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Workplace Harassment in Delhi's Healthcare Sector

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ABSTRACT

Within Delhi's medical industry, workplace harassment is a persistent and systemic problem that takes the form of sexual violence, psychological stress, and verbal abuse. The prevalence and effects of these behaviors are examined in this study, which finds that they are the result of strict institutional hierarchies, stressful work environments, and a widespread culture of silence. Although there is a theoretical foundation for protection provided by legal frameworks such as the Sexual Harassment of Women at Workplace (POSH) Act, 2013, there are still large gaps in institutional implementation and the redress of non-sexual forms of harassment. The study investigates how administrative flaws and fear of reprisals contribute to systemic underreporting using a mixed-method approach and empirical survey data from 54 healthcare professionals. The results show that harassment increased medical errors, lowered staff morale, and jeopardized patient care. The study comes to the conclusion that institutional culture must fundamentally change in order to achieve true safety and professional integrity in healthcare, going beyond simple legal compliance.

I. INTRODUCTION

Workplace harassment is a major and persistent problem in the medical profession, especially in busy, high-pressure areas like Delhi. Although healthcare is widely viewed as being a place for healing, compassion and ethical conduct (and although healthcare workers may see their own experiences with this environment as one with great promise and a sincere commitment to their profession), the reality for many healthcare workers has been that they have experienced significant amounts of psychological/mental stress, verbal abuse, trauma/indignities based on gender, and, in some instances, serious physical sexual harassment or violence. Therefore, the medical workplace is not only a function of a workplace defined by professionalism; it is also a workplace of normalised harmful behaviours, unreported behaviours, and poorly managed

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behaviours.[1]

The nature of the medical profession lends itself to being an incubator for harassment. To begin with, long hours, intense emotional settings, the hierarchy of an organisation, the stress associated with having to be precise and/or correct every time contribute tremendous amounts of pressure to the practice of medicine. Under such pressure, individuals with authority may abuse their position of authority deliberately or through a lack of awareness.[2] For instance, junior residents and nurses employed within the teaching hospitals and large private hospitals located in Delhi have consistently reported being subjected to bullying, humiliation, being dismissed or devalued by their superiors and punitive actions directed toward them. Behaviours directed toward another healthcare worker, in this case, constitute an indirect way of contributing to the systemic environment of harassment that is prevalent throughout the healthcare industry in India.

In addition to the potential to encounter harassment and abuse from your co-workers within the workplace, healthcare providers in Delhi are also subject to harassment and abuse by their patients and/or those accompanying them. Some contributing factors that could lead to staff being verbally and/or physically abused are the high patient volume at government hospitals, the lack of security at many government hospitals, and the restricted nature of space within some government hospitals. With all of these factors combined with the heightened level of emotional volatility experienced by the patient's family members, it creates an environment conducive to staff experiencing either verbally or physically hostile treatment. Emergency departments at government hospitals have experienced a significant amount of media attention over the past several months, related to the increasing amount of violence directed at doctors and/or nurses due to disagreements over the length of time it takes to assess and/or treat the patient or the end results from the treatment. These incidences are indicative of a broader societal issue regarding how the society in general views the role and value of the healthcare profession and its providers.[3]

Perhaps one of the most disturbing aspects of workplace harassment experienced by healthcare professionals working in the medical field is the pervasive culture of silence that surrounds this issue. Because of the potential for retaliation, negative career ramifications, or social stigma, many healthcare professionals refrain from reporting incidents of maltreatment. For example,

[1] Devi, Prabha & Nair, S.P., Workplace Harassment in Healthcare: Understanding Risks and Responses (SAGE Publications 2019).
[2] Gupta, R. & Anand, P., Healthcare Workforce in India: Challenges and Policy Solutions (Routledge 2021).
[3] Basu, Shubha. "Violence Against Doctors: A Wake-Up Call for the Healthcare System in India." Indian Journal of Medical Ethics 4, no. 2 (2019): 89–94.

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in hierarchical organisations, junior members of staff fear retaliation would occur if they spoke out against a senior member. Reports often say institutional mechanisms for reporting incidents of harassment generally lack transparency and/or clear communication. Even though legal frameworks such as the Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013 (POSH Act) and internal grievance committees exist, the mismatch between policy and practice remains significant.[4]

The issue of workplace harassment in healthcare is similar internationally as evidenced through research conducted in Canada, United Kingdom, Australia, USA and Asian countries. The results of these studies indicate that there are similar trends of high levels of bullying, verbal abuse and sexual harassment; however, these studies also show that there is a systemic underreporting of incidents. The WHO and ILO[5] have both reiterated that strengthening workplace safety for healthcare professionals is a global priority. Therefore, the state of workplace harassment in healthcare in Delhi continues to replicate an established global issue but also exhibits many local characteristics that are a product of social norms, limited resources and institutional culture.[6]

The understanding of workplace harassment goes beyond an academic pursuit to ensure the stability and effectiveness of the medical profession and the ethical integrity of our healthcare system in the future. It is essential to have a safe, respectful and psychologically supportive work environment in order to provide optimal healthcare in an environment such as Delhi, where healthcare professionals are subjected to enormous stress and pressure every day. If healthcare workers' grievances and challenges are not taken seriously and addressed, then the impact of these issues reaches far beyond individual healthcare workers and permeates the entire healthcare delivery system.

A. Aim and Objective of the Study

The study's purpose is to explore the different types, prevalence, and impact of harassment within the health care service industry in New Delhi. The objectives of this study include identifying the types of harassment experienced within the workplace; understanding the socio-cultural and systemic factors that contribute to these types of behaviours within organisations; documenting how these types of behaviours affect the mental health and professional

[4] Government of India, Ministry of Women and Child Development, Handbook on the Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013.
[5] International Labour Organization, Workplace Violence in the Health Sector: Global Research Findings (ILO Publications 2018).
[6] World Health Organization, Preventing Violence Against Health Workers: A Global Overview (WHO Press 2020).

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performance of health care providers; and evaluating the current systems (policies and programmes) in place for the prevention of, and response to, workplace harassment.

B. Research Questions

This research seeks to answer key questions:

1. What forms of workplace harassment are most prevalent in Delhi's medical field?
2. Which groups of healthcare workers are most vulnerable?
3. What institutional, cultural, and environmental factors contribute to harassment?
4. How does harassment impact mental health and patient care?
5. How effective are current reporting and redressal systems ?
6. what improvements are required to ensure safer working conditions?

C. Hypothesis

The study's hypothesis is that the current rate of reporting workplace harassment is extremely low in Delhi's healthcare service sector because workers fear retaliation, experience pressures from superiors within a hierarchical work environment, and the current institutional systems for preventing and responding to workplace harassment are insufficient. The study's underlying premise is that harassment impacts health care providers' mental health and, in turn, impacts on their ability to provide the best possible patient care – resulting in decreased efficiency, morale, and overall organisational performance.

D. Significance and Utility of the Study

This research is of significance to all stakeholders who fall under the umbrella of the healthcare field; policymakers, hospital administrators, health care professionals, and academia will all find value in this study as it provides information about the incidence and ramifications of harassment, allowing for better-informed policy creation, enhanced institutional accountability, and an incentive to reform organisations. The information gathered can also be used to establish programmatic interventions, enhance grievance reporting systems, and create a culture of safety and respect within the healthcare system.

E. Scope of the Study

Geo-chartically, this study is limited to a specific geo-chartical location (Delhi) and is focused on hospitals, clinics, and other healthcare institutions. Healthcare Workers as a group include all types of healthcare professionals (physicians, nurses, medical technician, medical intern, and medical support staff) and their experience of harassment is addressed. Types of harassment

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addressed include Psychological (emotional) harassment, Verbal harassment or abuse, Sexual harassment or assault, and Physical harassment or abuse. Analysis was done on both Internal organisational factors (i.e., HR policies, the institution's position on reporting etc.) and External Factors(influences from Patient contacts).

F. Research Methodology

This study used a mixed-method approach, using both qualitative data, as well as observation from the findings of the research, and incorporated secondary sources, including but not limited to, academic journals, reports, and media articles. An analysis was then conducted using various forms of thematically analysed literature, observational, and descriptive interpretations using the derived evidence collected within the study to draw conclusions.

II. Legal and Institutional Framework Governing Workplace Harassment in Delhi's Medical Sector

There is a many-faceted problem regarding workplace harassment for anyone working in the medical field, and especially in institutions that are more complex than just hospitals — including nursing homes, or teaching hospitals, private clinics and so on. On paper, there are legal protections available under a combination of federal and state statutes as well as institutional policies, however, the reality of most healthcare workers is that they work in a precarious environment. The challenge is not simply the lack of laws but rather is exacerbated by institutional inertia, hierarchical power structures, professional dependency, and culturally accepted standards for poor treatment.[7]

The Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act of 2013 (POSH)) is a landmark piece of legislation that has created a statutory framework for what had previously been addressed through the courts based upon the principles of the law. The POSH Act is primarily a civil/institutional remedy for workplace harassment and has criminal sanctions under the IPC (Indian Penal Code) on 1860/BNS 2023. In theory, this means that every hospital, clinic, medical college and nursing home, regardless of its type or ownership, must comply with the law by creating grievance committees, providing for a safe workplace, providing a redressal mechanism for staff who are being sexually harassed, and protecting the dignity of staff members at work.[8]

[7] Kishore, Jugal et al. "Workplace Bullying in Healthcare: Patterns, Consequences, and Interventions." Journal of Family Medicine and Primary Care 7, no. 3 (2018): 497–502.
[8] Sharma, Priyanka. "Gendered Dimensions of Workplace Harassment in Indian Hospitals." Indian Journal of Social Work 80, no. 1 (2019): 45–67.

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Nevertheless, there are numerous structural and institutional variables which prevent realisation of this promise in many health care settings. Steep hierarchies within the health system (senior consultants, Heads of Department, administrators, etc...) manage all aspects of professional growth (career progression, appointment and transfer as well as evaluation) for junior doctors, nurses, interns and allied support staff. Many of the most vulnerable groups within the health system (contract employees, interns, nurses and first-generation professionals) usually have little or no employment security and are often afraid of adverse job actions, being transferred, or being labelled negatively if they report harassment. Internal reporting mechanisms (committees charged with receiving complaints) are often established as a formality and lack independence or representation or confidentiality, and many staff do not know what their rights are, or do not trust complaint systems to support them.

In addition, a high proportion of harassment occurring in health care settings is not sexual in nature, however it can be very damaging in its own right: examples include instances of repeated humiliation, bullying, psychological intimidation, caste or status-based discrimination, excessive workloads, punitive transfers, denying staff time off, and retaliating against anyone who blows the whistle on, or otherwise raises legitimate concerns. Structural or institutional harassers often fall outside the limited definition of sexual harassment under current legislation, thus providing no effective remedies for the victim.

While there is a existing framework of law, the distance between what the law says and is lived through by individuals when their rights are violated (i.e., racism, sexism, etc.) is vast. To effectively bridge this gap, there needs to be more than just compliance – there needs to be reform in the culture of institutions, more accountability within those institutions, a broader avenue to help individuals seek out relief through processes of grievance redressal, and an expanded definition/understanding of harassment to incorporate all forms of harassment (not solely sexual in nature).

A. Evolution of Legal Protections: From Judicial Guidelines to Statutory Regime

Judicial intervention was the means to formally acknowledge workplace sexual harassment in India. This was accomplished via the Supreme Court of India's landmark decision of Vishakha and Others v. State of Rajasthan in 1997[9], where the Supreme Court identified that sexual harassment at the workplace violated women's fundamental rights, including the right to equality and dignity and the right to a safe work environment, as outlined by the Constitution

[9] Vishaka & Others v. State of Rajasthan, AIR 1997 SC 3011

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under Article 14 [10](equality before the law), Article 15 [11](prohibition of discrimination), Article 19(1)(g)[12] (right to practice any profession and carry on any occupation), and Article 21 [13](right to life and personal liberty).

Given that there was no statutory law addressing workplace sexual harassment in India, the Supreme Court established certain procedural guidelines for employers regarding creating and maintaining a safe work environment; implementing measures to prevent workplace sexual harassment; providing mechanisms for redress of grievances relating to workplace sexual harassment; providing awareness and sensitisation about workplace sexual harassment to employees and employers and establishing procedures for dealing with complaints of workplace sexual harassment. The guidelines derive from international standards, including the United Nations' (UN) Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and were created as an interim direction, pending legislative action.

However, the effectiveness of the implementation of the Vishakha Guidelines was inconsistent across workplaces, primarily due to a lack of formal grievance mechanisms in many workplaces; little to no awareness about workplace sexual harassment, and the requirement for voluntary compliance for protection against workplace sexual harassment. As a result of this identified gap, in 2013, Parliament enacted the Prevention of Sexual Harassment (POSH) Act (of 2013), effectively converting the judicial guidance outlined in the Vishakha Guidelines into binding law.[14]

The POSH Act applies to all industries, whether government or private, large organisations or small businesses, and to workers in both formal and informal sectors. The definition of "workplace" includes all areas where work is performed, including hospitals, clinics, nursing homes, medical colleges, and other institutions that are associated with the work performed. Therefore, all healthcare facilities are included within the scope of POSH.

The POSH Act also set out specific requirements for employers, including establishing and maintaining Grievance Committees, providing a confidential complaint mechanism, providing interim safety measures, and providing training on how to create and maintain a safe working environment.

Additionally, the protections provided under the POSH Act do not replace the criminal laws

[10] Constitution of India, Arts. 14,
[11] Constitution of India, Arts. 15
[12] Constitution of India, Arts. 19(1)(g)
[13] Constitution of India, Arts. 21
[14] Nishith Desai Associates, Prevention of Sexual Harassment at the Workplace (POSH): India Legal & HR Considerations (Research Paper 2023).

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already in place; therefore, those who violate the POSH Act may also be charged with committing a criminal act under the Indian Penal Code for things such as molestation and other crimes against women.

Over time, the process for protecting women working in the healthcare industry has changed from being a judicially created system of voluntary guidelines to having a single statutory regime that encompasses all healthcare industries across India and is, on its surface, one of the strongest protections available to working women in healthcare.

B. POSH Act, 2013 & Their Relevance to Medical Workplaces

The POSH Act, 2013 mandates that all Employers must comply with the provisions of the Act regarding Sexual Harassment of Women at the Workplace. The Act's definition of Sexual Harassment is broad in scope with respect to the Medical Profession and includes: a) unwelcome physical contact or advances; b) a request or demand for Sexual Favour; c) sexually coloured remarks; d) the exhibition of pornochartic material; and e) any form of verbal, nonverbal, or physical conduct that is Sexual in Nature and Unwelcome. The Act recognises both types of Sexual Harassment, namely, "quid pro quo" and "hostile work environment". Quid Pro Quo is defined as the Practice of providing a Benefit of Continued Employment in exchange for Sexual Favors or other unwanted sexual behaviours within the Workplace; Hostile Work Environment is defined as the Creation of an Intimidating, Degrading or Offensive Environment as a result of multiple unwanted actions of a Sexual Nature toward a Woman Employee[15].

The POSH Act sets out the requirement for the Established of an Internal Complaints Committee (ICC) to be set up by all Employers with 10 or more Employees. For Smaller and Unorganised Workplaces, the Appropriate Authority will set up a corresponding Local Complaints Committee (LCC).

To comply with the provisions of the POSH Act, the ICC must follow the prescribed procedures: receive Complaints in writing; Inquiry into the Complaint must be made within a prescribed time frame; complete the Inquiry Procedure; and have power to call for Witnesses and Documents; maintain confidentiality; provide interim relief (i.e., leave, transfer, alternate duties); and treat Sexual Harassment as a Misconduct Violation of Service/Employment Rules.

Employers must raise awareness of sexual harassment: keep employees informed of rights; post workplace anti-harassment policy; conduct ongoing training and educational sessions; create a

[15] Singh, Arjun & Goel, Vandana, "Impact of Workplace Violence on Mental Health of Nurses in Urban India." Asian Journal of Psychiatry 51 (2020): 102–108.

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harassment-free environment at work. Within the medical setting, the definition of a 'workplace' includes all areas where Healthcare Workers work — e.g., hospitals, clinics, wards, laboratories, staff accommodations, nighttime duty rooms, operating rooms — and therefore, all Employees working in a medical setting are protected by POSH. Employees Include Medical Doctors, Nurses, Interns, Residents, Paramedical Staff, Contracted Employees, Allied Health Staff and Visiting Consultants. Under POSH, in addition to Criminal Law under IPC (e.g., Molestation, Outraging Modesty, Assault), the problems related to grievous behaviors also fall under Criminal Provisions.[16] There is a Dual Method of Protection; an Internal Complaint and Disciplinary Avenues to Correct and/or Redress Sexual Harassment and Criminal Prosecution for Serious Offenses. Medical workplaces should also have, and in fact must have, A Safe Dignified Work Environment for all Employees and the Mechanisms for Reporting, Investigating, and Redressing Sexual Harassment.

C. Judicial Precedents, Real Cases & Their Implications for Medical / Institutional Settings

Only after Courts interpret Statutory Provisions do these Statutory Provisions become law; only after incidents in workplaces, including but not limited to Medical Institutions have been Judicially tested do Courts interpret Statutory Provisions. Several of the below cases demonstrate how Statutory Provisions have been successfully litigated, failed to be litigated or preserved an employer's rights under the Statute.

Case 1: Vishakha & Others vs. State of Rajasthan 1997

The fundamental judgement in this case established and defined Harassment Based on Sex as a violation of a Fundamental Right and outlined a set of Standards (Vishakha Guidelines) for Employers to ensure Safe Work Environments and create Grievance Procedures to remedy sexual harassment. The landmark judgment set the stage for the creation of Legislative Options (POSH Act) to establish Workplace Dignity.[17]

Case 2: Apparel Export Promotion Council vs. A.K. Chopra 1999

Very shortly after the Vishakha decision, this case was one of the first landmark cases defining sexual harassment as being much broader than what had been defined in the Vishakha case. In this case, the Court held that there does not have to be one event whereby a Person was in direct physical contact with another Person in order for the Person who is harassed to have a claim for

[16] Thomas, Reena. "Institutional Accountability and Implementation Gaps Under the POSH Act in Healthcare Settings." NUJS Law Review 14 (2021): 112–138.
[17] Supra note 9

Sexual Harassment; Furthermore, verbal or visual conduct of a Sexual Nature directed towards another Person would constitute Sexual Harassment if such conduct has created a Working Environment where it would be hostile and/or if the Person who is doing the harassing has made it clear that acceptance or rejection of such conduct could affect the Person's Employment Status or Work Performance. This ruling provided many Employees who work in Environments where Hierarchical Power may be exercised through intimidation, Verbal Abuse and/or the creation of a Hostile Working Environment, rather than through Physically Assaulting another Employee, a Clear Cut Method of how to prove Factual Evidence of Sexual Harassment through Circumstantial Facts.[18]

Case 3: Institutional setting — aftermath of R.G. Kar Medical College and Hospital incident (Kolkata, 2024)

The 2024 rape-murder incident of the female medical resident at RG Kar Medical College has brought to the fore the failures of institutions; there were no proper protocols for safety and security, weak mechanisms for making complaints, and no protection for female staff members. After the tragic event occurred all the media and advocacy groups showed how all those preventive measures created through the POSH Act and the institution's obligations have not been effective. As a result, the case will serve as a national wake-up call for all those in the medical field to call for stricter enforcement of the POSH Act by all medical institutions. Therefore, it has been demonstrated that despite having a legal framework, institutional cultures that undermine the framework or fail to enforce it can lead to horrific consequences[19].

Case 4: Payal Tadvi (2019) — caste-based harassment leading to suicide in a hospital context

The incident involves the alleged caste-based humiliation and harassment of a doctor by her senior colleagues that led to her suicide. The police charge-sheet makes clear that they have included offences against the Scheduled Castes and Scheduled Tribes (Prevention of Atrocities) Act, as well as offences related to ragging and workplace harassment. Although the POSH Act covers sexual harassment, this incident illustrates that the issue of harassment in medical workplaces often intersects with issues of caste, status, discrimination, and professional hierarchy. All of these abusive actions are non-sexual in nature, but nonetheless have severely violated the dignity of the individual, and created a hostile work environment.[20]

[18] Apparel Export Promotion Council v. A.K. Chopra, AIR 1999 SC 625

[19] "R.G. Kar Medical College Rape and Murder Case: Updates from the Supreme Court," SC Observer (Sept. 24, 2024).

[20] "Dr Payal Tadvi case: Three women doctors held for abetting junior's suicide," Times of India (May 29,

These cases demonstrate four things: (1) sexual harassment in the workplace is legally recognized under wide definitions; (2) sexual harassment covers all types of institutions; (3) severe consequences will occur when an institution does not adequately protect its employees; and (4) there are many types of harassment (i.e., sexual, caste, status, and professional) that are coexistent and that most existing frameworks do not adequately address.

Nonetheless, there are significant limitations: As of 2020, judicial comments indicate that simply creating grievance committees (which are often labeled Internal Complaints Committees ("ICCs") or Litigation Committees (LCs)) is not enough. If there are issues surrounding the establishment, lack of knowledge, or prejudiced composition of the committees, they may be incapable of conducting a proper investigation and, therefore, will defeat the very purpose of having those committees. In addition, non-sexual forms of harassment, including psychological, institutional, caste-based discrimination, excessive work assignments, and bullying, often occur without being covered by statutory obligations, leaving many victims without adequate legal recourse.

Although legal definitions and interpretations exist for workplace harassment in India, there is still a disconnect between what the law prescribes as appropriate and how organisations implement those laws.

The legal structure in place to protect against workplace harassment in India consists of three parts: a statutory law called the POSH Act; judicial decree (Vishakha and related decisions); and a portion of criminal law (Indian Penal Code [IPC]). These three components combined provide a strong theoretical framework for preventing workplace harassment; however, it becomes increasingly important when dealing with the medical sector due to the unique nature of healthcare organisations. The medical field has large numbers of employees (including vulnerable employees like nurses, interns, and support staff), hierarchy-based management systems, and often long hours of work, making it an environment where harassment (sexual, psychological, and institutional) may occur frequently, thus making it necessary for organisations to implement formal mechanisms to protect against such harassment.

Unfortunately, there is still an enormous gap between the promise of statutory protection provided by the Hindu law (i.e., POSH) and the reality of institutional protection for those who work in hospitals and other healthcare-related organisations. There are many barriers to receiving protection that exist within the medical profession that include structural imbalances of power; dependence on hierarchical management systems; inertia within organisations; fear

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of retaliation from supervisors; very narrow definitions of what constitutes harassment; and a lack of formal procedures for filing complaints or knowing how to file a complaint.

Simply following the POSH Act alone will not help to close the gap between the requirements of the law and the reality experienced in many workplaces across India. It requires a fundamental shift in the way institutions perceive and address harassment as well as other forms of workplace violence, as well as how institutions view employees' needs for safe workplaces that support dignity, equity, and justice. To achieve true safety, dignity, and equity, there must be simultaneous changes to institutional culture, power dynamics, and regulatory structures. In order for the legal framework to be truly effective, it will require many of the structural changes listed above to be established in order to support the institution's vision for providing a safe and equitable work environment.

III. FORMS, PREVALENCE, AND IMPACT OF WORKPLACE HARASSMENT IN DELHI'S MEDICAL FIELD

Harassment in the workplace, especially when it comes to the medical sector based in Delhi, India, has become one of India's most important issues for healthcare systems, yet it is one of Delhi's most neglected issues and works against progress. The reason why it is ignored so often lies not only within the behaviours associated with harassment but also the systemic problems that enable it. There are many structural layers in which harassment occurs, as well as numerous levels of hierarchy that exist in all aspects of the operational pressure that come into play when providing medical care. Harassment does not just exist in one form; it exists in many different forms and will continue to exist in various forms, such as hospital, clinic, medical school, etc., all creating a similar societal concern for both the employees who work in healthcare facilities and the patients they serve.[21]

This chapter examines the various forms of harassment found in Delhi's medical settings, the reasons behind its high prevalence, and the significant impact it produces on the mental health of workers, the quality of patient care, and the functioning of healthcare institutions. Much like the structural inequalities faced by early-career lawyers navigating judicial eligibility reforms, healthcare workers face entrenched barriers when attempting to challenge or report hostile behaviour. Harassment in hospitals thus becomes a systemic issue requiring deeper structural understanding rather than superficial solutions.

[21] Garg, R., et al., "Low Reporting of Violence Against Health-Care Workers in India," International Journal of Community Medicine & Public Health 6, no. 4 (2019)

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A. Forms of Workplace Harassment in the Medical Sector

Harassment in healthcare workplaces has multiple dimensions, including but not limited to verbal, psychological, physical, and sexual harassment. With verbal harassment often seen as the most obvious form of workplace abuse, it manifests as yelling, embarrassing someone in public, reprimanding in an aggressive tone, using disparaging comments, using language based on gender/caste stereotypes, etc. Examples of how supervisors/department heads normalise this type of behaviour as part of the "training" process or maintaining discipline can be found; they use the term workplace abuse when referring to this type of behaviour. The vast majority of the reports concerning nurse harassment and junior residents come from nurses and junior residents, with most reports being made regarding harassment for something done (or not done) causing a minor error or for something beyond the employee's control, e.g., lack of staffing and/or equipment; hence, the reason for being targeted.

Concerns about sexual harassment have been around for years within the healthcare industry, and will likely continue to exist for nurses and female doctors and those working as interns. This includes unwanted sexual advances, inappropriate remarks made to them, non-consensual touching, and continual gender discrimination. In addition, although laws are in place protecting women from sexual harassment under the current POSH act, hierarchy within an organization, along with fear of retribution for reporting their allegations of sexual harassment, results in a lack of reporting.[22]

B. Prevalence of Harassment: Institutional, Structural, and Cultural Factors

In the medical sector of Delhi, there is significant prevalence of harassment due to various structural stressors, including a lack of accountability, culture that condones hierarchical dominance and a failure of the administrative system to implement accountability mechanisms effectively. There are stark variations in workplace culture and procedural safeguards among institutions in the medical sector as there are with the uneven application of legal education reforms among different quality institutions.[23]

Thus, because of the many patients, particularly at teaching hospitals and government-run hospitals; chronic overcrowding; staffing shortages; and high emotional intensity within these institutions, aggressive interactions and poor communication are prevalent within these institutions. Junior workers are often responsible for documentation, managing wards, and

[22] Gadapati, S. & Shamanna, B. R., "A Review on Violence Against Health Care Professionals in India and Its Impact," National Journal of Community Medicine (2023)
[23] Davey, K., et al., "A Qualitative Study of Workplace Violence Among Healthcare Providers in Emergency Departments in India," International Journal of Emergency Medicine 13 (2020)

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responding to emergencies, and as such, these junior workers face considerable aggression from their senior counterparts, many of whom are themselves under considerable stress.

Underreporting is another significant element of this issue. Many workers do not trust internal institutional grievance systems and perceive committees responsible for addressing these types of issues as either biased against staff members or functioning as a façade to appease workers. Private hospitals are particularly susceptible to having systemic issues go unacknowledged due to reputational concerns arising from complaints of this nature. Similarly, administrative inefficiencies within government hospitals limit the capacity for ongoing resolution. As a result, many medical workers function in environments in which harassing behaviours have become systemic and unrecognised.

C. Systemic Impact on Patient Care, Institutional Culture, and Healthcare Efficiency

Workplace harassment doesn't just impact those involved, but also affects workplace culture and ultimately affects the quality of care provided to patients. The presence of fear, intimidation, and/or uncertainty in the workplace are all detrimental to delivering safe patient care and will eventually compromise the standard of care provided. Workers in healthcare who experience anxiety and/or fatigue are at an increased risk of making mistakes that result in medical errors. A breakdown in communication between healthcare team members (especially between senior consultants and their junior staff) causes confusion and misunderstandings that put patients in jeopardy. Workers perceive a lack of support from management due to this type of issue, resulting in a culture of distrust, which can lead to absenteeism, resentment towards their employer, and disengagement from their employer's goals and mission.

In the long term, the work environment will create a culture of compliance rather than excellence, creativity, and empathy in caring for others. In addition to having a negative impact on patient safety, the public's perception of hospitals may also be negatively affected when workplace issues lead to delivery of substandard care, inefficiencies in delivering care, and employee disputes/arguments. Workplace harassment is not simply an issue of an employee's behaviour in isolation. It is a systemic issue that impacts healthcare delivery on many levels, including employee morale, employee turnover, patient safety, trust in the institution, and overall efficiency of the healthcare system in the city of Delhi. HR departments must address these workplace issues through every channel, including legal compliance, reformative practices to create an institutional culture of safety and respect.

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IV. FACTORS CONTRIBUTING TO WORKPLACE HARASSMENT IN DELHI'S MEDICAL INSTITUTIONS

To properly understand the ongoing issue of harassment in Delhi's Medical Sector cannot be reduced to viewing each case in a vacuum; rather, there are many factors that come together to set the stage for these Gaps and the resulting Harassment. These include an organisation's culture, policies and procedures, and the overall working environment for Employees who work within that area, including Inter Professional hierarchy. Additionally, there are multiple levels of organisational activity that influence work conditions, such as the expectations placed on Employees, the size of the caseloads or patient volume to be handled, the level of professionalism in the organisation to the point of one's Education, the overall economic climate in the area in relation to the number of People employed to care for Patients and Organisational Resources available to Employees. Thusly, the problem associated with Workplace Harassment in late 19th Century and early 20th Century is not only a Behavioural Phenomena but rather one that is part of the Design of Organisational Structures in Health Care.[24]

Harrassment is often a by-product of ingrained attitudes, that are entrenched in society and that are habitually viewed as 'normal', 'acceptable' or simply a part of the medical 'training culture', which promotes aggressive-, rude- or degrading-type behaviours. Many of the senior medical professionals who now perpetuate this behaviour were themselves subjected to similar environments when starting out in the profession and so to them it has become a rite of passage. At the same time, such behaviours feel more threatening due to the many levels of inequity and discrimination embedded within the structures of healthcare (that is based on gender,, different levels of seniority, socioeconomic status, and professional roles).

A. Institutional Hierarchies and Power Asymmetry

In the medical field of Delhi, there is a distinct hierarchy in hospitals that often promotes workplace harassment. Because the hierarchy is vertical in nature with many levels from the top to the bottom, the hierarchical levels include consultants at the highest level followed by senior residents, junior residents, interns, nursing-in-charges, staff nurses, and technical/support staff. As a result of the levels of the hierarchy, each level of health care professional has differing power, authority, and social status. Because of the structure of the hierarchy and the way it organizes work processes, as well as its influence on interpersonal relationships, there

[24] S. Gadapati & B. R. Shamanna, "A Review on Violence Against Health-Care Professionals in India and Its Impact," National Journal of Community Medicine (2023)

are significant implications for workplace culture.[25]

Furthermore, the hierarchical model creates significant latitude for unchecked authority. Senior staff may sometimes use aggressive verbal communication, impose unrealistic expectations, or publicly humiliate juniors in the name of discipline. When such actions go unchallenged and normalised over time, the workplace becomes an environment where harassment, instead of being viewed as unacceptable, is rationalised as necessary for maintaining order and clinical precision.

B. High-Stress Work Environments and Systemic Workload Pressures

Hospitals in Delhi, both public and private, are under intense pressure to perform due to excessive patient loads, overstretched resources and personnel, and the subsequent creation of emotionally charged work environments. Public hospitals tend to have much higher than normal patient volumes with an associated impact on both infrastructure and staffing levels. This is particularly apparent in emergency departments due to the excessive number of patients combined with long wait times, repeated emergency situations, and minimal available resources to deal with them. Private hospitals are generally better prepared than public ones; however, they operate with revenue-driven performance goals on a strict productivity basis. This creates a very high-stress working environment in which minor frustrations can quickly become highly escalated situations.[26]

In some cases, excessive workload itself becomes a tool of harassment, particularly when rosters are manipulated to burden specific individuals or groups. Nurses frequently report being assigned double shifts or night duties disproportionately, often as a consequence of complaining or refusing unreasonable tasks. These patterns mirror broader occupational concerns where systemic pressures create environments ripe for exploitation.

C. Cultural Norms, Gender Dynamics, and Social Attitudes within Medical Institutions

The gender-based and caste-based social values that India has in its developmental patterns permeate the medical institutions — like those based out of Delhi. As a result, women working in the medical profession are often subject to various forms of workplace harassment due to the dominant cultural stereotypes that exist within that profession. While there is more diversity within this sector now than there was previously, it is still very much an industry dominated by

[25] S. Srivastava, "Predictors of Workplace Violence in Indian Hospitals: A Systematic Review," Online Journal of Health and Safety (2025)
[26] T. Anand et al., "Workplace Violence Against Resident Doctors in a Tertiary Care Hospital in Delhi," National Medical Journal of India 29, no. 6 (2016)

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patriarchal norms and gender stereotypes. Many nurses, nursing students, and junior female doctors are particularly vulnerable to verbal, psychological, and sexual harassment due to these gender stereotypes.

In addition to the negative impact that gender has on women in the medical profession, there are also social hierarchies that exist which prevent certain groups of workers from being treated in a respectful manner. Workers who come from lower socio-economic backgrounds (e.g., technicians, ward boys, sanitation workers, and first-generation healthcare workers) frequently experience behaviours of condescension or exclusion from participating in the decision-making process. These social values perpetuate a culture in which respect is distributed unevenly through the workplace, thereby fostering a culture that is tolerant of harassment.

D. Administrative Weaknesses, Poor Accountability, and the Normalisation of Silence

One of the key reasons for the ongoing prevalence of harassment in nursing and care establishments is a lack of effective management structures. While legislation such as the Prevention of Sexual Harassment (POSH) Act requires hospitals and healthcare providers to establish Internal Complaints Committees (ICCs), the majority of hospitals have not effectively implemented these mechanisms. Many hospitals have ICCs that exist only in name, and many of the ICCs that are formed are currently dormant and have not been fully or adequately trained. For the majority of government hospitals, excessive administrative burden results in lengthy processing time for grievances, inadequate monitoring of processes, and little to no follow-up actions. Conversely, in private hospitals there is a concern for the institution's reputation, which results in a tendency to discourage complaints, as well as the ability of the worker to express their concern.

Thus, workplace harassment persists not because of a lack of law but because of a systemic failure in enforcement, cultural acceptance of hierarchical dominance, and the absence of safe channels for redressal. As the next chapter will show, these systemic weaknesses become especially visible through empirical evidence and field-based observations.

V. Empirical analysis of workplace harassment in Delhi's medical field

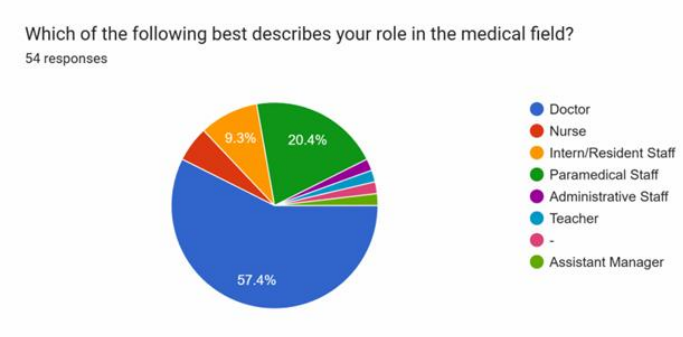
In this Chapter, the study's empirical research base using results from a survey of 54 Healthcare Professionals from numerous Healthcare facilities across the city of Delhi was presented. The survey assessed both the different patterns of workplace harassment; levels of awareness regarding Institutional protections; how Healthcare Professionals report their experience of

Harassment; the perceived safety that they experience at work; how effectively the Institutions respond to workplace harassment and the emotional and professional effects of workplace harassment. Participants consisted of Doctors, Nurses, Interns, Paramedical Staff, Administrative Staff and Managers. The resulting diversity of responses provides a comprehensive representation of the experience of Healthcare Professionals in the Medical Sector of Delhi.[27]

The results from the Survey illustrate not only the scope and types of workplace harassment occurring in the Healthcare Profession, but also the cultural and administrative deficiencies that exist in Healthcare Institutions creating unsafe working conditions for Healthcare Professionals. In addition, Survey responses demonstrated the Intersection between Institutional Power Structures, Accountability and the Workers' Lived Experiences in the workplace.

A. Professional Composition of Respondents

According to the first chart, most people that responded to the survey were doctors (57.4%), followed by paramedical staff (20.4%), and interns, paramedics, and administrative staff who had lower than average representations among respondents.



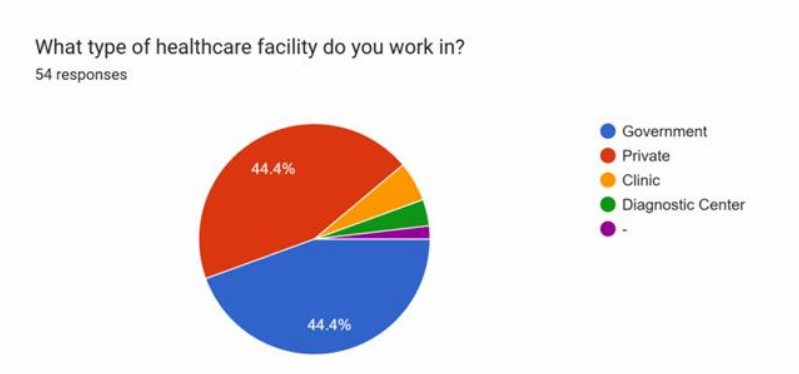
There is reason to believe that because these are the most common groups represented by the population sample responding to this study, they lend themselves to being the most accurate reflection of how different levels of hierarchy experience workplace violence through the study of the numbers submitted to us.

Therefore, the variety of professionals submitting their information in this manner will help provide a foundation for reasonable and factual statements regarding how individuals in medicine have experienced a range of types of violence toward themselves throughout their careers. Thus, these professionals will be able to provide a clearer and more unclouded view of what has occurred to them, so that they can identify the most effective means to counteract or prevent further occurrences.

[27] T. Ahluwalia et al., "A quantitative survey study of healthcare providers in India's emergency departments on workplace violence," International Journal of Emergency Medicine (2024)

B. Employment Settings and Institutional Diversity

The second chart reflects an almost equal representation of respondents from government hospitals (44.4%) and private hospitals (44.4%) along with much smaller numbers from clinics and diagnostic centres. This equal distribution provides a means of comparing both types of institutions (government and private) at the same time because they are organised differently with regard to organisational culture, allocation of resources, administration, oversight and hierarchy.

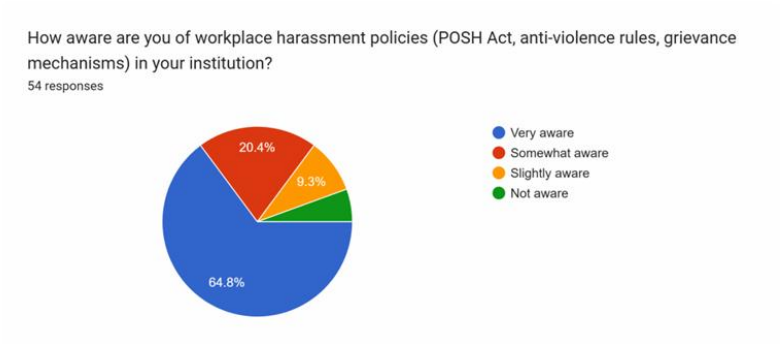


Government hospitals, typically understaffed, overcrowded and dealing with large amounts of aggression from patients, can have an increased prevalence of employee-on-employee aggression. Conversely, Private hospitals typically have a very rigidly defined corporate structure that creates additional workplace-related stress for employees. Therefore this almost equal representation of both hospital types in this survey allows for the evaluation of the harassment (abusive) behaviours and patterns across the two distinctly different institutional models and thus increases the breadth and comparative value of the findings.

C. Awareness of Harassment Policies and Institutional Mechanisms

According to chart three, a notable result is that out of all individuals responding to the survey, 64.8% reported being either "very" knowledgeable about policies/procedures regarding workplace harassment including the POSH Act, anti-violent behaviour guidelines, and grievance resolution processes along with some reporting being partially informed of these policies/protocols. A small number reported having little to no knowledge of these legal protections.

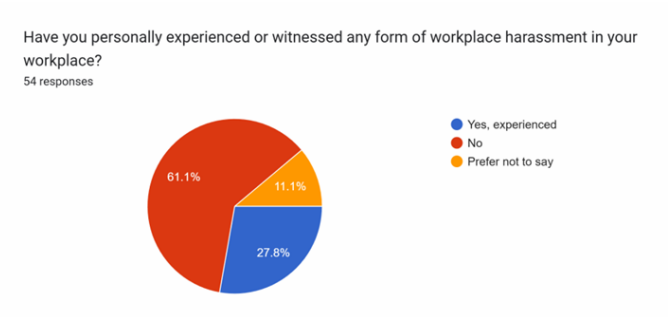
Factors contributing to the relatively high level of knowledge include the increased media attention surrounding issues/concerns regarding workplace harassment in healthcare settings and the requirement of mandatory compliance outlined in law under the POSH Act, as well as the fact that employers provide a summary of the policies to newly hired employees during onboarding. As the charts illustrate, lack of awareness amongst employees does not necessarily mean that there will be a corresponding level of trust in organisations for reporting incidents, and therefore we see discrepancies between levels of employee awareness with regard to



personal safety and security within their work setting and whether that knowledge translates into behaviour.

D. Prevalence of Harassment and Lived Experiences

The proportion of individuals who responded 'yes' to having personally experienced or witnessed harassment is equal to 27.8%, whereas 61.1% of respondents stated 'no', and 11.1% chose 'prefer not to answer'.

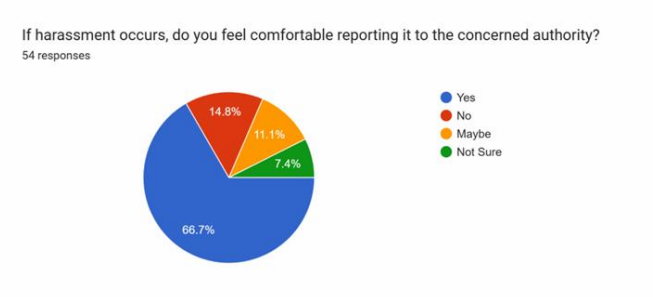


Two trends arise from this breakdown. First, the high percentage of those claiming to have personally experienced harassment indicates that harassment is a real issue for the industry. Secondly, the large percentage of those denying any experience of harassment also represents two possibilities: it may reflect a true lack of any such experience, but could equally be the outcome of fear of disclosing information; being affected by stigma associated with experiencing harassment; or the perception that harassment is normalised as "acceptable working conduct", particularly for junior staff members. Therefore, the ‘prefer not to say’ category reinforces the likelihood of underreporting harassment incidents.

E. Comfort in Reporting Harassment

This chart provides another indication of a growing willingness to use reporting mechanisms, as 66.7% of individuals participating in this survey indicated that they would feel comfortable reporting harassment. However, a substantial minority of respondents still have a level of disagreement, uncertainty, or hesitation regarding using such mechanisms.

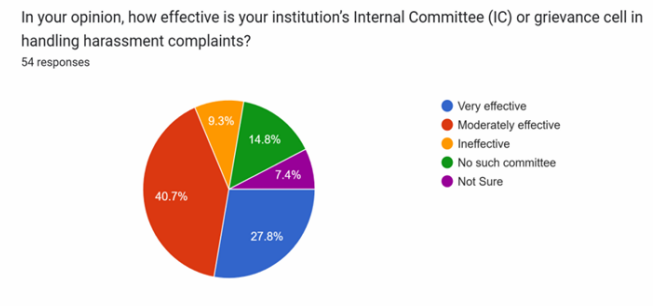
Further, this data indicates that there is now a growing willingness for individuals to use reporting mechanisms, but at the same time highlights the continued level of hesitation of nearly one-third of individuals who participated in this survey. The level of hesitation is likely driven by factors such as concerns about hierarchical pressures, fear of retaliation, and concerns about fairness/administrative impartiality within institutions. The earlier chapters demonstrated that hierarchical structures discourage the use of reporting mechanisms and, furthermore, this data



indicates that, despite there being awareness of the issues, there is not consistent confidence among respondents within Delhi's healthcare institutions.

F. Effectiveness of Internal Committees (ICs) and Grievance Cells

In evaluating internal committees or grievance cells, the responses reflect a split; for example, 40.7% rated them "moderately effective," 27.8% rated them "very effective," and 14.8% rated them ineffective. Of the remaining respondents, there were small numbers who did not know whether these types of committees exist or stated they did not exist.

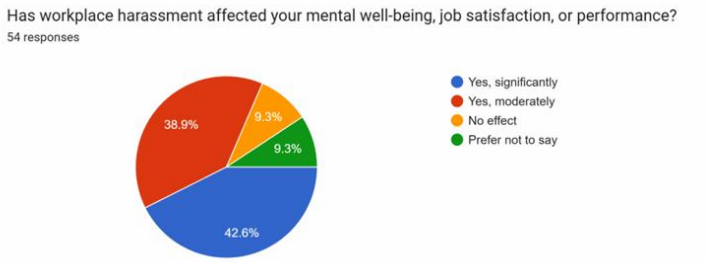


The differing perspective and levels of confidence regarding the internal committees and grievance cells suggest that institutions are legally required to establish grievance cells but that the actual level of functionality of each institution differs. The responses given as "moderately effective" illustrates an incomplete sense of confidence in the value these internal committees serve. The results also reaffirm concerns previously raised in the legal framework chapter regarding the implementation of compliance measures as being superficial and attributed to bureaucratic inefficiency.

G. Psychological and Professional Impact of Workplace Harassment

Findings indicate that there are significant impacts of harassment upon workers; 42.6% said they had a significant impact, while 38.9% said they had moderate impacts. Very few reported no impact of harassment. The findings suggest that harassment has significant consequences for the mental health and job satisfaction of health care workers, as well as their clinical performance.

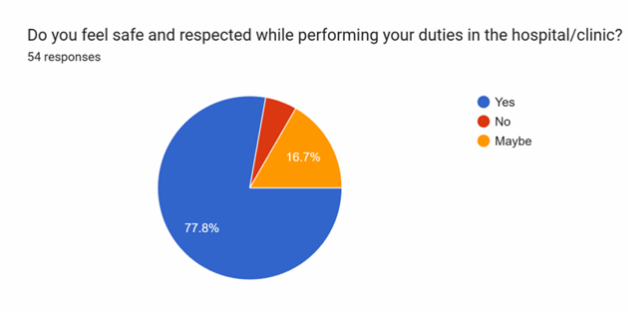
These results support global research demonstrating that workplace hostility leads to increased risk for burnout, emotional exhaustion, and increased likelihood of committing a medical error. There is ample empirical evidence to support the arguments in sections 1-4 that harassment is an issue that affects not only those who have been directly affected by harassment, but it is also



a systemic threat to the provision of quality health care.

H. Perceived Safety and Respect in the Workplace

When asked if they feel safe and respected at work, 77.8% of respondents answered "yes" and the remaining respondents answered "unsure" or "no";



Thus, while the high percentage of respondents who expressed feeling safe may be seen as a positive finding, the nearly 16.7% of respondents who do not express feeling safe or respected represent a large number of health care workers who are feeling vulnerable and/or undervalued.

Since safety and respect are key components to providing quality health care, the results call for reforming both workplace culture as well as the way in which the administration functions.

I. Factors Hindering Reporting and Institutional Barriers

The information collected by this survey indirectly shows some of the factors that discourage individuals from reporting harassment. The survey data show (1) Moderate Level of Institutional Effectiveness; (2) Fear of being judged; and (3) Perceptions of Power Imbalances.

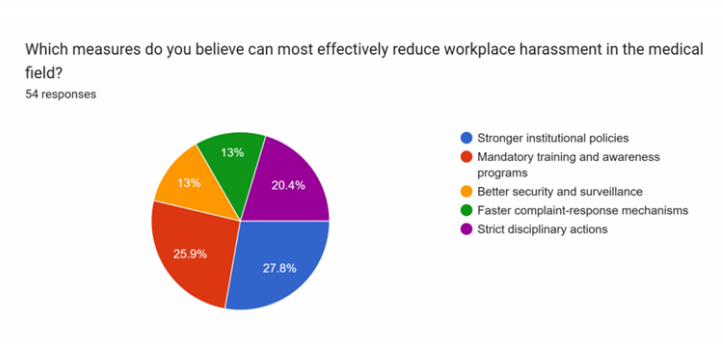
Many of the respondents expressed a lack of trust or ambivalence with respect to the committee(s) of their organization, indicating that the perceived credibility of the institution is a significant barrier to reporting harassment. As found in the global health workforce, many individuals fear that, if they report harassment, they will (1) experience career stagnation; (2) have interpersonal conflicts with coworkers; or (3) be branded as "problematic", and the data collected here reveal similar patterns.

J. Preferred Measures for Reducing Workplace Harassment

Respondents were asked to identify their preferred solution(s) to address workplace harassment. Below is the breakdown of those responses:

- **27.8% advocated stronger institutional policies**

- **25.9% supported mandatory training and awareness programmes**
- Smaller but significant groups called for stricter disciplinary action, better security, and faster grievance processes



Based on the above data, there is a strong preference for structural reform of the institutions to address harassment as opposed to superficial awareness sessions. All three groups of respondents prefer a stronger level of institutional accountability and we believe that a consistent level of training and supportive/disciplinary policy will greatly assist in reforming the workplace culture identified by earlier chapters as needing legal compliance, and moving toward accountability to all stakeholders.

The results from this empirical study reveal that the prevalence of workplace harassment within Medical & Healthcare Sector of Delhi is widespread and has a Negative impact on those subjected to it. Workplace Harassment has roots in both Systemic and Cultural factors. In regard to awareness, respondents were aware of their surroundings; however they had very poor levels of Institutional Trust, Reporting Willingness, and committee effectiveness. Additionally, Findings confirm the arguments presented in prior chapters. Thus, there is an immediate need for Comprehensive Reform that will provide a better Workplace Culture and increase Accountability within this sector and improve the Psychological safety of Healthcare Workers.

VI. Conclusion and Suggestions

The research findings indicate that workplace harassment in the medical sector of Delhi is not only an individual problem of poor behavior, but rather a systemic issue that exists as part of the broader culture of health care organisations, including institutional norms, hierarchical systems and pressures associated with conducting business. As such, the research identified evidence regarding how employees in the medical sector (i.e., doctors, nurses, interns and all other medical professionals) experience different forms of harassment in the workplace that negatively impact their mental health, work performance and ability to deliver quality patient care. Additionally, while there are several laws (such as POSH) and internal processes (complaints) available for reporting incidents of workplace harassment, the data indicate that the application of these protections is inconsistent across organisations and there appears to be

a disconnect between what employees know about their rights and what they believe they should be able to access with respect to reporting an incident (e.g., fear of retaliation, favouritism, indifference).

Cultural changes must occur within hospitals to properly solve this issue beyond just meeting regulations. Hospitals' Internal Committees need to be strengthened and independent and transparent processes must be established, with the continued education of all staff members regarding appropriate workplace conduct being reinforced through regular training sessions. Misconduct must be dealt with severely by providing strict corrective action when necessary. Hospitals need to create a workplace environment which allows for open communication and rational discourse, where workers feel that they are valued and have a voice. The development of a framework within which Delhi's medical institutions can enhance their accountability, display compassion, and establish a large-scale network of supportive and effective workplaces will ultimately create a healthier, more equitable, and professionally sustainable work environment.

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