Dignity of women patients in health clinics

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Abstract

This essay draws attention to violations of privacy and confidentiality in healthcare. It argues that such violations are experienced not only by rural women and beneficiaries of government health services but also by better-off women in private clinics in urban areas. It is possible that the occasional reports of such violations represent a fraction of the actual number of such incidents. There is an urgent need to recognise the problem and take corrective measures.

Women's health has generally been of low priority in Indian society. Government interventions may have improved women's access to healthcare. But those women who do gain access to these services may find themselves poorly treated.

One such example is the lack of privacy and dignity for women patients in private clinics when procedures such as examination of the lower abdomen, or an internal vaginal ultra sound, are conducted by males without the presence of a female assistant, and a woman's request that a relative be present is denied.

We decided to write on this issue after receiving a number of reports of such experiences. These reports emerged through informal conversations and we do not suggest that these are representative of the problem at large. However, they do point to a serious issue that must be addressed by the medical profession, as well as by regulatory authorities.

This essay is an attempt to bring the subject to public notice. The incidents mentioned here are illustrative and recounted with the consent of the narrators.

S visited her gynaecologist's clinic and was sent to an adjoining room for a sonography. She did not expect the person conducting the sonography to be a man. He instructed her, in a brusque manner, to disrobe, and conducted an internal examination on her without preparing her for it, and without her consent. S had drunk a lot of water in preparation for an external sonography, which added to the discomfort caused by the internal procedure. She was confused about whether the examination had been appropriate or whether she had been exploited, and left the clinic humiliated and traumatised.

When N found that a man would be doing her ultrasound, she asked her husband to accompany her to the clinic. The doctor refused to let the husband be present during the examination.

Occasionally, reports appear in the press about a woman filing a police complaint accusing a medical professional of molesting her during a physical examination. It is reasonable to assume that many more such cases go unreported. In such situations, women may find it difficult to identify such behaviour on the part of healthcare providers as inappropriate. The women who spoke to us did not indicate that they were confident that the doctor was wrong; they felt uncomfortable and did not feel they could complain, and in some cases they simply withdrew from the treatment.

Injunctions to "loosen up and cooperate", a refusal to answer questions, dismissing patients who dare to ask for more information - all this seems to reflect the traditional model of doctor-patient interaction. This model, in which a physician's job is to provide information regarding disease and a patient's role is to comply with the physician's advice, still has a strong hold on the doctor's psyche. This is typified by the doctor who, when confronted by an anxious patient asking for information on her treatment before deciding on it, threw her file back at her and shouted: "Come back after you have made up your mind!"

Such reports illustrate the trauma, humiliation and loss of dignity that women can sometimes experience in interactions with healthcare providers. There may be technical reasons for the provider's actions but that does not change the women's experience of such encounters.

Patient privacy and confidentiality are essential elements of any quality, client-centred health service including service related to reproductive health. This is spoken of in various patients' rights charters in India, but these regulations have not been enforced. Clearly there is no system in place to ensure that female patients, especially in private clinics, are comfortable and secure when being examined by a health provider.

Gender seems to be a greater influence in such situations than socio-economic status alone, going by the comments of women seeking expensive, high technology care such as fertility clinics. When doctors refuse to listen to women's concerns, to answer questions on the prescribed treatment's costs, efficacy and side-effects, they are expressing a certain attitude towards patients. It is true that the status of urban women is generally better than that of rural women. However, that elevated status does not empower her enough to raise her voice against the doctor, seek an explanation for actions that distress her, and refuse treatment when it is uncomfortable for her.

Problems in both public and private sector

The issue is better recognised in the context of public health facilities which are largely used by the relatively weaker sections of society who are obviously vulnerable to exploitation and less likely to protest against discomfort,

negligence and misconduct of health staff. While in no way justifying unequal treatment being meted out to patients in public health facilities, it is ironic that women in such facilities may on occasion have more negotiating power because they come prepared for bad services and may be more willing to air their views, refuse poor treatment and demand better services as their right. The point is that while public health facilities face criticism, just or unjust, the health system remains blind to the procedures followed in a private healthcare facility. Those visiting private health services may be viewed as using them out of choice, not compulsion. They pay more, anticipating better services. But they are also left humiliated and helpless.

Government response

This issue has been taken up in the public sector in the context of deliveries conducted by male staff when female staff members are available. Another question concerns what is done to ensure the comfort of women coming to health facilities for delivery services when female health staff are not present. However, even if instructions are issued that if there is no female doctor/assistant at the facility, an accompanying relative of the woman should be allowed entry into the labour room. The issue is about creating the mechanisms which would ensure that such orders are followed.

Similarly, the union government issued an order making the presence of a female assistant mandatory when a male practitioner examines female patients (1).

The government of India's draft National Health Bill (2) states the following points under the right to confidentiality, information disclosure, privacy:

d) Every user has a right that he/ she may be subjected to any health care in a manner that proper respect is shown for his/ her privacy and dignity, and that a particular health care intervention may be carried out only in the presence of those persons who are necessary for the intervention, unless the user consents or requests otherwise; and for women users they may be carried out only if a female service provider is also present, unless the user herself waives this right or unless it is not feasible at all in given circumstances;

e) Users admitted to health care establishments have the right to expect physical facilities which ensure privacy and dignity, particularly when health care providers are offering them health care or carrying out examinations of personal nature.

However, while recognising the need to establish mechanisms to ensure privacy for women in public health facilities, private facilities cannot be left free to do as they wish. There seems to be an assumption that private health facilities are functioning ethically. Second, it is believed that women approaching private health facilities, due to their relatively better socio-economic status, are empowered enough to raise an alarm if a healthcare provider misbehaves. Unfortunately, neither of these assumptions is true.

In our country where doctors are still considered no less than God, trust in the doctor prevents a woman or, for that matter, any patient, from stating that what is being done is not required or is incorrect. Moreover, when a woman is desperate for a remedy for her ailment, she may also resign herself to tolerating a certain level of discomfort in order to get treatment. Is this acceptable in a civilised society?

Possible solutions

Just as patients are often unaware of their right to privacy, many providers too are unaware of their ethical obligations and the legal consequences of not meeting these obligations. It is, however, the state's responsibility to ensure that women do not suffer -- either at public health facilities or at private establishments. One measure to ensure this could be the provision of training in medical ethics so that providers uphold their ethical, moral, and legal obligations to the client.

The Clinical Establishments Act, which was passed in the monsoon session of Parliament (3), will ensure regulation of clinics and nursing homes across the country. The move is encouraging but, while licensing, certification and accreditation are important, safe services and maintenance of the dignity of patients cannot be ensured without proper implementation.

Another important step is to generate awareness among patients and practitioners. While practitioners should know about their duties, patients need to be made aware of their rights and the expected behaviour of the medical staff. Awareness needs to be facilitated, and contact details of those to approach in case of violations should be disseminated. Stricter action needs to be taken against offenders, in order for there to be a deterrent effect. Finally, the reporting procedure should be hassle-free so that women are not discouraged from reporting cases.

References

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