RESEARCH ARTICLE

Trust, regulation, and stewardship of the medical profession in India [version 1; peer review: awaiting peer review]

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Abstract

In this paper we discuss the consequences of commercialisation of medicine and the associated shift in professional values, identity, and practices for patients, doctors, and health care organisations in India. We do so within the broader frame of the widely reported fall in trust in the health system in India, and with a view to reflect on how trust may be restored to a level which sustains a different but effective type of relationship between the medical profession and society. We draw on interviews with high-level health system and social actors in India to shed light on the key influences which shape the stewardship and governance of the health care system and the medical profession in the light of mounting evidence of and concerns around the erosion of public and patient trust in these institutions in India. Analysis is presented through four interrelated thematic articulations. Two themes highlight the practices of doctors and the actions of patients which contributed to changes in their relations and particularly a decline in trust. Two further themes focus on the policy and practice implications for regulation and stewardship of the health system and the medical profession.

Keywords

Health Systems, Medical Governance, Stewardship, Regulation, Trust, India

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Background

The health system in India includes a complex and heterogeneous mix of a government-run healthcare delivery sector which co-exists with a vast, diverse, and rapidly growing, but poorly regulated, for-profit private healthcare delivery sector where payments are mostly made out-of-pocket (De Costa *et al.*, 2008; Minocha, 1980). The health system is pluralistic in that the public, private and third (charity) sectors fund and provide care but also where Western medicine and other traditions of medicine co-exist although perhaps not in harmony (Prasad, 2017). The Indian health system is also characterised by a multitude of regulations and, separate sets of regulations target professionals and healthcare facilities in the public and private sectors, medical education, the wider profession, and the pharmaceuticals market (Calnan & Kane, 2018).

The Indian health system is struggling with multiple burdens - of disease (double burden of infectious and chronic diseases), of inequities in access to health and health outcomes, and with declining in trust in the health system. This widespread failure of trust and the consequent disenchantment with the health system in India, can seriously, further undermine access to healthcare, by reducing adherence to treatment, by compromising continuity and quality of care, and by driving up costs; all ultimately leading to poor health outcomes for all sections of society (Calnan & Rowe, 2008; Taylor *et al.*, 2023). For example, earlier research from India (Calnan & Kane, 2018) has highlighted the problems of trust and the presence of widespread distrust and erosion of trust particularly on the supply side of the health system and showed how trust relations between private providers, public providers, health managers, policy makers and regulators are at an all-time low. It was argued that these problems are related to weaknesses of governance and stewardship of the regulatory apparatus and the professional associations. Various examples were identified around regulatory and stewardship failures in the Indian health system suggesting the need for and the importance of rebuilding trust relations on the supply side of the health system. One of the key mechanisms for enhancing trust relations is claimed to be effective stewardship which involves oversight and trusteeship. According to the World Health Report of 2000, stewardship involves oversight and trusteeship (p 119) and may be defined as a "function of a government responsible for the welfare of the population, and concerned about the trust and legitimacy with which its activities are viewed by the citizenry" (p119). It includes regulation of professional practice, management of performance and oversight of professional conduct and values.

The aim of this phase of our ongoing program of research was to focus principally on those responsible for the stewardship and regulation of the system. While the earlier work (Kane *et al.*, 2015) revealed a willingness amongst those mandated with the stewardship of the health system to improve practices, it pointed to many knowledge gaps around what might nudge various actors to translate this willingness into concrete action, and what approaches might work, and with whom. The objective of this study was to investigate further these gaps in knowledge with a view, at least over the long term, to formulate evidence-based strategies which can be adopted to repair, build, and maintain trust in the governance and stewardship of healthcare systems in LMIC's.

Methods

This study used qualitative methods (i.e., in-depth interviews) to explore: the views of high-ranking officials responsible for the stewardship of the health system - in government regulatory bodies, local and state parliaments, civil services, and professional associations, on the subject The objective was to gain insights into a) normative understandings; b) perceptions; and c) expectations, about distrust, trust and trust relationships, amongst and between different actors involved in the regulation and stewardship of the health system. The conceptual approach identified in our previous research (Kane *et al.*, 2015) was informed by the interviews and focus groups with key informants which included public and private providers, regulators, managers, complimentary medical practitioners, and other societal actors including patients/citizens, politicians, and the media. A topic guide was constructed exploring the three elements described above.

Study participants were purposively selected. We focused on conducting interviews with high-level actors involved in the stewardship and governance of the health system in the state. We identified key roles and respondents who exemplified and occupied (or had occupied) these roles. We focused on identifying those who had over their careers performed multiple roles. The achieved purposive 'roles' sample consisted of a Chairman and Managing Director of a company which runs three major tertiary hospitals (CMD); Head of a Private Corporate Tertiary Hospital (HPCTH); Former Dean of a Public Medical School (FDPMS); Former Head of a 1500 bed Public Tertiary Hospital (FHPTH); Former Vice-Chancellor of a medical university (FVC); Senior journalist in a leading local language newspaper (SJLL); Senior (health) journalist in a leading English language newspaper (SJEL); State Public Health Services in-charge of Health Promotion and Communication (SPHM); Senior Expert at a government advisory centre (SE); Senior Manager within the State Public Health Service (SM); a Senior Lawyer and Medico-Legal Expert (SMLE); a City Councillor/Politician (CCP); and a Health Activist (HA). These thirteen role profiles were spread cross ten respondents.

The interviews were carried out between 2020 and February 2023. Ethics approval for the study was granted by the independent ethics committee at Gokhale Institute Of Politics & Economics, Pune, India. The interviews were transcribed and translated where necessary into English. We adopted an abductive approach to analysis. This involved observations, interviews, discussions between researchers, revisitation of interviews in light of emerging findings and theory, to unpack what might nudge various actors to translate this willingness into concrete action, and what approaches might work, with whom, and in what circumstances. The abductive approach involves consciously being open to inferences that may fall outside of an initial theoretical frame or premise (Tavory & Timmermans, 2014).

Ethics

Ethics approval for the study was provided by the Ethics Committee at Gokhale Institute Of Politics & Economics, Pune, India; Letter # GIPE/IEC/2020/1 dated 07 Jan 2020. The ethics committee has not provided permission to allow the data (interview transcripts) to be shared in the public domain. The Extended Data i.e., the interview topic guide, is included (Kane, 2024).

Findings

The analysis is presented as four prominent but interrelated themes two of which highlight the practices of doctors and the actions of patients which have contributed to changes in their relations and particularly a decline in trust. The two further themes focus on the implications for regulation and stewardship.

1. A decline in public/patient trust in the health system and the medical profession

One argument which was consistently articulated by the participants was that public/ patient trust in the health system and the medical profession has declined; and, as the following participant, a senior journalist, suggests, this is clearly exemplified by the increase in violence against doctors which his paper regularly covered as a newsworthy story,

> *'Yes. I think the health system has evolved in a very peculiar way and the doctors are not satisfied with it. Every day we hear about some bickering occurring between the doctor and the patient. Patients probably don't believe in the doctor or if a mishap occurs or there is a death, the relatives come and beat the doctor. Now this is an extreme example of mistrust in the doctor. But I would say that patients have lost trust in the whole health care delivery system … in the government sector and … in the private sector also there is no trust for other reasons, and they are monetary reasons. For example, when a private doctor is visited by a patient, the first question that the doctor often asks … which to my mind is very wrong … have you got 'insurance'? So, if there is insurance the doctor's bill is going to be 5000. If there is no insurance, then the doctor's bill is going to 500. I do not understand this logic' SJLL.*

Another participant however, made a distinction between interpersonal trust relations with the doctor and institutional trust relations - with the latter in marked decline but the former being sustained which suggests the two might not be closely related:

> *'Trust has really gone down, but as I said earlier, when I have (go to) my own doctor my trust is there. But not as a system, the trust has really gone down' HA*

Participants accounts for this decline in institutional trust varied but one idea which seemed to permeate throughout was the perceived commercialisation of medicine as the following two participants clearly illustrate - although it is not something that either was comfortable with,

> *'It is now (profit oriented). Like when you must have profit and all those things…that is a different kind of industry. Medicine itself is a different profession. It is just not a business. When people start looking through that lens. People were previously also working in this profession, but with a different attitude. Also, the medical education has become very commercialized, I mean if you give money even the dumbest person can become a doctor. Sometimes. So, when it comes to the money, and if the idea is that then you can buy anything … then things become very difficult. CCP*

> *'Doctors are anyway not holier than thou ...they should not pretend to be … they are also as much a part of the society as other people. So, in order to build trust, the first thing that, this is something which I always think, you know the Supreme Court of India and the Mumbai High Court defined healthcare as a service and therefore they said that we come under the consumer protection act. And they also called it a business, so practice of medicine is a business. Once we call it a business ... I think there, all the problems have arisen out of it. If you say that it is a business then you give goods and, the patient takes the treatment, there is no human angle to it. Where is the question of trust? Medicine as a profession is an art and science, definitely not a business!' CMD*

As the following exchange with a Senior Expert at a government advisory centre points out, this erosion of trust might be exemplified in the related issue of unethical practices increasingly found in the private sector (and the public sector too) which leads to patients feeling the need to look for a second opinion once again reflecting a lack of trust.

> *R: In recent years, even in private practitioners the trust is …I mean it is more in private practitioners. But it is going down very fast due to the unethical practices, maybe charging the fees, to very high extent, then no control over it. Like some doctors might charge for some kind of heart surgery 2–3 lakh rupees and in another hospital, it is only 50–60 thousand. So, there is a huge gap between that. People don't trust the doctors these days. Previously it was not the case, previously doctor was kind of a God for them. But know it has become more of a business from doctors' perspective also and for patients it is no more God, which is good, still they don't trust them. I mean they keep asking for some further advise … even two or three people.*

> *I: So, they ask for a second opinion? R: Yes. Yes. And I mean the exploitation is rampant these days'.SE*

There is, as the following comment by a senior journalist illustrates, also the practice of overprescribing unnecessary

treatments or tests, driven by money i.e., supplier induced demand,

> *'That is there, then another thing, I feel is unethical, if I know the XYZ patient does not require this procedure or this admission for 2–3 days, unnecessarily if I am doing that for money, then that is also unethical … similarly, ordering unnecessary diagnostic tests, this is all very common currently'. SJEL*

One participant, while reflecting on these practices, was emphatic in saying that such practices were ethically questionable and inappropriate.

> *'It is unethical to charge a patient for paying somebody else ... Just referring a patient doesn't give you the right or a reason or the hospital or anybody else should pay you. It's your duty, you are already getting paid for the consultation' HPCTH*

There were some differences in participants explanations for these unethical practices. One explanation emphasised that they were a small proportion of individual doctors who were 'bad apples' suggesting that the problem is with individuals who need to be tackled and checked. A former top administrator argued that *'The bad apples will not be weeded out automatically. We realize the apple is rotten only after it is eaten, otherwise we are unable to find out whether you have got good apples or not. So, it becomes a little late to understand and to weed out, but certainly there are some doctors who have an image which is not good for their reputation, in which case the patient does seek second and third opinion. So maybe it is just occurring to me, that government can have a panel of doctors in every city, who obviously practice ethical medicine, and maybe their second or third opinion could be a solution to the problem of mistrust' FVC*

An alternative explanation offered by the senior local language journalist, as the following interaction illustrates, in contrast suggests that these problems might be structural, and that the practices are somehow understandable given how things are organised in the Indian health system i.e., medical practices are businesses, and a major inputs cost to these businesses is the long years training that doctors have to undertake before they can be competitive in this harsh marketplace:

> *'The regulator is the Medical Council of India. They do regulate, but it is just the system ... why do doctors do unnecessary tests? To earn money'.*
>
> *I: Okk.*
>
> *R: That is just one reason obviously. The second thing what happens in India or maybe around the world if you want to be a medical practitioner… normally … typically in India you need to study for 4 and half years after higher secondary studies. That means from age 18 to 23. At 23 years of age you become a doctor … then normally if you want to be a successful doctor you have to pursue a post graduate degree (specialist training) … that requires another few years. And then you need some time to practice … so it is only at 28 or 29 years of age does one becomes a full-fledged doctor. By that time an engineer or the teacher or others are long settled and earning well. So, a doctor starts earning much later and they also need capital for infrastructure. So, unless you have doctor parents you will obviously struggle.*
>
> *I: Sure. So, you are l saying that doctors take a long time for earning, and so it is understandable?*
>
> *R: No, no. I am not saying this is understandable or justified. I am just trying to understand their position. I am not offering an excuse for them to do any malpractices, but this may be one reason why these practices are happening' SJLL*

This explanation is made more explicit in the following participant's account. The implication the participant is alluding to was that that while this conduct could not be condoned, there may be understandable reasons why some doctors engage in these unethical practices even though they may be reluctant to partake in these,

> *R: There is a sizable number of doctors who do not want to do this kind of practice at all, some of them feel forced to do it, because there are no other options, because they have to survive. It is a question of survival for some of them as they don't have the backing of a hospital or a hospital established by their parents, forefathers. A sizable number of them do not want to be a part of such practices. Maybe 5 % of them could be really corrupt, but not more than that' SMLE*

Even 'good doctors', if one were to take a very narrow and strict view, engage in some kind of unethical practices as this participant, sharing personal experience, argued,

> *R: 'Even the general physician to whom I go to … if I were to see from this (a narrow) perspective. Every time he takes about 200 Rs as fees, but there is no receipt. Nothing. I mean he is a very good doctor, and we have very good relations with him, but I could not possibly tell him that he ought to start giving receipts or so ... because all that is his money. I don't know ... I am sure he must be paying his taxes, but he does not give any receipt or anything. That can also be construed as unethical. But he is really a good doctor. A good MBBS doctor … I know he is a good doctor.*
>
> *I: Okay ... you trust him? R: Yeah ...I trust him. I basically trust his diagnosis. SE*

As the following quote from a senior journalist points out, there is also the perception and widely held belief that doctors are under pressure from pharmaceutical companies, and therefore act in certain ways,

> *'A lot of Medical Representatives visit doctors. They pressurise … I mean that … please prescribe this drug and that drug. They may be taking bribes ... maybe gifts for Diwali and New Year. Starting from anything (small*

things) to … I mean sponsoring them to join cruises or holidays abroad … it includes all those things. SJEL

2. The rise of the enlightened user?

The previous discussion suggested that there had been an increase in patients requesting, or being forced to request, second opinions. But there were other examples of patients becoming more assertive which in turn was seen as driving doctors' practices. For example, there was an alternative explanation given by one participant that doctors in the private sector are over treating and over investigating which did not emphasise that the overriding concern was with making money but rather emphasised that it was the doctors' fears of litigation and the linked need to play it safe that underpinned these practices.

R: 'And one reason for the perception of over investigation or over prescribing, is because of the increase in the litigation that has happened in the last decade or so. Now, you know, there are patients who have become litigant and want to sue the doctor at the drop of a hat!

I: OKK. R: Now if I do ... say an MRI or CT scan you are upset about it. If I don't do, you are still upset about it. Now what do you, what do I do? So, the best thing to do in the situation is to do it. So at least I have done what is formally a reasonable requirement of care. But, it could well be perceived by someone as being more than what is really actually required.

I: So, doctors have a fear of litigation? R: Yeah! The pressure for ordering investigations is more because of the fear of litigation rather than anything else.' HPCTH

The second example reflects the common belief that due to the easy accessibility of information on the internet patients are becoming more assertive and critical, either by choice or necessity. As the following excerpts illustrate, given the backdrop of falling trust in doctors, some doctors appear to be uncomfortable with these developments.

'With googlisation and easy availability of half-baked knowledge, every patient thinks that he is a doctor because he has already googled up all the information about his ailment and he thinks what the doctor is doing is incorrect. For example, sometimes when I ask parents what the matter is with their child, they say that the child has a urinary tract infection.' FVC

'That they don't trust … is in fact harming their treatment. One can say that people trust the doctors … or they have no option, and they have to trust doctors … but at the same time they (people) are also now more aware, because of the internet and they are questioning the doctors' SJLL

3. A lack of effective regulation

The analysis so far has suggested that the decline in patient trust in the medical profession was due to a combination of drivers associated with the intentions and practices of doctors and patients. One key characteristic of medical professionalism (Calnan, 2020) is professional discretion, so doctors usually have the freedom to make clinical decisions even in the context of regulatory control and organisational constraint. As the following interview with a senior public health official (FHPTH) illustrates, in the setting of for-profit private practice, some participants suggested that doctors had both considerable clinical and economic autonomy not least because of a lack of regulation:

R: 'Because we don't have control over private practitioners. I mean the Clinical Establishment Act has been submitted, but that has been in the making since last four to five years. I mean… the activists are following it up. But still it has not been passed in the assembly.

I: Hmm.

R: Mainly, due to the pressure from the private practitioner's lobby. … I mean they don't want to be controlled by this kind of law and all those things. So currently private practitioners' actions are not under government's control. The medical education department gives them a license to practice, but apart from that we don't have any control over it. So, they can charge anything. They can. I mean the inspection is also very cursory sometimes. It is completely … I mean it is an uncontrolled thing. So, given that background, our public health system is much more organized in that way.

I: is it much more regulated too? R*: Yes. Yes … absolutely.*

I: And that works?

R: Actually, what is happening is that as price controls in the private sector are weak, many public health service doctors are getting attracted to private practice. So, while they are employees of public health department, they still practice privately. Government provides them with a non NPA i.e. Non-Practicing Allowance ... they cannot really have your private practice. FHPTH

Others, particularly the two private sector leaders (CMD and HPCTH), as the following quote illustrates, thought that there was no need for any further regulatory intervention from the government on the pricing front though, as the market would provide effective governance,

'The government should not regulate on this aspect of healthcare … price control. Let the market govern it and the market is the best way to govern it. Like in queuing theory, if you look at counters, you'll never find a counter to be having no queue and others with a long queue. So, this is the way the market functions always' HPCTH

In addition to this view that the market could sort out the pricing related problems, there was, as the following quote illustrates, also the concern for regulatory abuse by some unscrupulous regulators who might themselves be involved in unethical practices, which also clearly has implications

for trust relations generally, although primarily between doctors and regulators.

> *'But sometimes you are talking about bribes ... that possibility could be there but that is not everywhere. Currently we don't have any robust regulation but if we implement the act (the law, as is), some doctors fear that it would get weakly implemented or distorted during implementation. and … doctors will get harassed. And then it will lead to some other kind of corruption also, for money (extorted from doctors). So that kind of fear they (doctors) also have.' SE*

4. Management and stewardship in the public and private sectors

Different sectors of health care provision posed different problems for management and stewardship. The data presented so far has clearly shown the difficulties in controlling the unethical practices in the private sector (for-profit private sector) where regulation is minimal although the quality of care appears, or is at least perceived to be, relatively high. The key to addressing this issue according to this hospital manager is 'transparency'.

> *'So, in India there is a lack of transparency, with respect to sharing the costs or whether the treatment pricing, so to say. Every hospital, of course depending upon their overheads, would have to have their pricing. But you know, pricing, even if my investment here is high, I can't still outprice the market. I'll be out, I'll be out of the business. See, in the private sector, industry now has realised that if you are not transparent to the patient, the perception will not be good for you. So, in my previous organization and also here, for every patient who enters the hospital, for all elective surgeries, a proper financial estimate is given to the patient, signed off by the patient. So, he knows exactly how much money he's going to spend here. And we monitor the actuals ... the actual billing which happens at the end may have a variation of 5 to 10 percent. And we are also monitoring how we can reduce this variation. We want to be as close (to the estimate at the time of admission) and accurate as we can be. But you know medicine is not black or white … you can't really predict everything to the tee. So, it thus happens that in certain situations … exceptions, you deviate by maybe 10 odd percent. HPCTH*

The dominance of the doctor in the hierarchy, and the linked difficulties with managing doctors was also identified as a particularly difficult problem.

> *'It is (regulation) very difficult, I do know why it is very difficult, but maybe the hierarchical pattern of hospital … medical education and profession … that is what makes it difficult … this is what I feel. That doctors think no end of themselves. I think it lies with the egoistic behaviour of the medical profession… the problem I feel is that the leaders are not ready to listen to the people.' FDPMS*

Hospitals managers, particularly those who were themselves not medics, appeared to have the most difficulty managing doctors of all the staff although. As the following excerpt from a manager who was a doctor himself shows, it helped if the hospital (or health service) manager was a clinician.

> *'I am a doctor myself. I can understand their issues as well. I can think through their mind. It becomes easy. So, they cannot bluff me or fool me around. So, they don't like me sometimes, but they like me also because for a lot of times general requirement, equipment, technology orders or some other structures I can understand better. So, it works well because you know there is a sense of trust between medical administrators and physicians' HPCTH*

The quality of health care in the public sector appears to be more variable with marked differences between urban and rural locations.

> *'In rural areas the things are different because people don't have options. The public health system is (sometimes) the only option and that's why there it is very much needed. The outer scenario (the look) of health facilities in public system is not very good' …. Recently I visited a Rural hospital. They were having at family planning operation camp that day. They operated upon 50 cases ... they did laparoscopy. Now … they did not have enough beds for 50 patients, so they gave everyone mats … to lie on the floor, and all patients stayed in one large hall. And the relatives of patients were outside roaming here and there ... and there were the kids of the patients … some were crying. The atmosphere was such that it looked not well organized. It was lively ... maybe … but kind of a chaotic too. So, the public health department is struggling with these things too … we cater to a large number of people, but we don't have the resources and all those things. SPHM*

Overall, this appears to be explained primarily by a lack of resources despite the doctors being well trained i.e., the lack of robust infrastructure, and health and health services continuing to be a low priority for policy makers with low funding allocation in India.

> *'You need to spend on public health so, as a reporter now I am working as a editor but I started my journalism career as a reporter, where I used to report on health issues, at that time I was reporting that, the public spending or the government spending on health at that time was something around 1% of the GDP. Even after say 20 odd years, the spending has not gone up, it is still 1 or 1.5 % of the GDP.*
>
> *I: What percent would you like?*
>
> *R: Actually, scholars are advocating and saying at least it should be 3 or 4 % of the GDP. In education (sector) it is still 3 and 4 % whereas it should be 6%*

> *of the GDP. Spending on health and education is an investment for the society,' SJLL*

This under resourcing was seen as being particularly problematic in the public sector which experiences major shortages of qualified doctors and supplies,

> *'The point is these promises are made up in the national level also at the state level and these are historical that people have been told that they can expect MBBS doctor at the primary level at the secondary level specialist and so on and certain laboratory facilities pharmaceutical and so on but the financial resources and human resources such is not deliverable and there are shortages' SM*

Thus, in the private sector trust relations for the patient hinge on the motives of the doctor whereas in the public sector trust relations hinge on confidence in the technical quality of care being provided. As recent work by Kane *et al.,* (2022) suggests, in rural areas of India these relations are further complicated and undermined by the unregulated presence of unqualified or inappropriately qualified providers who often exploit desperate patients.

Discussion

The overall aim of this second phase of this exploratory study was to shed further light on the key influences on the stewardship and governance of the health system and the medical profession using evidence drawn from interviews with a purposive sample of key stake holders in one state in India. It is difficult to assess whether such findings can be transferable to other regions in India without more extensive research although the study revealed some important insights and confirmed the evidence from the earlier phase of the study (Kane *et al.,* 2015; Calnan & Kane, 2018) that public and patient trust in the health system and the medical profession was in decline, and at a low level. This decline appeared to be primarily in institutional trust as for some participants interpersonal trust remained intact. Similar findings have been reported from other countries (Knight *et al.*, 2020) – there they have been attributed to the dominance of the new public management perspective founded on the neo-liberal values of marketisation, and individualism. Our findings also cast doubt on the strength of the interrelationship between institutional and interpersonal trust and the latter's mediating effect where it is claimed that individuals such as clinicians perform face work for the abstract, institutional system (Giddens, 1990).

The decline appears to be most manifest in intentional trust as opposed to competence trust (Calnan & Rowe, 2008); this lack of intentional trust is a feature of the for-profit motives of the medical profession rather than any doubts about their competence. However, this clearly varies with the setting - with the doctors working in the private sector being associated with the former form of trust and the public sector health system associated with the latter although the lack of confidence in competence might be associated more with the infrastructure in the public sector rather than with the doctors themselves. Study participants also alluded to how the earlier form of trust i.e., blind or assumed trust, 'doctors as gods', was not now acceptable and did not benefit doctors, patients, or those managing the health care system (Fochsen *et al.*, 2006). A form of critical or conditional patient trust might be emerging and preferred by some; although the emergence of the more knowledgeable patient informed by information from the internet is not something that some of participants were comfortable with as they saw this as a nuisance and suggested that patients were ill informed. This is a concern expressed by doctors working in other health care systems too, although some evidence suggests that the overall impact of the internet may be to enrich the doctor-patient consultation rather than transform it into a consumer led encounter which is challenging to doctors (Nettleton *et al.*, 2005).

One of the aims of this study was to provide evidence to inform policies to rebuild trust - but where should the focus be, and should it be primarily on stewardship and governance? The evidence from this phase of the study suggested that the decline in trust was believed to be associated with a complex combination of influences associated with patients' actions, doctors' practices, and the organisation of the health system. The increasing commercialisation of health care, and medicine becoming more explicitly a business, appears to have had a major influence on doctors and on practices particularly in the private sector. hospital settings. Unethical practices appear to be driven either by individuals with unprofessional values (*the bad apples)* and by economic imperatives rooted in how the health system is organised and financed. Increasing transparency and accountability has been proposed as an effective policy approach for building institutional trust (Bachman *et al.*, 2015) and this was recognised by our study participants too. A further policy response could involve focusing on enhancing the ethical culture which entails the repair of trust deficits through a sustained approach wherein organizational routines and procedures are established to promote ethical conduct and to safeguard against unethical practice (Bachman *et al.*, 2015), and to communicate these efforts to the public. Such a policy might be appropriate but could be difficult to implement and communicate to the public given the entrenched for-profit and market-based organisation of the private sector of the health system in India. In addition, it will require a marked shift in how the healthcare market is organised and in the institutional logics which underpin the functioning of this market. This is going to be a big challenge given that India has chosen to organise the vast majority of its health system on a for-profit and market-based model.

One question which emerged from the participants accounts is - should doctors move back, if they are able to, to the altruistic values associated with more traditional characterisation of medical professionalism or whether being a 'good and trustworthy doctor', in current times, requires a commitment but does not necessitate such a vocational stance? It has been argued, by scholars analysing doctors' values in the pluralistic health system in the United States (Hafferty, 2003) that while most of the students entering medical school in the early part of this century can identify with a lay role model which epitomizes the altruistic person, these same students will view altruism, when applied to their own (anticipated) practice of

medicine, with suspicion and dread. They view the traditional imaginary of altruism as unrealistic and see it as harbingering burnouts; they fear that demanding and/or manipulative patients will take advantage of them. One sees the identification of a new identity of the physician, the physician-as-victim. Whether this difference in approaches to medical professionalism reflects the argument proposed by Freidson (2001) that the medical profession has undergone a process of restratification with the elite espousing altruism as a core value with the rank and file adopting a more pragmatic and less idealistic approach, however, as Kane & Calnan (2023) have recently argued, remains to be seen in the Indian context.

This shift in the values, identity, and practices of the medical profession may have also been influenced by other changes. For instance, the pluralistic health system in the US, where medicine is more of a business, has for some time been characterised by a culture of litigation (Dingwall & Hobson-West, 2006). According to the participants in this exploratory study, something similar is increasingly the case in India. Also, in line with what has been observed in the US, our participants argue that this is driving doctors into defensive clinical practice e.g., over-testing, perhaps even over-prescribing. This, one could also argue, might be an instance of unintended consequences of the rise of the enlightened patient as consumers who is being forced into being assertive given their lack of trust in the integrity and intentionality of doctors who are increasingly seen as working in organisational settings driven primarily by profit motives.

Doctor patient encounters in the settings of small private practices have tended to be characterised as a more patient-centred relationship at least compared with encounters in the public sector (Strong, 1979), and, according to some participants in this study, in the large for-profit private hospitals. Doctors in small private practices appear to spend more time with patients as they have more direct reputational imperatives to meet the demands of their patients. However, the increasing commercialisation of medicine particularly in hospitals appears to have led to a less patient-centred approach with our study participants suggesting evidence of poor communication, increasing distance from the patient and lack of visibility of the treating doctor. Doctors working in large for-profit corporate private hospital organisational settings no longer can, nor appear to feel the need to, develop a relationship with patients and their relatives. These market-based institutional logics seem to increasingly, and disproportionately shape various aspects of the doctor-patient relations in India, including but not limited to trust relations (Castellani & Wear, 2000).

What however of the stewardship and governance of the public health care sector? Trust relations were also seen as a problem in this context, but mainly in relation to the quality of services being provided. The assumption appears to be, at least by patients, that the health care in the private sector is superior but it is difficult to know if that image is based on experiential knowledge and/or popular discourse – both of which are problematic given the information asymmetries that characterise healthcare markets. Study participants generally felt that chronic under investment in the public sector had led to relatively poor quality of care. While the participants' arguments were primarily about the state of the public health services and improving it as the public sector is often the only option in remote areas and for the poor, McPake and Hanson (2016) have also argued that strengthening the public sector can help indirectly regulate the private sector through offering competition.

In conclusion, this exploratory study in its second phase reveals that key stakeholders in the medical profession and health system in (one state) India concur that public and patient trust is being eroded, and that more effective stewardship and governance action is needed. And that, given the state of evolution of the health system, it needs to primarily concentrate on better managing the consequences of commercialisation of medicine for patients, doctors and health care organisations and the shifts in professional values, identity, and practices it is driving. Concerted action by both, the stewards of the health system, and by the rank and file of the medical profession is necessary for trust to be restored to and maintained a level which sustains a different but effective type of relationship between doctors, patients, and the society at large.

Ethics and consent statement

Ethics approval for the study was provided by the Ethics Committee at Gokhale Institute Of Politics & Economics, Pune, India; Letter # GIPE/IEC/2020/1 dated 07 Jan 2020. Per the ethics committee's approval, all participants provided either written consent or oral consent (audio recorded). The ethics committee has not provided permission to allow the data (interview transcripts) to be shared in the public domain. The Extended Data i.e., the interview topic guide, is included (Kane, 2024).

The participants were assured at the time of consent that their interview data will not be shared with a third party. The participants agreed to participate under this condition. As per the ethics approval, all participants provided either written consent or oral consent (audio recorded). Given the high profiles of the study participants, and given their busy schedules, we had sought approval for interviews to be conducted via phone or via Zoom – hence the audio recorded oral consent for some of the interviews. The data contained some personal identifiers related to participants' roles. Revealing this in the public domain can be detrimental to the participants; this is particularly so given the small sample size and the unique roles of our study participants. The ethics committee has also not approved the sharing of the interview data beyond the researchers directly involved in the study.

Data availability

Underlying data

The participants were assured at the time of consent that their interview data will not be shared with a third party. The participants agreed to participate under this condition. As per the ethics approval, all participants provided either written consent or oral consent (audio recorded). The data contained some personal identifiers related to participants' roles. Revealing this in the public domain can be detrimental to the participants;

this is particularly so given the small sample size and the unique roles of our study participants. The ethics committee has also not approved the sharing of the interview data beyond the researchers directly involved in the study.

Extended data

Zenodo: Interview topic guide: Topic Guide Trust Study.

DOI: https://zenodo.org/doi/10.5281/zenodo.12736155 (Kane, 2024)

This project contains the following extended data:

- Topic Guide Trust Study .pdf

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