**Title**: Death of a Representative

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**Abstract**: Medical education is afflicted with a culture of abuse and workplace bullying of doctors/ medical students. Abuse is rationalized on grounds of arbitrary moral ideologies about standards of healthcare delivery. Poor standard of work sometimes gets attributed to caste due to meritocratic mindsets that prevail in our societies. The cycle of abuse that goes on in medical colleges is incorporated in its hierarchical structure. Focussing attention only on casteism tends to overshadow bullying of doctors and medical students by their senior colleagues at workplace.

**Main Article with references**:

What killed Dr. Payal Tadvi1? In a series of events that followed her suicide, three lady doctors were taken into custody and a trial is ongoing. Media is high on the caste-based discrimination propaganda. There are speculations about some torrents of casteist innuendos that may have precipitated the mishap. The clout of caste in India is overwhelming. Introduction of a caste angle to unfortunate events, like the one that happened with Dr. Tadvi, tend to overshadow a culture of covert workplace bullying and non-violent aggression that lurks in government medical colleges.

Teaching by humiliation and mistreatment is kind of standard operating protocol for medical education almost throughout the world2, 3, 4, 5. An arbitrary code of strict obedience, that despises personal freedom, is amalgamated within the hierarchical structure of healthcare. Those unable to fit in are surreptitiously sidelined or reprimanded for poor work. This authoritarian system is self-perpetuating and reminiscent of lemming behaviour. The cycle of abuse is sustained by victims becoming perpetrators (somewhat similar to ragging). Affective relations between senior and junior doctors are also patterned on the established hierarchical structure of medicine. Here in India, we consider such unprofessionalism as an occupational hazard rather than some kind of torment because the government healthcare system is inept at addressing such matters. In untenable situations, a standard administrative approach is to inculpate few or all humans in the proximate responsibility chain and move on with the unpitying work culture until another catastrophe happens.

The redundant adoration of healthcare profession as noble6, an apparently meritocratic selection process7, rising aspirations of doctors to become specialists and incessant volume of work in healthcare organisations have created artificial, arbitrary and unnecessary barriers to postgraduate medical education. Postgraduate medical education entails learning on the job. Demands for unrealistic high standards of healthcare performance, in our country where healthcare budget is just a minor fraction of GDP8, are inordinate and unworkable. A reality check is needed for developing pragmatic approaches to patient care9. An interesting phenomena in this regard is related to the ever-increasing workload on doctors, in terms of number of patients. Healthcare referral in India is a failed system10. Patients are able to come directly to medical colleges (tertiary health care centers) without referrals. Primary health care centers are barren land (mandatory rural posting of doctors is an effort to address this issue). Some centers do try to maintain this rational system of referral, but most succumb to irrational moralistic ideations or political pressures. This is a systemic problem. In addition, an overwhelming sense of pride betrays rationality. Patients are seldom refused and inpatient wards turn into a chaotic ecosystem of human suffering. In such scenarios, using moral high ground as legitimate grounds for abuse, senior doctors effortlessly tyrannize junior doctors, particularly when the latter are postgraduate students. They do it citing romantic western ideas pertaining to standards of patient care when in reality basics such as clean bed sheets are even seldom found. Caste issues may manifest within hierarchies in different ways depending on regional caste dynamics. In this system patients do get treated but at the cost of personal lives of doctors and quality of medical education.

The problem of casteism in medical colleges is seems to be partly fueled by reservation in entrance examinations11. We live in purportedly equal and democratic societies but there are profound undertones of equality defying meritocracy in people’s minds. There is no formal discrimination of doctors by other doctors on the basis of their caste in medical colleges but there seems to be a huge section of doctors who are resentful of reservation policies. In our experience, many doctors belonging to the so-called “general” category do think of doctors entering postgraduate medical education through a reserved quota of seats as “undeserving”. This happens because the selection process appears meritocratic in the sense that there is a rank order of selected candidates based on normative assessment. Ranking of candidates is done to offer priority in choice of subjects/colleges and is not a grading of “intelligence”. Normative assessments do not determine if candidates have met learning standards or acquired specific knowledge. Because of poor understanding of the exam’s purpose, an idea percolates amongst doctors that if a low ranking candidate is getting selected on a quota seat, he or she will not be as intelligent. This creates a background on which substandard performance at work sometimes gets attributed to caste. As such all trainee doctors get reprimanded for substandard work, irrespective of caste. The problems of living in a meritocratic system is that privileged individuals resist acknowledging their privileges because doing so would require them to acknowledge that whatever success they have achieved did not result solely through their own efforts. We are not sure whether a meritocratic system is constructive, even in principle, for societies12, 13.

General category doctors are upset when candidates belonging to SC/ST/OBCs are able to secure “open seats”. Total number of open seats for general category candidates are reduced. SC/ST/OBCs candidates getting selected on open seats is a good thing because reservation seems to be serving its greater purpose. But an interesting phenomena happens. General category candidates think of open seats as their own quota of seats, which is fundamentally wrong, and expect SC/ST/OBC candidates to restrict themselves to their own quotas, even if qualified for an open seat. If a SC/ST/OBC candidate switches to an open seat, then one more SC/ST/OBC candidate gets a chance to get the privilege of reservation. As more and more SC/ST/OBC candidates are securing open seats, the frustrations of general category candidates are rising. The selection process with reservation embedded within it, has created palpable conflicts amongst doctors with significant spillovers into the arena of medical education.

It is not critical to healthcare that only individuals with some imaginary cut-off level of intelligence should have access to medical education. That would be like a eugenics movement. High intelligence may be an asset for ambitious individuals but medical education is about having uniform minimum standards as prescribed by the Medical Council of India. This is probably why there is no reservation in medical exit exams. There are fixed benchmarks for earning an MBBS or MD degree, irrespective of social class. Despite knowing this, some doctors are unable to shed their cynicism towards all SC/ST/OBC doctors. Another potential source for development of such mind-sets could be coaching centres for undergraduate/postgraduate medical entrance examinations who magnify the amplitude of “competition” to unforgiving levels.

Institutionalization of caste and meritocratic ideologies have eroded social cohesiveness. Despite being a rational and progressive policy for social equity, quota based reservation is facing challenges because it is often poorly understood by most people. Reservation is a social privilege. Some general category doctors think of reservation as a set of circumstances that SC/ST/ OBC doctors are exploiting for self maximization without any principle or regard. Some SC/ST/OBC doctors tend to feel bad about acknowledging the “social privilege” because that might make them look less intelligent or deserving. This is a fundamental problem with meritocratic mindsets. It is too individual centric and defies socialism, an entity in the preamble to the Constitution of India.

Reservation has a bigger purpose of representation in services. It dynamic nature serves to constantly reshuffle people in political and administrative power so that class monopolies are avoided. The quota system is dynamic in the sense that it is not caste-based (caste being only an identifier) and applies to conglomerations of classes (scheduled castes, scheduled tribes, and other backward classes) where there is internal contesting amongst members (of different castes) for a position in services. This is an important concept to imbibe because reservation of appointments or posts in favour of any class of citizens is neither an opportunity (in the sense of an exploitable set of circumstances without any principle or regard) nor a redistributive strategy. Though reservation appears to a static entity in terms of quota percentage, heterogeneous nature of SC/ST/OBC population in India makes it sublime policy tool. A contentious matter in this regard is the interpretation of reservation as a tool for ensuring social justice. Though article 46 of the constitution mandates that the state will protect “weaker” sections from social injustice, the basis for reservation is made clear in Article 16 (4) of the constitution which states that “nothing in this article shall prevent the State from making any provision for the reservation of appointments or posts in favor of any backward class of citizens which, in the opinion of the State, is not adequately represented in the services under the State”. It clarifies that reservation is a social privilege for certain sections of society (that comes with a constitutional duty to represent) rather than a chance for personal advancement, progress or profit. India is like a consociationalist state. Proportionality in political representation and civil service appointments alongwith a minority veto in central to upholding democracy in a massively heterogenous state14.

“Discrimination” pops up frequently in “media trials” involving matters similar to Dr. Tadvi’s case. A negative connotation and its indiscriminate use makes discrimination a powerful expression. There are different meanings to this word when used in different contexts. In a political context it refers to prejudice against people and refusal to give them their rights. Government of India by any of its actions have never showed any prejudices against a certain class of citizens or have denied their rights. The state does not discriminate. What people generally mean by discrimination possibly refers to treatment of a person or particular group of people differently, in a way that is worse than the way people are usually treated by other individuals in their personal or professional capacity. It is not possible for people in government services to discriminate against certain classes. That would be unconstitutional. Punishable aberrations of behaviour are classified in sections of Indian Penal Code. In reality, people engage in interpersonal biased behaviour that are subtle enough to circumvent formal detection but quite effective in causing physical and mental disturbances. Sometimes dynamics of power get so aligned that some people are able to victimize others with authority and intimidation. These are grey zones where tribunals and institutional quasi-judicial bodies have an important role to play.

Suicide is a highly complex and multifaceted phenomenon, with many contributing and facilitating variables. Existing evidence15, 16 supports that the need to belong is a powerful, fundamental, and extremely pervasive motivation. The unmet need for connectedness and social competence result in psychologically painful mental states and these are proposed to be the most proximate mental states that precede the development of thoughts of suicide. Stressful life events, mental disorders, and other risk factors for suicide are relatively more distal in the causal chain of risk factors for suicide. It is important to note that the proximate causes are amenable to therapeutic change but that will require amicable work environments where doctors are not biased against other doctors for reasons seemingly unintelligible in the framework of medical education. Medical institutions must understand that healthcare delivery must not be at the cost of lives of doctors and strive to have optimal in-house policies regarding patient care. While it is unconstitutional for doctors to indulge in biased behaviour towards fellow doctors belonging to SC/ST/OBC, at the same time doctors from SC/ST/OBC must understand that they have a greater responsibility of representing their communities in services and must resist yielding to adverse interpersonal dynamics. Treating beneficiaries of reservation as liabilities instead of assets is an abominable act. All work creates value. When people don’t feel needed, they lose their sense of dignity. Abuse has become a matter of culture. India's proportional contribution to global suicide deaths is high and increasing16. Also, doctors have the highest rate of suicide among all the professions. A written code of professional conduct needs to be laid down and adhered to for preventing disruptive behaviours by doctors towards other doctors and medical students. Narcissism of individuals must be kept in check by healthcare organizations17. Addressing mental health of doctors as a policy matter could be a positive step towards ensuring patient safety as well as the lives of doctors.

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