Journal of Political Studies, Vol. 21, Issue - 1, 2014, 281:298

Caught in the Crossfire: Aggression and Violence against Doctors in Pakistan after 9/11

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Abstract

In the backdrop of 9/11 and war against terror in Afghanistan, Pakistani society has witnessed recurrent episodes of conflict and violence. The level of intolerance has substantially increased and use of violent means has become a norm. While citizens across the board have suffered from rising insecurity, doctors have particularly been the victim of violence. This study intended to investigate the extent of violence committed against the doctors in the hospital settings, their coping strategies, and emotional sufferings due to their violence experiences. For data collection, cross sectional survey was conducted with 200 randomly selected doctors in four randomly selected teaching hospitals of Lahore. The data revealed that house officers were most vulnerable to violence in the hospital setting among the doctors. Significant gender variations were observed and male doctors reported to have suffered more form violent acts as compared to female doctors. Doctors mostly used passive coping strategies against violence and reporting to police was the least cited response. They felt angry over these incidents but reported to feel helpless about the situation. The study concluded that the root of problem lies in the inefficient health care system and the lack of capacity to cater the needs of population. It is suggested that the healthcare system in the country may be strengthened to the satisfaction of patients and his/her relatives so that the doctors may be protected against the aggression of disgruntled people.

Key words: Violence against doctors, health care system, war against terrorism, coping strategies,

Pakistan has been a front-line state in the war on terror since the terrorist attacks in the USA on September 11, 2001. At an official level, Pakistan supported the US invasion of Afghanistan although it had previously been on

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friendly terms with the Taliban regime. Conservative forces within Pakistan seriously resented the Pakistan government's alliance with "Western forces". Many people, including some sections of the Pakistani security establishment considered that the government had "sold out" its sovereignty and had become a client state of the USA (Fair, 2009). As a result, conservative forces within the country and beyond launched a violent resistance against the "secular and pro-Western agenda" of the Pakistani government.

In order to defeat the Western onslaught, many local militant groups organised themselves and a new outfit with the name of the "Pakistani Taliban" emerged on the scene (Fair, 2009). One strategy adopted by these militant forces was to attack the symbols of state power. They also targeted public places like hospitals, hotels and popular shrines. Terrorists not only killed police or military officials, but also attacked doctors, including the Surgeon General of the Pakistan army, Dr. Baig, who was assassinated by a suicide bomber in 2008 (NYT, 2008). Mostly, these militant outfits had sanctuaries in the northern areas of Pakistan. In order to "flush out" terrorists, the government launched several military operations in tribal areas populated by a majority of *Pashtun* people. One outcome of such operations was the creation of hatred among the ethnic Pashtun (Ahmad, 2010). In many ways, the war on terror seems to have sharpened the regional, ethnic, and ideological divisions in Pakistani society.

The terrorist and counter terrorist operations produced massive and persistent violence across the country. More than 1500 individuals were killed and countless numbers were injured in 171 events of suicide terrorism in 2009 (HRCP, 2009). Terrorist attacks, especially suicide bombing, call for a special kind of emergency planning and preparedness (Helpern, Tasi, Arnold, Stock & Ersoy, 2003; Shapira & Cole, 2006). Thus far, Pakistan's healthcare system lacks the organisational capacity and technical sophistication to face this challenge. Each new terrorist attack creates chaos in hospital emergency departments.

Socioeconomic conditions and the healthcare system

Decades of military rule and weak government accountability have promoted massive corruption and mismanagement of public resources. An overall deterioration in economic conditions has pushed more and more people below the poverty line. Additionally, high food insecurity (WFP, 2011) has caused malnutrition, damaging the health status of the majority of the poor population and adding to the burden on the already fragile healthcare system. After 9/11, the government of Pakistan received billions of dollars in aid from the USA and its allies. But a huge chunk of this money was spent on security and

defence-related endeavours. Healthcare allocations were rarely enhanced, but rather declined. For example, the healthcare budget is 0.5% of gross domestic product today, down from 0.8% in the 1980s (Mustafa, 2011).

The country's deteriorating economic conditions and political instability damaged the healthcare system in many ways. Firstly, government-run hospitals rarely got enough resources to expand and upgrade their operational capacity. As a result, ill-equipped and poorly staffed hospitals failed to meet the healthcare needs of the growing population. Secondly, the overall weak governance and corruption negatively influenced every tier of the healthcare system. One can well imagine the functioning of a hospital in the face of frequent breakdowns of electricity, disrupted gas supplies and a congested transportation system. The inability of the government to control spurious drugs or the effective disposal of hospital waste also undermined the credibility and efficacy of the healthcare system. All these factors created increasing difficulties for staff. Since these conditions reduce the quality of their services, doctors have fast been losing public trust. Frequent news of mob attacks on hospitals and aggression against doctors may be an indication of the increasing public anger.

Violence against doctors

As in many other developing countries, Pakistani doctors have been facing violence in hospitals and other healthcare outlets (Ahmed, 2010; Khan, 2002). Doctors face multiple kinds of violence, ranging from harassment, aggression and extortion to abduction and murder (The Dawn, 2011). It is reported that 85 doctors have lost their lives in target killings in Pakistan since 2000 (Muppala, 2011). A healthcare system does not operate in a vacuum; it is a sub-system of the larger social system. If society is divided according to sectarian, ethnic and religious identities, the healthcare system is also seen through this identity lens (Agadjanian, 2003). These identities lead to discrimination, service exclusion and hospital-based violence (AbuAlRub, Khalifa & Habbib, 2007; Burnham, Lafta & Doocy, 2009). For example, in Pakistan's northern areas, the strategic use of sectarian identity in clinical settings led to conflict-incurred service deprivation. Additionally, both patients and doctors were harassed based on their *Shia-Sunni* identities and affiliations (Varley, 2010).

Pakistan has a pluralist medical system and biomedicine competes with indigenous medical systems (e.g. traditional healers, etc.) (Zakar, 1998). The ideology and practice of "biomedicine" is sometimes considered "pro-Western" and secular and is not always admired in conservative religious circles. Attacks on medical staff providing polio vaccine in the North-Western region of Pakistan could be a case in point (Warraich, 2009). Other biomedical

interventions and technological advancements, such as test-tube babies and birth control surgery, may be a cause of considerable discomfort for some clerics in Pakistan. Medical facilities and staff providing such services feel threatened and are vulnerable to attacks and violence, especially in northern areas.

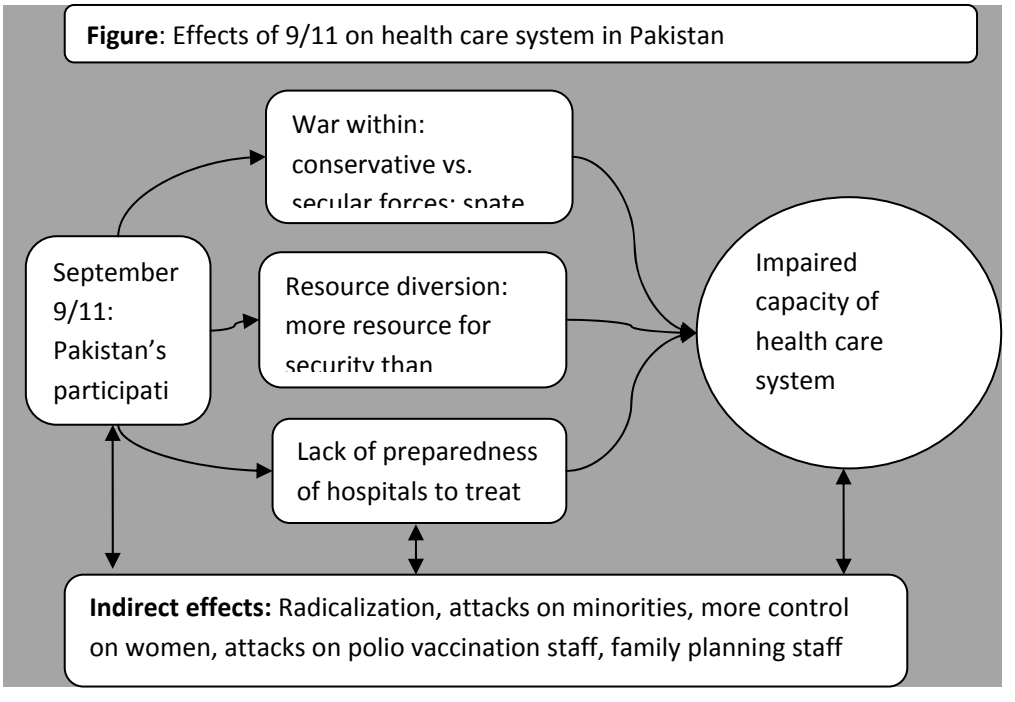
Post 9/11, Pakistan has witnessed increasing ideological conflicts, religious intolerance and bloody ethnic violence. In some situations, actual violence or threats of violence has become the norm. One can observe manifestations of violent behaviour in almost all social institutions, including courts, universities and hospitals. In a healthcare setting, in both emergency and routine doctor-patient (or doctor-victim in the context of terrorist attacks) encounters, violence or the threat of violence is used as an instrument of social control and professional accountability.

Consider the example of hospital emergency departments where the victims of terrorist attacks are taken. Immediately after the attacks, security personnel rush to the hospital in order to maintain law and order. Sometimes, hospitals are virtually taken over by the security agencies, which may disrupt the orderly functioning of the hospital. Additionally, after attacks, media reporters, photographers and members of the civil society rush to the hospital to "cover the event". Hoards of politicians visit the hospital to express their "solidarity with the victims" and "condemn the terrorism". The hospital appears to be a place of political wrangling. Doctors are advised and sometimes threatened not to ignore the victims.

After an attack, emergency departments are usually stuffed with police, investigators, evidence collators and personnel from various "special agencies". They add panic and chaos to the situation and potentially violate the decorum of the hospital. A mob-like congregation of people exposes doctors to violence and intimidation if they are perceived to be "lazy and non-caring". In this situation, doctors are under pressure to save the lives of the greatest number of people by ignoring the "nitty-gritty" of medical technical procedures. They are forced to abandon standard procedures of safety and sterilization. In this way, hospitals become a source for the spread of infections. Ironically, at the end of the day, doctors are blamed for their non-professionalism. For example, in DHQ Hospital Muzafargahr (Pakistan), a mob attacked a doctor accused of negligence, depriving him of one of his eyes (One Pakistan News, 2011) In addition, doctors are not only at risk of violence from rowdy mobs and an angry public, but could also be a direct target of the terrorists. Immediately after a terrorist incident, hospital emergency rooms are full of victims and their relatives as well as the general public. Hence, hospitals may be an attractive place for the terrorists to launch

another attack to cause damage to a greater number of people. In such attacks, doctors' lives are in immense danger. Sometimes, terrorists kill prominent and respected doctors in order to create a climate of fear.

In the face of insecurity and fear of violence, doctors may adopt various strategies to save themselves. Some young doctors who see bleak prospects for career development in medicine may struggle to change their profession. Private hospitals are winding up their emergency facilities instead of expanding their business (Khan, 2002). The expatriate Pakistani doctors who were planning to come back to serve their "motherland" abandoned their plans. More and more doctors are leaving the under-developed, "conservative" and insecure areas shifting to relatively secure and affluent urban areas, thus leaving the poor and unprivileged masses at the mercy of quacks and traditional healers. And predictably, the brain-drain rate of Pakistani doctors, already the highest in the world, will further increase (see figure) (Ahmad, 2002).



Doctors working under dogmas, dilemmas and damages

Pakistan had suffered years of military rule, quasi-representative and incompetent civil government long before 9/11. Nonetheless, after 9/11,

matters deteriorated further. The worsening law and order situation and the state's weak grip directly hit the healthcare sector. For instance, corruption in the purchase of equipment and the use of substandard material in construction impaired the capacity of hospitals to provide satisfactory services to healthcare consumers. Cumulatively, poor infrastructure, low salaries, and a non-motivating and insecure working environment made things even more difficult for doctors.

Still, there is another worry for doctors in post 9/11 Pakistan. Predictably, while fighting the war against terror, the police and security services were granted more powers to arrest and investigate terrorists. To fight against a hidden and invisible enemy, torture and extrajudicial killings are known tactics. Doctors working for government institutions are expected to help the government to curb this "menace". This creates a dilemma for doctors between their "organizational dictates" and professional obligations. In some situations, "physicians may be active witnesses or participate in the torture" (Amin & Gadit, 2009). So doctors' "duty to treat" leads to complications when the patient happens to be a criminal or terrorist (Amin & Gadit, 2009). Doctors' jobs are not just to provide medical treatment; they are part of the state power structure. The doctors who conduct medico-legal cases are supposed to present evidence in court, which may lead to the conviction of terrorists. Sometimes, these doctors are harassed or pressurised by the terrorists not to fulfil their medico-legal obligations. While the security of politicians, prosecutors, and police officials is taken care of, doctors are ignored. They are simply left at the mercy of terrorists.

Normally, every patient accompanies one-to-two attendants who have been mostly relatives and friends. All of the departments of hospitals including emergency remain overcrowded especially during the daytime. Besides administering medical treatment, doctors have been routinely expected to explain to the patient as well as his/her attendants about the nature and severity of ailment and the mode of prescribed medical treatment with possible time of recovery of the patient. Most of the times, the attendants prefer to personally observe how the doctors treat their patient. At times, they even try to interrupt the procedures of administering medical treatment such as stitching minor wounds, or even pricking needle for injecting to the patient. They show great concern if their patient complains about pain. Given this situation, it becomes very difficult and challenging for the doctors to treat the patient and to explain the multiple queries of the attendants of the patient.

Given this backdrop, the objectives of the study were to identify medical doctors': i) exposure to different types of violence in the hospital setting; ii) the

types of coping strategies they adopted; and iii) the emotional sufferings of their violent victimization.

Study methods

The study area consisted of four public sector teaching hospitals in Lahore. For the selection of hospitals, a list of all public sector teaching hospitals was obtained from Department of Health, Government of the Punjab. Four hospitals were randomly selected from the list. The selected hospitals had emergency, indoor and outdoor patient departments offering multiple healthcare facilities. Almost one thousand patients, on average, visit each of these hospitals daily.

A face-to-face cross sectional-survey was conducted from a randomly selected sample of doctors working in four hospitals. A structured interview schedule was used for data collection by indigenising the Senol-Celik and Bayraktar's (2004) questionnaire. The questionnaire contained questions regarding the type of violence doctors were experiencing in the hospital setting, their coping strategies to minimize the incidents of violence and the emotional traumas suffered by doctors due to violence. Doctor was considered "experiencing violence" if he/she experience any act of violence at least once in the hospital setting. The tool was pilot tested with 5 doctors and necessary changes were made in view of the feedback. The interviews conducted for pilot testing were not included in the final analysis.

The first and third authors conducted all the interviews. Given the busy schedule of doctors, the prior appointments could not be taken. Walk in interviews were conducted with the doctors. The interviewers went to the hospitals' out-patient department (OPD) in the mornings and interviewed the doctors during the tea breaks. The interviewers also visited emergency and In-patient departments (IPD) in the evenings for collecting data with doctors working in these departments. Confidentiality of data and anonymity of the respondents were maintained throughout the course of this research.

Initially, 211 doctors were approached for the purpose of data collection. However, 8 doctors refused to participate in the study because of time constraints and unwillingness to talk on the topic. Three interviews were incomplete, which were excluded from the analysis. Finally, the data of 200 respondents were analysed by using statistical package for social sciences (SPSS) version 20.

Results

Out of the sample of 200 doctors, 126 (63%) were males and 74 (37%) were females. Data revealed that there were significant gender variations in the experiences of different types of violence by doctors. It was found that about 24% female doctors reported exposure to any type of violence. Similarly, no female doctor reported to be physically assaulted as compared to the 23 male doctors who were exposed to physical violence. Nonetheless, a majoirty of male doctors (79%) reported to be verbally abused as compared to a little more than one fifth (20.9%) of female doctors. Additionally, 37 (80.4%) male doctors and 9 (19.6%) female doctors received threats (Table 1).

Physical assault was found to be more common with the doctors aged 31-40 years and 56.5% doctors who belonged to this age group reported physical assault. About one half of doctors who experienced verbal abuse were aged less than or equal to 30 years as compared to 33.8% doctors aged 31-40 years. Similarly, 45.6% doctors aged less than or equal to 30 years and 34.8% doctors aged 31-40 years received verbal threats. A substanital number of doctors aged 41 or more years (40.6%) reported to have never suffered from violence.

Data revealed that 14 doctors who have been the victims of physical assault were working as house officers, 7 were trainee residents and 2 doctors were senior medical officers. A similar trend could be observed with regard to verbal abuse where 36 victims were house officers as compared with 18 trainee residents and 8 senior medical officers. Situation was almost identical in case of verbal threats where 27 house officers doctors had received threats followed by 14 trainees residents and 5 senior medical officers. 26 of 103 house officers suffered no violent incident as compared with 21 of 60 trainees residents doctors. A significant majority of senior medical officers doctors (22 of 37) reported to have never suffered from violence (Table 1).

Data showed that 7 doctors with 5 years or less service in hospital were physically assaulted as compared with 10 doctors with 6-10 years' service. Additionally, 6 doctors with 11 or more years of service in hospital were a victim of physical assault. A similar pattern followed with the victims of verbal abuse where there were 23 doctors with 5 years or less service, 27 doctors with 6-10 years' service and 12 doctors with 11 or more years' service. Verbal threats were significantly more common with doctors having 10 years or less service. 17 doctors with 5 years of less service and 22 doctors with 6-10 years' service were verbally threatened as compared with only 7 doctors with 11 or more years' service.

With regard to working specialities, general physicians and surgeons were most susceptible to all reported forms of violence. 9 general physicians and 7 surgeons were physically assaulted as compared with 1 cardiologist, 2 gynecologists and 4 pediatricians. Similarly, 23 general physicians and 20 surgeons were verbally abused as compared with 3 cardiologists, 6 gynecologists and 10 pediatricians. With regard to verbal threats, 13 physicians, 18 surgeons and 7 pediatricians reported to be the victims as compared with 3 cardiologists and 5 gynecologists. An overwhelming majority of cardiologists (20 of 27) did not report any violence followed by gynecologists (16 of 29) and pediatricians (13 of 34).

Table 1:

Doctors' Self-reported Ever-exposure to Violence by their Socio-demographic Characteristics

(N=200)

Socio-demographic variables	Types of violence				Total
	Physical assault n=23 n (%)	Verbal abuse n=62 n (%)	Verbal threat n=46 n (%)	No violence n=69 n (%)	n=200 n (%)
Gender					
Male	23 (100.0)	49 (79.0)	37 (80.4)	17 (24.6)	126 (63.0)
Female	0 (00.0)	13 (20.9)	9 (19.6)	52 (75.4)	74 (37.0)
Age (years)					
≤30	7 (30.4)	31 (50.0)	21 (45.6)	23 (33.3)	82 (41.0)
31-40	13 (56.5)	21 (33.8)	16 (34.8)	18 (26.1)	68 (34.0)
≥41	3 (13.0)	10 (16.1)	9 (19.6)	28 (40.6)	50 (25.0)
Designation					
House Officers	14 (60.8)	36 (58.0)	27 (58.7)	26 (37.7)	103 (51.5)
Trainee Residents	7 (30.4)	18 (29.0)	14 (30.4)	21 (30.4)	60 (30.0)
Senior Medical Officers	2 (8.7)	8 (12.9)	5 (10.9)	22 (31.9)	37 (18.5
Service in hospital (years)					
≤5	7 (30.4)	23 (37.1)	17 (37.0)	14 (20.3)	61 (30.5)
6-10	10 (43.4)	27 (43.5)	22 (47.8)	24 (34.8)	83 (41.5)
≥11	6 (26.0)	12 (19.3)	7 (15.2)	31 (44.9)	56 (28.0)
Working Speciality					
General physician	9 (39.1)	23 (37.1)	13 (28.3)	9 (13.1)	54 (27.0)
Surgery	7 (30.4)	20 (32.2)	18 (39.1)	11 (15.9)	56 (28.0)
Cardiology	1 (4.3)	3 (4.8)	3 (6.5)	20 (29.0)	27 (13.5)
Gynaecology	2 (8.7)	6 (9.6)	5 (10.8)	16 (23.2)	29 (14.5)
Paediatrics	4 (17.4)	10 (16.1)	7 (15.2)	13 (18.8)	34 (17.0)

Table 2 showed doctor's self-reported ever-exposure to violence, with regards to their coping strategies. It was found that out of a sample of 200 doctors, 65.5% doctors reported to be the victim of one or the other form of violence. Disaggregation of data revealed that out of 131 victims of violence, 47.33% of the doctors reported to be verbally abused, followed by verbal threat (35.11%) and physical assault (17.56%). Results of the study showed that the doctors adopted multiple strategies to cope with the incidence of violence. In this regard, it was found that among 23 physically assaulted doctors, a significant number 21 (91.3%) of doctors coped by pretending to be indifferent, or by threatening to discharge the patient. This coping response was followed by giving shut up call to the abuser by 20 (86.90%) doctors, and by pretending to give special care to the patients by 19 (82.60%) doctors. In case of physical assault, only a very small number of respondents (6 of 23) reported to police.

Out of verbally abused doctors (62), more than three fourth (80.6%) doctors also pretended to be indifferent, as a coping strategy. However, 42 % of the doctors tried to cope with the act of verbal abuse by diverting the patient form conflict with measures such as explaining medical complications. It is worth mentioning that in case of verbal abuse, no doctor reported to police.

Interestingly, doctors who were verbally threatened (46), a vast majority of them 42 (91.3%) also pretended to be indifferent to cope with the act of violence. Almost the similar proportion of doctors (89.1) coped with the act of verbal threat by threatening to discharge the patient. In case of verbal threats, there were only 5 doctors (10.8%) who reported to the police.

Results of the study showed that in all three types of violence, ‘pretending to be indifferent’ was the most reoccurring strategy to cope with the incidence of violence. It was followed by ‘threatening to discharge the patient’ which was more prevalent in case of physical assault and verbal threat. However in all three types of violence, ‘reporting to police’ was considered as the last resort to combat with violence.

Table 2

Doctors' Self-reported Ever-exposure to Violence by their Coping Strategies

(N=200)

Coping Strategies*	Types of violence					
	Physical assault n=23 n (%)		Verbal abuse n=62 n (%)		Verbal threat n=46 n (%)	
Trying to explain medical complications	17	(73.9)	42	(67.7)	31	(67.4)
Pretend giving special care to patient	19	(82.6)	26	(41.9)	19	(41.3)
Pretending to be indifferent	21	(91.3)	50	(80.6)	42	(91.3)
Giving shut up call to the abuser	20	(86.9)	28	(45.1)	33	(71.7)
Showing similar behaviour	15	(65.2)	17	(27.4)	12	(26.0)
Calling to subordinate staff for help	18	(78.2)	35	(56.4)	39	(84.7)
Distancing oneself	16	(69.5)	21	(33.8)	27	(58.7)
Leaving the scene	14	(60.8)	38	(61.2)	31	(67.4)
Threatening to discharge patient	21	(91.3)	25	(40.3)	41	(89.1)
Reporting to senior management	19	(82.6)	16	(25.8)	13	(28.2)
Reporting to police	6	(26.0)	0	(00.0)	5	(10.8)

* Multiple responses

Table 3 showed doctors' emotional suffering with respect to type of violence. Data showed that a vast majority of doctors (95.6%) felt anger when they were physically assaulted. However, in case of verbal abuse, 59.6% of doctors reported to be helpless. In case of verbal threat, the level of emotional suffering was reported to be very high with 84.7% anger, followed by 80.4% helplessness, and 69.5% powerlessness.

Of those doctors deeming a sense of powerlessness as a result of violence, 69.5% were verbally threatened doctors, 60.8% were physically assaulted, and 46.7% had been verbally abused. The data also indicated that helplessness, as a type of emotional suffering, was experienced mostly by verbally threatened doctors, that is, 80.4% of them.

A considerably harmonious trend was seen among doctors faced with physical assault, verbal abuse, and verbal threat, with reference to feeling shock/astonishment. 82.6% of physically assaulted doctors reported feeling shock/astonishment; 79.0% of verbally abused doctors, and 93.4% of verbally threatened doctors reported the same. Disappointment, as an emotional suffering in response to violence, was felt by 86.9% of physically assaulted doctors, 91.9% of verbally abused doctors, and 95.6 % of verbally threatened doctors.

Data also showed that a significant number of doctors facing all three kinds of violence, suffered low self-esteem. In this regard, 91.3% physically assaulted doctors, 95.1% verbally abused doctors, and 76.1% verbally threatened doctors reported having low self-esteem. Facing violence also made doctors sad, as advocated by 82.6% of physically assaulted doctors, 79.0% of verbally abused doctors, as well as 82.6% of verbally threatened doctors. Henceforth, despair as an emotional suffering was felt most by 95.6% of physically assaulted doctors, 89.1% of verbally threatened doctors, and 75.8% of verbally abused doctors in hospitals.

Table 3

Doctors' Exposure to Violence by Their Emotional Sufferings

Type of emotional sufferings	*Types of violence*					
	Physical assault n=23 n (%)		Verbal abuse n=62 n (%)		Verbal threat n=46 n (%)	
Anger	22	(95.6)	21	(33.8)	39	(84.7)
Powerlessness	14	(60.8)	29	(46.7)	32	(69.5)
Helplessness	18	(78.2)	37	(59.6)	37	(80.4)
Shock/astonishment	19	(82.6)	49	(79.0)	43	(93.4)
Disappointment	20	(86.9)	57	(91.9)	44	(95.6)
Fear	16	(69.5)	43	(69.3)	38	(82.6)
Low self-esteem	21	(91.3)	59	(95.1)	35	(76.1)
Sadness	19	(82.6)	49	(79.0)	38	(82.6)
Despair	22	(95.6)	47	(75.8)	41	(89.1)

Discussion

Findings of the present study revealed that a significant proportion of doctors (65.5%) faced violence from patients or their care takers during performance of their duties in hospitals emergency departments. It is well researched that doctors in emergency department have frequently been a victim of violence in Pakistan and across the globe (Morrison, Lantos, Levinson, 1998; Mirza et al., 2012; Arimatsu et al., 2008). In this connection, present study found that male doctors have been more likely (83.20%) than female doctors (16.79%) to be the victim of such episode, wherein they faced physical assault, verbal abuse, and verbal threats. Consistent with the finding of the present study, it has been found by the earlier researches that medical sites contain the greatest

risk of verbal abuse and threats to the staff working in emergency medicine (Khan, Ahasan, Mahbub, Alam, Miah, & Gupta, 2010).

Age of the doctors appeared to be a strong predictor of violence against them. Age of doctors was found inversely proportional to the incidence of violence (Mirza et al., 2012). Doctors with younger age group (equal to or less than 30 years) reported to suffer more violence as compared to their colleagues of relatively higher age groups. It was found that doctors with forty-one or higher age group suffered significantly less violence. Among types of violence, verbal and physical abuse was more associated with the doctors of lower age group, whereas, verbal threat was found high among the doctors of higher age group. Moreover, it was observed that house offciers were more exposed to violence (51.5%) as compared to senior medical officers (18.5%). Arguably, it may also be due to the age factor as doctors with house officers education were relatively younger as compared to senior medical officers.

Results of the study showed contrasting picture with respect to results of association between age and violence. The doctors who had five years or less than five years of service in hospital reported less violence (30.5%) as compared to the doctors whose length of services in hospital was from six to ten years (41.5%). However, doctors having specialization as 'general physician' or in 'Surgery' were highly exposed to violence as compared to the doctors having specialization in Cardiology, Gynecology, and Paediatrics. Arguably, the work of general physician and particularly of surgeon related to emergency cases which were more often of criminal nature and associated with litigation. In this regard, the chances of aggressive behaviour by heirs of patients increased (The Economists, 2012) and subsequently victimization of these doctors also increased (Binder & McNiel, 1994).

Since a majority of the doctors reported to be exposed to violence in different forms they adopted multiple coping strategies. Pretending to be indifferent emerged over arching coping strategy in all three types of violence including physical assault, verbal abuse, and verbal threat. Followed by the said most prominent and cross cutting coping strategy, doctors adopted some other coping strategies with respect to type of violence. For instance, during physical assault and verbal threat, doctors dealt with the violent behaviour by threatening to discharge the patient, followed by giving shut up call to the abuser. Similarly, Khan, Ahasan, Mahbub, Alam, Miah, & Gupta (2010) found that among coping strategies included increasing prescribing, referring,, threatening patients to discharge and taking them off their lists.

The situation was somewhat different in case of verbal abuse where doctors tried to explain medical complications to the patients and their caretakers in

order to avoid and mitigate the violent situation. Result of the study also revealed that reporting to police was the last resort in cases of physical assault and verbal threats whereas in case of verbal abuse not a single doctor reported to police. This trend showed that the most undesirable solution to deal with the violent behaviour was to report police. In this regard, some doctors feel coping with aggression as a part of their job whereas other feel too guilty or embarrassed to report act of violence against them (Schnieden, 1993). There is a scope for future research to explore the reasons of non-reporting of the act of violence by medical professionals.

Results of the present study showed that almost all of the abused doctors had been facing emotional sufferings. The most prominent emotional suffering across all three types of violence included anger, disappointment, and despair. However, in case of physical assault, the vast majority of doctors felt despair and anger together with the similar frequency of each. There was a distinguishing finding of the study with respect to verbal abuse and emotional suffering that majority of the victimized doctors felt themselves helpless. This was probably because of the non-existence of institutional structure to deal with the act of violence within hospitals in general and within emergency departments in particular. A strikingly high response of doctors (93.4%) was obvious in case of verbal threats where they were shocked and astonished. It has been researched that possible effects of aggression on an individual are varied and likely to depend on the nature and type of violence and perceived vulnerability of doctors (Zahid, Al-Sahlawi, Shahid, Awadh, & Abu-Shammah, 1999).

Conclusion

The aftermath of September 11, especially Pakistan's involvement in the war on terror, deeply influenced the country's social psychology, economy and politics. While some institutions (e.g. the security establishment, higher education, etc.) and individuals (e.g. military dictators and civilian politicians) might have benefitted from the "generous" foreign aid, the common people have suffered a great deal. We do not argue that all the ills and problems of Pakistani society are due to its participation in the war on terror after 9/11. But the fact is that, perhaps due to its own failings and miscalculations, Pakistan experienced tremendous violence, economic deterioration and political instability in the post 9/11era. Pakistan has failed to invest in human development, especially in public health. As a result, the country has witnessed unchecked urbanisation, overpopulation and high infant and maternal mortality. The existing healthcare system lacks the capacity to bear the existing burden of disease and it is increasingly difficult for doctors and healthcare staff to face the angry and exploited people.

Policy-makers in Pakistan have yet to realise the gravity of the situation. The government ought to comprehend the fact that the army alone cannot win the war on terror. The healthcare sector is equally important for its role in creating peace and maintaining public tranquillity. But first, doctors must be saved from intimidation and violence of all kinds. They must not die in the cross-fire of a war between conservative militants and pro-Western forces. If the government of Pakistan and its allies want to win the war on terror, health and well-being should be promoted and the healthcare system ought to be strengthened.

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