Ethnographic Investigation into Medical Violence in Nepali Healthcare Facilities

Una investigación etnográfica sobre la violencia médica en los centros de salud de Nepal

Uma investigação etnográfica da violência médica em centros de saúde no Nepal

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Abstract

Introduction: Violence is not an inherent by-product of human relationships, but conflicts are. This article examines the factors and circumstances that lead to tension and conflicts between health seekers, and their counterpart Nepali medical establishments, and their staff members. *Development*: The article is divided into four sections by embedding a relevant literature review, analyzing ethnographic data generated from field research, and analyzing the content analysis of selected news portrayals. The first section discusses the context of the medical consultations that lead to the development of a problematic relationship. This is followed by examining the various types of violence, confrontations, and protests that arise from such relationships. The implications of rising medical promises and resulting heightened expectations are discussed in the third section. The last section focuses on how common medical practices in Nepali hospitals increase the possibility of confrontations and violence. *Conclusions*: The prevalence of tussles and medical violence in Nepal's public and private hospitals suggests that they can occur in any hospital, regardless of ownership. Because of the esoteric nature of medicine, there is always a communication gap between service providers and patients. Conflict and violence against service providers can thrive in the context of a two-sided differential explanatory model. The growing hostility also indicates a decline in trust between healthcare providers and patients in Nepal.

Keywords: Medical promise; medical violence; Nepal; patient expectations; provider–patient relation.

Resumen

Introducción: la violencia no es un subproducto inherente de las relaciones humanas, pero los conflictos sí lo son. En este artículo se examinan los factores y circunstancias que conducen a la tensión y los conflictos entre las personas que buscan atención médica y los establecimientos médicos nepalíes

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y los miembros del personal que trabajan allí. *Desarrollo*: embebido con una revisión de la literatura relevante, a través del análisis de datos etnográficos generada a partir de la investigación de campo y el análisis de contenido de la representación de noticias seleccionada, el artículo se desarrolla en cuatro secciones diferentes. La primera parte trata sobre el contexto de las consultas médicas que resultan en el desarrollo de una relación problemática. A esto le sigue el examen de los diferentes tipos de violencia, enfrentamientos y protestas que surgen a través de tales relaciones. En la tercera parte se analizan las implicaciones de las crecientes promesas médicas y el consiguiente aumento de las expectativas, mientras que la última parte destaca cómo las prácticas médicas típicas que existen en los propios hospitales nepaleses aumentan la posibilidad de enfrentamientos y violencia. *Conclusión*: la frecuente ocurrencia de peleas y violencia médica tanto en hospitales públicos como privados en Nepal sugiere que hay una brecha de comunicación entre los proveedores de servicios y el paciente debido a la naturaleza esotérica de la medicina. El conflicto y la violencia hacia los proveedores de servicios también pueden prosperar en el contexto de un modelo explicativo diferencial de las dos partes. La creciente animosidad también indica una disminución de la confianza entre los proveedores de atención médica y los solicitantes en Nepal.

Palabras clave: Nepal; expectativas del paciente; relación proveedor-paciente; violencia médica; promesa médica.

Resumo

Introdução: a violência não é um subproduto inerente às relações humanas, mas o conflito é. Este artigo examina os fatores e circunstâncias que levam à tensão e ao conflito entre as pessoas que procuram cuidados médicos e os estabelecimentos médicos nepaleses e os funcionários que aí trabalham. *Desenvolvimento:* incorporada a uma revisão da literatura relevante, através da análise de dados etnográficos gerados a partir da pesquisa de campo e da análise de conteúdo da representação noticiosa selecionada, o artigo desenvolve-se em quatro seções distintas. A primeira parte trata do contexto das consultas médicas que resultam no desenvolvimento de uma relação problemática. Em seguida, examinamos os diferentes tipos de violência, confrontos e protestos que surgem através de tais relações. A parte três discute as implicações das crescentes promessas médicas e o consequente aumento das expectativas, enquanto a última parte destaca como as práticas médicas típicas que existem nos próprios hospitais nepaleses aumentam o potencial de confrontos e violência. *Conclusão:* a frequente ocorrência de brigas e violência médica em hospitais públicos e privados no Nepal sugere-nos que podem ocorrer em qualquer hospital, independentemente do proprietário. Sempre existe uma lacuna de comunicação entre os prestadores de serviços e o paciente devido à natureza esotérica da medicina. O conflito e a violência contra os prestadores de serviços também podem florescer no contexto de um modelo explicativo diferencial das duas partes. A crescente animosidade também indica um declínio na confiança entre os prestadores de cuidados de saúde e os requerentes no Nepal.

Palavras-chave: Nepal; expectativas do paciente; relação prestador-paciente; violência médica; promessa médica.

Introduction

Access to and the quality of healthcare services in Nepal are determined by various factors. Poverty, illiteracy, insufficient infrastructure, deficient medical professionals, attitude toward healthcare professionals and their security concerns, bureaucratic and inadequate

health insurance policy, geographical barriers, and government policies are among the prominent ones that some scholars consider to have a direct bearing on (1,2). In this context, Nepal's referral-level hospitals with specialized healthcare services are primarily concentrated in a few urban areas. When we consider the operations of these hospitals and their relationships with patients, a depressing picture emerges.

Confrontations between healthcare users and providers of those services are becoming more common in this country, and they are often violent. Doctors are typically made liable for negligence when a hospital patient dies or suffers a decline in health. The victim's family, friends, and relatives have been known to physically assault hospitals and/or medical personnel. In response to such actions, health professionals have also gone on strike, directly impacting the healthcare system. During one such strike, which lasted 3 days from December 27 to 29, 2006, all medical facilities in Nepal closed, except for "emergency services" (3).

To better understand such tense relationships, this paper investigates the dynamics of major contributing factors to the emergence and persistence of conflicts between health service providers and health seekers in Nepal. It describes the pattern of conflicts between these two parties and the causes of such situations. The main concern of this paper is why patients' family members, relatives, and friends—collectively referred to as "the significant others"—occasionally resort to violent action against the hospital and/or service providers. This article fills a gap in Nepali medical anthropology by focusing on the conflict between the two groups rather than the healthcare system in general, particularly the context and pattern of relationships between healthcare providers and healthcare seekers (4-6). Dahal's investigation of the roles of paternalism and commodification in escalating tensions in Nepali healthcare settings can be viewed as one of the initiatives that brought forth this public health concern, opening the door for more culpability in this area (7). As a result, the issues raised in this essay are specific to the situation in Nepal. Nonetheless, the importance of this article in understanding medical violence extends beyond the national social, cultural, and political boundaries to various low- and middle-income countries where the healthcare system has become incapable of self-regulation (8, p. 432).

According to Bjorkqvist, the underlying causes of violence are aggression and frustration. In his opinion, violence, such as hunger, is not an innate impulse; instead, it has a social origin (9). Veena Das observes that "everyday life is corroded by betrayals, accusations, and the sheer exhaustion of keeping political energies from waning" in societies where conflicts have persisted for a long time and that "experience of violence travels from one threshold of life to the next" (10, p. 798). Such structural violence is prevalent in the daily lives of ordinary people in many societal and cultural contexts (11-13). It frequently prevails in the "forms of pervasive social inequality that are ultimately backed up by physical harm" (11, p. 4). Taking structural violence into account to comprehend violence eventually leads us to the question of whether violence itself has a determined ontology or not. Finally, it acquaints us with its

relational and social nature. In this paper, I will define violence as an incident in which there is not only a threat of physical harm but also a physical assault/attack.

On a social level, people learn how to act in conflict situations, and the cultural environment largely shapes this learning (9). While conflict is essential to social life, Bjorkqvist believes that violence can be avoided. This paper critically examines the context in which Nepali health seekers and, at times, healthcare providers engage in conflicts, as well as their participation in the formation of the group or, at the very least, collective actions and methods of violence.

The Centers for Disease Control and Prevention's National Institute for Occupational Safety and Health defines workplace (including physical assaults and threats) as acts committed against anyone who is at work or on duty (14). On the other hand, the United States Department of Labor characterizes workplace violence as behavior that aims to control and cause or is capable of causing death or serious bodily harm to oneself, another individual, or property damage (15). As a result, it encompasses abusive, intimidating, or harassing behavior, threats, and verbal or written aggression.

I intend to conclude with both definitions, which blame patients for "aggression directed toward service providers" (16). In other words, neither side is immune to being a victim. I am aware that healthcare workers are four times more likely than other workers to be victims of victimization and that health seekers are the source of the majority of violence in these settings (17,18). Although they are from the United States, these statistics are extremely useful in understanding the situation in Nepal.

People get into disagreements when they hold opposing beliefs and ideals. When people's fundamental interests are jeopardized, whether in a group or individually, they express their rage, which can lead to violence (9). People become violent when they see that their loved ones die, suffer a long-term illness or disability, or are financially and emotionally exploited. This is interpreted as an attack on their primary interests or even a threat to their survival. Thus, confrontations at health facilities go far beyond what Ramsay sees as people's inability to manage life's stress at work (19).

In this paper, the leading theory used to investigate the pattern of conflicting relationships between healthcare providers and health seekers is insights from a critical medical anthropological perspective, which "understands health issues in light of larger political and economic forces that pattern human relationships, shape social behavior, and condition collective experiences, including forces of institutional, national, and global scale" (20, p. 128).

Patients and health professionals have different perspectives on how to treat illness episodes. They perceive illness differently within their therapeutic subculture and according to their worldview. It is true that interactions between the two different "explanatory models" occur during consultations with medical practitioners, as Kleinman claims (21). In such conversations, health professionals frequently pay insufficient attention to the explanatory

models of health seekers, exacerbating the disparities between the two sides. The naturalized customary paternalistic relationship thus creates a barrier to effective communication between the two parties. Service providers lack the patience to understand their patients' idiomatic, metaphorical, and analogous illness narratives (22).

The following sections discuss the research methods briefly before focusing on the study's key findings. These sections are organized in the same order as the investigation's background and theoretical perspectives. The paper then proceeds to examine a few typical contentious scenarios, the analysis of which serves as the foundation for the composition of this work. Then, various types of clashes and protests are shown. The following two subsections discuss biomedical knowledge and its promises in Nepal, boosting people's aspirations while fueling hostilities. The article then shows how medical practices in Nepal have become a barrier to providing adequate healthcare services, resulting in medical violence.

Research methods

This article relies on microscopic ethnographic research not just because it is not concerned with large-scale interpretation but because it approaches meta-narratives and abstract analyses in this manner, staying closer to the ground and emphasizing "small places speak to large issues" (23, pp. 21-23, 24). This study is also classified as hospital ethnography because it focuses on the relationships within the hospital setting and is how I approach the healthcare phenomenon (25). The research was conducted in urban settings between 2018 and 2019, primarily at Bir Hospital in Kathmandu and the College of Medical Sciences (CMS) in Bharatpur, Chitwan. These hospitals were selected to consider previous conflicts between service providers and patient parties due to the concentration of medical facilities and the mixed demographics of the health seekers.

The study that formed the basis for this article always followed the ethical standards, norms, and values that govern the use of human subjects and the involvement of healthcare institutions in research. The approval for the study was obtained through the research management wing of the Central Department of Anthropology, Tribhuvan University, Nepal, to ensure the protection of the rights and dignity of the research participants, affirm the highest academic and social values, and honor the field study environment. Furthermore, the ethical clearance has confirmed the concept of professional competence and commitment to publishing research findings.

I made contact with both hospitals through social connections. Due to the sensitive nature of the subject, research participants at Bir Hospital, where I first conducted the study, agreed to speak with me only informally. However, I have met all ethical requirements by obtaining their informed consent on the conversation topics. I have avoided using their true

names and titles in my writing and study presentations. Fieldwork in Chitawan began in January 2018 with casual discussions with a doctor. In accordance with my contact advice and suggestions, I properly requested authorization for interactions with service providers. I gratefully received permission for conversations from the ethical committee and hospital management, the latter serving as an institutional gatekeeper.

The hospital management team, medical doctors, nursing staff, paramedics, administrative staff, laboratory technicians, and private pharmacists from both sites participated in the study (2-4). This article's information was also gathered from patients and regular people, primarily about their experiences with medical consultations (9). I spoke with 31 people in these various capacities. The conversations occurred in hospital waiting rooms, pharmacies, and the outpatient departments (OPDs) of the surgery, medicine, and dentistry units.

In addition, information was gathered from selected national newspapers and online media websites. I gathered information from there because "the online material can always be considered in light of our offline knowledge" (26, p. 4). This information generation method compensated for my inability to travel to the sites of medical violence. Over the last 5 yr and beyond, I have used such internet resources to generate information by conducting content analyses of news reports and articles, primarily published in Kantipur, Annapurna Post, Nagarik, myRepublica, Onlinekhabar, and Swasthyakhabar. I chose a small number of cases based on their commonality and variety of occurrence. I sought fairly balanced information by looking for the same story reported in multiple newspapers or news outlets.

I am aware of the reality and the principle that in ethnographic research, understanding the underlying meaning of data begins concurrently with the information generation process (27). The information collection process was terminated when it was determined that it had reached saturation and that new cases did not reveal any new features (28, p. 158). Later, I conducted a thematic analysis of the ethnographic data to investigate the explicit and implicit ideas contained within it. Rather than quantifying occurrences, the primary goal of data analysis was to discover significance.

As Braun and Clarke elaborated, the process of data analysis used in this study during the post-data collection phase can be divided into six phases (29): becoming familiar with the data, generation of initial codes, combining codes for themes, reviewing themes, naming the themes, and producing analysis report. Nonetheless, I did not regard these phases as a rigid prescriptive framework; instead, the analysis process progressed iteratively, moving back and forth repeatedly among data, themes, and concepts.

Development

Consultations that result in the development of a problematic relationship. The parties on both sides of the conflict have deemed different conditions challenging. This article contains a few examples demonstrating the causes and types of conflicts.

Mr. Kuldeep Bista, 30 years old, was rushed to a private hospital in Kathmandu. The patient's mother had told doctors that her son was having a heart attack. She informed the medics about his history of hypertension and ongoing medication. The service providers completely ignored her. Instead, they were preoccupied with treating his gastritis, which turned out not to exist in the first place. Family members believe that his death was caused by doctors who failed to effectively and timely diagnose his condition (30). On the other hand, the hospital claims that all reasonable efforts were made to treat him. Following his death, they realized that performing the angiogram on the patient would have satisfied the late Bista's family and friends. As Mr. Bista's case demonstrates, patient parties and service providers have different perspectives on the incident. They interpret the incident differently because of their disparate "explanatory models" and divergent interests (21). They base their perception on their relationship with the deceased and/or the desired outcome.

Trishna's case exemplifies medical negligence went through with it. Trishna's mother brought her to a Tripureshowr private hospital when she was an adolescent because she was suffering from headaches and eye strain. The visiting ophthalmologist referred her to another nearby private hospital. The doctor at the hospital prescribed some medication for her, but the medication caused her to lose her vision in her left eye, gain unnecessary weight, and eventually develop multiple disabilities. She filed a claim against the doctor for such negligence with the assistance of a non-governmental organization. After 4 yr, the Nepalese Supreme Court imposed a fine of Rs. 6,17,119.00 on the hospital (31).

In a separate incident, patient parties pelted stones at a private hospital, blaming the hospital for their negligence in performing a surgery that killed 52-year-old Chandra Prasad (32). Because the hospital had determined that his condition was minor, he went to the hospital on his own for the removal of an abscess in his gallbladder. He was declared dead on the way out of the operating room. His son stated that they were highly dissatisfied with the doctors because Chandra was fit and fine when he went to the hospital for surgery. The hospital director provided a different explanation than the medics. For him, this was one of the most unusual cases in which the gallbladder skin was ripped off during surgery. The body had to be dissected for the stitching. Despite the medical team's best efforts, Chandra died from a heart attack. The director believed that the incident was unfortunate and unexpected, but it was not their fault.

According to the Nepal Medical Council (NMC) inquiry committee, Mr. Sami Risal, 47 years old, died at Norvic Hospital in Thapathali due to several medical flaws and mistakes in diagnosis and treatment (33). Mr. Risal was admitted to the hospital for nausea, headache, diarrhea, and stomachache. Although Mr. Risal had visited the hospital for gastroenteritis treatment, the NMC report stated that the consulting physician was unable to identify Mr. Risal's neurological issue in time, resulting in his death. According to the report, neither proper emergency nor critical care is provided when the patient becomes unconscious.

In a separate case, Mr. Dinesh Pokharel[2] complained to the NMC about a Bir Hospital medical professional who performed his neurological surgery and was dissatisfied with the results. He accused the doctor of dissecting his body when it was not necessary. When he went to another hospital for further evaluation and treatment, a top neurosurgeon informed him that the treatment had failed. After failure of his first attempt at the hospital, he sought compensation from Bir Hospital and the physicians who treated him, he had to pay for expensive treatment at a private hospital.

Mr. Shankar Rimal of Kabhre filed a complaint[3] against a group of doctors at a Swayambhu hospital. According to his complaint, the doctors removed his left kidney rather than removing the stones that were found there. They kept him in the dark about this, but they did inform his wife and forced her to sign the document. His kidney was removed without permission, so he filed a complaint against everyone involved.

The aforementioned incidents demonstrate a variety of misunderstandings and conflicts regarding who is to blame for what happened, how people interpret the incident, how institutions that mediate and regulate investigations are involved, how the patient party responded to the developing situation, and whether the incident occurred at a private hospital or a government-owned healthcare facility. A recurring theme in these examples is that patients' autonomy and centrality in clinical medicine are not fully respected by Nepal's modern medical procedures (34). These cases served as the foundation for the creation of this article.

Various forms of violence, confrontations, and protests

When a patient's close friends and family believe that the patient received subpar medical care that harmed or killed them, they frequently choose to protest and engage in confrontations. Nepali describes a situation in which a doctor was initially assaulted by a patient party and then threatened to sue with false accusations if he pursued legal action (35):

> On February 19, 2018, a doctor working in a district hospital was brutally attacked by the patient's relatives. The physician filed a lawsuit against the people who attacked

2 A complaint registered (R.N. 64) at Nepal Medical Council on October 10, 2017.

3 A case registered (R.N. 488) at NMC on July 9, 2017.

> him for attempted murder. In response, they threatened to sue him for allegedly trying to rape a woman during the video x-ray if he did not retract his petition against them.

The hospital buildings, both private and government-owned, are spread throughout the city. The security guards employed there are sufficient to provide security only during regular operating hours and when dealing with individual patients and patient parties. In the event of a protest or mob, they cannot protect the facilities, equipment, and the people who work there. Typically, patient groups target hospital buildings, including wards, medical equipment, and infrastructure (36). "In response to the death of the 16-month-old girl, the child's family and the general public attacked a hospital in Thapathali, Kathmandu. Windows, doors, and some computers at the hospital were all broken."

People frequently draw a relationship between the country's democratic transition and an increase in verbal and physical abuse of medical professionals (37). Similarly, in response, the doctors have repeatedly urged the termination of services. A Chitawan doctor attributes vandalism in healthcare facilities to the current political climate. She believes that if they had any civic sense, they would have taken legal action instead of engaging in such vandalism. She is displeased that the police arrested the doctors but not the hooligans. She has noticed that people have become anarchic in 10 yr because the federal republic was established. Her relationship between political change and medical violence shows an increase in "deviance against legitimized agents of social control" (38).

Few patients or caregivers may find other ways to express their frustration. One of them, Mr. Poudyal, decided to write in a national daily about his traumatic 5-day experience as an attendant at Patan Hospital, a major teaching hospital for the Patan Academy of Health Science (39). Its operational mode recently shifted from being run by the United Mission to Nepal, an international Christian organization, to that of a self-sufficient institution. Mr. Poudyal wrote the "uncovered evil activities" to bring the doctors and hospital involved to justice. He later admits that his hospital stay turned him off to the Nepali healthcare system and made him distrustful of hospitals and doctors in general because of the way his wife was coercively persuaded to have a cesarean delivery. On top of that, he charges the hospital with profiting from forced cesareans.

Medical knowledge, expectations, and promises

Christian missionaries traveling to Tibet and China introduced biomedicine to Nepal in the sixteenth century, when it was still in its infancy even in the West. Despite having access to the nation's primary healthcare system for over a century, traditional medicine in Nepal has not evolved into a successful healthcare system (40). As the country transitioned to democracy in 1951, biomedicine was widely introduced into Nepal as part of the promise of national

development. According to Streefland, one of the major trends in healthcare expansion at the time was the construction of health centers in rural areas (41). By the time hospitals (biomedical institutions) were introduced to Nepal, they had evolved from goodwill institutions to institutions that implied significant power to the medical staff (42, p. 148).

Divergent explanations for the course of treatment and its outcome result from patients', doctors', and other healthcare providers' differing perspectives on the illness (21). Many patients are unfamiliar with biomedical jargon and terminologies. Their understanding of the illness is based on the symptoms of the disease conditions and various methods of interpreting health, illness, and the body. As a result, people cannot always understand what medical professionals consider wrong with their bodies. According to a CMS doctor:

> Patients may present to the hospital with seemingly innocuous symptoms, such as fever or stomachache. They mistakenly believe that symptoms are the illness when, in fact, they may be symptoms of more serious medical issues. Stomachaches can be caused by gastritis or an intestinal rupture, for example. Thus, we must base treatment decisions on what we believe is best for the patient rather than the patient's requests.

Nepali, a medical doctor working in a hospital outside of the capital city, argued in an online health journal that the cause of rising conflict is not only due to inadequate medical education but also to misconceptions and incomplete knowledge of medical science (35). People tend to accept disease as normal when seeking traditional healers. On the other hand, if the patient is not feeling well, they make a fuss, say after 2 days of medical consultation. Many people believe that any illness can be cured miraculously in a hospital and that medicine, such as Amrit, can make one immortal.

During our conversations, a doctor from Bir Hospital also acknowledged that patients' expectations have grown, although healing ailments and diseases are not always possible. He admits that medical professionals must sometimes treat patients even if they believe the patient will not recover. They must do this for the patient's comfort and pain control. They must follow the adage "sas rahunjel aas hunchha," which translates as "we must hope as long as the patient is breathing."

In the Dishanirdesh program on AP1 television, Dr. Basanta Panta, a famous neurosurgeon, also stated the context of rising patient expectations (43): "Many people are dying in hospitals as they try to recover. When family members bring patients to the hospital for treatment, their expectations naturally rise because they already perceive the hospital as a place of therapy."

Dr. Panta claims that medicine cannot consistently and universally cure, and every patient requires further examination. A human body's lifespan is finite and cannot be predicted. When investigating a patient's death, this viewpoint must be adopted. Instead of condemning

the doctors for not being able to save or take a life, this leads to a greater acceptance of the fragility of human life (44).

The medical profession's code of conduct prohibits advertising and making recovery guarantees (45). However, numerous instances of this provision being violated raise people's expectations of medical care (37). These advertisements claim to have doctors with a national reputation who were educated abroad and can provide a treatment guarantee. Some study participants associated this type of therapeutic assurance primarily with medical institutions' financial motivations. Mr. Kharel of Bir Hospital stated:

> Physicians working in both government and private hospitals have a strong desire for financial gain. Employees in government hospitals cannot make a living solely from patient examinations. They always push patients to have unnecessary testing, treatment, and even surgery. Patients' expectations rise in tandem with their payment.

Patients' obedience to medical authorities is critical to surviving paternalistic forms of doctor–patient relationships (46). Because of the rising commodification of medicine, the long-cherished status of "medical paternalism" has declined, and patients are now making demands based on the price they must pay, both financially and in terms of their health and lives. People are becoming more concerned about the medication process due to a decline in medical paternalism. Conflicts between the two sides have been ongoing in Nepal as the healthcare setting has transitioned from the stage of Credat Emptor, "let the buyer trust," to the stage of Caveat Emptor, "let the buyer beware" (47).

Medicine's scope and inherent limitations place it in a typical situation and limit its ability to meet all patient expectations. In his interview for the Dishanirdesh program, Dr. Bhagawan Koirala explained the limitations of medical science in simple terms that anyone could understand (43):

> As I save more lives, I become more aware of my lack of control over other people's lives. I have realized how frail humans are as a result of this. When the results do not match my expectations, I think similarly. This is not due to a lack of access to healthcare; it occurs even when cutting-edge techniques are used. I understand that we are not the only ones who decide whether a person lives or dies… we understand that the human brain controls every other organ. Consciousness drives the brain, and scientists are still puzzled about where awareness comes from.

Other doctors have described unexpected outcomes as common occurrences during treatment. Given that medicine is not a mathematical science, a doctor from Bir Hospital relates this to the field's level of precision. While it is occasionally possible to save a patient in a hopeless condition, it is often impossible to heal a seemingly simple condition. He regrets that if the patient recovers, his party will attribute it to God, a miracle, or the doctor; otherwise, the doctor will only be held accountable.

Medicine is more valued as a science in determining disease origin and diagnosis (48). The level of expertise, experience, and perspective of the doctor may even influence how well a diagnosis is made. As a result, one medical professional's path to diagnosis may differ from another. A doctor at CMS pointed out:

> In medicine, science and art coexist. The instances of "sensitivity and specificity" influence diagnostic precision and treatment. Even if the best course of action is chosen, it may not be completely accurate. So, in retrospect, it is impossible to evaluate a method that was thought to be the best choice at a specific time and place…the time of the test also impacts the diagnosis report. As a result, rather than precise numbers, range-based diagnostic signs are used. In contrast, the patient party would consider a lab report untrustworthy if it differed from another.

Another deductive argument can be developed based on the assumption that medicine is not a perfect science. Medical errors and medical malpractice are not the same things. "Frequently, the general public and media are unable to distinguish between them and present the errors as medical negligence," a CMS doctor complains. This is likely to lead to confrontations. Another critical scholar, a trained physician, emphasizes the prevalence of negligence in the larger healthcare field. This negligence may be caused by a lack of knowledge, inadequate technology, a delayed approach to treatment, or a failure to adhere to ethical standards.

Its limitations can occasionally hamper medicine's ability to diagnose and detect problems. This endangers medicine, and a weakness is frequently interpreted as a failure by the doctor or the medical staff. CMS experts have noted the following:

> Priority is always given to the most cost-effective examination of patients. We may be unable to identify the problem even with a complete body check-up. Sometimes, the precise condition of a patient can only be discovered after the patient has died. The patients' financial situation must be considered when making decisions about the diagnostic trajectory.

When a patient's diagnosis and treatment are intertwined with their cost, doctors believe that they must adopt the appropriate therapy trajectory based on their unique circumstances. Medical effectiveness suffers when the appropriateness of the treatment trajectory is determined not by the patient's pathological condition but rather by the patient's financial circumstances.

In an interview for the Dishanirdesh program on AP1 television, renowned neurologist Dr. Basanta Panta stated a common relationship between a patient's ability to recover and willpower (43). He emphasized that the primary role of the patient is to fight against the illness. The goal of medical staff and facilities should be to help patients maintain their spirits and mentally prepare for illness.

> We have seen that people with a strong will to live can survive serious illnesses. We are only supporters; the patient is the one who must fight the primary battle. Even a patient with the same degree of the disease may have various outcomes because their biology and body must battle the disease. The disease may manifest differently if he is not mentally prepared for that.

Not only do doctors play a role in and influence therapeutic processes. A laboratory worker at Bir Hospital, asserting the clinicopathological correlation, has observed that pathology has recently surpassed therapeutic power (49): "The doctor's role has been reduced to 'arranging the match' and 'filling in the blanks' (*joda milaune and khali thaun bharne*). Their job is to look over the diagnosis report, determine how the patient reacts to various situations, and then prescribe an appropriate course of treatment."

This analogy also connotes that the doctors are doing the tasks that are usually done by the primary school children as part of their knowledge test and verification. People commonly use this analogy in Nepal to show the mundane status of a phenomenon, negligible social status, and minimal knowledge and skills required to perform a task.

Medical practice as a hindrance

Medication must follow a specific procedure when making treatment decisions, such as whether or not to admit patients to the hospital. Procedures in hospitals, particularly those run by the government, can be drawn out not only due to bureaucratic incompetence or service provider's refusal to provide prompt service but also due to an excessive patient flow (50,51). However, based on my observations in both hospitals, I can assert that doctors check many patients daily, always putting them in a hurry. The protocol does not mention how many service users a doctor can visit daily or how much consultation time is required to fully comprehend a patient's condition.

A laboratory technician who has worked at Bir Hospital for nearly two decades has noticed that the hospital's procedures frequently create barriers to patients receiving timely care:

> There are numerous procedures that patients must undergo, and each one creates a barrier. They are drained of all remaining annoyance and frustration when they see the doctor. They frequently have to wait an extended period to see the doctor. The doctors see OPD patients every other day. People are forced to search for a week to present their report to the doctor they first saw. During this time, a severe patient's vulnerability increases. Finding an ICU bed and prompt care for the general public is nearly impossible here. The director's family, friends, connections, doctors, nurses, ministers, and political figures are among those who receive ICU beds.

In emergency departments, conflicts with patient parties are more common. A medical professional at Bir Hospital said:

> Patients usually arrive at the emergency department under stressful circumstances. It takes a long time to gain admission there. Patients are directed to the appropriate department only after their illness has been diagnosed. To admit a patient, a representative from the relevant department must visit the emergency room, which may take some time, depending on how busy they are in their department. Patients in the emergency room may have to wait for an entire day before doctors apologize for the lack of available beds. In this situation, finding a space in other government hospitals is impossible. At this point, the patient party becomes enraged and occasionally fights with us.

Government hospitals may encounter confrontational situations because of their infrastructure and staff's lack of emotional intelligence. Furthermore, Pandey stated that difficult working conditions, reluctance on the part of other specialties and hospital administrators to collaborate, and rising healthcare costs have slowed the advancement of emergency medicine in Nepal (52). He and Qian identify doctor workload as contributing to medical conflicts based on their research from Chinese public hospitals (53, p. 16). I would like to emphasize that these issues have made providing patients with timely, adequate, and effective care difficult.

In Nepali hospitals, the protocol is frequently unavailable. Norvic Hospital, as the NMC investigation committee noted in the Sami Risal case, lacks a well-defined treatment plan. This investigation also revealed that Norvic lacks a reliable method for patients admitted to the facility to contact the appropriate physician. Adherence to clinical guidelines is expected to improve adherence to desirable therapies and reduce unwelcome variation in care (54). Therefore, it is unclear how many patients a doctor can diagnose in a day and how much time they should devote to each one. This uncertainty complicates matters and lowers the quality of consultations.

People hesitate to see a doctor or undergo check-up procedures outside government hospitals. Even in luxury facilities, doctors are occasionally subjected to such accusations. On that day, I first met Dr. Sharma at CMS, and he was discussing a situation he had that morning with a patient who was upset about having to wait a long time, about an hour. Even when they are in hospitals, doctors can be distracted by other things, such as being in the operating room, in class, or walking around the wards.

Conclusions

Conflicting parties frequently see the same episode from different perspectives, depending on whether they are on the side of the patients, the healthcare institution, or the service providers (21). Patients and doctors may disagree about what constitutes a health concern and how it should be managed (55, p. 45). In such cases, conflict between service providers and patients is unavoidable. Medical conflict is influenced by people's perceptions of what constitutes good care, which also reflects their frustration and suffering (9). Any loss of life, health, or deformity is accompanied by violence directed at people and institutions providing healthcare services.

The various illustrative accounts presented above show that service providers, whether medical professionals or not, have begun to regard medical violence as a common occurrence and a necessary component of the "normal" process of providing healthcare. Conflict normalization also implies that insufficient efforts have been made to resolve the grievances of the disputing parties, particularly the patient party. Parallel to this, there is a tendency to relate conflicts to ordinary times, people, and circumstances, which exoticizes conflict because it does not occur in normal cases but results from such times, places, and circumstances. Finally, this portrayal was used to represent clashes to save the reputations of the hospital, concerned doctors, and the medication. Contrary to what Elston et al. claim from their study on workplace violence against general practitioners in the United Kingdom, participants in this research primarily associated medical violence with anarchy rather than with the disease of the offenders (38).

When there is a disagreement at the hospital, people frequently assume that the patient is at odds with the doctors or physicians. However, the situations discussed in this article show that elements associated with conflicts are not only closely related to the treatment or diagnosis process. Because a hospital comprises several entities that collaborate to form a collectivity, they all contribute to its primary goal of providing medical services. In reality, because the media and the general public do not understand the different roles that hospitals, doctors, labs, and other service providers play, they tend to blame doctors when problems or conflicts arise at the hospital. Even if there are flaws in the service delivery procedure, blaming the doctors is not always accurate. I have used the term "service providers" to describe this variation as a catch-all.

Conflict is common in public and private hospitals, indicating that it can occur in any hospital, regardless of ownership. The general belief and perception is that private hospitals exist for financial gain and thus may pressure patients to receive excessive diagnosis and treatment. Furthermore, as illustrated by the case of Latin America, management capacities of public healthcare services are constantly limited due to market, social, and political forces, as well as poor regulation of the privatization of public healthcare (56, p. 1).

Even hospitals that self-identify as nonprofits have been accused of profiteering and commodifying healthcare services (57). On the other hand, conflicts involving government hospitals are frequently related to bureaucratic practices, such as delayed diagnosis and treatment, favoritism of those with connections to or who can influence the hospitals, medical malpractice, and problematic relationships with service providers.

Medical professionals openly admit that medicine is not an objective and complete science, contrary to popular belief and projections made by hospitals and medical colleges to appeal to consumers. Hospitals inform the public about the treatments they provide and frequently go beyond medical ethics by making promises outside the realm of medicine, raising public expectations. Second, a communication gap exists between the parties providing services and the patients due to the esoteric nature of medicine and the medical profession. Aside from that, the rise in conflicts reflects the demise of medical paternalism as more people become aware of and learn about proper healthcare delivery. Commoners assert that they are not ignorant and that the medicine is not esoteric by staging confrontations. Paternalistic governance is also being called into question.

The Public Health Service Act states that medical facilities can only refer patients in limited circumstances (58). It may guide "to the health institutions that can provide extra therapy to such patient" if there is no longer any way to treat the patient due to "structure, equipment, a lack of specialist's service, or any other acceptable cause." The practice of defensive medicine in Nepal exceeds the scope of legal referral provision. Doctors' desire to help people has waned as a result of increasing conflicts in hospitals, which have put them in danger and forced them to seek safer alternatives. As part of this, they may practice defensive medicine to avoid conflict with the patient parties (55). To bridge the gap between the two sides and thus avoid conflicts, doctors must respect patient autonomy, provide patient-centered outcomes, and re-center clinical practice from the patient's perspective (34). Because it is equally important to other healthcare reform components, restoring a healthy doctor–patient relationship requires significant attention from health policy reform initiatives (53). The growing number of court cases also suggests that if the healthcare system is unable to address healthcare-related grievances on its own, it paves the way for "recourse to the courts as an essential 'escape valve' in a health system," leading to the "judicialization of social demands" (8, p. 432).

In Nepalese hospitals, violence and arguments may be viewed as different manifestations of biomedicine. I would like to compare it with the current state of affairs, which is characterized by a lack of effective tools for law enforcement and restitution. It reflects Nepal's present sociocultural environment, which includes deepening and expanding commercialization, a lack of law enforcement, and a decline in the traditional authority of social institutions, including biomedicine (59).

Based on these insights, it is clear that when there is increasing commodification of medicine, the medicalization of social problems, structural inequality, and inadequate trust not only between these two parties but also toward legal recourse mechanisms in seeking justice, rupture, and conflict between health service providers and patient parties increases. Medical violence cannot be blamed solely on one side. While the ethnographic illustrations are drawn from a particular Nepali context, I would like to make a general point that, to avoid medical violence, the healthcare system and legal recourse mechanisms should strengthen their capacity to enhance the trust that the general public is expected to maintain.

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Conflict of interests

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