


THE STEADY DRUMBEAT OF INSTITUTIONAL CASTEISM:

Recognise Respond Redress

NOW!

Forum Against Oppression of Women Forum for Medical Ethics Society
Medico Friend Circle People's Union for Civil Liberties, Maharashtra





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Preface

Dr Payal Tadvi, a young woman who aspired to a bright future for herself and carried dreams of being of service to her community and society at large lost her life to the machinations of a cruel, discriminating, and hierarchical system. Many others before her have also been driven to death by a system that is dominated by those in power, that operates through a systematic denial of dignity and which seems to be impervious to even the constitutional principles of inclusion, equality, and justice. This is the understanding from where this enquiry starts.

This enquiry has been initiated and conducted by members of Forum Against Oppression of Women (FAOW), Forum for Medical Ethics Society (FMES), Medico Friends Circle (MFC), and People's Union for Civil Liberties (PUCL) ¹.

- FAOW (Forum Against Oppression of Women, Bombay) is an autonomous feminist collective, part of the Indian women's movements for over four decades. It has worked on issues of violence against women, communalism, reproductive health, laws related to family, and many others. It has always striven to work with and learn from those marginalised because of caste, religions, sexuality, and gender identity.
- FMES (Forum for Medical Ethics) is a 28 year old organization which was formed in response to unethical and exclusionary practices in health care settings, medical education establishments; and malpractices in governing bodies such as Medical Council of India. It carries out its work through its three platforms namely, the Indian Journal of Medical Ethics (IJME), National Bioethics Platform (NBC), and Health, Ethics and Law Institute (HEaL Institute).
- MFC (Medico Friend Circle) is a nation-wide platform of secular, pluralist, and pro-people, pro-

poor health practitioners, scientists and social activists interested in the health problems of the people of India. Since its inception in 1974, MFC has critically analyzed the existing health care system and has tried to evolve an appropriate approach towards health care which is humane and which can meet the needs of the vast majority of the people in our country.

- PUCL (People's Union for Civil Liberties), Maharashtra is affiliated to the national PUCL which has been active for more than four decades as a civil liberties organisation striving to protect the human rights of all citizens in India. It has also attempted to expand the meaning of civil liberties by including the lived realities of those from the social margins of society.

While each of these organisations has engaged with the issue of inequity, exclusion and discrimination along various axes of marginalisations and made efforts towards social, gender and health justice, it is also true that we have neither worked specifically with marginalised castes and tribes nor are we seen as working on issues of Higher Education Institutions (HEIs). While our membership is diverse, a majority of our members come from dominant communities and have had easier access to HEIs. This enquiry was undertaken by us with full cognisance of these individual locations and the histories of our organisations.

Over the years we have learnt from the struggles of those from the margins, the importance of writing from experience. At the same time we have also learnt that as those coming from dominant communities, we need to put in the labour to understand how these dominant ideologies which have facilitated access to HEIs for many of us (writing this report and doing this work), actually work against those marginalised. This is our labour to learn, to unlearn, to not take things for granted while also bringing our own experiences of living and working with other marginalisations and structural inequalities like those of gender, location, language, sexual orientation. We did it to further understand the dominant ideology and ethos of HEIs and to find ways to transform it and make it accountable to the real inclusion of those from marginalised communities.

1FAOW can be reached at faowindia@yahoo.co.in). Details of the other three can be had from their respective websites: FMES (fmesinstitute.org); mfc (mfcindia.org); PUCL (pucl.org). Along with activists from these 4 groups, a few individuals also participated in the preparation of this report such as Rashmi Divekar, Hemlata Jivnani and Deval Sawarkar. Additionally, Dr Sanjay Dabhade, Advocate Disha Wadekar, Rachita Shah, and Shilpa contributed to the report.

This work has helped us 'see' much more than what we began with. It has made us introspect our own dominant caste locations and examine the many 'blind spots' that these had left in our real understanding of discrimination and the quotidian ways in which it operates. As activists involved in social change, we have never denied the existence of caste-based discrimination and oppression and the injustice and inhumanity of the caste system over the last several centuries as well as its persistence to the present moment. However, this work has helped us understand better the everyday routine yet brutal existence of caste and the manner in which it pervades every breath and every aspect of all our lives and the insidious ways in which seemingly 'neutral' institutional practices actually discriminate.

Finally, a few words about nomenclature. We began with an unease at the way in which these incidents are reported and investigated as 'suicides' thus putting the onus back on the individual and their abilities. As we did the work we began to see more starkly the violence of these approaches themselves and hence choose to call such incidents 'institutional murder'. By doing so, we wish to underline institutions as sites of not only lethal violence but locations of and bodies with which the ultimate responsibility should be rested with and hence the real locus of investigations. In so doing we add our voices to those of many others who have done this before us. They have helped us and so we build on this existing knowledge with gratitude and humility.

Amita Pitre, Chayanika Shah, Meena Gopal, Sandhya Gokhale, Sujata Gothoskar, Sunita Sheel

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Chapter I

Introduction

I.1 Who are we? And why this report?

Following the media reports of the death by suicide of Dr. Payal Tadvi, a 2nd year post-graduate in Gynaecology and Obstetrics and resident doctor in the Brihanmumbai Municipal Corporation's (BMC) BYL Nair Hospital in May 2019, some of us who belong to health, human rights and women's rights organizations, i.e. Forum Against Oppression of Women (FAOW), Forum for Medical Ethics Society (FMES), Medico Friends Circle (mfc), and People's Union for Civil Liberties (PUCL), Maharashtra, felt compelled to enquire into the incident.

As is usual, the situation had impelled several committees to be formed, beginning with investigations of the police, the medical college authorities, the State and Central Commissions for the Scheduled Castes (SC) and Scheduled Tribes (ST), and so on. Over the last few years we have seen this happen over and over again in higher education institutions (HEIs) – students from marginalised castes and communities being driven to suicide under circumstances of deliberate and extreme caste-based discrimination. Under these circumstances the deaths amount not to suicides but institutional murders. Every time the system responds with appointment of committees and their recommendations, that may vary in depth and impact but which are often not complied with nor have they stopped these instances from happening.

We are activists, with diverse disciplinary backgrounds, in broader movements to safeguard right to health, rights of workers and marginal communities; researchers in the broader domain of health, health

systems, medical education, gender studies, policy analysis and legal advocacy; and academics. As feminists who have attempted to understand the intersections of caste and religious identities in our campaigns, we believe we need to go beyond the specific facts of the death by suicide of Dr. Payal Tadvi. Justice for her is important and crucial and to that extent we have been following her case as closely as we can. However, understanding the larger picture of systemic caste-based discrimination in medical education, specifically towards students of SC and ST communities and the perceived apathy towards issues of inequity within medical institutions is critical for long term solutions and this guided us in this enquiry.

The incident of the institutional murder¹ of Dr. Payal Tadvi served as a trigger as we spent months looking at practices within the higher education system, and the medical education system in particular. We realise that the larger context for this exploration is the entry into higher education of students from marginal backgrounds, as always a sore point for those from the dominant castes. What has been different since the 1990s is the entry of a larger number of students from marginal castes that has brought overt tensions into university campuses and classrooms (Rege, 2010). The public sphere has in addition been rocked by constant challenges to the affirmative constitutional policies for reservations in education and employment for the SC and ST communities. Simultaneous to this, has also been a phase of privatization of higher education with attempts to integrate India into the global economy, finding space as a knowledge economy. This enquiry attempts to study the combined effect of all of this specifically in the case of medical education.

A reading of the UGC (Promotion of Equity in Higher Education Institutions) Regulations, 2012 (UGC, 2012) mandating the setting up of mechanisms to prevent discrimination in higher education institutions, and the very specific enquiries into grave situations of discrimination within medical colleges, by the 2007 Sukhdeo Thorat Committee report (Thorat, n.d.) as well as news reports of the Mungekar Committee recommendations of 2012 (IE, 2012), confirmed our objective. The discussion on

¹Our experience as we put together this report compels us to use this term, institutional murder, as we have seen and learnt that it is institutions and practices that drive individuals from marginal groups to suicides.

reservations and 'merit' prompted by a reading of the 2019 Chandrachud judgement ([SC, 2019](#)) which upheld validity of the Karnataka law granting reservation in promotions for government employees, further crystallized our belief in this enquiry.

These reports, and some voices from the news reports following Dr. Payal Tadvi's institutional murder, brought to light starkly the highly systematic and endemic nature of caste-based discrimination² and harassment which has been persistent for decades. And continues to recur! Activists and students from marginalised castes have repeatedly hit a wall and faced insurmountable resistance in their struggles against caste-based discrimination. We realised that systemic caste-based discrimination has been acknowledged time and again. And yet none of the measures recommended are put in place. It seems as though, had the recommendations of the Thorat Committee and the mandate of the UGC (Promotion of Equity in Higher Educational Institutions) Regulations, 2012 ([UGC, 2012](#)) been implemented, several of these suicides and the pain and heartburn felt could have been avoided. But by not implementing them, the system steeped in dominant caste-based privilege entrenches the exclusion of these students indicating in no uncertain terms that higher education is not what they deserve!!

This enquiry hence begins with the presumption of existing discrimination against people coming from SC and ST communities in medical institutions. It attempts to unpack the systemic manner in which this caste-based discrimination pervades medical institutions – how it is experienced in daily life and how it gets strengthened in every day practices, how changing economic and political contexts impact this negatively, and how the absent institutional mechanisms further push the students to hopelessness. This enquiry reflects on the negligent way in which it has been addressed within and by the system.

The enquiry also looks carefully at the nature of medical education itself and warns against ongoing changes within it that may reinforce discrimination in obvious and subtle ways. It also wishes to highlight

²Throughout the report, although we have used the term 'caste-based discrimination', it also includes the situation of those from marginalised Tribes/Adivasi, Denotified/Nomadic Tribal communities, and in some instances religious minorities. Students from Adivasi/ Denotified/Vimukt Tribal communities are also entitled to access "reserved seats" and hence treated with the same disdain as those from the marginalised castes. We recognise the difference between these experiences but use caste-based discrimination as a sociological concept to indicate similar experiences of marginalization and discrimination of other groups at the margins, too.

the absence or ineffectiveness of mechanisms that are constitutionally and legally mandated to alleviate this discrimination and harassment, and analyse this institutional reluctance to address the discrimination. Some of us are deeply involved in the campaign for prevention of sexual harassment at workplace that led to the enactment of The Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013. We bring this experience of addressing systemic discrimination to this enquiry to see parallels and the differences in the ways in which efforts at implementation of established legal procedure have been made or not made in both these instances.

In doing all of this, we record that Dr. Payal Tadvi's institutional murder is one among many that have occurred within higher educational institutions across the country due to the failing of a system of higher education that trains professionals. It points to the pervasive practices within it that lead to a consolidation of systemic discrimination, and the ethos of insensitivity and hostility that is evident only to those at the receiving end of this structural dominance and systematically overlooked or ignored by others in an insensitive and callous manner.

I.2 Objectives

- a. To understand the lived experiences of different sections of students and employees in medical institutions regarding caste-based discrimination and undertake contextual analysis both at macro and micro levels of the systems and practices in medical colleges and teaching hospitals that led to the institutional murder of Dr Payal Tadvi and many others like her;
- b. To document and analyse the response/action taken (or its absence) by the institution(s) in terms of its mandated responsibilities to prevent occurrence of such events;
- c. To understand the contours of the policies and mechanisms or lack thereof at the national, state and local administration levels in health care establishments in relation to safeguarding rights and dignity of the socially marginalized on the basis of caste, religion, ethnicity, gender, and other parameters and explore if these policies are being meaningfully implemented and gaps therein;

- d. To study the nature of medical education system as a whole to understand why and how issues of systemic discrimination get perpetuated and strengthened in a sustained manner within it and;
- e. To propose recommendations to put in place mechanisms and systems at such institutions towards completely eliminating any discriminatory behaviour in the institution.

I.3 Our approach to the exploration

Given these objectives we adopted four key approaches to identify our data sources for this exploration. These included:

- a. in-depth conversations and interactions through individual in-depth interviews, joint interviews (involving two or three persons at a time), and group discussions with select key constituencies by drawing individuals from different professional groups within the medical institutions as representatives for our purposes
- b. media reports – contemporary and historical – formed a significant part of the material accessed for capturing voices reporting caste-based discrimination and allied issues
- c. key documentary materials, as well as secondary data sources, such as reports produced by select committees such as Sukhdeo Thorat Committee (STC) (2007), and Mungekar Committee (MC); UGC Regulations on Curbing the Menace of Ragging, 2009 (amended 2016); the UGC Regulations for Promoting Equity in Higher Educational Institutions, 2012, and other provisions for protection of individuals from SC and ST communities; select public interest litigations relating to the theme of exploration; as well as petitions to the High Court and Supreme Court and legal proceedings as referred to by the participants. Some committee reports, such as the Mungekar report are not available in the public domain at all and we had to rely on the media coverage of their findings and recommendations.
- d. We filed application under the Right to Information (RTI) Act with the Directorate of Medical Education and Research (DMER) and the Maharashtra University of Health Sciences (MUHS) to

understand the practices that are likely to discriminate students and resident doctors, especially with respect to free-ship, and the amount and period of serving the bond. We also sought access to the Reports of the committees with the Home Department, Government of Maharashtra through RTI processes. However, RTI processes were not successful in gaining any information, including reports of government committees.

Specific sections of professionals in the exploration included: resident doctors, both senior and junior; doctors, both currently working in the public health care system (allopathic and Ayurveda) and retired; doctors from private practice who are engaged with the health care movement and engaged with issues of medical education; members of associations such as Dr Ambedkar Medicos Association (DAMA) and Maharashtra Association of Resident Doctors (MARD); technical staff; nursing students; nurses; nursing professionals who are members of the unions of nursing professionals, such as, the Municipal Nursing and Paramedical Staff Union, Mumbai; and scholars engaged with matters relating to medical education system, equal opportunities, and medical entrance examinations and its governance. Above mentioned participants in this exploration spanned both the dominant castes and marginalized castes/communities. We also approached office bearers of the Indian Medical Association (IMA) to engage with. However, they declined to interact with us.

Our approach to identify potential participants in this exploration: one of the points of initial contacts seeking participation of resident doctors in this enquiry was the associations – MARD, DAMA; and unions of nursing professionals such as Municipal Nursing and Paramedical Staff Union, Mumbai. This helped us to connect with others in these networks including alumni, and served as a snow balling approach to drawing the representatives of these constituencies in the state of Maharashtra.

We also relied on sources from within our nationwide networks associated with health care and women's movements, civil society entities, FAOW, FMES, MFC and PUCL networks to identify individuals who could shed light on the environment in medical education institutions and to document their insights into potential factors that explain the patterns and trends in suicides in these institutions.

Approach to data collection: Given our interest in getting deeper insights into the issue at hand, as mentioned earlier, we relied on in-depth interviews and conversations with key informants, joint

interviews, and group discussions. Many a times, individuals preferred to talk to us along with their friends and colleagues as they seem to have felt more comfortable doing so rather than talking to us all by themselves. Participants' experiences are covered in depth in the interviews and discussions. The perceptions of doctors from both the dominant caste and marginalized caste/community highlight their specific locations within the system. We attempt to establish connections to draw out the picture of systemic discrimination and the everyday exclusions. The sample of participants is thus only indicative and not exhaustive of the various levels within the medical establishment.

The list of anonymised interview participants by their designations and social locations can be found in the Annexures.

I.4 Structure of the Report

Following the Introduction, chapter II lays out briefly the incident of the institutional murder of Dr. Payal Tadvī and provides select key developments, such as various enquiries including court hearings. We document this here to maintain a record of all happenings till the publication of this report as the enquiry has been triggered by this incident. Chapter III lays out the entrenched nature of caste-based discrimination in society and in education. In Higher Education Institutions (HEIs) the issue of affirmative action in terms of reservation has been contested by the language of 'merit'. This chapter also lays down the debate around these issues with particular reference to medical institutions, as a background to the voices in the current enquiry.

Chapters IV, V and VI explore the specific experiences and instances of the practices within the system of medical institutions as experienced by undergraduate (UG) and postgraduate students (PGs) and employees respectively. More specifically, chapter 4 looks at the quotidian experiences of UG students, chapter V looks at the particular situation of resident doctors, that is, PG students who function also as full-fledged doctors responsible for running the public health care system. Chapter VI examines the wider context of the experiences of different employees within an extremely hierarchical system.

Chapter VII provides critical insights into and discusses the provisions mandated for the protection from

discrimination of students from SC and ST communities and a detailed analysis of its actual practice in institutions. It also looks carefully at the mechanisms for prevention of ragging in colleges and universities, its limitations and possibilities since it is invoked every time there is an incidence of violence involving students. Chapter VIII, Discussion, draws upon insights gathered from our conversation with participants and analysis of other secondary sources. We center-stage the concept of 'transformative justice' and argue that it should form the foundation for suggested strategies to work towards eliminating caste-based discriminatory practices in HEIs. Finally, Chapter IX, Recommendations, offers suggestions based on this enquiry and what emerges from our discussion in the foregoing chapters adding to the recommendations from other reports.

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Chapter II

The death by suicide of Dr Payal Tadvi: The incident and the follow up

The present report is not a fact-finding effort. However, a description of the death-by-suicide of Dr Payal Tadvi is necessary to place in perspective the objective of an enquiry into the institutional underpinnings of the incident. We describe the incident drawing upon news reports from the English and Marathi media.

II.1 Nature of harassment leading to death by suicide of Dr Payal Tadvi

The tragic news of the death-by-suicide of Dr Payal Tadvi, 2nd year Post-Graduate resident doctor at the BYL Nair Hospital (BYL-NH), Mumbai, Maharashtra became a newspaper headline on 23 May 2019. ([First Post, 2019](#); [India Today, 2019](#)) She was the first woman from her family to become a doctor, and the first woman from the Adivasi Muslim Bhil Community, a scheduled tribe, to pursue a post-graduation in medicine, as told by her mother Abeda Tadvi to the First Post ([First Post, 2019](#); [India Today, 2019](#)) She aspired to return to her home town and to her community in Jalgaon to serve them and help improve her community's access to quality health care services.

As per the media reporting ([Gupta, 2019](#); [Indian Express, 2019a](#)), over a period of one year, three women resident doctors from the third year of residency in Obstetrics and Gynaecology at the BYL-NH, namely, Hema Ahuja, Ankita Khandelwal and Bhakti Mehre, continually harassed Dr Payal. The harassment, which had become serious, included persistent derisive remarks about her caste, and on she being from a backward community, being an Adivasi, and having been admitted to medicine through the reserved categories. The latter reflects deep rooted hostile sentiments many students across the board harbour about the reservation policy which, according to them, has allowed undeserving students from various

reserved caste and tribe categories to enter into professional courses, such as, medicine and how they take away opportunities of the deserving candidates from the dominant castes. As a result, such remarks are not only casteist but carry a sting of humiliation, insult and offence to those belonging to these communities. The harassment included, as media reported ([Gupta, 2019](#); [Indian Express, 2019a](#)), ill-treatment Dr Payal faced at the hostel where she shared a room with the three senior residents. For instance, these seniors would often wipe their feet on her bed after using the wash rooms/toilets ([Gupta, 2019](#); [Indian Express, 2019a](#)). The media also reported that the three senior women residents had threatened Dr Payal that they will not allow her to complete her Masters in Medicine (MD), and prevent her from entering the operation theatre or perform deliveries. Dr Payal had shared details of the continued harassment with her family, and her mother helped her to lodge a complaint to the head of the Department of Obstetrics and Gynaecology at the BYL Nair Hospital, the teaching hospital for the Topiwala National Medical College (TNMC), Mumbai. It is noteworthy that the officials from the said hospital charged with addressing the complaint referred to the sustained harassment that Dr Payal experienced as mere “ragging”. It indicated their complete apathy to look into the matter from the perspective of Dr Payal and her family members, of the deep sense of humiliation she was suffering arising from these sustained caste based harassments. The authorities seemed to have learnt very little from this tragic incident.

The media brought out many narratives through her family and friends, the police, institutional responses, as well as others in similar situations. A number of these media reports sourced their conversations with friends and colleagues of Dr Payal Tadvi post her death by suicide on May 22, 2019. For example, Dr Snehal Shinde, a friend and colleague of Dr Payal, it was reported, was witness to and confirmed the use of casteist comments against Dr Payal, in her statement later to the Crime branch. She reported that Payal was asked, “You are from the reserved category, right? And what rank did you get in NEET (entrance exam)?” ([Hakim, 2019](#)). Overall, the media reportings, drawing upon their conversation with friends of Dr Payal, highlighting various instances of harassment that Dr Payal and others from similar background get subjected to, cannot be reduced to sheer ragging. Central to such harassments is casteism and the disgruntled sentiments of some of the medical students from the dominant castes, related to the reservation policy.

One of the important aspects in the narratives from friends of Dr Payal Tadvi, was her specific personality

strengths that they knew about. Many of them averred that it was unbelievable that someone like Dr Payal could have taken such a step, except in an extremely dire situation. Such expressions indicate that the extent of harassment Dr Payal faced, must have been of an extreme nature. One of the close friends and a fellow student of Dr Payal Tadvī a resident doctor (RDM4) spoke to us about her as a cheerful, capable and courageous person. She was also a friendly and people's person in the hospital. Also, her friend continued, in their undergraduate days at the Government Medical College, at Miraj (GMCM) they used to independently assist deliveries. Against this backdrop, the three senior residents allegedly not allowing Dr Payal to conduct deliveries would cause a sense of humiliation, harassment, and also anxiety about losing important opportunities to train herself in her post-graduate gynecology specialization. Normatively, this would be disconcerting to any post-graduate student as in the long run it would adversely impact their skills and knowledge as health care providers and in turn likely affect their career paths.

There was some indication, her friend mentioned, of something foreboding. There seemed an isolation that the system had pushed her into. Alongside the reports of the harassment that pushed Dr Payal to resort to such a drastic measure, several experiences of caste-based discrimination and profiling that happens within higher education institutions emerged from experiences of other students. Reservations are a tool to bring about caste based equity in higher education. The above experiences, however, reflect utmost bias against reservations in professional studies, such as, medical colleges which are already ridden with extreme hierarchy and competitive ethos ([Vaidya, 2019](#)).

In fact, in mid-September 2019 another incident of ragging from the same BYL Nair Hospital was reported to the Anti-Ragging Committee, where a senior resident doctor had harassed a junior in the ENT department. Although the complaint from the junior doctor, Dr Sadiya Shaikh Tadvī had been registered, the senior Dr Reshma Bangar also filed a counter complaint. The Dean of the hospital Dr Ramesh Bharmal mentioned that it was referred to the Anti-Ragging Committee, saying it may possibly be a case of petty fights among seniors and juniors, and so attempts were being made to build bridges among them ([Mishra, 2019](#); [The Wire, 2019d](#)).

Redressal sought by Dr Payal and institutional response

In December 2018 when it became unbearable for Dr Payal, her mother had complained of caste-based

harassment to the Head of Department (HoD) of Obstetrics and Gynaecology (Ob-Gyn).

In response to that complaint and request by Dr Payal and her family seeking redressal, the Head of Department (HoD) of Obstetrics and Gynaecology transferred Dr Payal to another department possibly to contain the direct interactions between Dr Payal and the three accused senior women residents. However, as shared with us by her friend as well as reported in the media, ([Lele, 2019](#)) in the second year she was posted to the same unit and the harassment resumed which must have been even more humiliating and toxic. For example, the accused would call her *bhagoudi* (that is, an escapist, coward or a person who runs away from challenges instead of confronting them), and embarrass her in front of patients in wards. Following this, her mother gave another written complaint on the 10th of May 2019, but received no response, this time either from the college or hospital authorities. Being unable to bear the torture, Dr Payal Tadvi committed suicide in her hostel room on 22 May 2019, having spoken to her mother only a few hours before about the continued harassment. She had even conducted two surgeries before speaking to her mother ([Bhuyan, 2019](#); [Harad, 2019](#)).

The immediate response of the three accused doctors was that Dr Payal could not shoulder the “work pressure” at the hospital. They alleged that this led to Dr Payal's decision to resort to suicide. They had also gone missing, having absconded and it took 4-5 days before the police could arrest them as the press covered the incident. The fact that the harassment of Dr Payal continued in the second year of post-graduation and despite complaints, raises a serious question both on whether it can be termed as ‘ragging’ and whether there is accountability of the college authorities to the safety of its students. How was it that ‘ragging’ had continued into the second year? And why are the circumstances clearly pointing to caste-based discrimination, consistently ignored? ([Ali, 2019](#); [Indian Express, 2019a](#)).

What is evident is that, the family was the most significant support that doctors like Dr Payal had. The authorities were largely unresponsive. The Tadvi family has levelled serious allegations against the four senior doctors, including the unit head who did not act on the complaint given in early May, pertaining to discrimination, professional harassment, torturing Payal with casteist remarks on her tribal Muslim background and had demanded "strictest action" against them.

Even during the court hearings, the family of Dr Tadvi was skeptical about the change in the Public

Prosecutor's appointment in the case and even demanded their preference for advocate Ujjwal Nikam as Public Prosecutor. There were also questions as to why an SIT was not constituted in place of the Crime Branch ([Loksatta Team, 2019a](#)).

II.2 Action taken against the accused and concerned officials in the BYL Nair Hospital

The Mumbai police had initiated an investigation into the incident. In addition, a number of actions were taken against the three accused by concerned professional associations and other entities, such as, the Brihanmumbai Municipal Corporation (BMC) ([Huffpost India, 2019](#); [Naik, 2019](#); [Pandit, 2019](#); [The Wire, 2019b](#))

- a. On May 24, 2019, the Maharashtra Association of Resident Doctors (MARD) suspended the three doctors accused in the incident from the organization.
- b. On May 27, 2019, Brihanmumbai Municipal Corporation (BMC) which runs the BYL-NH , the site of the incident, suspended medical licenses of the three accused.
- c. BMC suspended medical licenses of Dr Yi Ching Ling, the Head of Department of Obstetrics and Gynecology, BYL-NH on May 27, 2019
- d. The police authority arrested two of the accused on May 26, 2019, and one on May 27, 2019.
- e. In addition to suspending the three accused doctors from the organization for making casteist remarks, MARD also adopted an innovative approach to respond to the incident by undertaking sensitization programme for second and third year undergraduate medical students.
- f. BYL Nair Hospital organised a panel discussion on 8 June 2019. Doctors and psychiatrists said that any incident of harassment has to be reported, and intervened, and the hierarchy has to be ended ([Debroy, and Srinivasan, 2019](#))

Response from the civil society and social organizations

The incident served as a trigger to civil society and other social organisations to demonstrate and express their concerns by taking to the streets. The city witnessed a number of protests by organisations with left persuasion, and by those working to safeguard the interest of tribal communities and

scheduled caste communities. Amongst others, it included organizations, such as, All India Democratic Women's Association (AIDWA), Students' Federation of India (SFI), Democratic Youth Federation of India (DYFI), and *Vanchit Bahujan Aghadi* (VBA). Along with activists, medical students and family members of Dr Payal joined these protests. Alongside, *Akhil Bharatiya Adivasi Vikas Parishad*, raised queries with the BYL-NH administration ([First Post, 2019](#); [Logical Indian, 2019](#); [Huffpost 2019](#)).

We see later that in August 2020, the *Jati Anta Sangharsh Samiti*, a collective of organisations in Maharashtra focused on anti-caste/tribe discrimination, appealed to the Maharashtra government to seek a directive from the Supreme Court to continue the restraint disallowing the accused resident doctors from resuming their studies, until the trial was completed as this would interfere with the trial by intimidating the witnesses who were still in the college ([Deshpande A, 2020](#)). The Supreme Court had been approached by the three accused residents, asking that they be allowed to resume their studies.

Response of the Professional Associations & Government Appointed Bodies

After the incident of Dr Payal's death-by-suicide, a number of 'fact finding' initiatives were underway in addition to the one by BYL Nair Hospital, the site of the incident. These included fact findings undertaken by professional associations, such as the Indian Medical Association (IMA), and Maharashtra Association of Resident Doctors (MARD). There were also other enquiries conducted by committees appointed or commissions instituted by the government, such as, Maharashtra State Commission for Scheduled Castes and Scheduled Tribes (MSCSC-ST); Social Justice and Special Assistance Department, Government of Maharashtra; National Commission for Women (NCW); and Maharashtra State Commission for Women (MSCW) ([Times, 2019](#)). Likewise, political outfits aligned with the interest of SCs-STs, such as *Vanchit Bahujan Aghadi* (VBA), civil society organizations and national level networks representing people's movement aimed at safeguarding human rights, health rights and gender justice also steered their own independent efforts to look into the matter, such as the one we undertook on behalf of People's Union for Civil Liberties (PUCI), Forum Against Oppression of Women (FAOW), Forum for Medical Ethics (FMES), and Medico Friend Circle (MFC). The overall objective for each one of them had been, to enquire if it was a case of ragging or if it involved caste-based harassment. We mention below some of them and provide brief analytical insights into their approaches and the outcomes of investigation.

The **Anti-Ragging Committee**, BYL Nair Hospital (ARC – BYL-NH): This was first investigation initiated at the Topiwala National Medical College (TNMC) where the death-by-suicide of Dr. Payal Tadvī took place. The Committee brought out a report ([Barnagarwala, 2019a](#); [The Wire 2019a](#)) based on its interaction with nearly 30 persons which included staff, family members of Dr Payal and her colleagues. Drawing upon these conversations, the Committee (submitted on Tuesday 26 May 2019) reported evidence of extreme harassment and casteist remarks. However, it stated that it was a clear case of ragging. The report vindicated that there was continuous harassment, humiliation, and preventing Dr Payal from work. The report mentions that harassment also included casteist comments, such as, “...*These people don’t know anything; she got admission through caste quota.*” This report was sent to MUHS which took cognizance of the report, and constituted a five-member committee under the chairmanship of JJ Hospital Dean Dr Ajay Chandanwale with an objective to study the report. It is noteworthy that the report mentions that the hospital’s mechanism to deal with harassment was ineffective. ([Loksatta Team, 2019a](#); [Mumbai Mirror, 2019a](#); [Ganapatye, 2019](#); [The Wire, 2019a](#))

Maharashtra State appointed Committee (MSAC): Maharashtra State Government appointed a four-member committee to look into this incident. It came out with a 16-page report that was submitted to the Department of Medical Education. The committee suggested a series of measures to prevent and address ragging, including with the help of counseling and follow-up measures. However officials averred that any action “against Nair Hospital department head is under purview of the Brihanmumbai Municipal Corporation.” The Secretary of Medical Education however said the Nair Hospital is under the jurisdiction of the BMC ([Barnagarwala, 2019c](#)). This committee confirmed the findings by the ARC-BYLNH Committee report that it had evidence of harassment, and mentioned that casteist remarks were made against Dr Payal Tadvī ([Indian Express, 2019b](#)). However, while MSAC acknowledged ragging and high workload, it reported that there was no conclusive evidence of caste-based discrimination, that there exists no caste-based discrimination within the medical fraternity or with the patients and it doesn’t condone discriminatory behavior.

The Indian Medical Association (IMA) Appointed Committee (IMA-C): IMA appointed a five member committee to look into the incident in early June soon after the incident and was mandated to submit its investigation report within seven days ([Rawat, 2019](#)). Its mandate was to look into the complex issues of resident doctors’ working environment and suggest measures to respond to these issues. The report of

this committee denied any caste discrimination in the medical profession. The current national general secretary brushed off the issue of representation and participation of members of SC and ST communities within the IMA ([The Wire 2019a](#); [Harad, 2019](#)) IMA issued a statement on Dr Payal's death-by-suicide, making reference to the inhuman workload resident doctors carry causing depression and burn out. It further mentioned that allegations of caste-based discrimination have surfaced in the case of Dr Payal's death-by-suicide and that if it was true it would be of serious concern and would require redress. However, IMA seemed to be in 'denial' as it also included in the statement that the medical fraternity is ahead in overcoming barriers of caste and religion. It mentioned that there exists no caste-based discrimination within the medical fraternity or with the patients and it doesn't condone discriminatory behavior.

The Maharashtra State Commission for SC/ST (MSC-SC-ST) appointed Committee: This committee undertook an independent probe. As an outcome of this probe, it raised questions about the police investigation ([Barnagarwala, 2019b](#)). Member Secretary of the Maharashtra State SC-ST Committee, Dr Sandesh Wagh, said they noted several lapses in the way the police handled the case ([Indian Express, 2019c](#); [Correspondent, DNA, 2019](#)). The media reports cited Dr. Wagh raising two concerns: one, police had registered the case using a Section from the Scheduled Castes and the Scheduled Tribes (Prevention of Atrocities) Act, 1989 instead of registering under the amended Act of 2018; two, the case was registered using only one section from the 1989 Act relating to intentional insult to humiliate an SC-ST member in the public while at least five sections from the amended Act of 2018 which related to abusing, humiliating, and intimidating an SC-ST community member could be applicable to this case allowing consideration of severe punishment. It also noted that police investigation did not include caste angle until then. The media reports mention the other observations the Committee made that include: at least three other residents offered testimonies to the committee stating that the three accused senior residents scolded Dr Payal on May 22, 2019 after they all conducted a delivery; the room of Dr Payal where she was found dead was open for about four hours after her death allowing time and space for others to tamper with forensic evidence; against this backdrop, it noted, police must collect CCTV footage to ascertain the facts; the police must collect forensic evidence from the room of Dr Payal; the BYLNH did not have an SC-ST cell to handle complaints regarding atrocities; the Dean did not take note of the complaint letter by the mother of Dr Payal which had the 'inward' receipt stamp from his office.

National Commission for Scheduled Tribes (NCST): The Commission appointed a seven-member team to investigate the incident and worked independent of the MSC-SC-ST. The team met family members of Dr Payal, her room mates, faculty of the BYLNH, parents of the three accused senior resident women doctors, state officials, and the police as part of its fact finding efforts. It did play a crucial role in putting pressure ([New Indian Express 2019](#); [PTI, 2019a](#)), especially when the immediate focus of the Medical Institutions had been to strengthen anti-ragging efforts, and have sessions on how to handle work-pressure. NCST Commission also spoke of gaps in police investigation, and raised questions about presuming Dr Payal's death to be suicide before recovering the suicide note. It also emphasized that the allegation of casteism cannot be completely disregarded ([Debroy and Srinivasan, 2019](#)).

The National Commission for Women (NCW): Taking suo-moto cognizance of media reports regarding the death of Dr. Payal Tadvi over casteist slurs from seniors, the NCW said the incident is a matter of serious concern. The Commission requested the institute – BYLNH - for an investigation into the case and communicated to the Director of the institute to apprise the Commission on the action taken in the matter. The Maharashtra State Commission for Women also enquired about the anti-ragging rules ([Gupta, 2019](#); [Web team DNA, 2019](#)).

II.3 Police investigation and court proceedings

After the initial police investigation following their arrest where the three senior women residents accused in the case were charged under sections dealing with abetment to suicide, anti-ragging laws, and SC, ST (Prevention of Atrocities) Act, the case was transferred on 30 May 2019 from the Agripada police station to the Crime Branch ([Hafeez, 2019](#)). Upon this, the Crime Branch told the Sessions Court that information was received from the chief witness that the trio had been harassing Dr Tadvi regarding her caste. Meanwhile having applied for bail at the Bombay High Court, during the bail hearings, the accused doctors denied that they made comments on caste, but had called her '*bhagoudi*' once on WhatsApp. The High court denied custody of the three doctors to Crime Branch but allowed them to be interrogated in jail. Bail hearings continued ([Loksatta, 2019c](#)).

On 4 July 2019, the police shared with the Bombay High Court that the forensic lab has recovered a

suicide note's photo from Dr Payal's phone on 1 July, which mentions the three accused doctors and their caste harassment ([The Wire, 2019c](#)). The suicide note recovered by the forensic lab at Kalina, Santacruz, Mumbai had been considered an important evidence. The full text of the suicide note was accessed by the media on 25 July ([Mumbai Mirror, 2019c](#); [Vidya 2019](#)). An 1800 page charge-sheet had been filed on July 24, 2019 ([Mumbai Mirror, 2019b](#)). The charge sheet relies, as media reported, on call data records, and testimonies of 150 witnesses which included doctors and staff of the BYL-NH, Dr Payal's friends, and her family members – mother and husband; and WhatsApp conversations narrating the harassment Dr Payal was subjected to, which were found on her phone.

During the hearings the predictable pattern of blaming the victim for psychological weakness, inability to bear stress, inability to cope with the academic system and its work pressures were attributed as the cause for the death-by-suicide to deflect from systemic discrimination and caste based discriminatory practices from those powerful in the system. Former President of Dr Ambedkar Medico's Association said that *"unless the socialisation of savarna students and their casteist behaviour in educational spaces is brought into focus, the present discourse only causes more harm to Bahujan students."* ([Shantha, 2019](#)) As the court case progressed (on July 27th) the police told the court that Dr Payal Tadvī was earlier denied mandatory medical leave by one of the accused doctors following an injury she had during the delivery of an HIV infected patient ([India Today, 2019b](#)).

However, the High Court while hearing the bail pleas of the accused doctors, noted that there were several lacunae in the manner the prosecution was taking ahead the case. In particular Justice Sadhana Jadhav noted how several of the witnesses who were colleagues of Dr. Payal Tadvī, despite being witnesses in the case, continued to be in a vulnerable position in the hospital as their statements were still not recorded by the Crime Branch under Sec 164 CrPC, as well as not making the unit head Dr Ling an accused. The court gave a time limit of three days for the recording of the statements of witnesses. Nevertheless, the High Court granted bail to all three accused doctors on 8 August 2019. The conditional bail required reporting to the Crime Branch every alternate day, suspension of their medical license till the end of the trial, disallowing them from entering the jurisdiction of Aripada Police Station and the TNMC and not being allowed to leave the city without the Court's permission ([India Today, 2019c](#); [PTI, 2019b](#); [Mumbai Mirror 2019d](#)). The judge agreed to pass an order when the prosecution requested a media-gag for the rest of the hearing. In continuing hearings of the case, in early November 2019, there

was a news report that the forensic reports of Dr Payal Tadvī's mobile phone revealed that she had searched for details of the Agripada police station, perhaps to register a complaint. In addition the police also submitted recordings of some more witnesses and details of CCTV footage of the hostel on the day that Dr. Tadvī died ([Delima, 2019](#))

Key points from hearings – from January 2020

Further developments have taken place since the next hearing that was posted for 15 January 2020. They are:

- a. The three accused senior woman residents in the case of death-by-suicide of Dr Payal Tadvī had filed an application at the Bombay High Court (BHC) seeking to resume their post-graduation studies at the BYLNH. The BHC heard the case in **January** 2020. Their request was declined. The lawyer representing Dr Payal's family argued that the return of the three residents to the same institute runs the risk of tampering with the evidence to be gathered from the witnesses as the trial was still on. It was noted that all the witnesses to the tune of 50 doctors have been at the said institute and subordinate to the three accused residents and were liable to be threatened by them thereby jeopardising the case. The public prosecutor Raja Thakare argued that the three residents could be shifted to other institutes so that they can complete their post-graduation. However, the rules of the Medical Council of India (MCI), it was noted, would not permit it. Justice Sadhana Jadhav directed the Maharashtra Medical Council (MMC) to complete its inquiry into this case and take action as per the law if the three residents are found guilty. ([Modak, 2020](#)) On 8th August 2019 itself, Dr. Payal Tadvī's mother, Ms. Abeda Tadvī gave a complaint to the Maharashtra Medical Council (MMC) against the bail order, but this was acted upon only a year later on 4th December 2020 and it was only on 5th February 2021 that the MMC has issued a notice of charges and called upon the accused doctors to respond to the complaint. No further action taken by the MMC has been conveyed to the complainant or to the public at large. This gross inordinate delay in taking action against the complaint indicates complete lack of seriousness on behalf of MMC in performing their legal responsibilities and duties.
- b. In the subsequent hearing at the BHC on 21 **February**, 2020, the justice noted that the three

residents will be able to pursue their post-graduation only after completion of the trial in this case and mentioned that the special SC/ST court should complete the trial in ten months. The court also **recalled their bail condition** of revoking their licenses to practice and directed the Maharashtra Medical Council to conduct their enquiry and take action as per law. The MMC took back their suspension put into effect on 10th January 2020, on the 16th March 2020 without informing Ms. Abeda Tadvi, the complainant. She says because of this they managed to get the SC order. She claims that if MMC meets once a month, how could they revoke the suspension in just 23 days? The court also **relaxed the other conditions** that allowed them to start practicing medicine or get a job based on their graduation degree, as well as report at the Crime Branch office every alternate day ([Deshpande S, 2020](#); [Mumbai Mirror 2020a](#); [Mumbai Mirror 2020b](#)). The public prosecutor however argued that the staff and the other doctors in the institute who were witnesses in the case were not comfortable with this idea and had expressed skepticism with returning of the three residents to the same institute before completion of the trial ([Newsonair.com, 2020](#)). Dr Ganesh Shinde, Head, Department of Gynaecology, BYLNH said during the hearing that he had called for a meeting with the students to discuss this possibility but noted apprehensions amongst them upon hearing of the return of the accused residents and therefore argued that if they returned to the institute it would ultimately affect the working of the health services. The public prosecutor also argued that at least six colleagues of Dr Payal informed him that they will simply not be able to concentrate on their studies when they were left with just one year to complete their post-graduation if the three residents returned to the institute.

It is to be noted that lapses on part of the BYL Nair Hospital led to the Bombay High Court granting bail to the accused doctors but with conditions, and subsequent developments in the Supreme Court. Despite report of the Ragging Prevention Committee recommending the suspension on 27th May 2019, including action against the Unit Head and Head of Gynaecology, corroborated by the signature of the Dean, there was no action taken. Suspension of their licenses was done only on cognizance of the FIR registered by the police on 29th May 2019.

The sequence of events point to the extreme neglect and lapse on part of the BYL Nair hospital authorities: (a) the outward number for the Order of Suspension is NDN/172 while that of the report of Anti-Ragging Committee is NDN/183, which means the Order of Suspension was issued earlier to the report of the Anti-Ragging Committee; (b) both the communications are under the signature of the Dean of the College and the Hospital and yet, the Order of Suspension does not make any

reference to the report of the Anti-Ragging Committee; (c) the Order of Suspension is based purely on the registration of FIR registered against the Appellants which is why “taking cognizance of this” the Order of Suspension was passed; and (d) when a request for revocation of suspension was made, it was rejected on 25.10.2019 because of order dated 09.08.2019 of the High court and not because of the report of the Anti-Ragging Committee.

To take appropriate action under Section 6(1) of Maharashtra Prohibition of Ragging Act 1999, the concerned head of the educational institution must prima facie be satisfied that the allegations against the student have been found to be true, whereafter, an order of suspension can be passed. As stated hereinabove, the Order of Suspension does not even record any such finding or prima facie view. As a matter of fact, the order of suspension was not passed by virtue of the power entrusted under section 6(1) of the Maharashtra Prohibition of Ragging Act 1999 but was based on the grounds that the Appellants were creating hurdles in the enquiry by the police and that there was an FIR against them. It can thus be concluded that the Order of Suspension is not referable to Section 6(1) of the Act ([Govt. of Maharashtra, 1999](#)).

- c. In **March** 2020, the special SC/ST court in its hearing **permitted** the accused doctors **to travel outside the city**, a condition imposed on them during the grant of bail, to their home town for one week. Prior to this the court also allowed Dr. Payal Tadv's mother to assist the prosecution during the trial. The Bombay High Court had earlier directed the special court to complete the trial within 10 months ([Delima, 2020a](#)).
- d. In August 2020, the *Jati Anta Sangharsh Samiti*, a collective of organisations in Maharashtra focused on anti-caste/tribe discrimination had appealed to the state government to seek a directive from the Supreme Court to prevent the three accused residents from resuming their studies until the trial was completed. The Bombay High Court had also requested the MCI to complete its enquiry in this matter. The accused had filed a special leave petition in the Supreme Court challenging the decision of the Bombay High Court and the conditionalities imposed on them, including their entering the jurisdiction of the hospital. ([Deshpande A, 2020](#)).
- e. However, on **8 October** 2020, a three judge bench of the Supreme Court, comprising Justices U U Lalit, Vineet Saran and Ajay Rastogi, permitted the three accused residents in the Dr. Payal Tadv

death-by-suicide case to complete their post-graduation studies from the same college, stating that the law presumed that they were innocent until proven guilty ([Bharadwaj, 2020](#); [Samervel 2020](#)) The court permitted the accused to resume their studies from 12 October 2020 which was the next working day after the verdict. This led to several rights-based organizations (*Adivasi Adhikar Rashtriya Manch*, *Jati Anta Sangharsh Samiti*, Tribal Doctors' Forum among others), making representations to the government to file a review petition in the Supreme Court. Further they asked why the Anti-Ragging Committee's report was not made actionable, as it was only made available after the case went to the Supreme Court. Just after the Supreme Court verdict, there was a social media campaign as well seeking justice for Dr. Payal Tadvi ([Gaikwad, 2020](#)). On **27 October 2020**, as the trial picked up in the special SC/ST court, one of the accused residents sought exemption from the court to appear for hearing citing that after COVID duties at the hospital and subsequent quarantine, she was not able to appear in court ([Delima, 2020b](#)) Additionally at the hearing on **6 November 2020**, one of the accused doctors sought to restrain the role of the complainant, the mother of Dr. Payal Tadvi, as intervener in the case, even as she was assisting the prosecution as permitted by the special SC/ST court ([Delima, 2020c](#))

In summary, from May, 2019 following the death-by-suicide of Dr. Payal Tadvi, the hospital and college authorities were negligent and ineffective in taking action against the accused doctors. There was delay and indecisiveness in putting into effect the report of the Anti-Ragging Committee, indicating severe lapses on part of the authorities.

The accused doctors on the other hand had been able to delay their arrest and were able to approach the courts with ease, seeking the help of lawyers with the systems responding to their efforts both at the High Court and Supreme Court level. The case at the trial court/special SC/ST court meanwhile proceeded slowly.

The Maharashtra state government, the Medical Council as well as other authorities were lax in taking ahead the court hearings, that the accused could approach the High Court and subsequently the Supreme Court to seek relief from the conditions of bail by presenting themselves as being denied their fundamental right to pursue education, even as they were under the scanner for a grave crime: abetment to institutional murder having been charged also under the Prevention of Atrocities Act!

The only bail condition that was retained by the High Court was entry to the medical college and hospital following the Head of the Department of Gynaecology noting the apprehensions of the witnesses who were students and employees there, liable to jeopardise the case. However, this was also bypassed by the Supreme Court order.

Meanwhile the speed at which the trial was proceeding did not augur hope for justice for Dr. Payal Tadvi's family and all those who had approached the courts for relief in this case of caste based discrimination. It was the consistent efforts of the family and civil society organizations supporting marginalised groups that had kept up the efforts to sustain the case by consistently approaching the authorities, with the recent being the MMC which had begun to intervene.

What emerges significant is the constant pressure by family and civil society groups exerted on the authorities and the justice system to respond, and its continuance.

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Chapter III

Structural casteism and beyond: Historical and contemporary contexts

So far, we have briefly presented the background of Dr Payal Tadvi, the incident of her death by suicide and preliminary outcomes of committees constituted by various professional associations and the government bodies to look into the incident. In this chapter, we attempt to look at three broad frames within which we would like to locate this enquiry. The first is the existing systemic casteism in society, second is the impact of affirmative action like reservation of seats in educational institutions and workspaces, and finally the changing nature of medical education with growing privatisation to see how this intermeshes with the socially conscious values of inclusion and righting of older wrongs.

We feel that the experience of Dr Payal Tadvi who belonged to the De-Notified Tribes (DNT) community and was eligible for accessing the 'reserved category' seats as a matter of her right has to be seen against this backdrop. The Constitution of India acknowledged the casteist structure of society and the resultant exclusions of various marginalised castes and tribes from the 'mainstream' of society. To rectify these historical wrongs, affirmative action in terms of reservation of seats has been proposed and upheld. Over the years, however, this has become a point of huge contention which has given rise to a different vocabulary and experience of the daily practice of caste. The horrific practice of untouchability has been criminalised by law but the indignity and humiliation of the caste system is experienced by all those who avail of 'reservation'. So even if Dr Payal Tadvi was not herself from a marginalised caste, to understand her situation as someone who came from a similarly excluded tribal community, we have to unravel the existing daily reality and practice of caste in Indian society today.

We put this understanding out here upfront because the enquiry on institutional causes which allowed such an incident to take place, which we conducted, was not for corroborating this which has been extensively written about and does not need to be enquired into. All our conversations with the people that we spoke to as part of this enquiry were with this understanding. This chapter lays out this understanding in reasonable detail and also with as much evidentiary support as is possible.

III.1 The all-pervasive nature of caste based social structure and socio-cultural practices

Hierarchical caste system continues to be a key characteristic of the Indian society. There is a great deal of literature available which describes the lived realities of the caste system, through ethnographies, short stories, autobiographies, songs, essays and performances. ([Ghadyalpatil, 2018](#)) Although it is not unique to India, (American anthropologist Gerald Berreman in his 1960 essay *Caste in India and the United States*, concluded that towns in the Jim Crow South bore enough similarity to the North Indian villages he had studied to consider that they had a caste society) ([Subramanian, 2020](#)), its persistence and stronghold on all spheres of our lives in India is rather inimitable. It reflects in its polity, socio-cultural fabric and overall social structure and social organisation. This dominance of the caste system at times is subtle and yet lethal, and at other times it may be overt and explicit.

The caste system is deeply entrenched to the extent that it withstood introduction of other religions, such as, Buddhism which critiqued the caste system. However, in practice, caste system also infiltrated Buddhism. ([Krishnan, 2010](#)). It also influenced other religions like Christianity and Islam. A Status Report on *Current Social Scientific Knowledge on Dalits in Muslim And Christian Communities*, by Satish Deshpande and Geetika Bapna prepared for the Minority Commission of India, bears witness to this. One of the conclusions reached in that report states,

There can be no doubt whatsoever that DMs (Dalit Muslims) and DCs (Dalit Christians) are socially known and treated as distinct groups within their own religious communities. Nor is there any room for disputing the fact that they are invariably regarded as 'socially inferior' communities by their co-

religionists. In short, in most social contexts, DMs and DCs are Dalits first and Muslims and Christians only second. ([Deshpande, & Bapna, 2008](#))

Caste identities continue to be a principle for spatial organisation of residential neighbourhoods and communities. For example, rural communities have long been organised on the basis of caste identities of persons and families. The dominant and oppressed castes almost always lived in segregated neighbourhoods. *Maharwad*as, the neighbourhoods where members belonging to *Mahar* and other dalit communities reside, situated far away from the 'main' village still exist in many of the villages. Many of us who either come from smaller towns or belong to rural India or have worked in rural India have witnessed intrepid segregation of oppressed castes.

In urban India, caste-based neighbourhoods and segregations might not be as visible and stark as in rural India but they do exist. Often the names of settlements indicate which communities live there. Instances where persons belonging to oppressed castes are denied apartments for rental purposes in urban India are not rare. The census 2011 ward level data exposes the extreme segregation existing even in so-called cosmopolitan cities and towns. The data indicates that even in big cities, a large number of marginalised castes and tribes live in clusters in few concentrated wards, near railway lines, in slum areas lacking in sanitation, water and other civic amenities. ([Devulapalli, 2019](#))

A study *Isolated by Caste*, published from IIM Bangalore in 2018, which uses 2011 enumeration block (EB) level census data for five major cities in India, offers an important window to understanding the robust perseverance of caste structures in contemporary urban India. ([Bharathi, Malghan, & Rahman, 2018](#)) Based on the census data many major cities stand exposed to the kind of caste segregation that is practiced routinely. ([Mandal, 2020](#)) Furthermore, spaces for socio-cultural engagement for oppressed castes remain separate. For example, *samajmandirs* – the community halls constructed by the government for social and cultural activities in rural India and in pockets of urban India such as slum areas – are different for oppressed castes and dominant castes.

Access to common resources in a neighbourhood is also denied to members of oppressed caste communities. For example, in many parts of rural India, members of the oppressed caste still cannot

access temples in their own villages, or are denied the right to build their own community hall. (Thirumurthy, 2017a) Similar exclusion continues in rural India regarding access to common water bodies, such as, wells. Traditionally speaking, water wells were not shared with oppressed caste communities. They were not allowed to access water from these water bodies located in the heart of the villages. The article from Journal of Social Exclusion Studies by Swarup Datta and others concludes: "Far from being a sore remnant of the past, caste discrimination still thrives in its traditional forms: physical and occupational segregation, as well as discrimination and privation in terms of access to natural resources like water". (Thirumurthy, 2017b)

Brahmins, the dominant caste and many other caste groups do not usually accept food from the oppressed caste communities and largely do not dine and drink together, especially in rural India and even in traditional families in urban India. Stringent endogamy restricting marriages to one's caste – marked Indian society all along. Analysis from Indian Statistical Institute, based on IHDS-II (India Human Development Survey) data, conducted in 2010-11 states that," The rate of inter-caste marriages, even as recently as 2011, was merely 5.82% and there has been no upward trend over the past four decades". (Roy Chaudhuri, Ray, & Sahai, 2017)

Of late we have seen many instances where persons from the marginalised communities are humiliated if they are seen as transgressing the norms of the caste hierarchy. This could be just the fact that a groom from the marginalised caste chose to ride a horse, or that they got educated and asserted their rights in the community. (Kissu, 2020; The Wire, 2019)

In terms of social practices and relationships with oppressed castes, it is not rare to come across practices which are shaped by the prejudices against the oppressed castes in general. For example, we do observe even today that dominant caste families continue to use services offered by members of the oppressed castes. Certain shifts have occurred over time and some we have witnessed while growing up. For example, stringent norms were followed in the past regarding caste identities of domestic helpers and cooks in many dominant caste families. Earlier cooks had to belong to the Brahmin caste but these days it is not so strict. Now, dominant caste families do hire cooks who are from other castes and sometimes even from the more marginalised castes.

Two observations are very commonplace: one, dalits are still not considered for cooking help in many well-off families; two, in many households the house help which is usually from oppressed castes are given separate utensils such as cups and plates for their personal daily use while at work, which are also kept separate. These utensils are never used by the family members of the employer. In certain families, the utensils washed by their house maids/domestic help are sprinkled with water before they are back in the kitchen for use. These practices which prevail even today in modern India are indications that caste-based identities and prejudices against the oppressed castes persist. It demonstrates that the prejudices against oppressed castes in terms of their being lesser human beings, remaining entrenched.

Caste and 'caste consciousness' is deeply embedded in our psyche and our way of thinking. Often, we are not conscious of the way our thinking manifests in our behaviour. At times, even those viewed as liberal and progressive fail to look at the experience of dalits or adivasis in the framework of structures or systems. They look at it as individual experience. As a result, when a dalit or adivasi person points out the subtle discrimination they are subjected to, the response may also be of disbelief. At times, persons who are sharing experiences of caste-based discriminations, get accused of being obsessed with caste identities or being 'over-sensitive' about caste identities, or of being paranoid about it, or of seeing caste issues where none exist. Such dismissals without adequate deliberations or scrutiny or willingness to appreciate the experiences of persons from their own 'locations' contribute to further marginalisations of such persons and their experiences.

Growing up in such a context, shapes our worldviews and relationships including- who we are friends with, who we eat with, who we hang out with or build intimacies with. We may or may not be totally conscious of it. Our living arrangements in the cities or villages we live in contribute to this. Hence, when a person faces casteism in their workplace, they cannot see it in isolation from their other experiences in the rest of their life outside of the workplace. Similarly, those that come from the dominant castes carry with them unrecognised biases they have been encultured in, as part of the larger society. Hence workplace interactions and experiences can never be seen dissociated from the larger social milieu and there is an enmeshing of the structural casteism of different institutions and society in general.

III.2 Casteism in higher education through opposition to reservation

Discrimination along caste lines and other axes of marginalisation is common in all domains of professional and public life. However, it is much more pronounced in higher education, probably because knowledge production and learning is supposedly seen as a fully savarna enterprise. Affirmative action through reservation in seats to Higher Education Institutions (HEIs) and for jobs in State funded HEI has been the only action that has been taken because it is mandated by the Constitution. No other proactive steps towards creating a conducive environment for greater diversity and reducing caste inequality in access have been made in most HEIs.

As far as reservation of seats goes, a peculiar narrative has been generated of this affirmative action being seen as anti-merit, completely bypassing the fact that far from it, affirmative action is actually a way to compensate for centuries of lack of social capital. Such discussion is seen the most in the case of professional courses like engineering and medicine. These have been for a long time professions and careers that are competitively sought by most urban, *savarna*, middle and upper class people.

During our conversations with representatives of various stakeholders, we heard voices and arguments against the reservation policy. The grounds for their argument are that the candidates who get admissions through accessing reservation, do not have required merits and capabilities to complete these professional courses and be equipped professionals or practitioners in medicine or engineering. We attempt to revisit this debate and the central question to this debate, whether the reservation policy is justified and whether the merit related argument is well founded in ground realities. To do this we look at some of the judgements on this aspect and writings that got published after the news of Dr Payal Tadvī's institutional murder to refer to understand the particular situation of medical colleges.

A landmark judgement of the Supreme Court in 2019 *B. K. Pavitra and Ors v The Union of India and Ors*, while dealing with validity of the Karnataka Extension of Consequential Seniority to Government Servants Promoted on the Basis of Reservation (to the Posts in the Civil Services of the State) Act 2018 stated ([Bhaskar, 2019](#)):

For equality to be truly effective or substantive, the principle must recognise existing inequalities in society to overcome them. **Reservations are thus not an exception to the rule of equality of opportunity. They are rather the true fulfilment of effective and substantive equality by accounting for the structural conditions into which people are born.** (Pg 106)

Further, the judges responded to the argument opposing reservations and in favour of efficiency in the system:

The benchmark for the efficiency of administration is not some disembodied, abstract ideal measured by the performance of a qualified open category candidate. Efficiency of administration in the affairs of the Union or of a State must be defined in an inclusive sense, where diverse segments of society find representation as a true aspiration of governance by and for the people. (Pg 116)

This judgement offers a substantive constitutional interpretation of the concept of merit for society in the context of adopting 'reservation' policy to correct long standing inequities. The judgement falsifies the perception that reservations imply lack of merit.

Once we understand -- merit as instrumental in achieving goods that we as a society value, we see that the equation of -- merit with performance at a few narrowly defined criteria is incomplete. **A meritocratic system is one that rewards actions that result in the outcomes that we as a society value.** (Pg. 120)

This substantive interpretation of equitable opportunities to all, on which the reservation policy is founded, is being questioned over a couple of decades by those from non-reserved communities. Since the 90s a section of the society has been opposing affirmative actions, such as the reservation policy for those from the marginalised sections. Some of these are students and are organised as 'Students for equality'. This and other similar organisations argue and support the viewpoint that NEET ranking is the indicator of merit of students aspiring to be doctors and engineers. These organisations run hashtags, such as, #TheDoctorYouDeserve and #MurderofMerit to imply that those getting admitted from the reservation quota are not up to the mark and therefore cannot be deserving doctors.

We wish to reiterate that the reservation policy in India is a system of compensatory and positive

discrimination towards castes and communities that have been stigmatised and oppressed for centuries. It has to be adopted as a constitutional obligation by workplaces and institutions to integrate students coming from various marginalised sections. And the institutions' responsibility does not end with providing access and admission. They also have to ensure that people from marginalised communities are able to thrive in these spaces without experiencing exclusion or stigma. Yet, this is an obligation that is rarely met, indicating the persistence of casteism in these spaces as well.

A highly competitive system layered with inherent casteism has led to a peculiar situation in medical colleges where we see particularly rampant discrimination, alienation, and even incidents of self-harm by students from marginalised communities pushed to the corner. The two committees that have investigated caste in HEIs, Thorat Committee and Mungekar Committee, both were set up in response to complaints of discrimination in medical colleges. (Ali, 2012)

A number of students have repeatedly voiced the exclusion, discrimination, hateful treatment they have got in medical institutions. A medical student writes in an article in *The Wire*:

Banal hash-tags such as #TheDoctorYouDeserve and #MurderOfMerit have been trending on Twitter and Instagram for more than a month. Just today, I came across a Facebook post by an Internal Medicine resident from Mumbai. The person had updated their name on Facebook to include the phrase “Open Category”, while urging the general public to inquire about their doctors' caste. Not only does this person have the audacity to display their casteist prejudice – by labelling themselves “Open Category” – but also to express that doctors from reserved categories are not competent to practice medicine. (The Wire, 2019)

In a blog post dated June 5, 2019, the site *Health Executive* put together the responses they got from various people on the “pros and cons of caste-based reservation in medical colleges”. We give below three narratives from this blog post. (Desai, 2019)

A medical officer at the Antiretroviral Therapy Centre of the National Institute of Tuberculosis and Respiratory Diseases, Delhi, says, “When I joined AIIMS Jodhpur in the Masters in Public Health course, I faced a lot of discrimination and bullying. Some of my seniors used to utter words 'neech to

neech hi hote hain' behind my back. The college disposed of the matter, saying that it was just a fight among students. I was harassed indirectly many times in my class, which compromised my mental peace. I finally resigned from the program after 11 months of joining. Many counter allegations were put against me to cover the matter."

A graduate from Jawaharlal Medical College and Hospital AMU, Royal says that during his field visits, patients at times ask his caste before letting him examine them. "Recently, when I raised my voice on these caste issues in medical education and posted this on FB page comprising of 1.25 lac Indian doctors as its members, I got trolled whether I sweep roads. I was tagged in many hate comments," he says.

Even institutes like Indian Medical Association (IMA) take no steps to counter this situation. Dr Roshan Radhakrishnan, consultant anaesthesiologist in Kochi, Kerala had to say this about IMA in the context of Dr Payal Tadvi's case: "For me, that seemed to be a very 'ostrich burying its head in the sand' approach. You could have set up an enquiry or sent the members of the association a questionnaire, at the very least, instead of laughing it away. Casteism is not something that is actively planned and practised in hospitals and departments. It just needs one senior doctor with a narrow mind-set to throw caste based comments on his or her juniors consistently and get away with it because others laugh it off or refuse to stand up to the bigotry. I am sure doctors across India have seen this in their workplace, both as students and as staff,"

This narrative of merit is invoked for all those coming from socially deprived communities who access reservation as a step towards affirmative action against their historical marginalisation. An equation of 'non-merit' with those accessing reservation is in itself a discrimination which is brought more to the foreground when we see the same discourse not being used when one speaks of those accessing admissions through 'paid' seats. It is strikingly intriguing that these organisations are silent on the system of allocation of 'paid' seats in these professional courses for those who stand lower in NEET rankings and secure admissions on the basis of their capacity to pay fees of the order of INR 10 to 12 lakhs a year.

In fact, Times of India in 2018 analysed details of 57,000 students admitted to 409 colleges in the

previous year. The average NEET score of students admitted under SC quota was much higher than the average of privately controlled seats. (Nagarajan, 2018) The NRI quota in fact has the lowest NEET score, but there are no protests or talk of discrimination raised in such cases. (The Wire, 2018) This reflects the double standards being applied by these students' groups for two different constituencies of students – those from marginalised communities and those from richer classes. It is fairly well established that in the Indian context caste and class align quite closely. The National Family Health Survey 2015-16 (NFHS-4) shows the following: 45.9 percent of scheduled tribe members were in the lowest wealth bracket compared to 26.6 percent of scheduled castes, 18.3 percent of other backward caste, 9.7 percent of other castes and 25.3 percent made up of those whose caste is unknown. (Yadavar, 2018a) If so, shouldn't one be concerned about the underlying caste-based biases amongst the sections of students belonging to dominant castes ?

III. 3 Privatisation of Medical Education

Growth of private medical colleges has changed the nature of medical education from the decade of the 1980s. Maharashtra is one of the states to have a large number of private medical colleges. As a result of this there are a larger number of medical graduates from the state but it has also meant a change in the nature of education itself. A study of medical colleges conducted in 2006 states that Maharashtra had the highest number of medical colleges (39) in the country. Of these 19 were private medical colleges. (Supe, & Burdick, 2006) The private medical colleges have been critiqued by the authors of the study as inadequate in infrastructure and also leading to high fees for those getting admissions here. Privatization of medical education is impacting adversely the quality of education, and more importantly the opportunities for deserving students from the underprivileged and the marginalised communities to be in the medical stream.

The two categories of seats in medical colleges via which the students could be admitted are: one, the ones called 'merit' seats which have subsidised fees and two, the 'paid' seats which have full pre-stated tuition and other fees. The usual fee structure is around Rs 1 lakh per annum for the 'merit' seats.

However, the 'paid' seats require to pay about four to six times higher fees compared to the fees paid by those who get admitted on basis of merit. The ratio of 'merit based' and 'paid' seats is announced for each medical college and is usually 50:50.

There are many kinds of categorisation of seats and seats are 'reserved' for each of these. The statutory reservation for SC/ST/NT/DNT and people with disability applies to the 'merit' seats. States determine a number of seats for in-state students, and for the rest of the country. Till 2019 the state was divided into three regions – Konkan, Vidarbha, and Marathwada and the state quota was further divided – 70 % for the region in which the college is located and 30% for the rest of the state. In the admissions for 2020 this division has been discarded. (Tandon, 2020) Thirty percent of all seats are reserved for women.

All seats from every category are ultimately allotted based on the NEET score and as per preferences mentioned by students in their applications. The 'merit' seats are so called because they are entitled for subsidised tuition fees whichever college they may be in. The 'paid' seats too are filled as per NEET ranking except the ones which are allocated to be filled via management quota. The latter are filled at the discretion of the members of the management board and seems to be offered to those students who agree to pay the largest amounts amongst all those who aspire to secure a seat from the management quota.

The fee structure of the paid seats is different across medical colleges and is often linked to the scope and quality of infrastructure and other facilities made available to students. These college specific fee structures are approved by the Fee Regulating Authority to ensure it remains within the fee norms by the Regulatory Authority. As a consequence, students who secure a spot through the 'paid' seats options either via NEET or management quota tend to belong to economically better off families or indeed rich families. **Essentially these seats are reserved for the rich but are never referred to as such.**

In spite of these high fees, medicine has remained a coveted profession over the years. New medical colleges have opened and most of these are private medical colleges. In 2017, the Vedanta Institute of Medical Sciences in Palghar became the first 'for profit' medical institution in Maharashtra registered under the Companies Act. This has changed the meaning of a private medical institution. In September

2019, about 400 seats in private medical colleges remained vacant after three rounds of admissions. Of these 117 seats belonged to this college and 95 of these were reserved for students from SC/ST/NT/DNT communities.

There are many reasons why students are not taking admission in this particular college. Firstly, the institute does not have its own necessary infrastructure to run a course in medicine as yet. Secondly, the fees at this institute are currently capped at Rs 14.5 lakh per annum set up by the fee regulatory authority although the college wanted to charge Rs 32 lakhs per annum. The institution plans to challenge this in court and get rid of the cap. This dissuades students from joining this course. (Yadavar, 2018b) It is noteworthy that Rs 14.5 lakhs per annum is a much higher amount compared to other colleges. For the 2020 admissions, the government college fees (for the “merit” seats) is about Rs 95,000 per annum. The private colleges, however, vary from Rs 5,50,000 to Rs 16,60,000! (Khan, 2020)

The situation of students entitled to the seats reserved for SC/ST/NT/DNT communities was worse. Not only did students from the marginalised castes and tribes not take admission but they cancelled their admission after realising that their fees will not be reimbursed by the State in this college unlike what happens in other colleges under the free-ship scheme. (Bhandary, 2019) This is because this college is a ‘for-profit’ company and hence the State cannot reimburse the fees for the students under its fellowship scheme if they studied in this institution. As result these 95 seats meant for marginalised castes and tribes would be available as paid seats for those who can afford to pay these fees.

By allowing a ‘for-profit’ institution such as Vedanta which attempts to avoid even the basic fee regulation, the State itself is violating its own commitment to affordable education. Further it is withdrawing free-ship for the students from SC and ST communities who have got rightful admission in the ‘merit’ seats, thus going back on its own assurance for students from marginalised backgrounds. This indicates that the State is taking a step towards denying access to education to the marginalised and thus turning away from the constitutional promise of affirmative action.

This enquiry into Dr Payal Tadvi’s institutional murder begins with locating it in the larger context of caste-based prejudices and exclusionary practices existing in higher education institutions, particularly

medical colleges and hospitals. We explored the ways in which these aspects coupled with increasing privatisation of medical education and health care impacted the lives of those from marginalised sections of society who accessed admissions via reservations. While one aspect of the enquiry sought to understand the exact ways in which such discriminations were experienced, we went beyond to ask other questions as well.

How are these practices institutionalised through the ways in which the institutions function and are structured? How do these work in conjunction with already held societal beliefs that emanate from an unequally structured society? Can there be practices that mitigate the possibility of existing individual societal bias? What systemic mechanisms exist to redress such prejudiced treatments meted out to some by other groups? Are they optimally functional and help the ones who are at the receiving end of such differential treatment? What is the meaning of 'merit' that is always juxtaposed with the question of reservation as affirmative action? Should medical education itself be thought of differently to become more representative of the needs of a just and empathetic health care system?

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Chapter IV

Discrimination against students in medical institutions

As we discussed in an earlier section, the experience of discrimination begins the moment a student from a marginalised caste or community aspires to enter a medical institution, whether it is for a nursing course or a medical college. It may be the last name of the person, or language or accent spoken, the attire or persona of the person, or marks secured by the person, the caste identity of the person features in as an explanatory parameter. In this chapter, we approach the data from a 'life-cycle' perspective of a student, starting from students' 'admission processes' to 'evaluation', through 'examination'. We also present insights into the experiences of social life of the students from marginalised backgrounds on the campus and hostel of a medical college.

IV.1 Admission process: Beginning of a long-drawn journey of institutional discrimination

A number of respondents shared with us discriminatory practices they experienced during their own admissions to medical or nursing colleges.

Two senior Ayurvedic doctors (AM1 and AM2) from marginalised castes/tribes we spoke to, who were working in a medical Institution said that there have been several old and new strategies employed to filter out students from marginalised castes and communities who want to enter into professional degree programs such as medicine and engineering. They made reference to NEET through which admissions to

these professional training institutes are centralised. All students from across the country regardless of their place of origin, such as rural or urban, are required to get through NEET in addition to clearing their 12th standard state level board examination. Both AM1 and AM2 opined that introduction of NEET turns out to be a hurdle for students from marginalised communities because they don't have resources required to prepare for NEET. This newer strategy, therefore, prevents this section of students from accessing the course in medicine and from progressing in their careers. They said:

“NEET is a strategy planned to demoralise SC/ST students. That is the first door that shuts the students out. Students get good marks in 12th standard but now there is one more hurdle created that is NEET. Open category students study only for NEET. They are able to go to various private tuitions outside the routine school. But students from marginalised backgrounds cannot study for both 12th as well as (take coaching for) NEET. Besides, there is always a delay in admissions for Government colleges. Private colleges have admissions before Government colleges. Poor SC/ST students cannot wait and they are forced to take admission in other fields, else they will be left out and lose the year.”

A senior tutor from a marginalised community working in a nursing college (EM2), narrated details of the ground reality for nursing school students from marginalised communities when they reach nursing schools to get admissions. Nursing students from remote areas are often accompanied by their parents or guardians. They are completely new to the city, as well as to the admission processes. In such a context, it is reasonable to expect that these students and their family members get appropriately guided to make the admission process time and resource efficient; and also, respectful. It was reported that such guidance is rarely available. There is no system in place to enable guidance for the new students to nursing schools. Neither the administration nor teachers come forward to provide such guidance. The students are required to undergo medical fitness tests as part of the admission process. We were told that if these tests were appropriately arranged and facilitated, these could be completed in 2-3 days. However, in absence of any systemic arrangement, family members accompanying nursing students hailing from remote places are forced to languish in the corridors of hospitals for about two weeks or even longer. There are no facilities for them to board and lodge and therefore are forced to

sleep in the veranda. It is against all these odds and distressful situations that these students must obtain admissions. This complete lack of facilities amounts to creating hurdles and adverse conditions that discourage the students from marginalised communities from taking admissions. There is no place where complaints can be lodged and where issues can be resolved.

IV.2 Internal, oral and written examinations: A fertile ground for discrimination

Based on our conversation with respondents, it appears that students from marginalised communities are subjected to unfair assessment practices. Such practices seemed more prevalent than one would have expected in the present times. Internal, oral examinations are an integral part of assessment of both nursing and medical training and a fertile ground for discrimination. The reason being lack of a robust and transparent system of oversight and accountability that would enable higher authorities to question examiners upon observing untowardly trends in marking. Lack of such oversight leaves potential for discriminatory practices adversely impacting students, especially from marginalised backgrounds. There have been examples of a supervisor repeatedly failing students, who passed when another supervisor, who did not know the caste of the students, was in charge of the examination.

A technician from a marginalised caste we spoke to, who is working in a medical institution (EM1), knew of students who had been deliberately given less marks in internal examinations. A case of such malpractices in marking and internal assessment of a graduate student from a college in Mumbai was reported. He was extensively harassed; his thesis was not signed until he lost six months. As a result, he had to reappear for the examination in the subsequent term.

An Assistant Professor from a marginalised community (RDM3), stressed that during oral examinations some examiners dare to heedlessly ask students about their caste and father's occupation. These are the avenues for faculty or examiners to allow their biases and resentment against students from marginalised castes and tribes to creep into the assessment system. Participants mentioned that in certain instances examiners/teachers repeatedly fail students from marginalised backgrounds. RDM4, a

resident doctor from a marginalised caste referred to a case of such discrimination in the district of Latur in Maharashtra in 2015/ 2016. In this incident, a post graduate resident, a young boy, was forced to kill himself as he could not withstand the harassment he was subjected to by the head of the department where he was pursuing his post-graduation residency. However, RDM4 mentioned, that the case did not get as much attention in the media or even otherwise. A resident doctor from a marginalised background (RDM2), who had been active in organisations like MARD and DAMA observed,

"Many a times both category students (open and reserved) are good in studies. You can make that out from comparable scores in theory. But in practical examinations, the reserved category student may score very less. That is entirely in the hands of the internal and external supervisor. Many a times, an external supervisor is not happy with both the students. He tells the internal examiner that your students are not worthy of passing. Then there is negotiation. The external examiner says: 'Ok I will pass one of them. You tell me which one.' Invariably the reserved category student is failed. Either both needed to fail (if they did not do well) or both should receive the benefit of doubt. But generally, it is the SC/ST people who are failed. This had happened in AIIMS and Safdarjung hospitals in Delhi. (There is an NDTV clip on this.) The students had passed in theory and repeatedly failed in practicals/ viva. They passed exams when taken to another institute with other examiners who didn't know them."

This was corroborated by the wide-ranging experiences of Dr. Bhalchandra Munekar, an economist, educationist and Rajya Sabha member, ex-vice Chancellor of the Bombay University, ex-member of the Planning Commission, apart from much else. Dr. Munekar was the single-member committee appointed by the National Scheduled Caste Commission to look into the allegations of caste discrimination faced by Scheduled Caste students at Vardhman Medical College, Delhi ([Gatade, 2012](#)). Dr. Munekar discovered that not only were the 25 scheduled caste students failed repeatedly in one particular subject – physiology – but the authorities had not even bothered to meet them to look into their complaints. He had to resort to an RTI application to seek information and approach the High Court to ensure their rights as equal students. As his report puts it, the faculty of the said department 'resorted to caste-based discrimination and neglected the duties assigned to them, not by omission but

by commission'. Even other staff in the administration, including the head of the institution, had not cared enough to intervene. Not only did the students lose years of education and practice because of this apathy, shockingly, the same authorities were guilty of showing leniency towards students from dominant castes. While they had no qualms about barring students from marginalised castes and communities from taking their examinations due to lack of attendance, four students from dominant castes, who were detained for inadequate attendance, were allowed to take the examination.

According to the article cited above, Dr. Mungekar had noted that the Delhi High Court had to intervene on a writ petition filed by aggrieved students of the college. Twenty-five Scheduled Caste students who had taken admission in 2004 and 2005 approached the court when it was discovered that they were deliberately being failed in physiology. Under instructions from the High Court the college was forced to conduct fresh examinations; 24 students out of the 25 passed. The system also resorted to other ways to allow biases against the students from the marginalised castes and communities to influence marking. Examiners tend to use the spaces of internal examinations of students in which laboratory journals carrying names are used to know caste identities of students. One of the respondents mentioned an instance when two students who, based on their surname, were given less marks by the examiner. These two students fought their case in court and the examiner lost his examinership; but at the same time the students too lost their semester of study.

We were also told that in certain situations, students could be asked about their scores earned in their entrance examinations. It is possible to identify students from marginalised castes and communities using different cut-offs of scores. For example, during the day of Common Entrance Test (CET), the ranking helped identify students who have taken admissions through reservations. Some respondents mentioned that even AIIMS is not free from such practices. In fact, the Sukhdeo Thorat Committee was appointed to investigate into these matters at AIIMS.

In most medical colleges, there are two groups of students: one comprising of students from the dominant castes and the other comprising of students from marginalised castes and tribes. It was reported that these are sort of hidden groups and not open ones. Some of the respondents raised a question during the conversation that why would students form organisations? They argued that if there

are students' organisations, it implies that there are problems.

This phenomenon of caste-based discriminatory practices is not confined only to medical and nursing school. Such practices are prevalent in other prestigious professional degree programs in higher education institutions of global repute as well.

IV.3 Experiences of abuse: Overt and covert humiliation

One of the dominant narratives presented to us was the means of harassment deployed by students or residents from dominant castes aimed at humiliating their peers from marginalised castes and tribes. This is largely drawn upon the latter's disadvantaged positions. More importantly, it is shaped by the prevalent perception that these are non-deserving entrants in medical and nursing colleges, and are able to secure admission only because of the reservation policy.

Some respondents described how it was fairly common for individuals from marginalised castes and tribes to be subjected to humiliation on account of their caste identities. Showing the students from marginalised castes and communities 'their place' in the social hierarchy and making them feel inadequate and lowly is a common practice. This tends to range from making them feel that they are undeserving of their place in the institution to openly saying that they should be grateful for the kind of food they could get in the institutional settings at the college canteen or mess. It was reported by the participants that it is a common practice of subjecting students from marginalised backgrounds to humiliating behaviour in canteens and college eateries and mess by passing comments such as: 'You must not be getting even such food back home.' Or 'Have you even seen this sort of food at your home?' "We will show them their place" seemed to be a shared sentiment amongst medical students and resident doctors from the dominant castes.

Some participants also noted that students from marginalised castes and communities get routinely abused in classes by the tutors too. The content of these abuses stem from the sentiment that these students do not deserve to be in these institutes. The tribal students are referred to as 'Dhule-wale',

'Nandurbar-wale'. This, according to some participants, contributes to spreading these adverse attitudes towards students from marginalised backgrounds amongst other students too.

One respondent, the senior tutor from a marginalised caste/tribe working in a nursing college (EM2) quoted earlier, noted an observation that there has been a gradual increase in the number of tribal students joining nursing schools. They come from remote areas and are not used to Mumbai and the ways of living here. It was emphasized that these students or residents have largely lived in neighbourhoods either in cities or their places of origins which are comprised of families and communities that are closer to their own. As a result, until they arrive at these higher education institutions, they have not experienced this sort of hatred and demeaning treatment.

RDM2, a young doctor from a marginalised caste/tribe, went into this aspect in greater detail.

Because of the fact that similar castes and communities live closer to each other, children may not face discrimination earlier in life. Up until school and even in junior colleges they do not face much discrimination or they have not really noticed it. But after that, when they join professional courses, they are pointed out as recipients of reservation. Not just now after NEET, but even earlier there used to be the MSCET (Maharashtra State Common Entrance Test) and the All India CET, the scores were known. Those who had fewer scores were marked out as '*quota se admission hai*'. *Maheshwar cha group ahe.*' ('They have got admissions through quotas' or 'This is the group from Maheshwar.') Also, there is an automatic enrolment of these students in DAMA which marks them out. Even then in the UG first few years there is hardly any difference; most don't experience any discrimination. But in internship we get to hear things like '*Arre he tar sarkar che jawai ahet.*' ('These are the sons-in-law of the Government.') Possibly because internship is the time most are thinking about PG and they think those who get admission from the reserved category will find it easier and are insecure that they themselves might lose in the process.

The tutor from the nursing college (EM2) reported that in the year 2017, three students spoke openly about the abuses hurled at them by the teaching staff in Mumbai due to the fact that they belong to ST community, which was carried in the press on 14th August 2017. These students were not given internal

assessment marks, even after their parents intervened. Finally, these three students lodged a complaint with Maharashtra Medical Council and the Medical Superintendent of the institute. ([Zee-24Taas News, 2017](#))

The harassment reported by the students included a wide range of abusive treatment. Allegations of theft, purposefully marking them absent in the class, attempts to interfere into their private life, taunting them about their being from a marginalised tribe, and therefore not equipped to be part of the medical profession, calling them 'neech', that is, a lesser human being, and throwing their files on the ground are some forms of harassment students shared with us. Furthermore, we were told that such sustained harassment by peers in medical and nursing schools drive the students from marginalised castes and communities to getting into self-harm to the point of taking their own lives. When such instances take place, peer students rush to declare them as mentally unfit. Participants reported that in such instances there have been attempts made to evaluate students from marginalised backgrounds, who attempted to harm themselves, for their psychological well-being.

Following this incident, a committee was instituted to enquire into the abuse and come up with a report within 15 days. However, no such report was brought to the attention of the media or the public. Finally, it was reported, that the Indian Nursing Council intervened, and these harassed and troubled students were allowed to take the examination.

EM2, the tutor, spoke about an incident involving a student from a marginalised community. This student had gone for her sister's wedding after securing necessary permission from her seniors. But on her return from the leave, the warden screamed at her. The parents of the girl came to meet the warden and tendered their apology. But the harassment of the girl continued which ultimately led to her attempting to hang herself. The institute suppressed this entire incident. This happened on 12th March 2019. (This reporting is based on the interview given to us.)

IV.4 Social life on campus and hostels: Manifestations of entrenched discriminatory practices

The insights from our conversations demonstrate that the discriminatory practices relating to caste identities of students in medical and nursing schools are not confined only to their admission processes and their assessments or examinations. It seems caste identities of students during their medical and nursing education also determine and influence their opportunities in the spaces of social and cultural life on medical and nursing college campuses and other necessary facilities such as their residences or allocation of facilities in the students' hostels. One of the respondents, an Assistant Professor from a marginalised caste (RDM3) reported that caste identities also determine whether a student would be privileged or disadvantaged regarding securing a good room in the hostel.

Another resident doctor from a marginalised caste/ tribe (RDM1) told us,

Even in the distribution of hostel rooms, the warden will give good rooms to the open category students and not to us, even when it is not their turn. When they have to ask to vacate the rooms, they will first make us vacate. They know we don't have any support. Unless your friend is in MARD, they don't look at your issues. They don't support. For us it is constantly a matter of survival – fighting for our rights. For them, this seems like a cosmetic thing- goes into the seventh priority (meaning distant priority),

Similarly, caste identities and class-based location of students serve either as facilitators for or barriers to participation in cultural events and academic conferences. It was reported that those from marginalised backgrounds experience subtle but immense pressure to prove themselves in cultural activities and students' annual festivals, the routine activities on college campuses in India and integral part of college lives. According to a resident doctor from a marginalised caste/tribe (RDM1),

There are other problems in the system. This system fosters (structural) violence. Scholarships never come on time and this adds to the stress. Sometimes scholarships come after three years. There is no accountability. Nowadays scholarships come into the accounts of the students. Some receive, others don't. Is it being done on purpose? We don't know. You draw your own conclusions. Earlier, either the order used to come for all students together or it would not. So, the solidarity among (SC/ ST) students is reduced.

It appears that as in several other institutions, in medical institutions too, caste is an ever-present reality that shapes the day-to-day experience of the people who inhabit those at whatever level, in whatever capacity. This also seems to be a reality that has lasted for a very long time, as 69-year-old Himmatrao Bawaskar, who has gained worldwide recognition for antidotes against certain scorpion and snake bites, writes in the *Indian Journal of Medical Ethics (IJME)*, an indexed medical journal, about his experience as a student in the reputed state-run Government Medical College in Nagpur, “I am still afraid to visit my so-called alma mater.”

His article talks of groups formed on the basis of caste, about being unfairly marked during exams and seeking treatment for depression that included a month-long stay with a faith healer as well as 10 sessions of electroconvulsive therapy (ECT).”

Experts say that 50 years on, caste is still an issue in Maharashtra's medical schools. Dr T P Lahane, who heads the Directorate of Medical Education and Research (DMER), Maharashtra, gets letters from students across the state complaining about ‘caste-based discrimination’. “It is certainly less than it was in the 1970s, but it hasn't disappeared,” said Dr Lahane. (Iyer, 2019)

However, the fact that this happens so extensively in medical institutions that so closely relate to our health and our life, institutions that presume empathetic and humane behaviour, is disturbing. We will now go in greater detail into the specificity of the pervasiveness and the workings of caste in medical institutions.

This chapter looked at caste discrimination against students in medical schools right from the process of taking admissions in medical colleges to giving examinations. While this is especially the case with internal and oral examinations, ways and means have been devised to perpetuate caste discrimination in written examinations as well. In fact, parts of non-academic life, like social life on the campus and in hostels are also marked by caste discrimination and its various manifestations. While caste discrimination is practiced at all levels of medical education, it seems to take even more serious hues when it comes to higher levels of education in medical schools as we will see in a later chapter.

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Specificity of discrimination in Post Graduate medical education

A lot of media reports suggested that one of the reasons for the drastic step taken by Dr Payal Tadvi was that the resident doctors are routinely very harried and over worked, and so maybe she could not cope with it. Others spoke of the discipline and hierarchy in the system itself. (Nagral, 2020). Most of the official statements and many of the mainstream reportage, however, interpreted these two conditions to imply that when resident doctors are forced to take extreme steps then they are not 'fit enough' or 'strong enough' to complete this gruelling course. In not questioning the system's role in maintaining these realities as part of medical education, they in fact project it as an individual's problem. Our conversations with the resident doctors made us look critically at this analysis.

Resident doctors' work conditions have been in the news from time to time because of the strikes and actions by the resident doctors' associations protesting against these aspects across the country. They have also been in the news because of several incidents of violence by patients against resident doctors that have been reported.

So we considered it relevant to delve deeper into the spaces of the overall structure of the current medical education system with a focus on the system of residency and post graduate (PG) studies. Dr. Payal Tadvi was a post-graduate resident doctor working in a public hospital in the department of Obstetrics and Gynaecology. The idea was to understand the underlying factors which better explain this particular space where discrimination around caste and other marginalisation are entrenched and possibly compounded. Our discussions helped us appreciate the overall eco-system in which post-

graduate medical students complete their residency.

We attempt to explore here in depth the system of medical education itself to appreciate the aspects of the system which help normalise the contemporary culture of harassment, bullying, and discrimination. These insights into the overall system of medical education explain the sustained pattern of non-implementation of various mechanisms to address targeted harassment of marginalised individuals – the faculty, the students, and the nursing, laboratory, technical, or administrative staff, or patients and their relatives – in the medical teaching hospitals.

V.1 Government medical teaching hospitals as sites of PG studies

In the recent past the resident doctors have come into the limelight because of the multiple incidents of attacks that they have been subjected to by the patients' families when the outcome of the treatment did not align with the expectations of families of patients. Over the past two years, 53 doctors have been assaulted and manhandled by the relatives of patients in Maharashtra, says a report that appeared in March 2017. ([Mishra et al., 2017](#)). Often these attacks are on the junior most doctors in the system, the residents.

After Dr Payal's institutional murder, one such incident which came to prominence was the assault on two junior doctors at a state-run hospital in Kolkata by a mob on June 10, 2019 after the death of a patient at the facility. ([Kumari, 2019](#)). This led to a strike by doctors from the hospital, followed by strike by doctors across the state of West Bengal on June 11, 2019, and an 'All India Protest Day' call given by the Indian Medical Association (IMA) on Friday, June 14, 2019. ([TNN, 2019](#)) On the said day protests were reported from various medical institutions in Delhi, Maharashtra, Bengaluru and Hyderabad. A demand for a stringent law to address violence against doctors in public hospitals was again put forth.

The patients' relatives almost always react with charges of delay, neglect, and lack of empathy. But the doctors have a very different point of view. Often times, doctors underscore the critical condition of patients when they reach public hospitals and it is the delay in bringing patients to public hospitals that has led to patients' critical condition reducing the chances of better outcome of treatment. The treating

team of doctors argue that they have done their best. At one protest held in KEM in June 2019 after the attack in Kolkata the constant sloganeering by the resident doctors was 'Save the saviours!' ([Daily Hunt, 2020](#)). In projecting themselves as the saviours the doctors were essentially refuting the claim of negligence that led to the death of the patient as claimed by the relatives.

The demands from the protesting doctors is hence around their safety to be attained through curtailment of relatives' movement inside the hospital, security checks, presence of guards outside regular wards, and other such measures. All of these are valid concerns emerging from a sense of fear that the doctors live in due to the attacks that are serious. There is however, a lack of critical analysis of the health care system and inadequacies therein to get to the roots of such instances which evoke deep anger amongst families and friends of the patient who could not be treated as per their expectations.

The trend of families inflicting violence on doctors is recent and is only on the rise over the past few years. This trend of violence warrants deeper analysis of the health care system to better understand frustrations, disappointments and anger amongst patients. On another count, the government is blamed for not enacting a law against violence against doctors and hospitals and not providing adequate security. However, inadequacies of health care systems are rarely discussed. The National Health Policy of India of 2017 envisioned that India spend at least 2.5 per cent of its Gross Domestic Product (GDP) on health sector by 2025. ([GOI, 2017](#)). This is way short of the recommendation made by a high-level expert group (HLEG) formed by the Planning Commission in 2011 ([PCI, 2011](#)). This recommendation by the HELG was that India should achieve allocating 2.5 per cent of the GDP by 2020. India spent 1.8 per cent of its GDP on health in 2020-21; it was 1-1.5 per cent in the previous years. This is among the lowest any government spends on health in the world. As a result, India is among the 10 top nations with the highest out-pocket-expenditure (OOPE).

It is to do with the overall organization of the health care system which includes the medical education system in India, unregulated private health care sector, and over-crowded and under-resourced public health care system. It is particularly concerning when India has more than 470 medical colleges with a capacity of about 70,000 seats per year for a graduate (MBBS) degree in medicine and yet there are insufficient doctors to meet the health care needs of the 1.3 billion population of India. ([Kumar, 2019](#)).

There are other reports such as the one quoted above which do highlight the fact that improving reach and quality of health services is critical to stop violence against doctors, especially the junior doctors. (Dora et al., 2020).

The reluctance to engage with such systemic analysis going beyond specific instances of violence against individuals, is quite prevalent and was also the case with Dr Payal Tadvī's institutional murder. In that, the hospital administration never admitted that it could be a targeted caste-based harassment, even as a possibility. They denied it outright; the management did not give any statement committing to look into the systemic issues such as issues of hierarchy and workload of residents and that it is causing distress amongst residents. A prevalent perception amongst many students from the dominant caste is that students from marginalised castes/tribes who may access admission in the 'reserved' categories cannot cope with this stress as they are not well equipped to pursue a higher degree in medicine. For them, this explains the decision of persons like Dr Payal Tadvī to end their lives.

This line of argument de-emphasises the systemic issues, over-emphasises individuals and their capabilities, and derails the discourse. This, in spite of the fact that time and again, especially when on strike, all resident doctors have complained of the immense workload that they have to bear of running the under-resourced public health care system. Many residents that we had conversations with, as part of our efforts to look deeper into this incident, tended to connect Dr Payal Tadvī's institutional murder to the workload during residency.

For example, RDD1, a senior resident doctor from a dominant caste, said:

“When in PG there is also a responsibility. The junior residents in the first year of residency (JR1) are most overburdened. Payal had just become JR2. Harassment began when she was JR1. In the first year, there is generally lots of work and in that if residents make any mistake, then people say things. If they know the *rank* (of the resident who makes the mistake) then they will say this one is on 30000 rank and so on. Tribals are very backward... Their ranks are low.”

This respondent RDD1, as mentioned above, draws attention to the fact that extreme levels of workload of residents can make them prone to committing errors in their clinical practice. It is noteworthy that the

errors might be committed by any residents regardless of their being from dominant or marginalised caste/tribe; open or reserved category. However, those from the marginalised caste are targeted, and that too on the basis of their caste; NEET rankings being used as an indicator. This trend, we understand, is rooted in the systemic casteism in which all of us survive along with the social prejudices carried by the students, teachers, and other members of the medical teaching establishments against those who belong to certain marginalised communities

V.2 Life as resident doctors

It is well established that the public hospitals in the Indian context bear an excessive workload beyond their capacities. This is not surprising, given that this is the only mechanism available to the vast majority of people for reasonably priced and functioning health services, while the system itself continues to be neglected and under-resourced in terms of finances, human resources and infrastructure. (Shukla, 2017) . As a result, the system often overstretches itself in an attempt to attending the case load at any particular point in time. This includes long working hours for the entire staff across the board, especially the junior cadre of residents given the entrenched hierarchical character of the system. In such a system, allocation of work on the floor, that is, in the clinical care wards, runs the risk of unequal distribution of work load amongst the residents, especially seniors assigning work to their juniors.

The constituency of PG medical students, comprise an important health human workforce who collectively shoulder a substantial work load of these busy public hospitals. This is not a homogeneous constituency. Instead, it is inherently hierarchical across gender, seniority, and social markers such as caste, religion, class, etc., and many of these are revealed right at the time of admissions. As a result, the system tends to be exploitative in a subtle and overt manner. Given the obvious power dynamics and imbalance between different sub-groups, the most vulnerable are left with no option but to bear with it.

In our conversation with residents and key informants, most agreed to the fact that resident doctors had a very difficult and tough life in the hospital. They also all agreed to the hierarchy that is followed within the system and the ways in which senior residents often harass, abuse, and may even be rude and

aggressive with the junior residents; exploiting them by making them work long hours; and expecting them to take care of the workload of the seniors. Almost everyone and a lot of articles written around that time have spoken of both these aspects.

RDD1, the senior resident doctor from the dominant caste, spoke of the pecking order in the unit: “There is a hierarchy and the HOD says that work needs to be done. So, Professor says to Associate Professor (who passes on) to Lecturer (who passes on) to Senior Residents (who are all MD and have to do a bond) to JR3 to JR2 to JR1.” The first year junior resident is at the bottom of the hierarchy and has to make sure that the work is done. As Dr Sanjay Nagral, a onetime active member of MARD in the 1980s wrote in The Indian Express:

For all its claims to modernity, medicine in India continues to be extremely hierarchical and regimented. This is especially true of the training period called ‘residency when postgraduate students work in hospitals, both to get practical training as well as a degree. In what is traditionally a top down approach, not unlike the armed forces, all work, especially the hard labour is handed down to the junior most trainee. The junior doctors, especially in the first year, are the scapegoats for anything and everything that goes wrong. Everyone is trying to please the one higher up in the ladder often at the cost of one below him or her. . . All this is facilitated by an outrageously feudal structure, which in its mildest form involves a junior resident addressing a colleague one year older as “sir” or “madam” to senior doctors getting personal work like buying household items done by resident doctors. Ragging is a gross trivialisation of what actually is a strong collective tradition of an undemocratic and regressive method of imparting training. (Nagral, 2019).

Our conversations with the resident doctors and other accounts that came up during this time period consistently pointed out two disconcerting facts – the rigid and violent hierarchy, and the strenuous workload. As RDD2, another resident doctor from a dominant caste/tribe, articulated:

“If I am senior, and I (he) have been made to work then he will ask his JR also to do all the work. If the other person can’t do, maybe person is married, may be family reason, then possibly ‘*comments pass karane*’ (he will resort to taunting). In the first year, it is more or less certain- ‘*sone ko time*

nahi, khane ko time nahi.' (there is never enough time to eat or sleep even) '*Log marriage dates bhi nikalate nahi.*' (Residents are clear to avoid setting up wedding dates too in this period- so well known is this system). If I am choosing Nair for Obs-Gynae or KEM we know what we are getting into. Students study the basic statistics, they know the work load. In fact, now the PG seats are more so some work has been re-distributed. Earlier, 4 yrs back, it was worse. We had 24 hours duties (effectively used to be 36 hours) and night duty twice in a week. Now night duty comes only once a week. Seniors feel you are better off. Seniors, lecturers think this is the time to show their power. They give punishments like- don't come to the OT for 7 days. This happens in every department."

A senior Muslim doctor KI1, who we spoke to as part of this enquiry, said:

"When a person newly joins, he/ she needs to be supported in the beginning. The pinch of work is the most in the first year. The responsibility needs to be taken by everybody. Harassment is not acceptable. This has been going on for a long time. All of us have faced it. So much has been written [about it]. ... Always some amount of politics goes on. If things go wrong, put it on the juniors. Bosses are unnecessarily strict. . . . The stress is most in clinical specialisations. In non-clinical departments, they manage with eight-hour long duty and therefore, the stress and the abuse are lesser. Within the clinical disciplines, obstetrics and gynaecology are seen as the worst."

From amongst our respondents, a senior Muslim woman doctor, KI2, who was amongst the first women to join the discipline of surgery in India said: "Obs-gynae is very heavy duty because two lines involved- medical and surgical. Very stressful. There are 15 deliveries daily in [the] Nair [hospital]. KEM [hospital has] 40 deliveries a day. ... The Obs-gynae stress is well known, students in the US drop Obstetrics and only do Gynaecology." KI4, who currently is a senior doctor working in a private hospital but who was associated with public teaching hospitals, added:

"Do not know why this happens but there is a peculiarity of gynae wards. Sometimes when students come to other departments after having worked in the gynae ward, we have to remind them that they are not in gynae anymore and should be gentler. ... It seems that there is particular anger even against the patients in the gynae wards. Do not know what is the reason but it is quite harsh. Maybe

because they are poor patients coming and women. Or the anger against the fact that they have to do night duty for labour. Whatever it is the situation is bad.”

All of these are known facts. The resident doctors are caught in the hierarchical system doing work that is too burdensome for them, adversely impacting their own well-being. It compromises the quality of services they provide to their patients. This is fairly well established and residents fighting for their rights is not new. The directives from the Central government issued way back in 1991 vindicate the long standing issue at hand. The Ministry of Health and Family Welfare (MoH&FW), Government of India (GoI) had issued instructions to all states and union territories vide letter number S-11014/3/91 ME(P) regarding implementation of Uniform Central Residency Scheme after the directives of the Supreme Court in its judgement dt. 25.9.87 in writ petition No. 348-352 of 1985 with respect to working hours. Some highlights of the directive include:

Continuous active duty for resident doctors will not normally exceed 12 hours per day. Subject to exigencies of work the resident doctors will be allowed one weekly holiday by rotation. The resident doctors will also require to be on call duty not exceeding 12 hours at a time. The junior Residents should ordinarily work for 48 hours per week and not more than 12 hours at a stretch subject to the condition that the working hours will be flexible as may be decided by the Medical Superintendents concerned keeping in view the workload and availability of doctors for clinical work. ([PG Times, 2013](#)).

However, in most parts of the country the directive largely has not been complied with. The sustained long standing problem led to resident doctors launching an ‘I Am Overworked’ campaign and mobilised graduate and postgraduate students in government medical college hospitals across states like Delhi, Madhya Pradesh, Andhra Pradesh, Kerala in June 2019. The president of the resident doctors' association at AIIMS, Dr Bhatti is quoted in an article in The Print, The health minister's job isn't merely to privatise the healthcare industry – if it was, then anyone could do the job. We're hoping the health minister, who is also a doctor, will better understand our pain because he's been through it himself.' Furthermore, he mentioned, ‘...even the suicide of Maharashtra doctor Payal Tadvani was a consequence of more than just caste discrimination.’ ([Singh, 2019](#)).

Since many years, almost every resident doctors' association have raised the issue of residents' overall work environment, especially the long working hours without breaks. Their demand has been that the issue be addressed squarely by the concerned authorities both at the policy level and at individual medical teaching hospitals. The point is that this has been an ongoing struggle of resident doctors. MARD had raised this issue with the Maharashtra state government which seems to believe that the residency scheme with fixed working hours was not possible and/or feasible. The hardship doctors go through as articulated by two doctors is captured in a news report of India Medical Times published in 2016:

Dr Mundada, the then President of central MARD,

"The residency scheme says 48 hours a week shifts for doctors all over India. The central government has asked all the states to implement the same but Maharashtra has not implemented it and in spite of many requests and letters to the concerned authorities nothing really happened."

Dr Shrikant Balwande, Medical officer, Primary Health Centre (PHC), Bembli, Osmanabad:

"We doctors of Maharashtra are asking for eight-hours duty as the doctors who are placed in rural areas like Osmanabad have to work for 24 hours and there is no holiday on Sundays as well. We face too much of family problems and there is a lot of physical as well as mental torture due to the overburdened long shifts." ([Pandey, nd](#))

These demonstrate the long-standing struggle of resident doctors on this issue but with no resolution. The State has neither conceded to these demands from the resident doctors nor has been able to enforce the implementation of the directives from the Supreme Court. This work environment and expectations from residents comes at the cost of their health. For example, since many years one of the demands, the MARD has been making is that of entitlement to Tuberculosis (TB) leave. ([DNA, 2015](#)). Bad working conditions and even worse living conditions while being exposed to infectious and contagious diseases is one of the reasons for the high incidence of TB among residents and has led the resident doctors' association to make this demand. As we noted earlier, residents' well-being or ill-health has direct implications for the well-being of the patients served by residents. As KI2, the senior Muslim

woman doctor we spoke to, said, “There is an argument that overworked doctors are actually dangerous to patients. But we don’t want to pay doctors. So, residents are the scapegoats.” It appears the government has failed to appreciate the residents’ concerns and remained in disagreement with professional association of residents. As a result, if one decides to pursue PG studies in medical stream, the work environment is ‘a fait accompli’.

In 2015 Vinod Tawde, the then minister responsible for medical education, is quoted in a news report to have responded to the demands with the following statement:

If you look at MARD's demands, some of them aren't feasible. For instance, the demand for reduction in duty hours is impossible to accept. They also want some leave for maternity and TB which is not in our hands. If the Medical Council of India permits us, we will definitely offer such leave to the students. ([Andhale and Pal, 2015](#))

The minister's remarks are preposterous. He is justifying putting at risk the health of both the patients and the doctors by saying that reduction in hours is impossible to accept! He goes against the SC order (1987) but also against all international standards. The European Working Time Directive (EWTD), issued by the Council of Europe to protect the health and safety of all workers in the European Union, became law in 1998. It empowered a set of minimum requirements, including a maximum work week of 48 hours; a minimum rest period of 11 consecutive hours per 24-hour duty; a minimum rest period of 24 hours per 7-day duty, or 48 hours of rest per 14-day duty; a minimum of 4 weeks of paid annual leave; a maximum of 8 hours’ work in any 24 hours for workers in stressful positions; and a minimum 20-minute rest period per 6 hours worked. ([Temples, 2014](#))

This has been the way in which the Institutions and the State have responded to issues relating to working conditions of residents. It seems like the whole system is operational because it relies on the excess labour put in by the PG medical students and takes it as a given. That no one wants to address this is also evident from the fact that even after so many struggles there is no change in the situation of the junior doctors in the health system.

While the resident doctors' associations have been the only ones consistently raising the issue of

working conditions of the resident doctors, within the daily grind, the hierarchy plays a significant role in sustaining the same. Pecking order is followed and the hierarchy is normalised. Senior doctors always feel that they can demand of their juniors what they had given when they were juniors. It is the same logic with which students continue ragging of every new batch. This tendency to make the other person go through the same difficulties almost make it seem as if this is inevitable and natural.

V.3 Experiences of students from marginalised communities

In this section, we briefly discuss how this working environment in which medical residents pursue their PG program impacts the residencies of those from marginalised castes and tribes. Residency is not only developing skills, and expertise in clinical care at hospitals. It also involves studies as part of preparation for examinations – written, oral and practicum. In this regard, we learnt from our conversations with our respondents including the residents from dominant and marginalised castes/tribes, that sentiments like the one below are common:

“Tula kashala abhyas karava lagto [why would you require to do studies and readings]? Tu tar sarkarcha javai ahes [you are the son-in-law of the government].’ Very humiliating to hear this. Some understand us and some don’t. Some accept us and some don’t.” [RDM1, a resident doctor from a marginalised caste]

Another dalit resident doctor RDM3 mentioned that ‘You don’t deserve this’, is said too often to students who enter through the affirmative policy of reservations. It has become a way to invoke the aspect of merit and suggests that medical students from marginalised castes and tribes who are entitled to reserved seats don’t have the capabilities to be in medical training programs. At times, these students are subject to these abusive and humiliating comments even if they secure seats through open category. Whether the student enters through affirmative action or not, the sheer fact they belong to these communities is enough to attract such abusive remarks hurting their self-esteem, and dignity and more importantly their entitlement to be in professional training programs, such as, medical education.

The normalization of the hierarchy allows for humiliation as a method of interaction across seniority lines. In the first year everyone has to not only take the load of the work, because everyone else did it, they also need to take the blame for anything that does not get done. When systemically there is little that is working in favour of a decent work environment an acceptable punching bag for all is the JR1. JR2 onwards doctors may not do night duties, and by the time they are in the third year of residency anyways they are preparing for exams and hence take exemptions.

If in this situation the JR1 is from a background that is established within the general culture as undeserving to be in that place and has been collectively established to be lacking merit, it is easier to dump all lapses on them and also hold them responsible for it. Of course, in this if there is a mix of people who are blatantly casteist then the situation gets worse, but the lack of attention to these working conditions on the whole is also responsible for the ways in which those from the margins are treated daily and for their subsequent loss of self-confidence and ability to resist.

Additionally, there are other ways of discrimination built into the system. It is well known that hospitals are graded as per the type of facilities, availability of overall infrastructure and other related standards. From the point of view of medical students, patient case load and diversity of health conditions they would get to study and manage also are important. For example, RDM1, a resident doctor from a marginalised caste, pointed out the ways in which the residents from the dominant caste benefit from favours in the form of getting placements in the big hospital attached to a medical college:

“...there is discrimination in the way PG student postings are given and PG students therefore fear to protest or raise issues. For example, when getting admitted to a medical college in a surgical branch like Obs-Gynae or Surgery, they post ‘category’ students to those affiliated hospitals which are not dynamic and vibrant enough, or where the faculty is not that good or where there are fewer academic activities Basically hospitals where you only get practical experience, no academic learning.”

Those from the marginalised caste/tribe tend to get posted to smaller hospitals and as a result, miss out on opportunities to work with the more experienced faculty. Such, rather subtle and yet obvious

discriminatory practices, we were told, have long term implications when PGs complete their trainings and be part of the larger eco-system of the health care system when they initiate their practice. This implies that those from the dominant caste having had the opportunity to work with more experienced faculty have already initiated developing their professional networks and professional capital that would contribute to furthering their careers and establishing their practice.

Academic engagement with peer community in the form of opportunities to participate in seminars, conferences is significant in academic settings. However, access to resources enabling such participation, mentoring and approval from seniors or concerned offices within the system determines possibilities of such engagement opportunities. In this regard, some participants shared their views and experiences highlighting caste-based discriminatory practices in this sphere, too. We were told that it is harder for the PG students belonging to the marginalised caste to get an opportunity of participating in conferences and/or presenting their work at these avenues.

“...discrimination doesn’t happen in a straightforward way, so it is not always easy to catch [such discrimination], but we know [about such discriminatory practices]. One of my ST friends in Yavatmal is doing a PG in surgery. The HOD is Brahmin and there is a Brahmin student along with my friend. The HOD doesn’t do any discrimination on a day to day basis. But the Brahmin boy is given the opportunity to present papers in conferences or such other opportunities.” [RDM2, Senior resident doctor from a marginalised caste]

There seem to exist other subtle ways of discrimination to which those from the marginalised caste/tribes are subjected to. For example, the senior residents not only humiliate the junior residents but they also deny juniors opportunities to learn in the clinical care practices in the hospital. RDD1, a dominant caste senior resident doctor, told us of a situation where a student who initially complained of some kind of ragging, ended up withdrawing his case because of the fear of being denied a chance to carry out surgeries as part of their posting. Also, there are no active and visible mechanisms that seem to take the situation into account. So even if a student wishes to complain there is no avenue to do so.

Lack of an efficient and meaningful redressal system to prevent ragging and harassment, and robust timely response to the registered complaint makes residents rather reluctant to register a complaint.

They also worry about the consequences of registering a complaint. The respondents also mentioned that, the unit in-charges are oftentimes not well equipped and aware of the ways in which such situations in their own units need to be handled.

Such neglect was reported from senior doctors across medical colleges as well. The lack of transparency in allotment of work makes the situation troubling. Respondents ADM1 and ADM2, both dalit doctors from the Ayurveda stream, shared an incident from a Pune based medical college wherein a student of medicine from a marginalised caste was never allowed to even touch the patients. The student complained to the University. An enquiry committee was also set up to go into whether there was a bias in the behavior of the teacher. The student was very disturbed and had to seek help to address the distress felt. They also shared how teachers behave with students:

“There are lists put up on a routine basis. . . . The PG list is put up in the departments. All professors already know which students are coming. PG teachers also support discrimination. In fact, most divide up the students identifying them by surnames, or as ‘bright’ or high scoring students amongst them *‘ha mala pahije’* (I want to guide this student) and the remaining who do not have a guide are mostly the category students. Sometimes the professors comment to their students- *‘Bara zhala me tula ghetala. Tu hushar ahes’* (I am happy to have chosen you. You are bright.) The system of reservations is not well maintained, not sensitive at all.”

In the private medical colleges there are more concrete and clear ways in which this kind of discrimination gets institutionalised. The students who secure admission via 'paid' quota to these private medical colleges are not expected to do the rural bond. We were told:

“The non-donation seats have admissions from reserved categories and they get scholarships. So, they were asked to do the one-year rural bond. But if you consider that the reserved quota and scholarship is in lieu of the historic injustice done to these groups and that it is the duty of the government to support their education then why should other rules be different from the ones the institution follows. *Reservation mhanje bheek dilyasarakha nasave.* [seats secured via reservation policy should not be considered as ‘alms’] We didn’t beg to the social welfare department for this - this has come to us as a right.” [RDM2, Senior resident doctor from a marginalised caste].

This is a very valid question and also raises many issues around the rural bond and the role of the postgraduate student in the overall health care system. The idea of the bond for the State probably comes from its need for doctors to be available in the rural areas. Not many people wish to go to rural areas to work especially since a large number of the students come from urban areas and more privileged socio-cultural backgrounds. Hence the compulsory bond helps the State to ensure the presence of doctors in rural areas. In case the PG bond of a year is not fulfilled, currently the bond amount that the student is expected to pay is about 50 lakhs, which is steep. So in a sense the government is making sure that the rural health centres and PHCs are staffed by students in the subsidised seats almost like a pay-back for the subsidy.

The bond, however, indicates another difference between public and private education -- those expected to serve the bond and not, respectively. The bond in some sense is a contract that the State is making with the PG students, whereby their period as residents is seen as an apprenticeship and an opportunity to learn in lieu of which they are expected to work for the system for the period of the bond. If and when this demand is not made of the students whose education is not subsidised, the meaning completely changes. It then means that because the fees were subsidised, the person needs to complete the bond even if the training is in a private hospital that otherwise does not demand this bond. The training is not at the core of the bond, the subsidy is!

In fact, the joint secretary of DMER, Dr Prakash Vakode, is reported to have made this exact statement:

Students from government colleges are made to serve the bond as they get education on a very subsidised rate from the government. And hence they have some liability towards society. Nothing of the sort exists with private colleges. They charge huge fees. Hence the students cannot be forced to serve any bond. (Geeta, 2018).

And this is what is being challenged.

V. 4 The stipend and free-ship question as an example of systemic discrimination

This also brings us to the question of the stipend that students get when they work as resident doctors while pursuing their PG degrees. A stipend is obviously not a salary although it is comparable to the salary that they could have got if the jobs were available and they could have taken them. These are not scholarships. A stipend is actually a fixed amount given without any employment benefits to those who work as apprentices or trainees in a workspace. So we have the doctors actually keeping the public hospitals functional while completing the hands on hospital learning that is required for their PG degree.

Medical education takes many years. The undergraduate programme takes five and a half years and then there is a one-year bond. This used to run concurrent with the PG programme but now this is separate. After this there is three years of specialisation and then another bond of one year. So all in all if someone clears everything at the first attempt and also gets admission soon enough by the time they have a PG degree they have already spent ten and a half years of education and service. A super specialisation is another three years of studying and two years of bond after. Obviously then a reasonable stipend is essential for post graduate medical students, since they also help run the public hospitals.

The overt discrimination is implemented in another way also. And that is in the context of the free-ship which essentially is a scheme for students coming from SC/ST/VJNT/OBC backgrounds. Their fees are waived as an acknowledgement of centuries of discrimination and systemic violence which has not allowed students from these communities to access higher education, which is termed as a 'free-ship'. Thus it is understood as an entitlement due to those coming from marginalised backgrounds. This free-ship or waiver of fees is granted under 'Centrally-sponsored scheme of post matric scholarships to the students belonging to scheduled castes for studies in india' of 2010. (Gol, MoSJ & E, 2010).

A clause in the scheme says,

(xii) a scholarship holder under this scheme will not hold any other scholarship/stipend. If awarded any other scholarship/stipend, the student can exercise his/her option for either of the two scholarships/stipends, whichever is more beneficial to him/her and should inform the awarding

authority through the Head of the Institution about the option made. No scholarship will be paid to the students under this scheme from the date he/she accepts another scholarship/stipend. The student can however, accept free lodging or a grant or ad hoc monetary help from the State Government or any other source for the purchase of books, equipment or for meeting the expenses on board and lodging in addition to the scholarship amount paid under this scheme.

One reading of this scheme equated the stipend that resident doctors get with a regular stipend that other Ph D scholars get and so in 2012 the Government of Maharashtra came out with a circular denying free-ship for the students entitled to it. The fees for medical education are not small sums. They run into lakhs and so impossible to pay for those accessing admission in the reserved categories without actually a fee waiver. Most people who enter through affirmative action policies are also first generation learners. For them the stipend is not for personal use alone, but serves as salary to also support other family members. For many of them a PG degree is only possible because they have been given the stipend.

According to RDM1, the senior resident doctor from a marginalised caste, the institution doesn't recognise that the 'stipend' which is considered 'pocket money' or only for personal use by the open category students is a 'salary' for the 'category' students which also supports their families. They said,

"Even those in authority don't understand our rights. We have heard people mixing the issue of freeship and our stipends. Stipends are given for the work we do- like a salary and freeship is a support for education. The two are different. They say we are giving you 15 lakhs- either take your freeship or take your stipend!! Ok, then we won't work. If you don't want to pay us a salary, then why should we work? They don't understand that the basis for the two are different. Both are our rights."

In a similar vein another senior resident doctor from a marginalised caste, RDM2, also said that this was an arbitrary violation of the rights of the students from marginalised backgrounds which led to them being deprived of the education that they deserve to get. "I have seen cases where students have left their admission even secured through category because they don't have money to pay. Also medical

students who got in PG, took a drop and worked to collect money for fees. This puts them behind their peers.”

This question of rights is negated by the Institution in multiple ways. There is no recognition of the difference in situation for different students. As RDM1, in their conversation with us emphasised that this compounded with other discrimination just makes it too difficult to survive the severe working conditions for those accessing the reserved seats. He said,

“Out of four students, at least 3 will have no doctor in their family. They support their families financially. The per capita income of other (dominant) students is also more than these. Then you can imagine not receiving your free-ship, or not receiving scholarship, or being discriminated against or harassed, what Payal faced is on top of their other problems. This adds to their stress.”

To make things worse the administration adds to the indignity with which all of this is done. Earlier the fees would be paid directly to the Institute. Then the State started asking the students to pay first and then get it reimbursed. To this he said, “Free-ships are our right- then why do you make us pay the fees in the first place? Work on your system first.” [RDM1, Senior resident doctor from marginalised caste]

Students have to pay fees and then wait for reimbursement. So students take loans but then they have to pay the instalments, which is a further strain on their already tight budget. The reimbursement also does not come on time. The college administration does not help either. They ask students to go to the state departments. The whole attitude is of not caring. This kind of wilful systemic neglect and the ways in which the recipients of any kind of rightful help are unthinkingly subjected to procedures that make their life more difficult, all reeks of the incipient casteism in the system. It indicates that the system is not only harsh but also unjust towards those that it chooses to officially give access to.

This situation got worse in 2012 when the government declared that those who got stipends would not be eligible for the free-ship. Although the order came in 2012, students on free-ship were continuing to get their fees waived till September 2015 when they were asked to submit their fees for the past three years as well. Students made representations to the State from December 2015 onwards. As a result of this on 10th March 2016 Minister for social justice gave assurance in writing and directed authorities

not to disturb education of the students.

But still by 28th March 2016 students were directed to pay their fees, an amount of 1.5 to 2 lakhs. Despite all their efforts these students were prevented from appearing for their exams unless they paid all their fees. This order was challenged in the Bombay High Court by the office bearers of MARD. In the petition they contended that withdrawal of freeship scheme was arbitrary, illegal, unfair, discriminatory and unconstitutional as it was violative of the principle of equality as enshrined in article 14 of Constitution of India. (HRLN, 2016). The court granted immediate relief whereby it was clarified that non-payment of fees cannot be the basis to prevent the students belonging to SC, ST, VJNT and OBC category from appearing for the Post Graduate Medical Entrance examination to be held in 2016 . This made it possible for those students to appear for the examination in 2016 and not lose a year.

The freeship and stipend issue in that sense highlights for us the wilful neglect by the State of its constitutional promise of equality and equity for all and prohibition of targeted discrimination on the basis of caste.

Doctors need to be trained through dealing directly with patients. There can be no learning that can substitute this. Large public hospitals are the spaces where this education can best happen. Also for reasonable patient care it is essential that the system has sufficient number of staff managing these hospitals and their workloads. These two are, however, independent needs and cannot be made co-dependant on each other as the State seems to do in case of the resident doctors. The increased workload and the stress that it entails adds on to all the other stresses that the students are dealing with.

The system is failing in multiple ways in addressing the needs of those from the margins for better health care and for fair access to education as well. We need to recognise the nexus between these two and the systemic failure in this model of postgraduate education because without that, the State responds with individualised explanations and solutions. All systemic changes that are expected of it, are not implemented and instead students' inability to cope is made out to be their individual weakness or problem. In chapter VII we talk about the multiple things that should have acted to help a bright

young person like Dr Payal Tadvī continue her education but how each of them failed and continue to do so.

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Chapter VI

Discrimination in medical education institutions as workplaces

Medical colleges and teaching hospitals are workplaces for a whole range of people, including those working as nurses, doctors, pathologists, ayahs, ward-boys and so on. So far in this document, we discussed the discrimination and hierarchies within these institutes centre-staging medical students – undergraduates and PGs, that is, residents. There are a number of spaces within these workplaces where discriminatory practices are prevalent across sections of the workforce constituencies within the system. Some of these include, preparing confidential reports for staff/faculty; assigning type and volume of work, departments and shifts to individual residents; allotment of posts; giving promotions and drafting and finalizing policies regarding promotions; representation on different bodies; and representation in positions of authority. In this chapter we discuss some of these avenues of discriminatory practices to offer brief insights into the ground reality in medical and nursing colleges and teaching hospitals, all integral parts of medical institutions. During our conversations with the enquiry participants, we got to hear about discriminatory practices in these institutes to which even the staff and faculty is subjected to in various ways. In this chapter we present experiences of different groups of personnel in the work force in the medical institutions, such as, technicians, nursing staff, doctors, including resident doctors.

VI.1 Confidential Reports

Confidential reports (CRs) for the staff as part of their periodic appraisal are part of the system for the institute to help decide deserving staff for consideration of promotion. These promotions, if the

processes are fair, are earned by the personnel. These reports have a determining impact on the career prospects of the workforce at medical establishments, that is, medical colleges and medical teaching hospitals. The enquiry participants shared their impressions about unhealthy practices and opaque processes in preparing the CRs. For example, they mentioned the influence of caste identities of the personnel influencing the content of the CRs.

According to two senior Ayurvedic doctors from marginalised castes/tribes (ADM1 and ADM2) working in a medical Institution,

“Confidential reports are given as per your caste. (*‘Confidential reports jaat baghun lihile jaataat’*) Adverse CRs are not shown to you. If they are shown to the person concerned prior to acting on them, you may get a chance for improvement. Straightaway, promotions are denied and opportunities snatched away from you. Even while granting you your PhD, there is discrimination and caste is considered.”

As one technician (EM1) from a marginalised caste working in a medical institution told us,

‘I was not even shown my Confidential Report. There were negative remarks about me. If the CR had been shared with me, I would have tried to better my performance by working on those aspects. That should be the purpose anyway.’

According to a senior doctor (KI3) and former HOD who worked for four decades in a medical institution, ‘discrimination in giving confidential reports happens quite often. I have reversed bad CRs a few times. Discrimination happens in terms of arranging duty patterns too.’

Overall, adverse CRs stand to be a sore point in medical institutions. Often the processes of preparing CRs lack transparency due to the absence of a robust system within an institution. This opaqueness leaves room for potential favouritism as well as for open or hidden biases depriving the deserving personnel and workers of their ‘earned advancement’ in their own careers at these institutions.

VI.2 Assignment of work

It is well established that the public hospitals in the Indian context bear excessive workloads far beyond their capacities. The reason being, that the overall organisation of the healthcare system is skewed in many ways and that the public health care system continues to be under-resourced in terms of finances, human resources and infrastructure as discussed in chapter five (Duggal and Jadhav, 2018). It is a common practice for patients to approach tertiary care hospitals for illnesses which can be and should be attended to at primary or secondary hospitals. As a result, the system often overstretches itself in an attempt to attend to the case load at any particular point in time. This includes long working hours for the entire staff across the board, especially the junior cadre given the entrenched hierarchical character of the system. In such a system, allocation of work on the floor, that is, in the clinical care wards may run the risk of unequal distribution of workload amongst the staff, especially seniors assigning work to their juniors. This is true of the health care workers including the doctors, the nursing as well as all categories of employees.

Some of the responses we heard indicate that the caste identities of the individuals also play a role when they are assigned a duty on the floor as reflected in the narration below:

“...It is very often the case that SC/ST nurses are deliberately placed in wards which have more work and continuous work — ‘heavy duty work’. One male ST nurse was put in the trauma ward for 3 continuous years. In the trauma ward, there is no opportunity to even sit and the duty is for 24 to 28 hours at a stretch,” says a senior tutor (EM2) from a marginalised tribe working in a nursing college.

The lack of transparency in allotment of work makes the situation troubling. At times, these situations might involve conflict of interests, overt or covert.

VI.3 Reservations in staff recruitment, promotion policies and practices

Recruitment to the reserved category posts and their promotions were two areas of concerns that emerged during our conversations with enquiry participants.

One of the representatives of a Nursing staff union, the Municipal Nursing and Paramedical Staff Union

(KI6), told us that the number of posts for Matron Grade I and II and Junior grade are 6, 6-7 and 45-48 respectively. Some posts have been filled by recruiting members from SC and NT categories. However, no one from the ST category has been recruited for any of these posts so far. According to KI6 of the Municipal Nursing and Paramedical Staff Union:

“These BMC [Brihanmumbai Municipal Corporation] matrons posts have remained vacant for 10-15 years. Even SC category posts are filled by open category candidates at times. According to 2004 norms, if SC/ ST category person is not available, then NT (A, B, C, D) have to be selected, but this norm is not followed. For the post of matron, if eligible persons [candidates] from ST and NT category are not available within the BMC [run health care system], these posts can be advertised and persons [candidates from reserved category] from outside the BMC [run health care facilities] can be recruited. Instead, in all these 50-60 years, these posts for [candidates] from reserved categories are filled up by open category candidates. Senior sisters-in-charge are asked to manage the work. Thus, posts are filled temporarily but no attempt made to recruit candidates from the ST category.”

Some enquiry participants brought forth their concerns about the policies and processes relating to recruitment and promotions within medical institutions. For example, representatives of the Nurses' Union and the technician we have quoted earlier (EM1) shared an opinion about the problematic nature of the existing promotion policies in the medical institutions. They perceive that these are geared towards favouring the individuals belonging to the dominant caste.

‘If the management wants to recruit anyone from the dominant caste, they go ahead and create specific posts in order to enable the entry of that person. They also go ahead and have an outward show of conducting interviews; but finally, the person they have wanted is selected. One doctor from the reserved category is legally fighting a similar case in the High Court for some years now and that doctor's promotion has been blocked', said the technician.

A resident doctor from a marginalised caste who had been active in organisations like MARD and DAMA (RDM2) told us that there are similar experiences regarding promotions for the marginalised caste/tribe staff.

“...many a times promotions are influenced by the caste factor. There was a lecturer of Anatomy who was from a marginalised background. He was quite active in DAMA, used to organise Ambedkar Jayanti and such events. Some dominant caste faculty did not like his activities. He was suspended. There are other cases, where promotions are denied to reserved category doctors and they are not made the Director when they are actually qualified for the post. Instead, they would be given the Joint Director’s post.”

Participants shared their own experiences of having witnessed institutional strategies and tricks to deny opportunities to staff members from marginalised castes or tribes. Another representative of the nurses’ union (KI7), shared some examples:

“...It is about one person namely, Ms. G, who was in the sub-clerical category in the psychiatry department. She used to be given the work of the clerical category and when she could not do it, she was harassed saying: You do not work. She was also given an insubordination memo. There were different ways of harassing her.”

“In yet another instance, an eligible employee from SC/ST category was bypassed in the process of promotion denying her the opportunity to move upwards on one’s own merit. It was only after the Union raised the issue that the authorities took appropriate steps to issue the promotion order,” she added.

The two Ayurvedic doctors (ADM1 and ADM2) from marginalised castes/ tribes, working in a medical institution also talked about a case where the promotion of a faculty in college was withheld by the advisor to a minister without giving any adequate reasons; the doctor continues to fight the case. They mentioned that there was one other, similar case of an expert physician from Ayurveda. “He has treated the Governor too. But yet he is not given any respect and not called for lectures etc. He belongs to a marginalised caste”, said one of the doctors. Even outside of formal medical institutions, this attitude and the discrimination that follows continue. They also told us of several instances of challenges a number of Ayurvedic doctors faced when they desired to open their own clinics. They experienced a low caseload of patients visiting their clinics. In their view, dominant caste people, who more often use

Ayurvedic medicines, would not visit them due to their caste which was obvious from their surname. As a result, they resorted to changing their surnames in an attempt to conceal their caste identities which are often reflected in one's surname in the Indian context. As we were told by these participants, once those doctors changed their surname, they began to get many more patients.

According to an Assistant Professor (RDM3) from a marginalised caste/tribe, once doctors start their practice patient referrals in both private and public hospitals are based on caste and community. References to colleagues are also based on these social factors.

VI.4 Opportunities for academic engagement

It is well established that academic engagement with one's peer community in the form of opportunities to participate in seminars, conferences, etc. is significant in academic settings. However, access to resources enabling such participation, mentoring and approval from seniors or concerned officials within the system determines possibilities of such engagement and opportunities. In this regard, some participants shared their views and experiences highlighting caste-based discriminatory practices in this sphere, too. It is harder for the staff belonging to the marginalised caste or tribe to get an opportunity for participating in conferences and/or presenting their work at these avenues, as also described in chapter V in the context of PG resident doctors.

This denial of opportunities to students from marginalised castes and tribes was experienced in the nursing colleges too. There are studies showing the extreme shortage of nurses in the country. ([Economic Times, 2019](#)). This also adversely impacts patient care. Some of the participants argued that this situation could be improved if more nursing students from the marginalised castes and tribes could pursue higher-level training, but these opportunities are denied to them on the grounds of their being from the reserved category. One of the participants, a senior tutor from a marginalised tribe (EM2) articulated the concern as follows:

“...There are many ST candidates with diploma. After five years of service, they are entitled to go for higher studies on deputation. They can actually be sent to get BSc and MSc degrees on deputation.

Those who can afford to pay for this education do these courses. But those coming from economically weak backgrounds cannot afford the fees, along with having to forego one's salary while completing the course. Currently, there is no ST candidate amongst tutors. There is an urgent need for persons from ST categories to be sent on deputation to pursue these courses so that these posts [of tutors at BSc nursing schools] can be filled. For such candidates, the course fees should be waived, and they should be paid salaries while on deputation. But that has not been the policy and hence it results in ST candidates being deprived of those opportunities [for pursuing further studies or higher-level degrees]. This will be even more so, as the future plan of the Government and the Indian Nursing Council is to close down diploma colleges and continue with only degree colleges."

"BMC has five diploma institutes with 350 seats. These will be converted to BSc nursing degree colleges. This requires candidates with MSc in nursing as tutors for the degree program in nursing. There was an acute shortage of eligible candidates [for this purpose] and it is imperative to send people from SC/ST category on deputation, with their fees and salaries covered, but there is no such provision made. The NABH (National Accreditation Board for Hospitals and Health Care Providers) recommends appropriate ratio of patients and medical staff. In reality there is a tremendous shortage. If these norms have to be adhered to, then more trained staff needs to be recruited. This is not only in the interest of SC/ST staff but of patients as well," said the same nursing tutor (EM2).

Yet, another aspect of discrimination in the field of nursing related to bedside care was also pointed out. The nursing tutor (EM2) continued:

"Persons occupying higher positions in nursing do not have to do bedside care or even visit wards. A large part of their job involves desk work. The entire bedside care requires patient interactions, hard work and dedication. But it is not as valued or respected as it should be. The bedside care work is usually assigned to nurses who have come to nursing courses after their 12th standard (diploma holding nurses), which is the case with nurses from SC/ST/NT backgrounds. Nurses from dominant castes usually come into nursing after their graduation (BSc degree holders in Nursing). It is mainly the nurses from SC/ST/NT backgrounds that do the back-breaking work of bedside care."

Other representatives of the nurses' union corroborated this experience.

This helps us understand how the hierarchical social structure in India is a self-perpetuating one. It is a stark reality that it is so very often the case that historical or 'past oppression' continues to negatively and drastically impact the present and the future and perpetuate it.

VI.5 Representation on different bodies

In terms of representation of SC/ST people on different bodies, there is likely to be both, a conscious attempt to keep them out or a routine neglect of the need to be inclusive to bring them on board. Most committees, such as, the sexual harassment committees are often comprised of individuals only from the dominant castes, with the conspicuous absence of any representation from the marginalised castes or tribes. Similarly, offices-bearers of professional associations have been dominant caste people for several decades and the trend continues.

One of the technicians mentioned above (EM1), further told us,

“There is not enough scope given for representation in various committees such as dealing with sexual harassment at the workplace. There is no explicit expression of exclusion, but different methods are used like not providing an application form or not responding to a filed application. There is no recourse available to raise the matter of such exclusions.”

Further, she narrated her own experience of wanting to be part of the Committee for prevention, prohibition and redressal of sexual harassment of women at workplace. She requested the concerned office at the medical teaching hospital that she be given the application form to offer her candidature to serve on the Committee. But, as she narrated, she was never given the form despite her many requests and reminders.

“They may look at us as Ambedkarites and hence as people who always raise issues or fight for their rights.” (EM1)

An Assistant Professor quoted earlier (RDM3), brought out the denial of representation of marginalised

castes/tribes at multiple levels, as follows:

“... In the last 20 years of the existence of students' associations there never has been a secretary from a marginalised community, nor any women student. It is said often that there is no discrimination in the medical fraternity but if one is to look at the caste composition of bodies like IMA, one gets a clear picture.”

VI.6 Representation on offices of authority

The trend of exclusion of marginalised communities from positions of authority, like Heads of Departments or other higher posts with authority, is similar to the one observed above in the case of lack of representation on different committees of significance. People from marginalised communities rarely hold positions of authority in these medical establishments. One of the participants we spoke to said:

“Those positions and posts have been, should be and will be ‘reserved’ for people belonging to the ‘non-reserved’ castes, because they belong to the ‘right’ castes.” [Nursing tutor, quoted earlier (EM2)]

The Nursing tutor (EM2) continued:

“There is complete domination by dominant caste persons in higher posts. The Trained Nurses Association which is an international association is 114 years old, and spread across 140 countries. Most of the posts in this association that are held by Hindus are held by the dominant caste, primarily Brahmins, whichever country they may be based in right now. Most other people do not even have adequate information about this Association. Elections are held but due to lack of information the organisation is in the hands of a few. These people keep promoting each other and getting awards. Presidential awards are only given to Brahmins.”

VI.7 Mechanisms for redress

There are no mechanisms adequate to deal with such issues and complaints. Hence there is no in-depth analysis of the issues and no long-term solutions or resolutions attempted. As per the experience of the senior resident doctor from a marginalised caste (RDM1), even if there are any complaints, they are resolved in the department and are seldom reported outside. On the face of it, the problem appears to be resolved but the root cause remains. Plus there are other aspects such as huge workloads, neglect of working conditions and basic facilities and severe shortage of staff at all levels. No one else seems to support the people who have such complaints. The same situation is there in almost every department as well as institution. We will go into this aspect of mechanisms in greater detail a little later.

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Chapter VII

Review of mechanisms to combat institutionalised caste-based discrimination in medical colleges: Gross failures!

In this chapter we reflect on the various efforts made in the past and mechanisms that evolved to address the institutionalised culture of marginalization of students and staff belonging to oppressed castes, such as, SC/ST/NT/DNT. These efforts include public interest litigations and their outcomes, legislative frameworks, various regulations by the University Grants Commission like equal opportunity and redressal of grievances of students, reports by the committees appointed in the past to look into institutionalised nature of caste discrimination and processes of marginalization. We locate both, these efforts, and the empirical reality of effective implementation of these legislations and regulations, in the broader framework of justice, equity and rights that the Constitution of India ensures.

We look at how ragging is conceptualised, its all pervasiveness, especially in Higher Educational Institutions (HEIs) and caste-based discriminatory practices in this context. We briefly discuss the empirical evidence of prevalence and the psychological impact of these on students brought out by various committee reports on ragging, mandated by the Supreme Court of India and supported by UGC. These reports are based on testimonies of students, faculty and others from HEIs from around the country and provide substantive empirical evidence on caste-based discrimination being rather inseparable from ragging.

Our overall goal of conceptualizing this chapter is to underscore the fact that, regulations like equal opportunity, redressal of grievances of students, as well as anti-ragging legislations have a significant role to play in containing caste-based discriminatory practices and facilitating the end of this endemic

phenomenon, which takes so many lives of young people studying in HEIs across India. At the same time we question whether the framework and conceptualisation of ragging as commonly understood is sufficient to recognise and provide redressal to caste based discrimination. For this to happen the effective functioning of various committees formed to simultaneously work on prevention and prohibition of the deep-rooted discriminatory practices is critical.

We start with legislation to deal with “Ragging in Educational Institutes”, as it evolved through efforts of Civil Society approaching courts, resulting in the constitution of various committees, their recommendations and resulting legislations and policies.

Next the specificity of caste-based discrimination, and redressal efforts specifically in context of Medical Educational Institutions is presented.

Finally, UGC regulations on Promotion of Equity in Higher Educational Institutions and Redress of Grievances of Students are covered.

The chapter concludes with the ground reality in terms of compliance and effectiveness of these legislations and regulations.

VII.1 The Constitution of India

The majoritarian Hindu religion founded on caste hierarchy and Brahminical supremacy has been continuously striving to perpetuate the hierarchical caste-divisions to establish hegemonic ideological power over Indian society. This had been recognized and anticipated by the framers of Indian Constitution, right at the inception. The Constituent Assembly debated the Constitution, drafted by a seven-member committee chaired by Dr Babasaheb Ambedkar which worked on it for a period of three years, and finally adopted it on 26th November 1949. Gautam Bhatia in his book entitled, 'The Transformative Constitution' says ([Bhatia, 2019a](#)):

There are two clear legacies the Constitution sought to repudiate and transform. First, the Constitution transformed the legal relationship between the individual and the State. It transformed

the subjects of a colonial regime into citizens of a republic. It replaced the colonial logic of governing and administering a population with the democratic logic of popular sovereignty, public participation, and limited government. Apart from the guarantee of universal adult franchise and the structures of parliamentary democracy, this transformation was expressed through the fundamental rights that embodied citizenship and made democracy possible: the freedom of speech, expression, association, and conscience; the right to life and personal liberty; and the right to equality before law.

The Indian Constitution was transformative in a second sense. **It sought a thoroughgoing 'reconstruction of State and society itself'. In its horizontal - or comprehensive - transformative avatar, the Constitution recognised that the State had never been the only locus of concentrated power in Indian society. Unlike the modern West, which understood sovereignty in centralised and unitary terms, Indian society had always been characterised by "layered sovereignty". Hierarchies were established and maintained by "self-regulating communities" taking multifarious forms (primarily, caste), and the State had "rather limited powers to interfere with [a] social segment's internal organization.'**

This helps us to understand the urgency of countering the discriminatory practices along caste, class, religion, gender, and ethnic lines in educational institutions, including medical establishments. When we look at the mechanism to counter the caste, gender or religion-based discrimination and harassment in educational institutions, we need to primarily look at the horizontal transformative ways of dealing with the malice in society.

There are multiple ways through which the transformation is sought to be brought about. To achieve substantial equality, formal equality is not enough, there is need to provide affirmative policies to create opportunities for structurally marginalized communities, enabling them to get educated and employed in the spaces which they otherwise would not be able to access given their disadvantageous positions in the society for centuries. At the same time, it is essential to provide deterrent measures to prevent and prohibit structural discrimination.

VII.2 Legislative approach adopted towards containment and redressal of ragging in HEIs and medical colleges

Ragging is normally seen as harassment faced by junior students from the senior students, where the seniority (in years) power is exercised, as a transient phase. But if we take into consideration the social background of the students then the transient nature of seniority is not the only power relation which operates, and in fact there is more likelihood of caste, religion or gender-based harassment being reported even after the first year is well passed.

The Supreme Court defined ragging in the Vishwa Jagriti matter (1999) ([Case No, 1998](#)) as,

Any disorderly conduct whether by words spoken or written or by an act which has the effect of teasing, treating or handling with rudeness any other student, indulging in rowdy or undisciplined activities which causes or is likely to cause annoyance, hardship or psychological harm or to raise fear or apprehension thereof in a fresher or a junior student or asking the students to do any act or perform something which such student will not in the ordinary course and which has the effect of causing or generating a sense of shame or embarrassment so as to adversely affect the physique or psyche of a fresher or a junior student. (Raghavan Committee Report, 2007, para. 3.19) ([Raghavan, 2007a](#))

However, this definition fails to capture the range, severity of aggressive acts, as well as involvement of social factors like caste, religion, gender, sexuality, region, physical appearances, ethnicity, language.

There has been consistent attempt over decades by various sections of civil society to approach Supreme Court to redress the menace arising out of ragging in educational institute. We provide below some vital information about the efforts made for amending the anti-ragging legislation and the outcomes.

VII.2.1 Report of the Committee constituted by UGC in 1999 “To Curb the Menace of Ragging in Universities/Educational Institutions”

In response to a public Interest litigation filed in 1999, under direction of Supreme Court University Grant Commission appointed committee headed by Prof K.P. S. Unny for framing guidelines with regards to combating the menace of ragging in Universities/Educational Institutions. This committee studied various documentations and efforts by government across India, which included eight different Ordinances/Acts across India.

As to the causes of increasing incidence and ineffectiveness of measures the committee concluded:

1. The powers and moral authority of the Wardens and other functionaries have eroded over the years, as many of them may not be committed to their work, but take up such responsibilities for the sake of perks attached to those offices;
2. Lack of interest and involvement in such matters among majority of faculty members.
3. Fear that the Head of the Departments and others may be pressurised later on for withdrawal of complaints or for revocation of the orders of punishment.
4. Fear that they and/or their family members may be harassed and victimised

It further emphasised:

It must be admitted that most of these causes are the direct result of politicisation of educational institutions and the resultant erosion of standards of behaviour. If there is no political interference, the concerned authorities will be able to take effective measures to curb ragging.

The recommended approach is based on **Prohibition, Prevention and Punishment**. It provided various guideline for prevention and prohibition. It also recommended enactment of State and Central laws making ragging a cognizable offence. It Suggested several “punishments” commensurate with severity of offences. It also recommended that defaulting Institutions should be penalized in the form of reduction in grants-in-aid or even disaffiliation. Till this time there was limited legal provision (State level ordinances/Acts) to deal with ragging in educational institutions ([Unny, 1999](#)).

In 1999 ‘**The Maharashtra Prohibition of Ragging Act, 1999**’ came into being, which was further

modified on 29th August 2012 (GOM, 1999). As the title suggests even the modified Act deals only with prohibition, without making provisions to deal with prevention. Neither it considers likelihood of caste or gender-based harassment being part of ragging.

In this ragging is defined as :

....display of disorderly conduct, doing of any act which causes or is likely to cause physical psychological harm or raise apprehension or fear or shame or embarrassment to a student in any educational institution and includes (i) teasing, abusing, threatening or playing practical jokes on, or causing hurt to, such student; or (ii) asking a student to do any act or perform something which such student will not, in the ordinary course, willingly, do.

VII.2.2 Report (May 2007) of Supreme Court appointed committee to suggest, means of preventing ragging (Raghavan, 2007b).

In response to a Special Leave Petition in 2007 a committee was constituted by Supreme Court under Dr R.K.Raghvan (former Director C.B.I). (Raghavan, 2007a) The committee visited Guwahati, Kolkata, Bhopal, Mumbai, Jaipur, Kochi, Chennai, Patna, Lucknow, Hyderabad, and Bengaluru, met all cross sections, of stake holders, including NGOs working in anti-ragging movements, student victims, their parents, students accused of ragging, their parents, teachers, wardens, heads of institutes, freshers and senior students, students' unions, representatives of government, media persons, as well as general public. In extensive report of 209 pages, there are various observations and recommendations.

While commenting on status of anti-ragging measures committee states:

3.15 In terms of the purpose of the various State laws, we find that other than the Chhattisgarh Act, no other State legislation is intended to prevent ragging. The subtle difference lies in the fact that while prohibition of ragging is a top-down approach where the law can be cryptic, an law on prevention must be more participative with a bottom-up approach laying down the detailed mechanism of preventive measures and instrumentalities.

3.19 Ironically, the Committee notes that the reported incidents of ragging have, far from abating, actually increased in the years since 2001.

The committee made extensive observations, some of most pertinent observations are enumerated here:

4.1.6 The political aspect of ragging is apparent from the fact that incidents of ragging are low in institutions which promote democratic participation of students in representation and provide an identity to students to participate in governance and decision making within the institute bodies.

4.1.7 The human rights perspective of ragging involves the injury caused to the fundamental right to human dignity through humiliation heaped on junior students by seniors; often resulting in the extreme step of suicide by the victims. In one instance we have already recounted the reported case of the mother of the victim committing suicide as she could not bear the ignominy of sexual assault on her son by his seniors

4.2 **In none of the interactions did the Committee come across any instance of the educational institutions approaching the police authorities in reporting even the extreme incidents of ragging.** Usually, the complaints with the police are lodged by the parents of the victims. Most of the parents have reported that the University/college support for following up on the case with the law and order machinery has been lukewarm – indeed in some cases the institutions have actively dissuaded persistent parents. The Committee is concerned with the evasive attitude of institutions and it is therefore necessary that the institutional authorities are made accountable in a variety of ways.

The committee made overall 50 recommendations, which include:

- Central Regulatory bodies to take ragging situation as an important factor in accreditation of educational institution.
- Set up anti-ragging cells at central, state and college level

- Setup of toll-free helpline for ragging victims
- Set up fast track courts, as well as shifting of burden of proof on the accused students

VII.2.3 Psychosocial Study of Ragging in Selected Educational Institutions in India: Report, 2015 (Rao, 2015a)

Supreme Court in 2009 (Civil Appeal 887 in University of Kerala vs Council, Principals, Colleges, Kerala and Others) appointed a committee of mental health and public health professionals to look into the issue of ragging and give recommendations. (SC, 2009b) The committee included Prof. Mohan Rao and others and submitted its report in 2015 (Rao, 2015a).

The study, the first and largest of its kind in India, used quantitative and qualitative methods to survey 10,632 students from 37 colleges (both professional and other colleges) across the country, which also captured diversity of castes. It conducted interviews and focus group discussions with students and staff of these institutions. Data was collected in 2013. The report observed:

Although it has been more than three decades since we recognized ragging to be an entrenched problem causing profound damage in our institutions of higher learning and have been looking for viable solutions through this time, it continues to make news at worryingly regular intervals. It makes one question our understanding of this phenomenon, particularly in the context of the deeper psychological and sociological determinants that eventually manifest as ragging behaviours.

In conclusion the report states:

Our survey and qualitative data clearly debunk the myth that ragging has ceased to exist or occurs rarely. In our survey, a large percentage (almost 40 per cent) of students admitted to having faced ragging. However, on further analysing the data college-wise, we find significant variations in responses. In some colleges, especially engineering and medical colleges, more than 60 per cent of students admitted to having faced ragging whereas in others such as a veterinary college in the North, a private degree college in the South, etc. almost 90 per cent of the students said they did

not face any ragging. Thus the major finding that emerged from our survey was that the psychosocial ecosystem of an institution, including the attitude of the college authorities and staff towards ragging, among other factors, determines the prevalence of ragging in that institution.

The committee gave several recommendations which include:

1. Institutional Role in Fostering Inclusion, Belonging and Acceptance of New Students : Organizing orientation, welcome programs involving all students, giving clear message of zero tolerance to ragging, sexual harassment and discrimination based on caste, religion, ethnicity etc.
2. Maintenance of Support Systems : Comprising human system of guardianship—of wardens, mentors, including senior students to be in regular contact with newcomers and to include them in activities such as games/ sports and extra-curricular, in colleges and in their residential facilities (hostels), where ragging frequently occurs.
3. Implementation of UGC Protocol and Guidelines: The study showed a reluctance to take action against perpetrators in incidents of ragging for fear of damage to the reputation of institutions. Consequently, the perpetrators themselves are reassured by the culture of impunity that pervades our social lives and feel that they can get away because they have the 'right' social and political contacts and/or because they rely on the institution's concern about its reputation.
4. Widening the Role of the Anti-ragging Cell of UGC: The cell should also actively function as a nodal body to disseminate various information/literature pertaining to harmful effects of ragging, ways to curb the practice and improve psychosocial climate in institutions
5. Accountability: NAAC (National Assessment and Accreditation Council) should actually check whether the institutions are fulfilling the conditions required for accreditation. Therefore, in addition to the mandatory form, institutions need to be regularly and systematically visited or inspected by the NAAC to ensure adherence to accreditation guidelines.
6. Psychosocial Support and Counseling: UGC should budget for the provision of counselors and should have a list of recognized nodal agencies which can be accessed for counseling services, till

such time as these capacities are developed within institutions.

7. Promotion of Diversity: Organize programs to appreciate and celebrate diversity in ethnicity, language, religion, sexuality. To counter homophobia, discriminations to persons with disabilities draw upon various social organization

VII.2.4 UGC Regulations on Curbing the Menace of Ragging in Higher Educational Institutions, 2009 (ICMR, 2009).

UGC brought about this regulation In view of the directions of the Hon'ble Supreme Court in the matter of "University of Kerala v/s. Council, Principals, Colleges and others" in SLP no. 24295 of 2006 dated 16.05.2007 (SC, 2009b) and that dated 8.05.2009 in Civil Appeal number 887 of 2009 (SC, 2009). In Section 3, under eight (a to i) categories it defines what constitutes ragging.

The UGC, in 2016, amended this section of the UGC Regulation 2009, to explicitly include social hierarchies to the existing definition of ragging.

In Section 3, What constitutes ragging after subsection (i) another subsection as below was added:

3(j) Any act of physical or mental abuse (including bullying and exclusion) targeted at another student (fresher or otherwise) on the ground of **colour, race, religion, caste, ethnicity, gender (including transgender), sexual orientation, appearance, nationality, regional origins, linguistic identity, place of birth, place of residence or economic background.**

This has been the first recognition of the power relations involved in menace of ragging.

This amendment to the UGC Regulation 2009 is an important milestone in anti-ragging efforts by the UGC since it is more comprehensive and captures the ground reality of the inherently discriminatory character of ragging across various hierarchies which otherwise is largely and conveniently conceived as an outcome of a unidimensional power hierarchy between juniors and seniors.

This regulation included:

- Measures for prohibition of ragging at the institution level

- Measures for prevention of ragging at the institution level
- Constitution and functioning of anti-ragging committee
- Action to be taken by the Head of the institution, which included
 - o filing of FIR within 24 hours of receipt of information or recommendation of the anti-ragging committee
 - o the institution shall also continue with its own enquiry initiated under clause 9 of these Regulations and other measures without waiting for action on the part of the police/local authorities and such remedial action shall be initiated and completed immediately and in no case later than a period of seven days of the reported occurrence of the incident of ragging.
- Duties and responsibilities of Commission: which includes fund and operate, a toll-free Anti-Ragging Helpline, operational round the clock, which could be accessed by students in distress owing to ragging related incidents
- Administrative action in the event of ragging by Institution include nine measures ranging from suspension, withholding scholarship to expulsion.
- Administrative action for non-compliance of provisions under this regulation included in section 9.2 and 9.3 include:
 - o Withdrawal of affiliation/recognition, prohibiting Institute from presenting students, withholding grant.
 - o **In case on non-compliance of the regulation a lapse is attributable to any member of the faculty or staff of the institution to initiate departmental disciplinary action, in accordance with the prescribed procedure of the institution against staff, faculty or head of the institute.**

VII.2.5 Non-compliance of UGC Regulations on Curbing the Menace of Ragging in Higher Educational Institutions

It is only through various media reporting we can get some idea of increasing menace of ragging over the years.

National Crime Records Bureau, Ministry of Home affairs does not publish data related anti ragging cases registered, hence it is rather difficult to get national level data to understand the trajectory of the menace.

In a written response to a query, Ashwini Kumar Choubey, minister of the state of MoH&FW, shared the status of ragging cases received year-wise with Parliament in December 2019. Interestingly, only six cases were recorded by the Medical Council of India (MCI) in 2019-20 session by then. The most cases, 25, were registered in 2017-18 ([Radhika, 2020a](#))

According to the NGO- Aman Movement, between 2015 and 2019, a total of 682 ragging cases were reported by different medical colleges in India. Since 2012, Aman Movement is responsible for running the national anti-ragging helpline for the higher education regulator, University Grants Commission (UGC).

Meera Patel, a lawyer has explained in a publication:

Most of the ragging cases are reported from technical (engineering) and medical colleges for which the All India Council for Technical Education (AICTE) and MCI maintain records,” explained Meera Patel, a lawyer. “But they show only the tip of the ice-berg. A lot of these cases are resolved through the helpline number or at the college level which should ideally be taken into account too.

The data presented by the ministry shows a wide gap in the number of cases registered. Gaurav Singhal of Society against Violence in Education (SAVE) explained:

There are several serious cases which do not get reported through the helpline. Those are directly reported to the police. There are several cases which are picked up from the media reports as well. Singhal said: We take cognisance of the media reports, especially those in the local language newspapers. English newspapers do not report such cases. ([Radhika, 2020b](#))

According to the University Grants Commission (UGC), 3,299 cases of student ragging in universities and

colleges were registered across India between April 18, 2012 and December 12, 2017. However, only 957 students were punished in all these cases, reported Hindustan Times. Such is the situation in spite of the UGC's strict guidelines to campuses to put in place effective anti-ragging measures. ([Dailyhunt, 2017](#))

The situation is not very different in Nursing Institutes. As many as 10 students had been under the scanner of the anti-ragging committee of HBT Medical College attached to the civic-run Cooper Hospital in Vile Parle in 2016 and 2018, but no complaint has been reported to the police, a Right to Information query has revealed. Of the 10 students, eight had faced suspension from the hostel but there was no dismissal or penalty. There is no clarity on the number of cases these students were involved in. The RTI also revealed that the hospital's anti-ragging committee held 11 meetings during this period. The University Grants Commission guidelines, however, make it mandatory to file a first information report in all ragging complaints. ([Shelar, 2019](#))

Among HEIs, the highest number of ragging complaints comes from medical colleges, says Raj Kachroo of Aman Movement, an NGO that runs the UGC's anti-ragging cell. Within that, a large number of complaints are from those facing harassment due to their social backgrounds. Last year, 38% of the ragging cases were reported from 450 medical colleges against 47,000 other colleges, where the figure was just 1.8%.

Kachroo was quoted in the Indian Express:

Students in medical colleges are harassed and discriminated against due to their backgrounds, the way they speak and the way they behave..

He added most cases of caste-based discrimination are not reported by students out of fear. Sources in the Medical Council of India-Board of Governors conceded they have not paid attention to caste-based discrimination ([Dutta, 2019a](#)).

On 21st August 2019, Hindustan Times, reported ragging incident of 19th August 2019 Around 200 freshers of the Uttar Pradesh University of Medical Sciences in Sefai were made to tonsure their heads on Monday night. They were paraded through the campus with the instructions to give "farshi salaam" (one bends close to the knees). The college administration said it would get the incident

investigated but maintains that such an activity was part of the tradition. (Naqvi, 2019)

In case of death by suicide of Dr Payal Tadvi, the report of anti-ragging committee dated 25th September 2019, could be accessed by Dr Payal's relatives only after one year, when Maharashtra Government filed an affidavit in Supreme Court on 7th Sept 2020, in response to appeal filed by three accused doctors to get some relief. It is only after one year it came to light that anti-ragging committee had recommended suspension of the three accused and had also recommended to initiate administrative action against unit head. But neither this report was made even available to Dr Payal's relatives nor any FIR was filed by the Institution as mandated in Maharashtra Prohibition of Ragging Act 1999, section 6(1).

It was only when Dr Payal Tadvi's mother lodged complaint with the police that It got registered under the provisions of Scheduled Caste and Scheduled Tribe (Prevention of Atrocities), Act, 1989 and also under Section 4 of the Maharashtra Prohibition of Ragging Act, 1999 [This has been recorded in SC judgement (SC, 2020a)].

And even today no action has been taken against head of the institute for violation of legal provisions. In fact, the non-compliance by the authorities resulted in Supreme Court revoking the suspension of the three accused doctors.

Supreme Court stated:

As a matter of fact, the Order of Suspension was not passed by virtue of power entrusted under Section 6(1) of 1999 Act but was based on the grounds that the Appellants were creating hurdles in the enquiry by the police and that there was an FIR against them. We, thus, conclude that the Order of Suspension is not referable to Section 6(1) of 1999 Act. (SC, 2020b)

VII.3 Redressing caste-based discrimination in medical institutions

'Adham jati mein shiksha paye, bhayahu yatha ahi dudh pilaye,' (educating a lower-caste person is the same as feeding milk to a snake)' — this was a saying I used to hear several times a day from a senior

professor,' recalls Dr Surya Bali, who belongs to a Scheduled Tribe and is currently working as an additional professor at AIIMS, Bhopal. He also holds a degree in Master of Health Administration from the University of Florida.

Bali recalls,

From SGS Inter-College in Jaunpur, Uttar Pradesh, to AIIMS Bhopal, there have been hundreds of incidents wherein fellow students and even teachers tormented me over my caste. In 1989, I topped in my Thakur-dominated college. In response, upper-caste students tore up my marksheet, as they couldn't believe that a Dalit student could stand first. They used to pass casteist remarks and mock me, asking why I was bothering to study, as ultimately I would have to work in the fields with my parents. (Mishra, 2019)

Nearly 13 years back, in 2007 following the suicide of an undergraduate MBBS student at the All India Institute of Medical Science (AIIMS) who got admission through quota system, the Union Ministry of Health and Family Welfare had constituted a committee under the then-University Grants Commission chairman Sukhadeo Thorat.

VII.3.1 Prof Thorat Committee Report on Caste Discrimination in AIIMS, New Delhi (2007)

Following the announcement of reservations for Other Backward Castes (OBCs), the Bill for reservation for OBCs was sought to be introduced by the Government of India in the month of April 2006. (GOI, 2007) Some groups of students who were opposing such reservation had launched an agitation called as 'Anti-OBC Reservation Agitation' (ARA) in the month of May 2006. A countrywide strike was organized by this group called Youth for Equality (YFE) beginning with 13th of May 2006. The media had reported that this group included medical students, students from IITs and IIMs and some other colleges. It was also reported that this group had its origins in the All India Institute of Medical Sciences and involved several members of Students Union, Resident Doctors Association and Faculty Association from All India Institute of Medical Sciences. (Dutta, 2019b). (Thorat Committee Report, 2007)

During the enquiry overwhelming number of students from the marginalised communities complained of discrimination at multiple levels, which included discrimination in teaching, in evaluation of theory papers, in practical and viva, in class representation, segregation in hostels, social isolation, discrimination in mess, in sports, cultural events, ragging with caste undertones. SC/ST junior and senior residents also reported caste-based victimization. The SC/ST staff complained of non-implementation of roster system of selection and appointments.

The Thorat Committee gave list of recommendation to counter the caste-based harassment and discrimination. The recommendations include:

1. Special Programs to assist students
 - i. to improve consultation with teachers
 - ii. for fair evaluation and examination
 - iii. on class representation
 - iv. to improve the interpersonal relations and bring social harmony
2. The Committee recommends that the AIIMS should set up a special office called **“Equal Opportunity Office”** to deal with all the issues relating to SC, ST and OBC students. This office should implement the remedial coaching programs and other schemes for the SC/ST students. It should also serve as an office which will address the grievances of SC/ST students and also other problems. It should be headed by a senior faculty and supported by one more faculty with proper supporting staff and funding.
3. Committee recommends that (i) the SC/ST students should be nominated as representative on all Committees dealing with matter related to students; (ii) the authority should develop the norms and regulations for the working of this Committee, which will be fair, transparent and democratic.

No medical college in Maharashtra has followed any of these recommendations

On the incident of death by suicide of Dr Payal Tadvī, Prof Thorat, now a professor emeritus at

Jawaharlal Nehru University (JNU), in an interview expressed that Tadvī and many before her in other professional institutes would not have taken the extreme step, if the recommendations from his committee had been implemented. Prof Thorat said the following about AIIMS:

Despite the non-cooperation by the then-AIIMS administration, I was relieved that they followed some suggestions like ending caste-based ghettoisation in hostels, discrimination in mess and getting an external examiner from SC/ST class in viva voce. Sadly, though, the government did not make any systemic changes. (Dutta, 2019c)

During our enquiry one of our key informants, a senior academic said to us:

Thorat report came, other reports came, even the UGC guidelines are not implemented. This is the bias of the Upper Castes and Upper Classes. That is also because there is no SC, ST representation in the bureaucracy; there are these political connections and vested interests. There is a very low representation in decision-making positions. That is why no action is taken. There is absolute apathy. The SC/ST representation, also of women in institutions is very low. The police are either neutral or partial to the upper castes. In the Sexual Harassment Committees too we see the same, decisions are pro-men. Unless there is your agenda (representation) in the system, (marginalised sections) cannot overcome their social origin.. (KI5).

Even today the situation in AIIMS clearly shows, that there is no implementation of any of the recommendations from the committees reports.

On 17th April 2020, a woman doctor from AIIMS, Delhi attempted suicide. The incident came to light on Sunday after the Resident Doctors' Association (RDA), in its letter to Union Health Minister Harsh Vardhan, said that the senior resident doctor at Center for Dental Education and Research (CDER) had written repeated letters to the administration, National SC-ST Commissions and Women's Grievance Cell but no action was taken.

In response to this attempted suicide, RDA in its letter, said,

The Resident has made repeated appeals to the Department, Director and also has been

represented through RDA AIIMS to the Administration. Despite multiple letters (dated 16.03.2020, 22.03.2020, 23.03.2020), there has been no adequate action taken to address this issue of grave concern and eventually leading the resident to the edge making her to take drastic step to end her life after losing hope of justice in this prestigious institute. (Kaushal, 2020)

VII.3.2 Dr Mungekar committee, 2012:

In 2012, Rajendra Kumar Meena, Lal Ji Meena and Vishal Meena, all students of Vardhman Mahavir Medical College (VMMC) in the New Delhi filed a writ petition in the Delhi High Court alleging bias in conducting examinations and seeking re-examination. After the court order, a re-exam was conducted and 24 of the 25 students cleared the paper. These three students from marginalised community claimed that the college authorities are intentionally failing them in pathology and pharmacology papers for the past four years (Chandra, 2012).

The court's observation is telling:

We'll be failing in our duty if we do not deal with the submissions of the students, who belong to a different stratum of society, and are facing a hostile atmosphere because they have approached us...(Raman, 2012)

Following this a committee was formed headed by Professor Bhalchandra Mungekar, who was appointed commissioner of enquiry by the National Commission for Scheduled Castes, to look into caste-based discrimination faced by students of Vardhaman Mahavir Medical college.

Professor Mungekar told reporters (IE, 2012).

Several students belonging to SC community were repeatedly failed in their subjects. During the course of our investigation, we have come to a conclusion that there was a feeling of deep rooted anguish and hatred towards the SC students. We have also given our recommendation for necessary action.

The committee apart from making wide-ranging recommendations, suggested compensation for the

students, as well as legal action under SC/ST Atrocities Act against the former Principal of the College, Head of Physiology, a Professor of Physiology and the liaisons officer.

(Note: There has been no report on action taken by the Institute in terms of filing any legal case under SC/ST atrocities Act against the persons in authority as recommended by the Committee)

VII.4 UGC (Promotion of Equity in Higher Educational Institutions) Regulations, 2012 (GOI, 2012)

Following many complaints of caste-based harassment, the Chairperson, UGC constituted a committee to frame regulations on caste-based discrimination/harassment/victimization and promotion of equality in higher educational institutions. These shall apply to all higher education institutions in India. The objective of the scheme is to eliminate caste-based discrimination and harassment of the SC/ST students in all forms by providing preventive and protective measures to facilitate its eradication and punishments for those who indulge in caste - based discrimination/ harassment. (UGC, 2012)

Thus UGC (Promotion of Equity in Higher Educational Institutions) Regulations, 2012 came into being.

A Conference of Vice Chancellors of Central Universities was held on February 18, 2016 wherein all Vice Chancellors and senior Officers of the Central Universities have been asked to be more vigilant & put a proper system in place to ensure that the students from marginalised communities are not put to any disadvantage/ hardship. Vice Chancellors have inter-alia agreed to appoint Anti-Discrimination Officer as provided in UGC (Promotion of Equity in Higher Education Institutions) Regulations, 2012.

UGC has also approved establishment of 126 SC/STs cells in various universities with a view to safeguarding the interest of SC/ST students. (Bhatia, 2019c)

This regulation is exhaustive in terms of enlisting various forms of discriminations which operate within institutes. Further, it has asked to establish equal opportunity cell and anti-discrimination officer not below rank of professor and associate professor for university, and colleges respectively.

While the Regulations have attempted to secure equality of treatment in universities, they have failed to secure actual protection through several lapses, including lack of monitoring mechanisms, evidenced by several universities failing to constitute Anti-Discrimination Officers and Equal Opportunity Cells ([Deepika, 2016](#)).

It is important to note that there is no provision made in this regulation to take action against non-compliance of the regulation. This has resulted in virtually complete absence of any guidelines to be followed in all colleges and universities.

It was only when, following death by suicide of Dr Payal Tadvi, it became public knowledge that UGC guidelines were not complied with in the universities and colleges, on 26th June 2019 UGC Secretary issued notice to all the Vice Chancellors of all universities, stating as below:

University Grant Commission has issued letters dated 19.07.2011, 02.07.2013, 07.03.2016, 05.09.2016, 15.05.2017 and 04.06.2018 requesting to take following action: ([Jain, 2019](#))

The official / faculty member should desist from any act of discrimination against SC/ST students on grounds of their social origin. Towards this-

1. The University / Institution / College may develop a page on their website for lodging such complaints of caste discrimination by SC/ST students and also place a complaint register in the Registrar's / Principal's Office for the purpose. If any such incident comes to the notice of the authorities, action should be taken against the erring officials / faculty members promptly.
2. The Universities and colleges should ensure that no official / faculty member indulges in any kind of discrimination against any community or category of students.
3. The University constituted a Committee to look into the discriminating complaints received from the SCs/STs /OBC students/Teachers and non-teaching staff.

The only mandatory requirement was an Action Taken Report that would to be submitted via email to the authority ([UGC, 2018](#)).

UGC (Promotion of equity in higher educational institutes) regulations, 2012 provides no mechanism against non-compliance of the regulations

As noted by a key informant that we spoke to:

“This country does not suffer from lack of imagination; it suffers from lack of implementation. Eleven acts to address corruption and still rampant corruption. Similarly, for gender – starting from Sharda act. There is no dearth. Then we have to look at the role of political party, of student organisation, role of NGO. Unless we create strong public opinion against these atrocities nothing will happen.” (KI5 Senior Academic and a key informant in this inquiry)

VII.5 University Grant Commission (Redress of Grievances of Students) Regulations (revised on 6th May, 2019)

In 2012 UGC published notification/regulation for Grievance Redressal Regulation, to provide opportunities for redress of certain grievances of students already enrolled in any institution, as well as those seeking admission to such institutions, and a mechanism thereto ([GOI, 2019](#)).

This includes:

1. Complaints of alleged discrimination of students from the Scheduled Castes, the Scheduled Tribes, Other Backward Classes, Women, Minority or persons with disabilities categories.
2. Grievance Redressal Committees are required to be formed at all levels, from Level of UGC, University, Institution and college. There is requirement of “Ombudsperson” to be appointed.

None of the BMC run medical colleges have these committees functioning. According to newspaper reports.

The University Grants Commission (UGC) plans to come down heavily on colleges and universities that are not complying with its guidelines on putting in place a mechanism to address caste-based discrimination on campuses. (Economic Times, 2019)

(Bhattacharyya, 2019)

But once again UGC failed to take any action for non-compliance of the regulations as provided in the Section 10 of the Regulation.

VII.6 Ground reality of caste-based discrimination in HEIs

Besides incidents of caste-based discriminations taking place in medical establishments and institutes, there have been numerous such instances in other HEIs. These have resulted in disastrous consequences for the aggrieved students. Inquiry committees at other universities found evidence of caste-based discrimination by faculty similar to ones reported in cases in medical institutes. For example, on 17th January 2016, Rohit Vimula, student from Hyderabad Central University (UoH) died by suicide. His death sparked protests and outrage across India and gained widespread media attention as a case of discrimination against Dalits. At UoH, since 2008, six dalit students have died by suicide. P. Senthil Kumar, a dalit doctoral student at the School of Physics, consumed poison in his room in February 2008. He was one of the four SC/ST students in the doctoral candidates batch of 2006 – two among them had dropped out after they were unable to find faculty supervisors for their research. The University of Hyderabad had appointed an enquiry committee chaired by Professor Vinod Pavarala (HT, 2016)

Year after year there have been similar incidences and various committees like The Professor V. Krishna Committee, Justice K. Ramaswamy Committee were constituted. However, these efforts have not resulted in any relief to the aggrieved families and individuals or justice delivery to the discriminated students.

In 2013, 28 professors from universities in Hyderabad impleaded themselves in a writ petition related to caste-based discrimination before the Andhra Pradesh high court. Their letter noted,

Students from marginalized groups also are troubled by lack of clarity and sometimes contradictions in examination and administrative procedures...rules that do not take into account their difficulties,

and discretionary and biased treatment from the administration. For example, 'don't waste my time', 'go away', 'come tomorrow', 'I am busy now', 'your presence irritates me' (the last spoken by a deputy registrar sitting in an air-conditioned room) have become routine. ([Sitlhou, 2017](#))

The petition in Andhra High court stated that:

We believe that the suicides are only the tip of the iceberg of many problems the student community (especially dalits and other marginalized groups) is experiencing. These include: failure and constant fear of failing the examinations; insult; a sense of being stigmatized, unwanted or rejected socially and academically; consequent demoralization and lack of self-belief; having failed not knowing how to face families who have struggled to educate them; not being able to fulfil the responsibility of supporting parents and siblings; sexual harassment; not having the economic resources to survive outside the university campuses--just to mention a few examples. University administrations have generally attributed these deaths to personal psychology instead of attempting to seriously study the problem and initiate broad systemic and attitudinal reforms.

Following which another committee was formed headed by Prof Faizan Mustafa, which gave various recommendations.

In August 2019, mothers of Rohit Vimula and Dr Payal Tadvi filed a public interest litigation (PIL) in the Supreme Court of India. The petition stated that: ([SC, 2019e](#))

By failing to prevent caste-based discrimination on the campus of HEI's, the state and its functionaries have violated the fundamental rights guaranteed under Part – III of the Constitution of India including the Right to Equality vis-a-vis Articles 14, 15, 16 and 17 and the Right to Life under Article 21 of Constitution of India. Repeated inaction by state functionaries is resulting in increasing number of student suicides due to complete social exclusion, harassment and trauma of being treated in an inhuman manner, justifying intervention by this Hon'ble Court. The Executive inaction by the Universities in failing to implement the advisories from time to time by the University Grants Commission, and by failing to take any concrete steps to prevent caste based discriminatory practice has resulted in a serious violation of the Fundamental Rights of not only the

students but also professors, teachers, staff and other employees who are employed or are otherwise associated with the Higher Education Institutions.

None of the systems devised on paper seem to counter the menace of Caste Discrimination and unless the aggrieved students, their parents or concerned members of civil society speak up, the situation does not even come to the notice of concerned authorities or judiciary.

VII.7 Continued non-compliance of UGC guidelines by various universities and colleges

Several efforts were made by concerned individuals to get concrete information about non-compliance of various anti-ragging regulations and guidelines by the HEIs. For example, an RTI filed by Kushal Nandwani with the University Grants Commission (UGC) in July 2019 has revealed:([SC, 2019f](#))

1. that out of around 880 Universities recognised by the UGC, only 419 universities have filed action taken reports for the year 2017-18.
2. that only 27 universities have received complaints of caste discrimination on campus during the year 2017-18, which means 393 universities have reported that they did not receive a single complaint of caste discrimination during the given period.
3. that 91 out of the 419 Universities that responded, do not have a separate website for the SC,ST Cell. On a general reading and verification of the RTI responses, many of the Universities that claim to have a dedicated webpage to file SC, ST complaints have either broken links or the general homepage of Universities which does not show any dedicated link to register online complaints by SC, ST students.
4. that the mechanism adopted to address these complaints differs drastically from “in-house committees” to “grievance redressal cells” to complaints before “concerned authorities” to “counselling and mediation” to “warnings to not repeat mistake again”.

5. that the criterion given by UGC does not provide for universities to disclose the mode of solving complaints against students, faculty and other employees, though such details have been asked from colleges.

E Edhaya Chandran writes while referring to the institutional response in the case of the incidents of Rohit Vemula in HCU, Muthukrishnan in JNU and Payal Tadvi in Nair Hospital:

By not acknowledging the role of caste in these crimes, the institutions have ended up indirectly authorising them. When discrimination is institutionalised, it kills upliftment. The new India has seen a new code of discrimination. Dalits who have been refused the right to education for centuries, have now gained it through the constitutional provision. But in the process, they are subjected to constant harassment and humiliation. They are whispered, told and beaten to the agreement that they don't belong "here"(Chandran, 2019).

Neha Madhiwala, Phd Scholar, who had interviewed generation upon generation of resident doctors about the issues they faced says in her article "Institutions should take responsibility for student suicides"

While the legal system takes its own measures, if the medical education system and its institutions are not implicated for their role in this case, I fear the consequences. The general population of students will not even reflect on their own discriminatory attitudes and instead feel like victims. Residents like Payal will be (sic)continue to be caught between immediate seniors who have unaccountable power and a college administration which they feel cannot be bothered to help. (Madhiwalla, 2019)

In 2015, Maharashtra reported most student suicides of any state: 1,230 of 8,934 (14%) nationwide, followed by Tamil Nadu (955) and Chhattisgarh (625). Maharashtra and Tamil Nadu are among India's most advanced states, and their high rate of suicides could reflect the pressures of economic growth. We do not have information on caste based breakup of the students or which stream of discipline they were pursuing, but it gives some indication of the disastrous situation existing in educational institutions.

The Economic and Political Weekly editorial on 23rd November 2019 while remarking on the role played by higher authorities in bringing forth the caste discriminations in educational institutions further states:

But, even more accountable than the media are the authorities of the higher educational institutions—many of them proud of their national and international rankings—which simply ignore their own students' plight. Most Dalit and tribal students and students from other minorities, who at great social and economic costs enter these institutions, struggle to get their bearings in unfamiliar surroundings. Usually, they, by and large, hail from non-English medium institutions, and find it difficult to follow the medium of teaching and modes of conversation with fellow students. How effective are the support structures for them, and, even if they exist structurally, how sensitive are these? There are reports on the differential treatment accorded to students from Scheduled Castes and Scheduled Tribes and other marginalised sections in top medical and other institutions. **It remains a mystery as to what is done with these reports and what is the mechanism to ensure that their suggestions are implemented.**" (EPW, 2019)

Once we take cognisance of all these lapses and ground realities, we cannot but conclude that these various legislations and regulations have completely failed to achieve the purpose of creating non-discriminating, level playing field for students coming from oppressed castes, who continue to be discriminated and subjected to extreme harassment.

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Chapter VIII

Discrimination isn't a thunderbolt... It's the slow drumbeat

We started this inquiry in the face of a drastic and violent incident of the institutional murder of Dr Payal Tadvi. As we wrote in the earlier chapters, we began with the premise that this incident was a result of neglect on the part of the Institution to address the discrimination, humiliation, harassment and violence that doctors like Dr Payal Tadvi face. Through the inquiry, hence, we wanted to throw some light on how such neglect actually gets built into systems and practices of the Institution.

Our conversations, readings and discussions brought us to an understanding that quotidian acts of discrimination are at the base of most interactions in the institution. We realised that the environment of institutions is such that even if people do not lose their lives, surviving it with dignity is in fact almost impossible for all those who come from marginalised castes and tribes. We agree with Megan Urry, Astrophysicist and Director, Yale University Centre for Astronomy, who says it clearly in her article, **“Discrimination isn't a thunderbolt, it isn't an abrupt slap in the face. It's the slow drumbeat of being under-appreciated, feeling uncomfortable and encountering roadblocks along the path to success”**.¹ (Urry, 2005)

As we looked at the policies and practices, we realised that institutions follow the legally mandatory actions of reservations in seats and posts grudgingly and in a manner of following the law of the land by the letter. Often times, even the compliance with these legal frameworks is poor and/or non-existent as we discussed in chapter VII. There is a hesitation to admit that there is an inherent casteism incipient in the system and is practised by all the members of the institution, knowingly or unknowingly. There is no

attempt at checking these biases, prejudices and the ways in which they impact those targeted. This itself lends it a sanction and encouragement to become a vicious circle that continues consolidation of such practices rather than stemming it and eliminating it from institutions.

VIII.1 Naming it discrimination

There seems to be a hesitation to acknowledge all discrimination, particularly that faced by those from marginalised communities. Institutions and all those in power continuously seem to find ways to call it everything but discrimination. Often only the most blatant or crass expressions of casteism or misogyny or communalism are identified as discrimination. If someone is subjected to subtler forms of discrimination or when the discrimination is couched within different frames, it is rarely identified as discrimination. Often times, we observed during our conversation with various participants in this enquiry, that there is an active denial of its existence.

Many a time, it is because people fail to think beyond a point and see only the spectacular acts as discriminatory. (SCS, 2021). In one of our interviews, some of the male union activists who were from the dominant castes said that they do not recall any instance of caste or communal discrimination. Similarly, a senior doctor (KI3), who retired from a prestigious medical college in Mumbai, denied the existence of discrimination in medical institutions. However, when we specifically asked him if there were instances like general comments being passed by faculty against reservation in the presence of students who may have accessed admission through this, he acknowledged that this could happen. He said, “If this is called discrimination, then yes it happens.”.

This denial itself acts as discriminatory because then those targeted have to do the extra labour to demonstrate that what they are experiencing and are subjected to is nothing but discrimination.

² We use spectacular here as used in critical race theory and work on discrimination. It is acts that are made a spectacle of as they are too violent and gross to ignore. But as the call for papers by Society for Classical Studies on **Race and Racism: Beyond the spectacular** states: “spectacular acts of bigotry and endangerment are not exceptional, not a blip in the otherwise ‘civilized’ rhythms of scholarly life. They are better publicized iterations of everyday experiences.”.

The problem is further exacerbated because instead of listening and paying attention to the voices of those discriminated against, the reaction to such articulation is often seen as unnecessary over-reaction even by those who are otherwise sensitive to social issues, in general. One of the resident doctors from the dominant caste RDD2 who we spoke to did not seem to have an open bias against any community. However, they seemed to neither see caste as a structure or system that tends to determine access to resources and power nor recognise how it shapes social and professional relationships that contribute to social capital acquired by all individuals.

Many times, these students (reserved category) become more (he meant unnecessarily) sensitive. They talk as though they are the only ones who have faced any hardship. They talk that you get everything in hand, but do you know how much I had to struggle for everything? . . . ‘*Tula sagala tatat vadhoon dilay*’ (you got everything right from childhood without asking.) It is a vicious cycle. Even if it is not meant like that, a category person starts perceiving discrimination. Anyone who has said anything against a category person, he starts looking at what they say and do with a coloured vision. [RDD2, a senior resident doctor from dominant caste]

The existence of discriminatory practices is not only denied, those throwing light on it are seen as ‘over-sensitive’! The allegation that the person from the marginalised community is “perceiving – a particular act/instance as discrimination” is itself the core of the problem. Discrimination is more about how the person facing it perceives it, as against the intention of the person seen to be discriminating. It cannot be defined by listing of certain acts are discriminatory. These perceptions of discrimination ought to be central to an understanding of it. Also as we start addressing discrimination, this is one of the first things that people have to be educated about – ***those who are privileged by a certain axis of marginalisation usually begin with denying the marginalisation itself.***

Probably it is this denial that is at the base of legislative provisions which have collapsed caste-based harassment under the misnomer of ragging, making it sound harmless and trivial; just something that inevitably will happen in peer group interactions. We discuss this in greater detail in the next chapter and make a clear case of how this has in fact hidden systemic issues that need to be addressed and how that has in fact had very dangerous and tragic consequences to an entire section of students, doctors

and employees.

Naming is a political act. For example, it took a long struggle and consistent efforts over decades to change the use of the term 'eve-teasing' which transformed a serious act of violation of women's bodily integrity to a trivial one, to 'sexual harassment' which is the core issue at hand. This shift in naming the act has made a whole difference to how it then gets perceived and addressed. So **it is important that caste-based discrimination be recognised and called by what it is, thereby partially relieving those targeted from the double onus of not only facing it but also proving it.**

VIII.2 A culture of not recognising discrimination

This culture of not acknowledging discrimination runs across all marginalisations. For example, when asked whether there is discrimination on the basis of religion, most participants from the majority community said no such discrimination happens. The union activists who had earlier denied the existence of caste discrimination also denied that of communal discrimination. A senior doctor, KI4, when asked of this question, spoke about instances showcasing communal attitudes in certain hospitals where there were more patients from the nearby poorer Muslim locality. In the same locality there have been protests against the communal attitudes of the doctors and other staff in the way patients are treated. When we asked him about discrimination within the institution against its own staff, he was surprised that he could not recall any colleagues from the Muslim community. He admitted later, that there were none, a fact that he had not really even registered as exclusion in spite of being sensitive to the issue!

We were able to interview some senior doctors from the Muslim community. They had experienced discrimination at various levels.

We do experience anti-Muslim attitudes. WhatsApp groups (medical) post anti-Muslim comments. We have lived together like a family. Currently the Hindu identity is getting emboldened. . . . This has happened only after 2014. Talk of a Hindu country. . . . One Muslim doctor, who was the first qualified gastroenterologist in Maharashtra, could not find employment in any hospital.

Another example was about one of our Hindu Maharashtrian colleagues. We became friends with him only when he came to Saudi Arabia for work. We were already there and he was alone. We started involving him, inviting him for dinners, vegetarian food is always there, on festivals etc and he came out of his loneliness. Later he told us that he had a lot of biases and prejudices against Muslim families and if it were not for this peculiar situation, he would have never made friends with Muslims and his eyes have opened. [KI2, Senior doctor from the Muslim community]

Unfortunately, this very doctor did not seem to agree with the logic of positive discrimination with respect to caste. He seemed reluctant to accept the logic of affirmative action. But felt that since there is a policy regarding reservation and it is part of the legal framework, one needs to respect it (we do not know what 'caste' within the Muslim religion they belonged to). This just indicates that even if a person faces some discrimination there is no reason to believe that they would be sensitive to other marginalisations. Essentially there is no simple way by which people get sensitised to marginalisation. **There has to be an active process of conversation and generating a conversation on the multiple experiences of inequity faced by different communities on campuses, for them to become a space where everyone feels welcome and able to learn.**

Besides, this is what education is all about. Learning to live with an understanding of the society around us. As we said in Chapter V and discuss further in the next chapter, this is even more important for medical education since once the students enter their professional spheres of practising medicine they will have to engage and provide care for people from across sections of society. Having an understanding of social structures along and across various axes of marginalisation is important to be an empathetic and ethical health care worker.

VIII.3 The hocus pocus of merit

Reservation in seats and posts as a measure of affirmative action has unfortunately become the cause for greatest acrimony. Most people from marginalised castes and tribes are referred to as '*sarkarche javai*' (sons in law of the state) indicating that they are undeserving persons who occupy seats and

positions as a special favour from the State. Most of the students and employees from marginalised castes that we spoke to, said that they had heard this being said. It hurts a great deal as it negates the hurdles, hardships and struggles of the students and employees in different areas of their lives. That possibly is the explicit intention! The metaphor used is ironically also extremely patriarchal because it implies that the son in law is respected and given everything on a platter irrespective of whether he deserves it or not. He has after all relieved the family of the burden of their daughter by marrying her!!!

There is a presumption that for those from the communities eligible for reservation, life is easy as they apparently do not have to work hard to get admission in any field they want. This is directed at even those from marginalized communities who may have accessed admission in the non-reserved seats, having scored a higher percentage of marks. In fact, some students who got admission through reservation were in the top 10 in examinations. However, the discrimination doesn't stop, even after they prove their 'merit'. There is a presumption of 'lack of merit' and the intention is to show 'them their place' and to humiliate. Even if this is not explicitly said, this is the environment within which persons from marginalized communities – students, teachers and other staff at HEIs are forced to live in.

RDM4, a senior resident doctor from a marginalised caste that we spoke to said:

Based on the free ship list and mark list, everyone gets to know the caste of the students. And so apart from close friends, one hears from others comments like '*Tuzhe koi stress nahi. Tuzhe to mil hi jayega PG mein.*' [You have no stress. You will anyways get a seat in post graduate program.]. Nobody directly does harassment on the basis of caste, but it may happen in other forms (on the sly, in the guise of something else.).

The assumption is that it is easy for those belonging to the marginalised communities. Such sentiments and perceptions also implied that for those coming from dominant communities it is very difficult because they have to face so much competition and have access to few seats! This statement reeks of entitlement of caste. All these seats in their minds belonged to the dominant community by default because they had easy access through centuries of advantage and privilege. An educationist and ex-VC of a university (KI5) from a marginalised caste, who we spoke to shared a perspective which provides insights into this attitude. According to him:

Those from the reserved category who are getting more marks than those from the general category also get targeted. This is not just discrimination. This is caste-based envy and jealousy. [The sentiment of those from the non-dalit communities on such occasions is that]. 'How could he get more marks? He must have manipulated.'. They do not accept merit of by a Scheduled Caste person. And this happens in all areas not only in medical [education].

It is this caste-based envy/jealousy or more starkly a belief in the rightness of the system that blinds most people from dominant communities to the impact of the system. Those who come from a marginalised location most often do not deny the presence of the casteist mindset because it is they who have to live it and experience it in the form of general comments, active acts of denial, subtle rejections, experience of an othering, a constant insistence that they prove their calibre, a constant feeling of being measured up and communication that they do not really belong, that they are there because of some 'unfair policy'.

VIII.4 Assessing assessments

Experience of marginalisation and studies around various kinds of discrimination along structural axes of marginalisation like that of race, caste, gender identity, sexual orientation, disability, etc have shown that assessments are flawed. That which apparently provides a measure of merit itself is a flawed system at different levels.

First of all, this has been well established that if two people get equal evaluations, the effort required by the person who comes from a marginalised background is way more than that required from the one who comes from a more privileged background. Subtle biases of the evaluator always show up. Many experiments where identical applications are given but applicants are assigned different genders have shown the 'men' always being favoured with job offers, better salaries, more acceptance of submitted articles – all critical parts of academia. (Corrine et al, 2012; Reuben, Sapienza & Zingales, 2014; Johnson & Kirk, 2020). Similar work has been done in other fields like for selections for orchestras (Goldin & Rousse, 2000) and for race discrimination in job applications as well. (Bertrand & Mullainathan, 2003).

Oral examinations in medical education and otherwise have always been contested. Seeing the person, knowing their name, hearing their accent, all of this influence the evaluator. Our research participants told us anecdotes of these as well as we have discussed in Chapter V. And this is over and above the other incidents of obvious and overt discrimination which also our participants reported.

There is another aspect which also our participants highlighted for us. The difference of background. As RDM4, a doctor from a marginalised caste told us, “It is true that the families of upper caste students and ours are very different- economically, in other ways too. In many of the upper caste students’ families their grandfathers etc are also educated, that is not so in our families”. As is often said, the starting points are so different that much more effort has to be put in by those who are first or second generation learners.

This is also because these spaces for so long have been dominated by certain castes and communities that a lot of the cultures of the space, the way language is spoken, the accent, all of these are also more familiar and aligned with that of the dominant communities. An assistant professor in IIT Chennai filed a complaint of caste-based harassment against his senior colleague. He said, “The concept of merit is exclusionary, as it mandates people from oppressed categories to keep their performance record impeccable even while facing discrimination. How are we supposed to teach our students and publish our papers when we have to do so much of internal fighting?” ([Henry, 2021](#)).

It is a vicious cycle. Those from the margins are battling against odds to put in their best. Considering that they are at a disadvantage in so many ways, their final outcome is usually not their own best. On top of that, all around them is an environment which judges them in harsher ways than it does those that come from dominant communities. In other words, the evaluation itself is also biased and hence they are evaluated lower than what they actually should have been. How then can equal performance mean equal calibre? This is discrimination.

People from the margins are not provided the environment to give their best and are also not given a really equal chance in the assessment. This is not absence of merit. This is what discrimination looks like and how it is experienced.

We discuss the issue of ‘merit’ and the affirmative action of reservation in greater detail in Chapter IX, ‘Discussion’. We believe that institutions need to put in multiple efforts to undo this harm. We give specific recommendations towards this in Chapter X. Here we would just like to say that not recognising these experiences and not making systems that can address some of these issues is in itself shirking of responsibility on the part of the Institution. **All failure to address this incipient casteism is structural casteism!**

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Chapter IX

Discussion

Stories of students' deaths by suicide continue to feature in the media. In these stories, students, members of resident doctors' associations, faculty and even those representing hospital administrations, speak of the caste-based discrimination that students are subject to in medical colleges and teaching hospitals, the location where post graduate medical professionals are shaped. (Puzhakkal, 2020; Sirur, 2020). As reported in Chapter VII, a number of committees appointed by individual institutes in response to public interest litigations, or by orders issued by the Supreme Court of India, or committees appointed by certain HEIs in the face of protesting voices against discriminatory practices documented rampant prevalence of such practices in HEIs across the country.

In this report we attempted to look beyond the incident of Dr Payal Tadvi's death by suicide or what amounts to institutional murder and go deeper into the phenomenon of caste-based discriminatory practices and institutionalisation of caste-based discrimination in HEIs. Drawing upon our analysis of these phenomena our proposal for responding to the problem at hand distinctly moves beyond the existing debates in this space on two counts. First, we argue that it is deeply flawed and self-defeating to treat caste-based discriminations at HEIs as ragging. Second, based on the first point of departure, we argue, that responding to caste-based discriminatory practices requires a legal framework distinct from the current legal frameworks and guidance available to address ragging.

As a way forward, we discuss, in this chapter, three key questions which emerge from this enquiry.

First, why are the institutional measures failing to prevent these practices; and respond to or redress the phenomenon? We identify three key problems which explain the failure of these mechanisms. **Second**, this enquiry has demonstrated deep resentment about the reservation policy, especially among the

dominant castes. What causes these constituencies, to be blinded enough to ignore poor NEET rankings where payment seats in private colleges are concerned, while, at the same time, siting NEET rankings to question the admissions based on affirmative action? In growingly privatised health care and education sectors, what do we see is the future of those coming from marginalised castes and communities?; and **Finally**, what frameworks of justice do we need to consider, in order to respond to failure of redressal mechanisms, and to address root causes of sustained trend of institutional murders amongst students from Dalit, Adivasi and other marginalised and minority communities? As a way forward, we foreground a framework of transformative justice, which is the foundation of the Constitution of India; and suggest strategies towards operationalising a plan to respond to the problem at hand.

IX.1 Failure of redressal interventions to contain ragging and caste-based discriminatory practices in HEIs

In this section, we discuss three key problems which explain the failure of using anti-ragging mechanisms in addressing all incidents of harassment: denial by HEIs and other authorities of caste-based discrimination for too long; conceptual malady of coalescing caste-based harassment with ragging; and implementation gaps stemming from institutionalisation of caste-based discrimination.

IX.1.1 External triggers for introduction of redressal mechanism: A reflection of sustained denial by authorities of caste-based discriminatory practices in HEIs

We observe that all the interventions, such as, appointment of committees to look into ragging or caste-based discriminatory practices, or formulation of regulations to prevent and respond to ragging or regulations to respond to unequal treatment in universities were developed in response to and as a reaction to vexatious incidents and episodes of harassment and ragging. Below is a snapshot of what we discussed in Chapter VII to highlight additional insights into some of the fundamental constraints of these efforts.

- a. The first intervention in 1999 by the UGC was to constitute a committee under the leadership of Prof K P S Unny of the Jawaharlal Nehru University, New Delhi. (Unny, 1999). This was in response to the PIL filed by the Vishwa Jagriti Mission for curbing the practice of ragging in educational institutes.
- b. The constitution of the Raghavan Committee in 2007 (Raghavan, 2007) was in response to the Special Leave Petition No. 24295 of 2006, University of Kerala vs Council of Principals of Colleges [with SLP (C) No. 24296-24299 of 2004, W.P. (CrI) No. 173/2006 and SLP (C) No. 14356/2;] and observations by the Supreme Court of India that recommendations provided in the case of the Vishwa Jagriti Mission judgement were not put in place.
- c. In 2008, UGC issued a circular (UGC, 2008) to the HEIs making it mandatory that their prospectus and brochures should include number of cases of ragging that took place in the previous academic year. This again was in response to the observation by the Supreme Court of India of failure to abide by recommendations laid out with reference to its hearing on Dec 10, 2007 in SLP (C) No.24295/2004 in the matter of University of Kerala v/s Council of Principals, Colleges of Kerala and others.
- d. The UGC anti-ragging regulation of 2009 (UGC, 2009) was in response to the same case as above and in compliance with the direction provided by the Supreme Court of India.

In two other instances, amongst others, individual institutes responded to the problem at hand by appointing committees to look into the matters at their own institutes. Below are two examples of such efforts.

- a. As discussed earlier in this report, the Thorat Committee (Thorat, 2007) was appointed by the Government of India in 2007. For the first time, the GoI center-staged the caste-based discriminatory practices in the medical colleges and other HEIs as a ground for concern and constituted the Thorat Committee.
- b. In yet another case, the death by suicide of student – Senthil Kumar, a doctoral candidate - at the University of Hyderabad led to constitution of Prof Pavarala Committee.¹

In our view, three key triggers shaped these measures to respond to ragging and caste-based discriminatory practices: (i) appeals and or public interest litigations to the Supreme Court of India raising concerns about ragging practices; (ii) episodes of death by suicide of students from marginalised castes and tribes in HEIs; (iii) the OBC reservation policy that evoked strikes and protests. None of these measures have been introduced without external triggers. The fact that it always has been external triggers to invoke a response from the system suggests that the concerned authorities/offices, ministries remained at best oblivious to, and at worst complicit in the prevalent and rampant caste-based ragging and other caste-based discriminatory practices in HEIs.

IX.1.2 Conflating caste-based discriminatory practices with ragging: A conceptual malady

Initially these interventions focused only on redressing and curbing ragging practices. Later, these interventions explicitly acknowledged existence of caste-based discriminations in these institutes. However, as discussed in Chapter VII, there were no specific substantive measures suggested to address caste-based discriminatory practices in order to identify and address the root causes. First, this shows, a much delayed recognition that caste-based abuse and discriminatory practices need to be paid attention to. Second, however, it was simply treated as a type of ragging. Caste-based discriminatory practices clearly violate constitutional right to equality (Article 14, Constitution of India) and non-discrimination (Article 15, Constitution of India). The provisions meant for ragging would not prevent and address caste-based discrimination. Therefore, conflating it with ragging, according to us, remains deeply flawed and address

¹ In 2008, the Prof Vinod Pavarala Committee was set up to investigate the death of Senthil Kumar, a PhD. student at University of Hyderabad, observed that the University was acting against the interests of the SC, ST students. (2008). It is referred to in a number of media reporting, such as, Apurva (2016), Henry (2013); Yamunan (2016); . Yamunan (2016) notes that the Pavarala committee made scathing remarks against the departments. “..it is a fact that most of the students affected by the inconsistencies and ambiguities in procedures were SC/ST students,” the report noted, adding that “all the physics students that this committee could meet have reported their sense that the School was acting against the interests of the SC/ST students.”. However, the Pavarala Committee absolved authorities in its final findings even though it brought out serious discrimination on the campus caste-based discrimination. Therefore, conflating it with ragging, according to us, remains deeply flawed.

We discussed the empirical evidence of caste-based discriminatory practices which emerged from our enquiry presented in Chapter III (structural caste-based discrimination in historical and contemporary context), Chapter IV (caste-based discriminations students from marginalised communities face all through their medical training), Chapter V (institutionalisation of caste-based discrimination) and Chapter VI (caste-based discriminatory practices in medical institutions as workplaces). These insights into the ethos at HEIs and functioning demonstrate that caste-based discriminatory practices in HEIs are all pervasive. These do not restrict to students alone but are prevalent at all levels amongst academic and non-academic staff. This vindicates the testimonies presented in various reports by enquiry committees (Rao et al., 2015; Thorat, 2007; Raghavan, 2007) and surveys undertaken by researchers (Hathi et al., 2018). It, therefore, is deeply disturbing and strange that until very recently the anti-ragging responses in the form of regulations, judgements, court orders and committee reports, treated all types of caste-based discriminatory practices as simply ragging and harassment in HEIs.

In certain instances, committees documented testimonies in their reports but stopped at that. For example, the Raghavan Committee (Raghavan, 2007) although documented testimonies regarding caste-based discrimination from various stakeholders, did not go beyond it. Similarly, the UGC Regulation 2009 specifically aimed at curbing ragging failed to consider the caste-based discriminatory practices even though at least three committees, namely the Thorat Committee (Thorat, 2007), Raghavan Committee (Raghavan, 2007) and the Pavarla Committee (Pavarla, 2008) recognised it prior to the UGC regulations.

It took about eight years from 1999 to 2007 for authorities to formally acknowledge prevalence of caste-based abuse and discrimination as an issue. It took UGC until 2012 (UGC, 2012) to form a separate regulation aimed at promoting equity in HEIs. And it was not until 2016 that the UGC regulation (UGC, 2009) was amended to revise the definition of ragging to explicitly acknowledge caste, gender, religion based discriminatory practices for the first time. It is inexplicable to understand the gap of 17 years since 1999 and about nine years since Thorat Committee Report (Thorat, 2007) for the UGC to recognise caste-based discrimination.

There was a much-delayed recognition of caste-based discrimination, abuse, and humiliation and then too it was merely included in the definition as a type of ragging. We consider it as a conceptual failure

given the serious violations of constitutional values and fundamental rights such caste-based discrimination involves. It indeed required a radically different approach to deal with it.

IX.1.3 Policy implementation gaps: Reflection of willful neglect of institutionalised casteism

As discussed in the Chapter VII, various recommendations were an integral part of regulations, committee reports, and SC orders, hearings and judgements to enable redressing ragging and/or caste-based discriminations. There have been well defined, elaborate and wide-ranging enabling campaigns against ragging, support mechanisms with the involvement of faculty, mentoring and supportive language coaching classes for those coming from disadvantaged constituencies. In many instances and as the time passed, recommendations included reporting of the instances of ragging and action taken on the same in program brochures and prospectuses of universities; and reporting to UGC.

We observe that there is one common thread in the recommendations across the regulations and committee reports. It is that the onus to comply with these frameworks and constituting redressal committees at institutional level rests entirely with institutions. Needless to mention that the quality and effectiveness of compliance with recommendations would be the key indicators of effectiveness of these measures on the ground. However, we are far from this since either HEIs are not implementing any of these or if they are, it is being poorly implemented making it a futile exercise.

The implementation gap and failure of the institutional level redressal mechanisms can only be explained by the entrenched nature of caste-based discrimination in HEIs which affects the functioning of the redressal mechanisms. We note three key observations which substantiate entrenched caste-based discrimination in HEIs. First, the insights from our conversation with representatives of different constituencies, such as students from medical and nursing colleges, resident doctors, faculty, and key informants during this enquiry demonstrate institutionalisation of such discrimination in HEIs. For example, starting from students' admissions to various assessments and examinations, students experience caste-based discrimination. There have been examples of students belonging to

constituencies of STs and SCs taunted and reminded of their entry through reservations, given postings considered less valuable, deliberately failed in oral examinations, denied opportunities to present papers at conferences as part of career advancement and exposure to emerging knowledge and discourses among others. We were also told that HEIs tolerate caste-based discriminations also by institute's administration. These, as per data presented in this report, include biases in allotment of hostel rooms, delayed scholarships and free-ships resulting in students not able to sit for examinations, denial of promotions, non-compliance with recruitment in SC/ST quota for employees, allowing these vacancies to remain and instead filling those seats temporarily with dominant caste candidates amongst others.

Second, recent amendments to UGC regulation ([UGC, 2016](#)) and reports of some of the committees, for instance, the Raghavan Committee report ([Raghavan, 2007](#)), or report by Rao and colleagues ([Rao, 2015](#)) acknowledged the entrenched nature of caste-based biases in society. However, because of such entrenched discrimination in HEIs, the representation of SCs, STs and other marginalised and minority communities on the redressal committees is either non-existent or when it exists it remains largely ineffective and tokenistic. Such representation has been ineffective due to prevalent power hierarchies within these redressal bodies rendering representatives of the marginalised communities powerless. These undoubtedly demonstrate empirically that decision makers, leadership, and administration in HEIs are deeply influenced by existing caste-based biases and that these play out in functioning of HEIs. This seems to be a vicious circular problem. Most positions of authority and power are occupied by people from the dominant castes and are hence willingly or otherwise quite 'blind' to the existence and proliferation of caste-based discrimination. Experiences of caste-based discrimination are often dismissed as paranoia or inferiority complex of the complainant.

Lastly, there are some other pragmatic or operational challenges in implementing these policies, such as, lack of commitment of HEIs to addressing the problem, lack of earmarked resources to ensure quality functioning of anti-ragging measures, and hurdles arising out of institutional politics, and interference by political forces. We note that the existence of policy implementation gaps around the world and across the sectors is well acknowledged and well established. ([CIPE, 2012](#)). India is not an exception and various policies and regulations developed to respond to caste-based discriminatory practices are not free of implementation gaps.

Against this backdrop, entrusting HEIs to be the keepers of inclusion and providing a discrimination-free institutional environment through mere policy announcements has proved to be ineffective and self-defeating. The authorities, ministries, and even the honorable SC of India, remained blind to the obvious institutionalisation of caste-based discrimination in education in general and in HEIs including medical colleges in particular. We argue, therefore, that measures which were expected to also cater to caste-biases as a form of ragging remained largely dysfunctional and ineffective over the last two decades. It will not be an overstatement to say that it is a 'design failure' of the measures because recommendations were founded on wrong assumptions and turned a blind eye to institutionalisation of caste-biases.

The only legal recourse to redressal remains invoking the Scheduled Caste and Scheduled Tribe (Prevention of Atrocities) Act, 1989 (Gol, 1989). The Parliament of India enacted this provision to prohibit discrimination, prevent atrocities and hate crimes against scheduled castes and scheduled tribes. There are two foundational constraints with this legal framework. One, recourse through this act involves criminal justice procedures. Given the daunting nature of the criminal justice system in India, this remedy is poorly accessible. Two, this Act doesn't make any reference to caste-based discriminatory practices and harassment in educational institutes. This makes it challenging for both the institutes and those subjected to caste-based discrimination to meaningfully benefit from this act. Against this backdrop, it is of immense salience that there exists some sort of legal redressal mechanism to ensure accountability within the institution. And for this to happen caste-based discrimination has to be acknowledged and the violence of it recognised.

IX.2 Policy of privatisation and corporatisation of medical education facilitating further marginalisation

We discussed in Ch III the rising inequity in medical education on account of entry of private entities in the last few decades and corporatisation of the same in more recent times. One of the core arguments we developed in the chapter was to draw the linkages between systematic privatisation and corporatisation of medical education and further marginalisation of those from already marginalised communities aspiring to get into medical colleges. Chapters IV and V further built on this particularly

from the point of view of our discussions with various resident doctors reflecting on their experiences as students within the system

In this section we wish to extend the discussion on the deep flaws in the argument that reservation leads to compromised 'merit' of medical students and therefore adversely impacts quality of health care system, that we had discussed earlier in the report. We attempt to draw out how the very privatised system of health education has geared medical education to cater to a corporatised and private health care system. From our discussions we show how regulations like compulsory NEET to access every level of medical education, increasing specialisation, and the overall curriculum itself lead to further exclusion of those already struggling for equitable access to education.

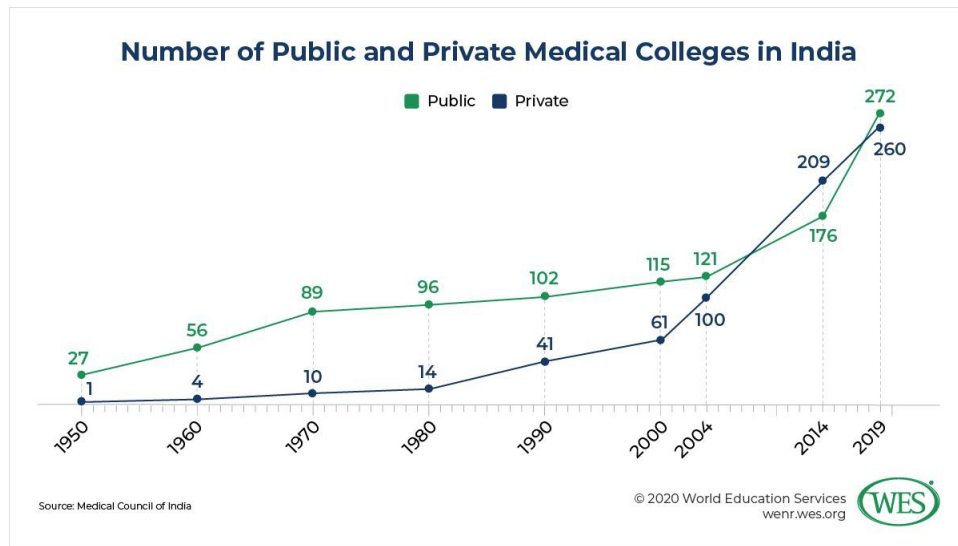
We locate this argument in the historical and contemporary contexts of the medical education in India and is intended to project what the near future looks like for those from the marginalised communities who aspire to pursue careers in health sciences and health care. We also hope to flag what the concerned authorities/offices ought to be doing to pre-empt adversities these students in medical colleges would be confronted with.

IX.2.1: A journey of medical education in India from public to private to corporate entities: Implications to students belonging to marginal communities

The growth and expansion of medical education in India since 1950 is marked by an increasing proportion of private entities. We wish to underscore the detrimental impact this has on the students belonging to marginalised communities, especially scheduled castes and scheduled tribes since it systematically excludes them given their inability to pay fat and unregulated fees and for lack of free-ship in private medical institutions. We consider this a form of systematic policy driven caste bias going beyond just inequity concerns as it also involves discrimination, an unconstitutional act. We, therefore, need to take this into account while discussing the issue at hand.

The graph below shows the trends in how number of medical colleges increased in India ([Trines, 2020](#)).

The growth in private colleges starts in 1980s but this pace suddenly increases at the turn of the century. Government medical colleges grew much faster in the first couple of decades after independence. This



growth, however, slows down starting from 1970 until again in 2000s especially in the last decade we find a sudden growth in government colleges. In the last twenty years the number of colleges have grown more than three times and most of these until the last five years have been in the private sector.

The economic policy of 1990s liberalising the largely state-run economy, broadly known as structural adjustment programme (SAP), enabled the growth of the private medical education institutions resulting in their holding up to 50 to 70 percent share in the space since 1990s. Under SAP, state policy viewed private medical education as a means of expanding capacity amid fiscal constraints and even led to government incentivising private entities by offering substantial subsidies (such as, free land to medical colleges), expensive to public exchequers with no return in terms of 'public good'. These policies gained ground and in the first decade of the 2000s we saw a sharp rise in the number of colleges run by

charitable trusts and societies.

Regulatory reforms and a few judicial orders further sealed the direction in which this overall growth took place. In the early part of this century some judgements upheld the right of private professional educational institutions to charge fees higher than those set by government. For example, the Supreme Court judgement in case of TMA Pai Foundation and Others vs State of Karnataka and Others ([SC, 2002](#)) argued that there can be no fixing of a rigid fee structure by the government. Each institute must have the freedom to fix its own fee structure taking into consideration the need to generate funds to run the institution and to provide facilities necessary for the benefit of the students. The judgement was with reference to minority institutions and their rights interpreted within the framework of Article 30 of the Constitution of India.

However, other judgements post the Pai Foundation case have provided diverse directions depending upon context of a particular case making it complex for setting any one single uniform standard. In the most recent judgement (ref, Para 16) dated May 2, 2021, the bench notes the rationale behind the Pai Foundation judgement permitting differential fees in consonance with quality of education offered at different institutions. However, it emphasizes with no ambiguity that commercialisation of education is not permissible; and that Government is equipped with necessary powers to regulate private institutions from indulging in profiteering. This still leaves scope for the fees to skyrocket, especially if government remains aligned to the interests of private capital. As of now, the National Medical Commission (NMC) is set to lay guidance for this. ([The Hindu, 2019](#)). The National Medical Commission Act 2019, Section 10 (1) Clause 1 ([GOI, 2019](#)) empowers the Commission to frame guidelines for determination of the fees and all other charges with respect to 50% of seats in private medical institutions and deemed to be universities under this Act.

This upward trend of privatisation of medical education is explained by sustained budget deficits or financial constraints of the government and lack of political will to invest in publicly funded health care. In the absence of government funding advances in medical technology led to further strengthening of private health care. This widened opportunity to cater to needs of well-paying patients including those from outside of India leading to growth of medical tourism. It automatically meant that students with

capability to pay fat fees who got admissions in private or corporate medical colleges were eyeing opportunities in this newer version of privatised health care to earn what they invested in medical education. This again drastically transformed medical education and in turn medical practice.

Historically speaking, till 2009, the official stance was that education could not be for sale or a for-profit venture. As a result, most of these medical colleges were run by trusts or charitable societies. (Nagarajan, 2019). Mahal and Mohanan (Mahal & Mohanan, 2006) noted that, "...By law, private sector medical education institutions in India must be organised as non-profit entities with admissions and tuition fees kept within reasonable bounds." (pp:1009). This changed, however, in February 2010 when the government allowed companies registered under the Companies Act to open medical colleges (Nagarajan, 2019) and in Nov 2016, the Medical Council of India permitted corporates and 'for profit' institutions to start medical colleges in the country. (Narayan, 2016).

In the last decade we also see an unusual increase in the number of government medical colleges. As Trines (Trines, 2020) discusses, this is an effort to increase the total number of doctors produced every year and to have a medical college for every three districts. On the face of it this does not fit in the trend of growing privatisation. We have to see it in the light of health policies that support growth of private health services and align its growth with public health goals. (Marathe et al, 2020). For example, policy interest in the expansion of insurance financing and private provision for healthcare are prominent in the National Health Policy 2017. In a way it is private sector performing as the public sector.

This same sense of merging of boundaries between private and public health care is seen in medical education as well. In 2017, the MCI Board of Governors amended the Establishment of Medical College Regulations, 1999 to allow consortia to set up medical colleges. (Nagarajan, 2019). A consortium can be a group of two to four eligible organisations including a society, trust, company, university or deemed university who enter a Memorandum of Understanding. This may allegedly change the standard of education, but it allows for private enterprises to come forward and take over the running of public hospitals and colleges. The impact on the ground for students will be more expensive education in the future. The case of Vedanta that we discussed in chapter III highlights what lies in store when these private entities become for profit companies.

In the last decade we have seen a complete shift from the philosophy professed more than a century ago by Abraham Flexner ([Flexner, 1910](#)) which has moulded most medical education across the world. We quote from Thomas ([Thomas, 2016](#)): “Among the fundamental insights of Flexner are: “Medical education is expensive. It can in no event be taught out of fees.” (5: p 142) and “Medical education is a social function; it is not a proper object for either institutional or individual exploitation.” (5: p 127). (pp: 201). In the contemporary context of policy and legal environment of medical education in India, privatisation and corporatisation of medical education has completely turned a blind eye to this philosophy contributing to a different kind of caste-based discrimination in these institutions.

IX.2.2 Introduction of NEET and its fall out: Historical and contemporary context

The new private colleges that came up till the last decade were unequally distributed across the country. Each state had its own admission criteria, sometimes a state examination and at other times different institutions had their own entrance examinations. Also, certain states – Tamil Nadu is a case in point – had relied on 12th standard scores instead of additional entrance examination. The students who came from more privileged backgrounds started moving across states seeking admissions in these private colleges and the colleges in turn bent rules of admissions to accommodate the paying “clients”.

In the bid to regularising all of this, in 2013, MCI introduced National Eligibility cum Entrance Test (NEET) which was to be a national-level and the only medical entrance exam for admission to medical and dental courses in India. ([The Hindu, 2016](#)). After it was conducted in 2013, the Supreme Court of India put a stay on the exam in response to petitions received against the exam and said that MCI could not interfere in the admission process. The exam made a come-back in 2016 and was to be conducted twice a year. The only other medical entrance examinations which remained operational along with NEET were AIIMS-MBBS exam and JIPMER-MBBS entrance conducted for admission to AIIMS, and JIPMER institutes respectively. However, since 2017, NEET is the only entrance examination.

This nationwide standardised NEET has been critiqued ([Sundaraman and Adithyan, 2019](#); [Nagarajan,](#)

2019; Thomas, 2016) on various grounds. Several state governments including Andhra Pradesh, Karnataka, Kerala, and Tamil Nadu viewed the national test as an infringement on the rights of states to keep the medical education a state subject. (The Hindu, 2016). They argued that centralised NEET undermines the federal powers of states to make plans to expand healthcare education in alignment with their specific needs on ground. (Sundaraman and Adithyan, 2019; The Hindu, 2016). These critiques have, however, not been heeded.

Some medical education institutions such as Christian Medical College which is known not only for the quality of education it provides but for its unique approach to selection of UG students from underserved areas, found NEET to be detrimental to their attempt at developing health care providers appropriate for the local context. National examinations held at this scale, like the NEET necessarily have to be standardised and hence cannot measure the ability of aspiring students to relate with communities they serve and if they find serving the underserved a fulfilling commitment.

These standard exams are in the form of multiple choice questions (MCQs) which require information to be broken down into bits and answered quickly without providing any context for the same. This requires a particular kind of preparation which has given rise to another private industry which is of coaching classes where this training is given. Obviously, those who cannot access these classes cannot fare as well in NEET. Introduction of NEET is hence less favourable to those students who studied in non-CBSE curricula, and those from rural backgrounds and marginalised communities who cannot spare that kind of time and resources for attending coaching classes thereby increasing the inequity in access. (Nagarajan, 2019; Nagarajan, 2018; Sundararaman and Adithyan, 2019).

One other discussion around NEET which is relevant to this enquiry is the question of 'merit' and the NEET rank. While the students seeking admission to the seats from the reserved category are continuously harassed, discriminated against and humiliated for so-called 'lack of merit', no one talks of the students with low NEET ranks who get admitted to medical colleges on 'paid' seats. A study of NEET scores for admission in various categories for the year 2018 showed clearly that the average score of students in the Scheduled Caste quota in government medical colleges was 398, and their average in government and private medical colleges together, was 367. Both are much higher than the average

score coming out of so called “open” seats in private medical colleges (management and NRI), where the average is 306. Clearly the ‘merit’ argument is hollow. While examinations like NEET never manage to assess the necessary calibre for becoming a good doctor, the increased medical seats are leading to creating doctors who cater to the corporatised, overly specialised care available to the rich in metro locations and not really to improving the public health care system or equity in distribution of health care providers.

Two key developments have taken place recently which will add to further marginalisation of individuals from marginalised castes and tribes in HEIs in general, and in medical schools in particular. These have happened as we were writing this report and so we have not been able to elicit respondents’ opinions on this. First, the MCI established in 1956 through the enactment of Indian Medical Council Act 1956 (IMC, 1956) has been replaced by the National Medical Council on Sept 25, 2020. Amongst others, the NMC Act 2019 (Gol, MoL&J, 2019) has proposed a common final-year MBBS examination, namely, National Exit Test (NEXT), for admission to post-graduate medical courses and for obtaining a license to practice medicine. This NEXT will again be in the form of an MCQ examination with the same flaws of assessment as NEET and will divert students’ attention from their clinical practice in the final year of their undergraduate degree.

Second, the Government of India has announced the National Education Policy (NEP) in 2020 (Gol, 2020). It will now be the guiding framework for education across streams and sectors including professional education. The policy has further strengthened the argument in favour of non-regulation of private entities in medical education institutions allowing them freedom to decide on the scale of fees. “... National Education Policy’s call for abandoning all regulation of fees in professional courses marks the latest in a series of steps that have aggressively pushed commercialisation of medical education over the last decade, say public health activists.” (Nagarajan, 2019). What this holds for the future is still too early to predict but the trends seem to indicate a greater dedication to corporatisation and neglect of both public education and public health care. And this we strongly believe will add to the marginalisation of the already marginalised both in terms of getting quality professional education and public health care.

IX.2.3 What do doctors need to study?

Having spoken of admission criteria and assessments, it is also important to the current discussion to appreciate the curricula being implemented in medical schools. Some key questions would be around whether the curricula align with the Indian eco-system, socio-cultural context, and specificities of health care needs. Also, if these curricula cover any robust and substantive training in medical ethics to safeguard and uphold professional integrity of the practitioners and the profession as a whole.

It is important that the medical curricula, at least at undergraduate level take into account particular communities and their socio-economic locations as important determinants of health and access to health care. Currently, as critiques show, the whole curriculum does not have any emphasis on social science subjects or courses that would help doctors understand the different realities from where their own colleagues come, or even the patients that they treat come from. We find one of the early debates on alternative medical curriculum in an anthology titled 'Medical Education Re-examined' published in 1991 by a national level network of individuals interested in public health concerns in India namely Medico Friend Circle.² (Mankad, 1991). It underscores that medical education with focus on technical aspects alone is insufficient and that it requires to be grounded in social realities and responding to prejudices developed while growing up amongst students and faculty in their own milieu and schooling. However, for various reasons this has not been at the centre of the discussions on medical education or health care and this non-alignment in the medical curricula has not been addressed.

The paragraph below captures these trends during our conversation with a faculty member:

² It was an outcome of a long-standing debates in this network based on experiential knowledge of practicing clinicians, medical college faculty, medical students, individuals from other disciplines, and those deeply engaged in health movement. It also benefited from conversations and discussions with those working in this area from the neighbouring countries including Bangladesh, Malaysia, Nepal, Philippines, Sri Lanka, and Thailand. The anthology center-stages informed critique of the existing curricula, and teaching methodology and offers alternative teaching/learning methods, and most importantly proposes introduction of sociology and ideological underpinnings in curricula.

“The language that medical fraternity uses is of quality. We choose students based on marks, caste, or money. Where are we choosing for good doctors? These are not the criteria for them becoming good doctors. For that we have to teach them compassion. That is not part of our teaching methods. If we do not have good doctors today, can we blame the intake [of students for medical schooling] or do we also need to look at the process of our education and training. What are we doing to inculcate compassion?” [KI3, Retired professor, BMC Medical College].

We note that while this investigation was in progress, the MCI announced the AETCOM (Attitude, Ethics and Communication Module) in 2019 (MCI, 2018) which was to be implemented starting from Aug 2019. Zayapragassarazan and colleagues (Zayapragassarazan, 2019) note that AETCOM, with 27 case-based modules, is designed to be delivered in a staggered manner spread over four years of undergraduate medical training comprising of a total of 139 hours. The MCI has put together a framework or curriculum for this foundation course.³ It includes modules on wide ranging themes, such as - social backgrounds of the patients that the students may encounter, understanding the history of modern medicine as well as of other practices in the region, ways of communicating with patients as well as peers and colleagues, language skills (including English language skills), and also issues of ethics of practice and such like.

The introduction of AETCOM is a welcome move. At present it is unclear if the current faculty across all the medical colleges is equipped to do justice to the foundation course and help achieve its goal. Towards this, the MCI introduced a mandatory training for the faculty of medical colleges through its nodal and regional centres as part of preparation for implementing the AETCOM. Further, the guidelines indicate that the medical schools would assess the performance of students in this foundation course, however, this will not to be counted in the overall results of students as part of their undergraduate degree program. In a competitive examination-oriented education, we know what is the fate of such courses.

It also seems that even this new module draws upon the same understanding of individual change and training. It highlights altruism and compassion as core values of medical practice and aspires to help students inculcate these through this month-long foundation course. However, the AETCOM module curriculum does not speak of the structural inequalities in society. These changes do not really take into

account the socio-cultural history of the person who comes in as patient to the learning and practice of medicine. Practice remains completely bio-medicalised thus also making it distant not only from the realities of the people whom it serves, but also from those that are part of the health service provision. Govind and Chowkhani (Govind & Chowkhani, 2020) discuss some of the critical limitations of the AETCOM. These include: assumption and constrained understanding that “...both patients and doctors as homogeneous and monolithic categories.” (pp:92); and lacks sensibility to diversity of patients in India in various ways. It is hence likely that implementation of this module alone might not bring any substantive change in medical practice.

In fact, how to treat a patient while respecting their privacy, confidentiality, dignity ought to be a central part of medical training. When KI3 was speaking of not teaching compassion, they were probably indicating the lack of thought given to inculcating this and ethics as a value and principle of medical practice. A curriculum that leads to a lack of sensitivity to inequalities in society be it seen in the lives of the patients or the co-workers lacks this understanding of compassion.

Part of medical education has to be empathy, a critical aspect of being a good health provider. This profession demands a constant engagement with people when they are most vulnerable. Empathy emerging from an understanding of structural inequalities of society is especially essential for the medical students belonging to dominant castes who do not seem to comprehend the need for affirmative action for elimination of discrimination and inequality and attack their colleagues in the name of ‘merit’.

A curriculum and an ethos of medical education that centers patients and their socio-cultural locations to their health and wellbeing as much as it centers the bio-medical skill-based approach to practising medicine would redefine what ‘merit’ in a good medical student would mean. Experiences and learnings from the margins that students from these locations bring to the classrooms would be seen as assets to the classroom and pedagogy and their inputs valued. We would move to an imagination of health care that is inclusive in its conceptualisation.

Unfortunately, what we are seeing is a growing corporatised and privatised model of health care which is

even giving up on public health as a concept. The pandemic that we are all currently living through has shown us the ways in which finally it is the public health system alone that can truly address issues of health both in terms of prevention of disease, through education for behaviour change such as need for vaccination, setting up standard treatment guidelines, uniform protocols for home-based care and management of severe cases of the disease and free vaccinations. It is the public health care system that finally has helped us in these moments of crisis. Apart from the nurses and resident doctors, it was the contractual hospital staff and ground level health workers who all come from marginalised backgrounds that sustained the public health response. It may be important at this point to see how many doctors who paid exorbitant fees in private medical colleges put themselves out for service in these difficult times. Inability to recognise all this and make fundamental changes to medical education is to our mind complicity of institutions to sustenance of inequality, an inherently caste-based approach to health care itself.

IX.3 Transformative justice: Reminding ourselves of the Constitution of India and its commitment to equity

In the closing, we foreground the concept of ‘transformative justice’, a foundational framework and spirit of the Constitution of India which enables addressing historical injustices, especially through its Articles 14 (equality), 15 & 16 (non-discrimination), 17 (prohibits practicing untouchability), and 21 (personal liberty). Extensive scholarship exists on ‘transformative’ interpretation of the Constitution of India ([Vilhena et al., 2013](#); [Bhatia , 2019](#)). Many of these scholars view affirmative actions in the form reservations for scheduled castes and tribes in educational institutions as transformative tools to achieve equality and social justice.

The concept of substantive equality, central to the notion of transformational justice, is characterised by four cornerstones, says Fredman ([Fredman, 2016](#)). They are: aiming at redressing disadvantage; countering prejudice, stigma, stereotyping, humiliation and violence based on a protected characteristic; enhancing voice and participation, countering both political and social exclusion; and

lastly, accommodating difference towards achieving structural change. Many other scholars, for instance Gready and Robins ([Gready, & Robins, 2014](#)), speak of operational facets to translate the conception of substantive equality and transformative justice. This implies recognition of and response to the underlying structural inequities, exclusion, violation of social rights along with political and economic rights, focus on processes and participatory approaches grounded in and considering changing contexts to bring about transformations are the mainstay of the concept of transformational justice. The underlying idea is to disrupt the social and economic hierarchies as a way of dislodging the status-quo which hinders substantive equality.

In a recent judgement on reservation policy, Justice Chandrachud ([SC, 2019](#)), elicits and further affirms this transformative fabric of the Constitution of India and salience of substantive equality. He draws upon the deliberations by the Constituent Assembly and its express recognition of the insufficiency of formal equality. He explains that the Assembly's key rationale for incorporating reservations for SCs and STs in the Constitution was the existence of inequalities in society based on discrimination and prejudice within the caste structure for centuries. The Constituent Assembly's belief was that the Constitution would serve as a transformative document that would eliminate exploitation based also on gender and religion alongside caste so that citizens of independent India could possess equal civil rights and live with dignity. Justice Chandrachud ([SC, 2019](#)) argued, "... Reservations are thus not an exception to the rule of equality of opportunity. They are rather the true fulfilment of *effective and substantive* equality by accounting for the structural conditions into which people are born. ...". (pp. 106-107). Overall, Article 15 (4) as well as Article 16 (4) of the Constitution facilitate and enable rectifying historic injustices SCs and STs are subjected to with the help of affirmative policies.

Do the various interventions in response to the tragic deaths by suicide of students from Dalit and other marginalised and minority communities match up to the notion of substantive equality that the Constitution of India has promised to citizens of India? The answer stands in the negative. The reasons being, as we discussed earlier, unwillingness to recognise existence of caste-based discriminatory practices in HEIs, most significantly the conceptual malady or definitional crisis stemming from not treating caste-based discriminatory practices, abuse and violence as constitutional violations, and

therefore a failure at both the design and at operational levels of the interventions planned.

Accused individuals, may or may not have to go through institutional scrutiny and/or face legal actions. However, families of victims suffer trauma of the loss and more so of grueling, treacherous long drawn journeys to justice with a deep sense of uncertainty of the final outcome of legal redressal, while navigating through this multilayered and complex legal system. Against this backdrop not every victim's family feels sufficiently empowered to resort to legal means to seek justice. More importantly, it is deeply troubling that the idea of justice in this context plays no role in prevention of loss of lives. The idea of justice equated exclusively to 'retributive justice' in the form of punitive measures if at all an accused is found guilty is fundamentally constrained and does little to realise 'transformative justice' embedded in the Constitution of India.

However, the priority in the coming times ought to be on meaningful and well-informed preventive resolves. These measures and in a way reforms ought to be, at the least, designed drawing upon the understanding of the historical injustices, grievous social and economic disabilities caused by the hierarchical caste system of India reflected in the transformative justice conception. If so, these need to go beyond individual perpetrators. Against this backdrop, as a way forward we note three strategic moves to rectify exclusionary environments in HEIs.

IX.3.1 Safeguarding reservations in higher education institutions including medical colleges

It is necessary that the reservation policy informed by the constitutional framework is safeguarded to meaningfully protect and uphold the rights of marginalised communities to equity. Drawing upon our conversation with various persons within the medical education system and analysis, we identify three sources of interferences to effective implementation of reservation policy with reference to medical education.

First, over the years some of the judgements and court proceedings have contributed to this

interference directly or indirectly (eg: TMA Pai Foundation and Others vs State of Karnataka and Others, 2002) (SC, 2002) as we discussed earlier in this chapter. Second, the newer policies indirectly have contributed to subverting the reservation policy. In this regard we discussed the role of the National Education Policy 2020 (GoI, MHRD, 2020), one of the most recent ones in this space. On both these fronts – judgement and policies - we brought forth in the discussion earlier in this chapter and elsewhere in the report that increasing privatisation and corporatisation of medical education and health care is making a mockery of the reservation policy.

Finally, the public narrative shaped over time has been able to create and nurture a perspective amongst students from non-marginalised sections of population about students from marginalised communities. This is shaped by the view that students who secure admission to medical colleges through reservation policy don't have the caliber to be there; that they are undeserving candidates, and they will be poorly qualified health care providers as and when they enter the profession. In this narrative, the poor NEET scores or 'merit' of those who secure admissions in private medical colleges because they have paying capacity is completely discounted. Such ill-informed public narratives work against those who are entitled to affirmative actions as well as those from marginalised communities who enter through open seats quota.

As a way forward, judgement and policy reforms require more due diligence to eliminate any collateral damage to meaningful implementation of the reservation policy. These developments over time warrant that reservation policy is safeguarded and it is ensured that new policies formed in the area of medical education and in allied domains do not in any way interfere with the mandate and brief of the reservation policy. Finally, it is the public narrative which matters to the students from marginalised communities in their daily lives on the campuses and work places of medical colleges. The current misinformed public narrative needs to be altered by deep engagement with all the concerned constituencies from across the section of students and general population.

IX.3.2 Resolving conceptual malady: Building on insights from reforms relating to sexual harassment at work places

The other set of learnings flow from some of the most radical reforms in the space of violence against women that we have witnessed in contemporary India. One such significant example is that of the Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013 (“POSH Act”) ([MoL&J, GoI, 2013](#)) which enabled explicit recognition of sexual harassment at workplaces and recognition of what comprise ‘workplaces’. Not only does the Act name sexual harassment as violation of rights of those that get harassed, it also puts the onus of providing a safe and secure environment on the management of the workplace, thus underlining the structural nature of the violation and taking it beyond the individuals involved. This could well be seen as a first antidiscrimination legislation in India towards making all workspaces safe for all people working there.

Operationally speaking, the POSH Act laid out dedicated mechanisms for every workplace to abide by. It is a civil legislation and in principle lays as much stress on building awareness around these acts of violence and their prevention as on redressing them. Involvement of all sections of people at the workplace in implementing this act also, in a sense, makes this a shared responsibility of everyone. One of the key features is to have a representation of a civil society member, and women on the redressal committees thus getting an outsider to help adjudicate within the dynamics of the workplace. While implementation gaps exist, the conceptual clarity allowed drafting a dedicated legislative framework and enabled bringing on board the representation of women and civil society to actively participate in implementation of the same making workplaces safer for women.

We suggest that it is high time that caste-based discrimination at various levels within medical colleges and hospitals be acknowledged and addressed with a similar legislative framework. There is need for an anti-caste-based discrimination legislation to take into account intersectional discriminations as well. These will provide us a direction to address caste-based discrimination both conceptually and operationally. Such a proposal for a specialised legislative framework was much discussed and demanded for in response to the incident of Rohit Vemula’s death by suicide at the University of Hyderabad on Jan 17, 2016. ([Newslick, 2018](#)). It also featured in the election manifesto of the United Democratic Front (UDF) during the 2021 Assembly election in Kerala. ([Benu, 2021](#)). Earlier, the University of Hyderabad Students’ Union had demanded that each HEI must establish a Committee Against Prejudice and

Discrimination (CAPD) in alignment with Article 15 and Article 21 of the Constitution of India and modelled on the anti-sexual harassment committee. ([Students Union, U of H, 2016](#)).

IX.3.3 Integrating science and humanities in medical curricula: A tool to translate ‘transformative justice’ in practice

We discussed earlier in this chapter the current medical curriculum. We highlighted the fact that it is devoid of any content which helps medical students to connect with social realities both at national and local level. We argued that this disconnect and overemphasis on technical aspects of medicine has contributed to immense deficit in medical students’ understanding of India’s diverse socio-cultural context and structural inequities. Against this backdrop and drawing upon the experiences in other countries, we take forward this discussion towards recommendations:

First, a far more radical approach is warranted to revisit medical curricula. In the past, scholars, especially those from the marginalised communities such as Thorat ([Thorat, 2016](#)) argued that civic learning needs to be an integral component not only at HEIs but at every level of education; and ought to robustly integrate social sciences, and humanities or simply put ‘liberal studies’ through the medical training both at under-graduate and post-graduate levels. These should not be ‘add ons’ or ‘optionals’ but part of the core curricula.

There is extensive scholarship on the relevance of integrating humanities and social sciences curriculum in science, technology and medicine programs both globally and locally in India. This scholarship demonstrates that such an approach contributes to, going beyond training students in professional skills and specialised knowledge of medicine, being aware of human history, lived experiences from the standpoint of the oppressed in multiple ways, institutional histories, ideologies and ideas, values, multiple perspectives on a single matter at hand, critical thinking, preparedness for ambiguities and uncertainties of medical science, adapting and adopting newer knowledge and advances in the field, and

⁴ In the recent past Thorat (2016) and Dhumal (2018) supported such a view.

most of all developing a sense of empathy for diversity in every respect. It is about learning the contexts and ability to situate one's professional practice in these historical and contemporary contexts. In a country like India with its diversity, integrating humanities and liberal studies in medical curricula holds even greater significance.

In this regard, the NEP ([Gol, 2020](#)) is yet another policy indicating that policy makers are out of their depth. It makes reference to integrating humanities across the disciplines and professional training but to us one of the core problems is that it has completely disregarded the very diversity of Indian society and multiplicity of knowledge systems. Thus, these statements could potentially lead to further alienation of marginalised communities, and their knowledge systems. As a result, this suggestion when seen with other clauses make this look like a non-starter. Sarukkai ([Sarukkai, 2019](#)) also argues that given the broader context of education system in India and a deep-seated apathy about humanities, social sciences and liberal studies at societal level, in the current form and in the overall context, these suggestions in NEP mean little.

The question is, are there any opportunities to introduce and integrate humanities in medical curricula? There are, and if not, we will need to create them rather than opting for a status-quo which is good for no-one, except possibly for a private health industry. We mention two spaces of imminent opportunities to build on and it would be a long way to go.

- a. In India, we do have a handful of medical education institutes with stellar history of making a difference by being un-conventional on this front of pursuing medical humanities. These include, St John's National Academy of Health Sciences, Bengaluru; the University College of Medical Sciences and Guru Tegh Bahadur Hospital, Delhi; G S Medical College, Mumbai, and the Christian Medical College and Hospital, Vellore. There are newer initiatives in this space, such as, the medical humanities journal namely, RHIME. In non-medical academic settings, too we see humanities and liberal arts are being offered. These include Manipal Centre for Humanities at Manipal Academy of Higher Education along with a handful of newly set up private universities such as FLAME University, Pune, Maharashtra and Ashoka University, Sonapat, Haryana. However, these latter ones might not have an appeal as yet amongst medical students and professionals as these are not integrated

in medical campuses.

- b. Introduction of AETCOM as the foundation course for the first-year medical students which we discussed earlier in the report and especially in section VIII.2.3. We argued that it certainly provides another opportunity as a strategic starting point of intervention towards a paradigm shift in the medical education. However, as we discussed in that section this is a very limited change and not a paradigmatic shift yet.

To us, these are windows of opportunity to exploit. The central idea of this approach to reforming medical education is that on the ground, it would help translate the idea of 'transformative justice' into reality by countering the exclusionary social milieu in these settings. It will serve as a preventive strategy going beyond legal safeguards which are often invoked after occurrence of an untowardly incident.

IX.4 Closing remarks

We need to acknowledge squarely and repeatedly the deep rootedness of caste-based discrimination in HEIs and in the societal structures. We need to treat caste-based discrimination and institutionalised caste-based discrimination as violation of constitutional rights of individual students, especially from the marginalised castes, tribes and minority communities and not simply as ragging. The inadequacies of the current legal frameworks, and colossal gaps in their implementation warrant a separate legal framework to prevent and respond to caste-based discriminatory practices in educational institutions.

The concepts of substantive equality and transformative justice which are pivotal to the Constitution of India provide a reasoned rationale for reservation policy for scheduled castes and tribes in educational institutions to respond to historic injustices. The current dominant narrative amongst those from dominant communities denouncing reservation policy can only be altered by including education about existing structural inequities. This can be done through making substantive interventions such as overhauling medical curricula by integrating knowledges from liberal studies in these curricula. This is an uphill task but a worthwhile effort to translate the spirit of the Constitution of India in real life towards creating humane human capital and inclusive HEI spaces.

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Recommendations

This closing chapter of the report presents key recommendations drawing upon the insights we gathered through conversations with various individuals including from medical colleges, nursing colleges, health care professional associations, perusal of reports of various committees formed in response to complaints of discrimination by medical students from marginalised communities and experiences from other allied spaces of policy making. We have organised these recommendations under seven key domains.

1. We begin with urgent **recommendations in the case of the institutional murder of Dr Payal Tadvi**. It is more than two years since her death and it is imperative that these steps be taken to prevent any further delay in delivery of justice.
2. Recommendations towards **closing the gaps in the existing regulatory frameworks** provided to ensure equitable opportunities in HEIs, including the provisions against ragging; designing stringent mechanisms instead of the current ones which are either inadequate or weak; and ensuring strict compliance with current regulatory frameworks.
3. **Emphasising reservation as affirmative action** we suggest measures to be taken to safeguard this policy in letter and spirit towards achieving substantive constitutional equality.
4. Recommendations to bring in a **new legislative framework to enable protection from caste based discriminatory practices at HEIs** which would be separate from the law on ragging. The new act would draw upon legal frameworks, such as, the Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013 and build upon the demands for

introducing such a legislation in response to similar incidents in the past. These are referred to as the Rohit Vemula Act since it was the nationwide agitations and protests after Rohit Vemula's institutional murder in 2016 which brought into sharp focus the need for such an act with its broad suggested contours.

5. Next, we articulate recommendations in the arena of **curricula and approaches to learning methods** in health care professional trainings with a focus on medical education.
6. Further we offer recommendations to ensure **transparency of various institutional bodies at the State and University level**. Lack of transparency, as we demonstrated in the report, has contributed to exacerbating adverse attitudes to reservations, and individuals availing reservations in medical colleges and strengthening hostile public narratives about affirmative policy, especially amongst students from dominant communities in medical and nursing colleges
7. And finally, we make a case for commitment from the state for **a robust public health care system** because without it there can be no equitable medical education possible.

We believe that to counter the caste based biases and abuse in HEI settings these measures are essential and non-negotiable to begin the process of uprooting institutionalised casteism and its unacceptable consequences in the form of discrimination and 'institutional murders'. These recommendations require immediate attention from the UGC and the newly established National Medical Commission (2020). We urge them to take it up urgently through active consultation with and participation of members of the marginalised communities as experts to design and operationalise these measures. We have argued for bringing in a new legislative framework enabling treating caste based discrimination in HEIs as not just ragging but as a systematic violation of constitutional rights of marginalised communities and entrenched in the system. Therefore, it also requires attention of parliamentarians and policy makers as part of the state apparatus. Outside of these echelons, broad based advocacy efforts from civil society and people's movements are warranted to influence a public narrative which is better informed, fair, and just to everyone.

X.1 Recommendations in specific instance of death by suicide of Dr Payal Tadvi

1. Action to be taken against BYL Nair Hospital authorities for:
 - Non-compliance of **UGC Regulations on Curbing the Menace of Ragging in Higher Education Institutions, 2009**, by not filing an FIR based on report of the Anti-Ragging Committee as is mandated. Authorities also did not provide copy of the report to parents or relatives.
 - Non-compliance of **UGC (Promotion of Equity in Higher Educational Institutions) Regulations, 2012 and University Grants Commission (Redress of Grievances of Students) Regulations (revised on 6th May, 2019)** as they failed to constitute Equal Opportunity Cell (EOC) or Redressal committee as mandated by these regulations.
2. The enquiry reports, recommendations and action taken reports, brought out by various government bodies as listed below need to be placed in the public domain. We note that even relatives of Dr Payal Tadvi have not been provided with these reports.
 - Maharashtra University of Health sciences (MUHS)
 - The Maharashtra State Commission for SC/ST
 - Maharashtra State appointed Committee (MSAC)
 - State Human Rights Commission (SHRC)
 - The Indian Medical Association (IMA)
 - Medical Council of India (MCI)
 - National Commission for Scheduled Tribes (NCST)
3. Stringent action to be taken against those responsible in the MMC for the inordinate delay in redressing a complaint filed by Ms Abeda Tadvi, mother of late Dr. Payal Tadvi, which asked for

action against the accused doctors. Almost one and half years after the complaint was filed no action has been taken, thereby delaying justice for Dr Payal Tadvi.

X.2 Responding to the gaps in and inconsistencies across the existing regulatory redressal mechanisms

We noted earlier in the report three key measures by UGC: **UGC Regulations on Curbing the Menace of Ragging in Higher Education Institutions, 2009**; **UGC (Promotion of equity in higher educational institutes) Regulations, 2012**; and the **UGC (Redress of Grievances of Students) Regulations, 2019**. There is a lack of consistency and uniformity across these frameworks which warrants immediate attention. We recommend the following to respond to these inconsistencies and to suggest changes in these existing mechanisms. In the meanwhile, we also note that these guidelines are not being implemented even in the present form and therefore insist that their implementation is expedited.

X.2.1. Uniform measures across all UGC regulations for non-compliance

1. All the UGC regulations whether relating to ensuring equity or against ragging in HEIs must have provisions against non-compliance. These provisions and measures must be uniform and consistent across these regulations.
2. These measures must be such that they serve both as legal action against those responsible for non-compliance and as a strong deterrent for future acts of non-compliance with laid out regulations.
3. The **UGC regulations for curbing ragging, 2009**, has a clause for measures against non-compliance. It mandates initiation of departmental disciplinary action against any member of the faculty or staff of the institution responsible for the lapse in compliance. This clause must be extended to the head of the Institution as well. **The UGC regulations for promotion of equity, 2012**, and the **UGC regulations on redress of grievances, 2019**, must be amended accordingly.
4. If the Institution does not set up mechanisms for redressal or support to those from the

marginalised communities, or does not appoint the relevant officers like anti-discrimination officer or the Equal Opportunity Commissions (EOC) then there should be provisions in the **UGC regulations for promotion of equity, 2012**, and the **UGC regulations on redress of grievances, 2019**, for action against it. These may include: withdrawal of affiliation/ recognition, moratorium on new admissions, or withholding of grant, while ensuring that the students and staff of the institution do not suffer.

5. **UGC regulations for curbing ragging, 2009**, have provision of action, such as, “withdrawal of affiliation/recognition, prohibiting institute from presenting students for award of any degree/diploma or award, withholding grant” against the institution for noncompliance. This must be amended to add that while doing so the interests of the students and staff must be protected since they are not responsible for this inaction on the part of the Institution and hence should not be made to pay the price for it.

X.2.2 Additional measures to be included in existing UGC regulations

1. In case of ragging of students from marginalised communities, there must be mandatory referral of the matter to anti-discrimination officer and the EOC, as specified in the **UGC regulations for promotion of equity, 2012**, and the **UGC regulations on redress of grievances, 2019**, thereby not only providing the student required support, but also to ensure that all caste-based discrimination at the level of institutions can be addressed.
2. The confidentiality of complainant must be maintained. To aid this, in-camera perusal should be instituted to verify the complaint and evidence, to prevent further discrimination and violence against marginalised community members as a fall out of complaints registered.
3. In all cases of caste-based discrimination, including those that come under ragging, the institution must also report the incident under the Scheduled Caste and Scheduled Tribe (Prevention of Atrocities) Act, 1989 (POA Act, 1989) if the aggrieved student so desires.

X.2.3 Representations of relevant constituencies in various redressal committees

1. HEIs must ensure majority representation from SC and ST communities on the redressal committees and other similar structures designed to respond to caste based discriminatory practices.
2. Institutions must also ensure representation of independent individuals from NGOs and/or invite social activists with necessary credentials of work against discrimination of marginalised sections of society. This is to ensure objectivity and transparency in the functioning of redressal committees as a way of ensuring procedural justice to those who are subjected to caste based discrimination.
3. Representation from elected members of the student communities and from professional association of resident doctors, such as, DAMA and MARD, on all redressal committees meant for students must be ensured since they would understand their own issues best. More specifically, elected representatives must be represented in all these committees, ensuring adequate inclusion of persons on basis of gender and SC/ST/VJNT categories.
4. A mechanism to ensure accountability and transparency in the functioning of the redressal committees and their ability to redress instances of caste based discriminatory practices must be instituted and periodically audited by those from the marginalised castes and tribes.

X.2.4 Implementation of existing preventive and redressal measures

1. Ensure setting up of SC and ST Cells in every college and University as mandated under the **UGC regulations for promotion of equity, 2012.**
2. Ensure implementation of the Thorat committee recommendations for AIIMs and Mungekar Committee recommendations for Mahavir College (Safdarjung Hospital) and extend the same to other medical institutions across the country.
3. Ensure implementation of the **UGC guidelines for prevention of sexual harassment on**

campuses read along with the POSH Act.¹(UGC, 2015)

4. Appointment of Special Public Prosecutors under the POA at both the lower court and High Courts trained specially to handle all cases and complaints of caste based discrimination in HEIs.

X.3 Reservation as affirmative action

X.3.1 Reaffirming reservations as affirmative action

1. All seats reserved for marginalised communities must be filled by members from those communities and not opened up to others. If no candidates are found they should be left vacant. Extra effort must be made to fill these seats by seeking applications for these through advertising in regional and national accessible media.
2. Financial assistance to students from marginalised communities must be made available by the State in all institutions, whether public or private.
3. The free-ship v/s stipend debate should be resolved by withdrawing with immediate effect the policy that states that “post matric scholarships to the students belonging to scheduled castes for studies in India will not be paid if they get a stipend”. (GOI, 2010) A stipend is compensation for their work as residents and hence distinct from a free-ship or waiver of fees and these should be treated as such.
4. Organising seminars on regular basis, in which leading voices from anti-caste movements should be invited to address the student and staff communities, which can help in bringing to focus the prevalent culture within the Institutes which allows caste biases to operate in educational spaces and can help work towards an atmosphere of zero tolerance to caste-based discrimination and exclusion.
5. Make it mandatory for all students, faculty and staff who come from dominant castes and communities to attend courses, sessions conducted by peers from marginalised communities on

discrimination, to reflect on their prejudices against students from marginalised communities which potentially can lead to discriminatory and abusive behaviour which contradicts the foundational principles of the Constitution of India. At the same time there is need for active programmes at the level of the institution to make sure that space is created for diverse communities to co-exist on HEI campuses.

6. Institutions must compulsorily provide free English language coaching especially for students from marginalised communities to compensate for the fact that many of them may not have had the opportunity to study in English in school.
7. Other academic support must be provided to all students who may need it so that they learn on an equal footing with their peers.
8. Students from marginalised communities should be given priority to attend academic conferences and other such academic events that provide an opportunity for individual growth and also provide a chance to build professional networks.
9. Students from marginalised communities must get priority in accessing subsidised hostel accommodation on campus.

X.3.2 Compliance with reservation policy regarding institutional staffing

1. All posts reserved for those from marginalised communities must be filled by those from these communities and not made open. Extra effort must be made to receive applications for these through advertising in particular channels and spaces. For example, if no reserved category candidate is found at the Municipal Corporation level, then the position may be filled from state level cadre.

¹ University Grants Commission (Prevention, prohibition and redressal of sexual harassment of women employees and students in higher educational institutions) Regulations, 2015

2. Implementation of the roster system for maintaining the seats under reservation must be followed and complied with.
3. No de-reservation of posts should be allowed.

X.4 Enactment of a new legislation to respond to caste-based discrimination in HEIs

Proposed Legislative reform: Prevention of caste-based discrimination in educational institutions (Prevention, Prohibition and Redressal) Act

Purpose of this legislation:

The Scheduled Castes and Scheduled Tribes (Prevention of Atrocities) Act, 1989, has quite a detailed description of offences included in it. As it focuses on atrocity, it does not enlist the subtle forms of exclusion, discrimination and deliberate disempowerment faced by students from marginalised communities in educational institutions. Various positions of authority and decision making within these institutions are occupied by persons from dominant castes, which fail to address the inherent caste bias that operates at various levels within institutes.

There have been innumerable recurring incidences of death by suicide of students coming from marginalised communities across institutions. Especially after the institutional murder of Rohit Vemula in Hyderabad Central University in 2016, many initiatives from anti-caste struggles have started a process of formulating a similar legislation, which has been referred to popularly as the Rohit Vemula Act, to address this lacuna within legal framework. This is absolutely necessary to provide access to justice for students from marginalised communities who face caste-based discrimination within educational spaces and to make these spaces truly accessible to these students upholding constitutional equality.

We offer below some of our initial suggestions towards enacting such an anti-caste discrimination legislation along the line of Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013.

The primary focus and basis of such a legislation:

1. Explicit recognition of caste-based discrimination in educational institutions
2. Places onus of providing a safe and secure environment on the management of the educational institutions
3. Lay out a dedicated mechanism for redressal of complaints for every educational institution to abide by.
4. Along with emphasising redressing acts of caste-based discrimination there must be an equal stress on creating awareness around caste discrimination and setting up of mechanisms to enable prevention
5. Processes under this legislation must involve all sections of people from the institution to implement this legislation, thus making this a shared responsibility of everyone.
6. Persons from marginalised communities representing all sections of students and staff of the institution must form the majority of members on all committees made for the implementation of this act.
7. These committees must also have participation of representatives of civil society members who have been active in anti-caste struggles.

Formation of a task force to deliberate and draft a new legislation:

There is an urgent need for setting up of a taskforce which will help understand the true nature of discrimination and accordingly draft this legislation. This task force has to be of persons from marginalised communities especially those who have worked on issues of discrimination, or in HEIs, or belong to organisations and movements that have raised these issues over the last many years. There must be an adequate representation of students and non-teaching staff, a diverse representation of communities, gender and also region.

This taskforce should help understand the nature of discrimination prevalent in HEIs by collating all

experiences from primary and secondary sources. Based on this it should draft a legislation that would outline the steps to be taken by an HEI for prevention and redressal of discrimination in HEIs

X.5 Changes in medical education

X.5.1 Revamping the curricula and pedagogy

1. A process must be initiated to revamp the medical and nursing curricula and necessary systems must be put in place to enable wider participation of multi-disciplinary expertise beyond medicine. Medicine is as much about society as it is about the body and so including humanities disciplines is critical to this exercise.
2. The course must emphasise the value of primary health care and also its importance in our collective commitment to social justice and equity. It must encourage this as a core of all medical practice.
3. In the immediate, for teaching of courses like AETCOM it must be ensured that there are resources and expertise available to include meaningful understanding from Humanities and Social Sciences to talk about social structures and constitutional values. The course must highlight discrimination in medical institutions and underline the normativity and hierarchy of the profession.
4. Doctor-patient relationship, especially when patients come from marginalised backgrounds, must be an integral part of this course and the future syllabus. All patients' demands of informed consent, privacy, confidentiality, dignity must be integral part of the course also.
5. Guidelines which would help faculty members to ensure unbiased and non-discriminatory teaching practices must be developed and introduced.
6. Guidelines to ensure elimination of any bias (gender, caste etc) that may have an adverse impact on students from marginalised backgrounds in assessment processes must be developed and

introduced.

7. An evaluation of the NEET must be done to objectively assess its possibilities and limitations in gauging students' capabilities for admission. While doing this the coaching classes that train for NEET must also be evaluated. Joining them means extra time and resource which is possible for only a few and leads to unequal access.
8. The need for NEXT, an exit examination that is being proposed should also be objectively evaluated.

X.5.2 Resident doctors duties

1. Various provisions made in the Central Residency Scheme 1992 must be efficiently and uniformly implemented. (SC, 1992) These include: nationwide uniform stipend/salary for resident doctors (post-graduate and senior), weekly off, set duty hours, access to accommodation, leave travel concession and miscellaneous allowance.
2. Fixed work assignment for JR1, JR2, JR3 levels must be ensured to make the resident workload reasonable towards eliminating adverse repercussion of humanly unmanageable working hours.
3. Rotating duties at clinical departments for resident doctors posted at non-clinical departments must be considered since the workload at the latter is lesser compared to the former.

X.5.3 Mandatory rural service bond

1. Stringent compliance with the one year mandatory rural service policy instituted by the Government of Maharashtra in 2018 must be ensured. (UGC, 2018) The policy makes mandatory for every medical graduate

² The Supreme Court of India had ruled in 1987 in favour of uniform nationwide residency scheme for resident doctors. This led to the formulation of Central Residency Scheme 1992.

passed out from both government and private medical colleges to serve rural areas for one year.

2. Similar service bond after completing post-graduation health care training must be considered an integral part of the curriculum and compliance by government and private medical colleges ensured.
3. Remuneration to both the graduate and post-graduate students during this rural service bond period must be commensurate with the education and specialization achieved by the graduate and post-graduate students. Towards this the responsibility of making necessary budgetary provision must rest with the government in the interest of upholding the principle of fairness.

X.5.4 Responding to needs of nursing colleges

1. While it is true that many students face challenges with accommodation, the young nursing student coming from remote areas of state with no familiarity with the city face formidable difficulties, when they arrive for the admission process, especially those from SC/ST/VJNT communities travel from other cities, and remote areas without any social capital or finances find it difficult to make arrangements on their own for their stay and other needs. Therefore, at the level of nursing colleges, residential arrangement must be made for the students and their families during the admission period.
2. At the Mumbai municipal corporation level, reservation in matron position posts must be instituted for those qualified for these positions from SC, ST and NT communities. If qualified candidates for these posts are not available within the municipal corporation, then recruitment needs to be opened for nurses from these categories from all over Maharashtra. Currently where such reservation exists, these posts are not filled. This practice, of drawing from state or municipal cadre or other possible sources needs to be practiced wherever there is difficulty in recruitment for reserved positions.
3. Financial support in the form of free-ship must be considered for nursing professionals from SC, ST and NT communities who hold diploma and have completed three to five years of practice if

they wish to pursue higher studies and /or specialization.

4. They must also be granted sabbatical leave for higher studies to be able to do so. This is because many of these aspiring professionals cannot join such courses due to the lack of support structures and financial backing. Incentivising higher education is essential because they equip nurses from marginalised communities to occupy positions of responsibility and include them in decision making.

X.6 Transparency and accountability in functioning of State and Institutional bodies

1. Every medical institution recognised by the Medical Council, must publish on their website with immediate effect, the cases reported, acted upon, and action taken under all the three UGC regulations mentioned in IX.2.
2. Various Institutions over a period have instituted committees to enquire into caste-based discrimination. They should immediately publish in public domain, the recommendations and reports of these committees and action taken on the same. This should be applicable for all such reports/enquiries in future.
3. Various government bodies including NHRC, SHRC enquire into instances of caste-based discrimination in various education Institutions. The reports and recommendations of these commissions should be placed in public domain on their website with immediate effect. They must also mention what follow up action they have undertaken after the report. This must be done in any future enquiries as well.
4. Any lapse, if attributable to any person in the state department/institution, must mandate initiation of departmental disciplinary action, in accordance with the prescribed procedure of the state department/institution against the individual concerned.
5. If the institution does not comply with any policy to prohibit, prevent or redress discrimination

laid down by the state there should be provisions for action against it like withdrawal of affiliation/ recognition, prohibition on new admissions, or withholding of grant, while making sure that the students and staff of the institution do not suffer.

X.7 Investing in a robust and inclusive public health care system

Many of these recommendations are made on the premise of a functional state supported public health care system. This has to be made robust and responsive to the changing needs of different populations, especially for those from the margins. Investing money and resources into the system is urgently needed for this to even begin to happen.

1. Increase budgets for health care and medical education (by a minimum of 4% of the GDP)
2. Posts for medical doctors in medical teaching hospitals and medical colleges must be sufficiently increased to ensure that both health care and medical education do not suffer.
3. Budget every year for training of all staff to address issues of discrimination within and outside the institution.
4. All bodies responsible for implementation of all the above to have clearly allocated funds and infrastructure.
5. Allocate funds to upgrade rural based health care systems to enable appropriate utilization of specialty skills of resident doctors posted there for rural practicum and to cater health care needs of people who otherwise have to reach to other health care settings at tertiary level.

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Glossary

1. AIDWA: All India Democratic Women's Association
2. ARC-BYLNH: Anti Ragging Committee-BYL Nair Hospital
3. AETCOM: Attitude, Ethics and Communication Module
4. BMC: Brihan Mumbai Municipal Corporation
5. BYLNH: BYL Nair Hospital
6. CAPD: Committee Against Prejudice and Discrimination
7. CET: Common Entrance Test
8. CLA 2013: Criminal Law Amendment Act 2013
9. DAMA: Dr Ambedkar Medicos' Association
10. DMER: Directorate of Medical Education and Research
11. DNT: De-notified Tribe
12. DYFI: Democratic Youth Federation of India
13. ECT: Electro Convulsive Therapy
14. EOC: Equal Opportunity Commission
15. EWTD: European Working Time Directive
16. FAOW: Forum Against Oppression of Women
17. FMES: Forum for Medical Ethics Society
18. GDP: Gross Domestic Products
19. GoI: Government of India
20. GMCM: Government Medical College, at Miraj
21. HEI: Higher Educations Institution
22. HLEG: High Level Expert Group
23. HoD: Head of Department
24. IIM: Indian Institute of Management
25. IMA: Indian Medical Association
26. INC: Indian Nursing Council

27. MARD: Maharashtra Association of Resident Doctors
28. MC: The Bhalchandra Mungekar Committee
29. MFC: Medico Friends Circle
30. MMC: Mumbai Municipal Corporation
31. MoH&FW: Ministry of Health and Family Welfare
32. MoL&J: Ministry of Law and Justice
33. MSCET: Maharashtra State Common Entrance Test
34. MSCSC&ST: Maharashtra State Commission for Scheduled Castes and Scheduled Tribes
35. MSCW: Maharashtra State Commission for Women
36. MSHRC: Maharashtra State Human Rights Commission
37. MUHS: Maharashtra University of Health Sciences
38. NCST: National Commissions for Scheduled Tribes
39. NCW: National Commission for Women
40. NEET: National Eligibility and Entrance Test
41. NEP: National Education Policy
42. NHP: National Health Policy
43. NMC: National Medical Commission
44. NRI: Non-residents of India
45. NT: Nomadic Tribe
46. OBCs: Other Backward Castes PG: Post Graduate
47. PIL: Public Interest Litigation
48. POA Act: Scheduled Caste and Scheduled Tribe (Prevention of Atrocities) Act, 1989
49. POSH Act: Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013
50. PUCL: People's Unions for Civil Liberties
51. RTI Act: Right to Information Act
52. SAP: Structural Adjustment Program
53. SCl: Supreme Court of India
54. SC-ST: Scheduled Cast – Scheduled Tribe
55. SFI: Students' Federation of India
56. STC: The Sukhdeo Thorat Committee

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- 57. TB: Tuberculosis Infection
 - 58. TNMC: Topiwala NaYonal Medical College
 - 59. TBMC: The Bhalchndra Mungekar Committee
 - 60. UDF: United Democratic Front
 - 61. UGC: University Grants Commission
 - 62. VBA: Vanchit Bahujan Aghadi
 - 63. VMMC: Vardhman Mahavir Medical College

Individuals who participated in the enquiry

| Codes | Select Professional Specifics | Gender | Community identity |
|-------|--|--------|------------------------|
| AM1 | Ayush doctor | Male | Marginalised community |
| AM2 | Ayush doctor | Male | Marginalised community |
| RDD1 | Sr Resident Doctor | Male | Dominant caste |
| RDD2 | Sr Resident Doctor | Male | Dominant caste |
| RDM1 | Sr Resident Doctor | Male | Marginalised community |
| RDM2 | Sr Resident Doctor | Male | Marginalised community |
| RDM3 | Sr Resident Doctor | Male | Marginalised community |
| RDM4 | Jr Resident Doctor | Female | Marginalised community |
| EDD1 | Employee | Male | Dominant caste |
| EDD2 | Ex-employee | Male | Dominant caste |
| EM1 | Employee -- technician | Female | Marginalised community |
| EM2 | Employee -- nurses' tutor | Male | Marginalised community |
| KI1 | Sr Doctor | Male | Muslim |
| KI2 | Sr Doctor | Female | Muslim |
| KI3 | Former Dean | Male | Other backward caste |
| KI4 | Ex MARD, Ex faculty Public Hospital, Present private hospital surgeon | Male | Dominant caste |
| KI5 | Sr scholar and academician | Male | Marginalised community |
| KI6 | Representative of nurses' union | Female | Marginalised community |
| KI7 | Representative of nurses' union | Female | Dominant caste |

Legend:

AM: Ayurvedic doctor from marginalized community, **EDD:** Employee from dominant caste, **EM:** Employee from marginalized community, **KI:** Key Informants, **RDD:** Resident doctor from dominant caste, **RDM:** Resident doctor from Marginalized Community



END OF THE REPORT