestic violence—demonstrates that while in-service training can improve awareness and skills, it is often constrained by entrenched attitudes, time pressures, and limited institutional support. GME builds on these learnings by arguing that violence must be addressed much earlier, within undergraduate medical education, before professional practices and ethical orientations become fixed. By integrating violence into foundational teaching, GME reframes it as a determinant that shapes symptom presentation, care-seeking behaviour, treatment adherence, and health outcomes across clinical contexts.

Reframing Medical Education: Gender, Ethics, and Pedagogy

Beyond individual teaching techniques, GME's pedagogical approach is grounded in a critical interrogation of how medical knowledge, authority, and ethics are produced and normalised within training institutions. Conventional medical education often prioritises biomedical objectivity and technical efficiency, leaving little space to examine how power, discomfort, and moral judgement shape clinical decision-making. GME deliberately brings these tensions into the classroom by engaging students with clinical scenarios that are ethically complex, emotionally charged, and routinely encountered in practice but rarely discussed openly during training. Pedagogical discussions explicitly engage with situations that students and clinicians often experience as uncomfortable or contentious. These include, for instance, providing second-trimester abortions within the legal framework, where students confront personal beliefs, societal stigma, and institutional resistance alongside clinical protocols. Similarly, discussions around ward allocation for transgender patients expose how binary gender norms are embedded within hospital infrastructure and routine administrative practices, often leading to misgendering, humiliation, or denial of appropriate care. By treating these moments as legitimate sites of ethical and clinical reasoning, GME challenges the tendency to reduce such decisions to "administrative issues" or to defer responsibility to institutional constraints.

GME also foregrounds scenarios involving coercion that are frequently normalised within reproductive healthcare. Case narratives and role plays examine counselling practices around sterilisation or intrauterine device insertion, particularly in contexts of poverty, high parity, or immediately post-partum care. Students are encouraged to reflect on how consent can become procedural rather than meaningful, how targets and incentives shape provider behaviour, and how women's reproductive choices are often framed through paternalistic assumptions about responsibility and compliance. These discussions enable students to distinguish between public health rationales and ethical clinical practice, reinforcing the centrality of autonomy and informed decision-making.

In teaching related to sexual violence, GME pedagogy directly addresses the culture of disbelief and moral judgement that survivors frequently encounter in healthcare settings. Through forensic and clinical case discussions, students are prompted to examine how questioning a survivor's narrative, focusing on sexual history, or searching for "objective" physical proof can retraumatise patients and undermine ethical care. Rather than positioning belief as naïveté or bias, GME reframes it as an ethical stance grounded in survivor-centred care, legal standards, and professional responsibility. This approach disrupts deeply entrenched medico-legal myths while reinforcing the doctor's role in documentation, support, and referral rather than investigation or moral adjudication. Adolescent sexuality is another domain where GME deliberately challenges silence and discomfort within medical education. Teaching sessions engage with cases involving adolescents seeking contraception, information about sexual activity, or care following sexual encounters. Students are encouraged to reflect on how personal values, cultural norms, and fears of social sanction can lead to judgement, denial of services, or breaches of confidentiality. By situating adolescent sexuality within a rights-based and public health framework, GME equips future doctors to respond with openness, clarity, and ethical sensitivity, rather than avoidance or moral policing.

These pedagogical engagements are intentionally designed to surface resistance, ambivalence, and emotional responses among students. Faculty facilitators are trained to work with discomfort as a productive element of learning, recognising that ethical growth often involves questioning deeply held assumptions about professionalism, authority, and control. Rather than prescribing "correct" attitudes, GME encourages critical self-reflection on how clinical practices—such as hurried consent-taking, dismissive communication, or rigid adherence to institutional routines—may inadvertently reproduce harm. Importantly, GME links classroom reflection to lived clinical realities. Students are invited to critically examine discrepancies between what ethical guidelines prescribe and what is routinely practised in wards, labour rooms, and outpatient departments. Discussions explicitly acknowledge hierarchical pressures, fear of

senior reprimand, time constraints, and infrastructural limitations, while still holding space for ethical responsibility. This approach strengthens students' capacity to navigate complex clinical environments without abandoning commitments to dignity, consent, and non-judgemental care.

GME does not seek to transform doctors into counsellors, but to strengthen their capacity to recognise vulnerability, respond without judgement, and provide appropriate first-line psychosocial care and referrals when required. In this sense, it aligns closely with the National Health Policy 2017 and Competency-Based Medical Education (CBME) framework, which envisions the Indian Medical Graduate as clinically competent, ethical, communicative, and responsive to gender and social contexts (Government of India, 2017; Medical Council of India, 2018). By embedding gender sensitivity, ethical reasoning, and reflexivity within routine teaching-learning processes, GME operationalises these competencies in ways that are meaningful for contemporary Indian healthcare.

Rather than isolating violence within a single subject, GME integrates it across disciplines such as obstetrics and gynaecology, community medicine, internal medicine, psychiatry, and forensic medicine. This approach reinforces the understanding that violence cuts across clinical domains. Obstetric teaching addresses domestic violence during pregnancy and obstetric violence within health systems, including coercive and non-consensual procedures. Internal medicine discussions highlight how chronic conditions or unexplained somatic complaints may be linked to abuse. Psychiatry engages with trauma and mental health sequelae of sustained violence, while forensic medicine critically examines ethical medico-legal responsibilities in sexual assault examinations. This integration aligns with national medico-legal guidelines and judicial pronouncements emphasising survivor-centred care, informed consent, and dignity during examinations (MoHFW, 2014, 2022; Madras High Court, 2022).

Conclusion

Viewed in this way, pedagogy itself becomes an intervention. Through experiential and reflective

learning, GME demonstrates how medical education can contribute to reducing the routine reproduction of structural violence within health systems, while fostering clinicians who practise with greater ethical awareness, respect, and accountability in everyday clinical settings. Integrating gender and violence into medical education thus represents a deliberate and necessary shift in how medicine is taught and practised. Drawing on CEHAT's sustained engagement with health systems and violence, GME underscores that responding to violence cannot remain peripheral to medicine or confined to specialist domains. Instead, it must be embedded within the core training of doctors if the goals of Competency-Based Medical Education are to move beyond policy intent and translate into clinically competent, socially responsive, and ethically grounded care in wards and outpatient departments.

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Amruta Bavdekar is the Director at CEHAT and leads the work on Integrating Gender in Medical Education. Her research interests include women's health, gender and health, and sexual and reproductive health (amruta@cehat.org).

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“Despite violence against patients being extremely common, what mostly gets news coverage is the violence against healthcare professionals by patients. There is no doubt that a hospital or clinic environment is an intense and dynamic space, where tensions may run high. However, health worker's safety is inseparably linked to patient safety. Negative patient experience and lack of patient safety are strongly related to workplace violence.”

– Vasundhara Rangaswamy

*from Violence Against Patients: The Hidden Part Of The Iceberg,
published on www.nivarana.org, February 2025*