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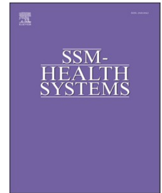

Shattered assumptions: Unravelling of the social contract between the medical profession and society in India

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ABSTRACT

Incidents of violence against doctors are increasing across the world. Beyond concerns of physical security, this raises questions about the state of the social contract between medicine and society. We analyse the situation in India as a case using the 'assumptive worlds' framework to understand how doctors are coping with the situation and situating themselves within a rapidly changing health system and society. Interviews were conducted with forty-two purposively selected medical and non-medical (patients, journalists, lawyers, police) participants over eighteen months. We found that professional autonomy, respect for doctors, and trust in doctors and their altruism – key aspects of doctors' assumptive worlds – are constantly challenged by assertive patients, an antagonistic society, and an apathetic administrative and regulatory system. The rise in violent attacks is creating a deep sense of being unfairly targeted and unjustly treated. To reconcile themselves with these developments, doctors in India are having to, often with anguish, reimagine their assumptive worlds and reshape their identities. Doctors are, however, unwittingly adopting a siege mentality. We conclude that the Indian medical profession's response to these societal developments needs to instead be critical, and self-reflective, and that change must begin from within the medical profession.

Introduction

> From 4 o'clock to 10 o'clock, we were in the operation theatre, all four of us. She (the patient) had two cardiac arrests on the operation table and could not be revived from the second one. When we started the operation, there was only one relative; by the end, there were fifty. We came out, explained the situation and informed the family that she was no more. And they started breaking things. They tore the shirt off the anaesthesiologist as he fled the hospital. They were about to hit me and the surgeon. We went and barricaded ourselves in a room, and they were banging on the door. The broken glass you see over there is because of this. They were breaking everything they could. There were 200 people outside. We finally managed to run away from the rear exit. All of them came inside, took pictures, made videos, took all the papers, vandalized the place, and ran away. The mob was outside the hospital and my home till 4 in the morning.

A gynaecologist narrated this tale during his interview although this is far from an isolated incident. In addition to verbal abuse or threats, cases of physical violence and vandalism against doctors and medical institutions are being regularly reported from across India (Nagpal, 2017; Shastri, 2019). The dramatic rise in incidents of violence against doctors in India is an important and emotive issue and has led to a growing sense of exasperation, victimhood, and injustice among doctors (Samant et al., 2024). Beyond the immediate trauma to those directly affected, the rise in incidents of violence disrupts doctors' worldview, their professional identity, and their role in society in general. Problematising incidents of violence in this light, we explore doctors' responses to this rising violence and their construction of a collective sense of victimhood. The perpetual threat of violence and an eventual readjustment of self can be explained by the concept of the assumptive world within its shattering-reconciliation dynamic. The concept of the assumptive world is widely used in trauma literature (Beder, 2005) to study the disruption and eventual reconciliation with traumatic life events, but it can also help us understand the broader disruption in the social contract and the resulting collective readjustment by the medical

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profession.

Assumptive World

Applying the concept of 'assumptive worlds' to analyse the relationship between medicine and society, involves outlining the assumptions both parties hold regarding each other generally and specifically within their particular relational context. Such assumptions ground, secure, stabilize, and orient individuals and the particular relational context - they form what is called an 'assumptive world'. The phrase denotes the assumptions people make about the social norms or rules that govern how the social world around them works (Janoff-Bulman, 1992; Matthews and Marwit, 2004). According to Janoff-Bulman (1989); (1992), people develop an internal schema consistent with their socialization, learning and experiences, enabling them to understand and organize new information. An assumptive world is akin to a theory people develop about themselves and their world, which helps them interpret their interactions with the world. In addition to being a set of firmly held assumptions about the external world, the assumptive world is also a perception of oneself and position in that world (Parkes, 1975).

The centrality of people's assumptive world in assessing and predicting the world around them may be challenged during traumatic or highly stressful events. These are schema-inconsistent, adverse real-life experiences that cannot be accommodated within one's 'cognitive conservatism' (Janoff-Bulman, 1992; Tedeschi and Calhoun, 2004). The disruption or shattering of the assumptive world upends, for many people, schemas and perceptions of an orderly, just and benevolent world and compels them to re-evaluate their sense of self (Beder, 2005). To accommodate this disruption, reconciliation with traumatic events initiates a re-evaluation of the assumptive world (Cann et al., 2010), often involving a radical readjustment of beliefs regarding the world and one's position in it.

The medical profession and the construction of self

One's assumptive world is shaped by one's role and position in society. Thus, to understand the assumptive world of doctors, we need to understand their professional identity and how they place their perceived personal and professional self within society. The construction and maintenance of one's sense of self or identity and the related assumptive world is shaped by social interactions across all facets of life (Simpson and Carrol, 2008). Collective notions of a role in society often form a core aspect of one's self-identification, thus rooting the assumptive world in social roles. Self-identity is constructed to meet one's socially ascribed roles and thus constantly reimagines itself with shifting narratives (Berzonsky, 2011; Swann and Bosson, 2010). This appears to apply to professional identities too.

Although defining professional identity is complex (Fitzgerald, 2020), for doctors it is undeniably rooted in the social contract (Gardner and Schulman, 2005). Cruess et al. (2014): (1447) argue that doctors' identities rely upon internalising the characteristics, norms and values of the medical profession until one is "*thinking, acting and feeling like a physician*". The professional identity and social roles of the medical profession are exemplified as much by 'being' a doctor as by 'doing' the activities of a doctor. This highlights the general norm and intersubjective consensus about the roles a doctor is supposed to play, which are both consciously constructed and developed experientially. The necessity of constructing an appropriate identity for doctors is particularly evident in studies of their socialisation in medical education (Cruess et al., 2014; Frost and Regehr, 2013).

It follows from the above that as part of their professional identity, doctors as a community adhere to certain intersubjective beliefs that form the core of their assumptive world. While an incident of violence may shatter the assumptive world of the individual involved doctor, each incident also casts doubt on the shared aspects of the assumptive world among the community of doctors. Continued stress over such disruptive events can lead to core beliefs about identity and one's future being questioned (Kramer, 2012; Schuler and Boals, 2016). Moving beyond its widespread use in trauma literature (Beder, 2005), the concept of the assumptive world can be a useful way to analyse how doctors situate themselves and their profession within the larger social context.

A brief account of the doctor-patient relationship in India

Social perception and representation of doctors in modern Indian discourse has been overwhelmingly positive, focusing on their altruism and benevolence (Tripathi et al., 2019). The vast majority of the population views doctors as competent, dignified, and helpful (Gupta et al., 2023; Singh, 2017), and the doctor-patient relationship, which is the most overt manifestation of the dynamic between doctors and society, is characterized by high interpersonal trust in the competence and benevolence of one's preferred doctor. While people's perceptions of and trust in 'their doctor' continue to be high, trust in the institution of medicine and the medical profession is under pressure in India (Kane and Calnan, 2016).

While no systematic studies have been conducted, several reasons for this change in the social contract are offered in the scholarly literature and in the popular media. These include inadequate doctor-patient ratios and linked arguments about high workloads, high costs of care, poor quality care, rising and unrealistic expectations, increasing commercialisation and corporatisation of medicine, and a broader rise in incivility in Indian society. For instance, Anand (2019) and Tripathi et al. (2019) point to the growing power and importance of hospital administrators and corporate managers interfering in or mediating the social contract between doctors and the public. Anand (2019) argues that people now have easy access to limitless (although often incomplete and unreliable) medical information online, possibly undermining the adage and assumption that the 'doctor knows best.' Mass media, including social media, seems to play an important role with doctors increasingly being portrayed in a negative light (Dewan, 2010; Samant et al., 2024; Tyagi, 2021).

The rise in cases of violence against doctors in India suggests that doctors' shared assumptive world of relationships underpinned by politeness, benevolence, and integrity is being constantly challenged and is under pressure. The experience of being violently attacked or being a part of an environment where such violence can destabilise the core assumptions which allow doctors to function. In our analysis, we examine this assumptive world and the challenges disrupting it, engaging with the notions of power, status, privilege, prestige, respect, and selfhood that constitute this assumptive world. Based on this analysis, we draw implications for reconfiguring and restoring the currently problematic social contract between the medical profession and society in India.

Methodology

Doctors' perceptions of their changing assumptive worlds and how it is being challenged are analysed at the individual level, at the group level (community of doctors), and at the health system level, drawing upon perspectives from participants within and outside the medical community. Over 18 months between 2022 and 2024, we conducted in-depth interviews with forty-two purposively selected participants who had, to varying degrees, been involved in violent incidents against doctors (including victims, witnesses, and perpetrators) or who had witnessed or publicly commented on these incidents. Table 1 outlines the number of respondents from different roles and occupational backgrounds who participated in the study.

Although doctors were central to the inquiry and comprised the majority of respondents, narratives from non-medical respondents provided crucial vantage points. We interviewed doctors working at government/public hospitals, small private hospitals (commonly called

Table 1
Details of Respondents.

Respondent Profile	Numbers
Doctors, including those who had personally experienced violence (n = 7)	21
Lawyers	06
Journalists and Social Commentators	04
Aggrieved Patients	08
Police Officers	03
Total	42

nursing homes), and corporate hospitals. We interviewed those who had personally experienced violence and those who had witnessed, had been indirectly affected by, or were in a position (leadership roles in the profession) to reflect on violent incidents.

All interviews were conducted in Maharashtra state of India. Snowball sampling was used to identify and approach respondents, drawing on our long-standing networks within the study area. We began our field with prominent doctors in different settings, gradually establishing our credibility and trust. This enabled us to approach doctors who have faced violence, many of whom were initially unwilling to disclose or recollect past traumatic incidences. There has not been any geographical clustering of a particular respondent category.

In addition to the interview transcripts, we maintained detailed notes outlining the circumstances, settings, and other non-verbal elements of all interviews. These interview memorandums were used extensively in conjunction with transcripts. We employed NVivo software to code the transcripts. Initially, some transcripts were analysed using open coding, where codes were generated directly from the data. These codes were then grouped and organized into a coding framework. This framework was subsequently used to code the entire set of transcripts. Data collection and analyses were carried out concurrently, enabling us to iteratively explore emerging themes and adjust or refine our line of inquiry. Regular debriefing sessions among the researchers were crucial for this iterative process. Some respondents were interviewed multiple times, engaging them with emergent findings and new themes, but this was not feasible for all participants.

Findings

We present our findings in three interrelated sections. First, we explore the assumptive world of doctors in India, identifying three primary themes underpinning its construction: the nature of the health system and medical practice in India (and changes to it), the distinctiveness and unique identity of the medical profession, and the effect of these two on the current state of the doctor-patient relationship in India. Second, we examine the various sources of friction and stress in these assumptive worlds for doctors. Third, and building on the first two sets of findings, we identify how doctors are revisiting their disrupted assumptive world in the face of the many changes in the health system and society.

Formation of the assumptive world of doctors

In India, doctors' assumptive worlds span three domains and are constructed by the doctors themselves and wider society. These domains are the nature of medical practice, perceptions of the uniqueness of the medical profession, and the nature of the doctor-patient relationships. As shown below, this assumptive world continuously evolves through various macro- and micro-level processes.

Family doctor: the nature of medical practice

Family doctors are generalist medical practitioners who provide primary care to individuals and families. They are expected to know their patients' medical history, provide personalized care and refer them to specialists as necessary (Lam, 2016; Hashim, 2018). Beyond the technicalities of a general practitioner, this imaginary of the 'family doctor' invokes a historically rooted social relationship where doctors transcend their medical responsibilities to become close confidants and advisors to their patients and their families (Loudon, 1984).

A nostalgia for 'family doctors' as the ideal model of medical practice emerged as a dominant theme. Many of our respondents, doctors and non-doctors alike, invoked this reference to frame their commentaries about the organization of the medical profession. We found that nostalgia for this imaginary of the 'family doctor' reflects and frames doctors' and society's understanding of the ideal relationship between society and the medical profession. The following excerpt illustrates this widely held view about what 'ideal' doctoring should look like.

> Somewhere in the 80 s; till that time, the concept of the family doctor was there, and that doctor was not only giving advice to the family about the health but was generally a very close friend of the family. Things have changed, but still, I think, that if we keep the basic principles of communication, what those doctors used to do, many things can be tackled. [Orthopaedic surgeon and social commentator]

Although there is little reliable evidence to suggest that 'family doctors' were once common in India, it is noteworthy that almost all our respondents invoked the idea and were nostalgic about it while discussing their views on the organisation of the medical profession in India. We present this sentiment as evidence, contending that the nostalgic role of the family doctor concept is a cornerstone of doctors' assumptive world, a foundational assumption underpinning the health system and the nature of the medical practice, emphasising the non-clinical, social dimensions of healthcare.

Another respondent, a lawyer, invokes the notion of family doctors to draw attention to the changes in the ethical/moral standards upheld by doctors, thereby connecting these changes to wider changes in the medical profession and the nature of medical practice, including but not limited to the transition to hyper-specialisation.

> In the past, we relied on one family doctor who provided treatment and relief for all our ailments. However, today's scenario differs slightly. Specialists now handle specific areas, such as the retina, and separate experts treat other parts of the eye. This super-specialization can lead to unnecessary increases in treatment costs. [Lawyer]

The 'family doctor' imaginary includes the idea of altruistic yet authoritative doctors and expectations (and assumptions) of certain conduct from the patients, particularly expressions of 'high,' often blind or assumed trust in doctors. The nostalgic reflections of many doctors in our study suggest they rue the fact that this is no longer the case. This persistent invocation of the idea of the trusted family doctor goes beyond mere nostalgia for an ideal past; our analysis suggests that it is a key element of the normative core of the assumptive world of doctors within Indian society.

The uniqueness of the medical profession

Many of our respondents indicated that the uniqueness of the medical profession shaped the assumptive worlds of doctors. One prominent assumption concerns the high moral and ethical framework within which doctors are expected to practise medicine. One of our respondents, an intensivist, talked about how he regularly gave discounts and did not charge for investigations *"when patients do not have the means"* to pay. *He talked about how doctors regularly "negotiated with diagnostics labs on behalf of their patients: Arguing how this was all expected and how in fact "it is intrinsic to being a doctor". [Intensivist]*

The perceived distinctiveness of the medical profession was also evident in ideas surrounding selflessness. Interacting with different stakeholders captured different facets of this uniqueness, and non-medical respondents tended to emphasize the altruistic values of the

medical profession more than doctors themselves. As the following excerpt from a lawyer reveals, while there is a readiness to accept medicine as a valid source of income, the service component is always invoked to caution against it becoming merely a business. The societal assumption remains (as part of the social contract) that the medical profession's historic, service-oriented core values will be preserved, even while doctors earn from their profession.

> Although we view medicine as a profession, it is a seva (selfless service). We are not suggesting that they shouldn't charge their fees when we claim that it is seva. We are aware that keeping a hospital running and employing people is essential, but the spirit of seva needs to be alive somewhere. 'Sevabhav' should be reflected in your work. [Lawyer]

When reflecting on this distinctiveness of their profession doctors invariably drew attention to the inclusion of the medical profession under the Consumer Protection Act (CPA) (AIR, 1996; CPA, 1986). They felt this inclusion had been wrong because it reduced them to the level of any other profession and equated doctors with ordinary service providers in the market. This drawing of a contrast highlights an important aspect of the assumptive world i.e., the unique ethical and moral responsibilities inherent to their work.

The assumptive world surrounding the distinctiveness of the medical profession is complex and messy, resulting in the formation of diverse and often contradictory assumptive worlds and multiple identities among doctors themselves. Both medical and non-medical respondents in our study have alluded to the uniqueness of the medical profession but from different vantage points. They consistently highlighted the need for doctors to remain altruistic and adhere to the traditional values of selfless service. From the doctors' perspective, this special responsibility towards society needs to be balanced with maintaining professional discretion and autonomy. As the CPA reveals, however, doctors' assumptions about the need for their professional autonomy were increasingly not shared by other key actors in society.

The doctor-patient relationship

Traditionally, the doctor-patient relationship was characterized by patients seeking medical help, doctors providing care based on specialized, privileged and generally inaccessible knowledge, and, in turn, patients accepting their decision with complete trust and compliance. The doctor was accorded complete autonomy and authority while being expected to be benevolent and give primacy to patients' wellbeing and interests (Kaba and Sooriakumaran, 2007). Patients were expected to fully trust and cooperate with the doctor and to submit to their expert knowledge and authority (Morgan, 2008). The information asymmetry in the relationship was accepted by both parties. A decline in trust in doctors and in the cooperation patients agreed to, repeatedly appeared in our interviews as impinging upon doctors' assumptive worlds. Doctors acknowledged that trust had been greatly eroded but reminisced about an ideal past during our interviews, as observed in the following excerpt.

> I have been practising medicine for 25 years. The behaviour of patients has changed drastically. Before 2000, they blindly trusted the doctor in whatever (s)he said. Now, even if you tell them the best of the things and treat them perfectly, they still want to find fault in the treatment. [Gynaecologist]

In the same vein, doctors in India have long been equated with 'gods'. This deification has been a prominent feature in the traditional doctor-patient relationship and in many ways serves as backdrop of doctors' assumptive worlds. Although almost all doctors in our study found this deification to be problematic, they paradoxically rued and lamented the decline in the implicit, almost blind trust offered by patients in the past.

> Before, people used to see the doctor as a god when they visited the doctor. They had a feeling that the doctor would surely relieve us from our illness and that we, the doctors, would not exploit them. And doctors used to behave like that in those days. But now that belief is no more. [Surgeon]

We argue that the assumptive worlds of doctors are shaped by the relationship between the medical profession and society and the roles each is expected to play in it. A key characteristic of this social contract has its antecedents in the historical nature of the doctor-patient relationship – specifically, the notion of the dominant, paternalistic doctor in control and the passive, dependent patient. The uniqueness of the medical profession, and the expectations around the doctor-patient relationship, contribute towards the formation of doctors' assumptive worlds. These assumptions determine doctors' norms of societal interaction and expected behaviours too. But when everyday experiences are increasingly at odds with these assumptions, as they were for almost all doctors in our study (and as the literature suggests, in India broadly), doctors' assumptive worlds are challenged and disrupted.

Shattered assumptions: disruption of the assumptive world

This section delves into how societal and institutional changes and changing social perceptions toward doctors are challenging and disrupting their assumptive world. In most cases, these changes are slow-moving and gradually undermining doctors' expectations and assumptions regarding their place in society. This increasing disharmony with the assumptive world was a source of stress for medical professionals throughout our study.

Growing suspicion in the doctor-patient relationship

The image of the doctor as someone who upholds and occupies a higher moral ground is a key aspect of the socially constructed assumptive world of doctors. Interviews consistently suggested that this aspect of their assumptive world is being challenged. As reported by Samant et al. (2024), allegations that doctors are charging high fees, being greedy or corrupt, and profiteering from unnecessary tests and interventions, while evident in some cases, have increasingly fuelled a sense of mistrust (Calnan, 2020; Kane et al., 2015; Kane and Calnan, 2016; Tripathi et al., 2019). Doctor-patient, and by extension, doctor-society relationship has traditionally been defined by trust and reverence. The evolving nature of the medical profession is challenging the heart of this relationship.

While recounting his experiences of changes in the medical profession, a senior paediatrician noted that respect for and trust in doctors was gradually diminishing, with patients becoming increasingly demanding, even arrogant. He argued that several issues, including the rise of consumerism in medicine, increased costs, and the growing interference of hospital managements, are factors contributing to this "*disruption in the doctor-patient relationship*". Additionally, the respondent opined, patients' inability or unwillingness to recognize these underlying factors has villainized doctors and damaged a cordial and respected relationship. This dilemma was captured clearly by a senior doctor.

> They feel that the cost or the charges are exaggerated, but we have to cover at least our bottom lines, our expenses, our staff expenditure, and the risk we are taking. And finally, there is some profit at the end of the day. This is disrupting the doctor-patient relationship. [Senior physician]

Accounts about the reasons behind rising distrust also referred to the increasing confidence and knowledge of patients, a trend contrasting the paternalistic relationship inherent in their assumptive worlds. The most frequent manifestation for this change within the doctor-patient relationship was the easy online access to hitherto privileged information,

referred to as *'the Google doctor'*, by one of our social commentator respondents.

These disruptions are not restricted to interpersonal relationship between doctors and patients either. They are symptomatic of the social perception of doctors at large. The increasingly hostile narratives and negative portrayal of doctors have created a rift between the medical profession and society, fuelling a deep sense of resentment among doctors. Our findings point to this bitterness among doctors because they see large sections of the state, civil society, and the media prejudging and condemning them whenever there is an incident of violence involving doctors. As the following excerpt, by a specialist physician, highlights, this resentment is amplified by institutional indifference. We contend that this mistrust, prejudice, resentment, and apathy disrupts the assumptions that make for a stable and healthy social contract, leaving doctors feeling increasingly like victims.

> Generally, when the police engage with two fighting parties, they think and differentiate in a black-and-white way. But when it comes to us (doctors), they don't think that way. Somewhere, they feel these people (the patient's family) have lost a family member, and understandably, they are angry. And, if on top of it, the bill is high, then they (police) feel it is entirely okay for them (patient's family) to lose their calm (and to get violent). [Specialist Physician]

Defensive medicine and commercialization: the antithesis of the idea of the family doctor

Increasing distrust and suspicion also infringes the core values embodied in the ideals of family doctor, who was implicitly trusted not only as a professional, but also as a close friend and confidante. The assumption of deferential and compliant patients enabled them to exercise full professional autonomy, exemplified in the adage of 'doctor knows best.' But with the erosion of this cherished social relation, respondents in our study felt continuously scrutinized for their actions. This stark divergence from the long-held assumptions of the family doctor ideal is most prominent in the rise of defensive medicine.

We found four forces at play perpetuating the rise of defensive medicine. First, patients today are no longer satisfied with their physician's clinical judgment alone and demand sophisticated investigations. Second, doctors are expected to adhere to guidelines and standards that often require sophisticated tests and investigations to confirm their diagnoses. Third, the growing risk of litigation pushes doctors and hospitals to document everything through tests and investigations. Fourth, and this is paradoxically at odds with the first force, patients and their family members harbour deep suspicion about the appropriateness of the tests and interventions (which they want) because they are expected to pay for these.

Guidelines and expectations for investigations tend to create a vicious cycle for costs and trust: declining trust leads to more defensive medicine, which increases costs, leading to further distrust. As society and government attempt to hold doctors accountable for every action and decision, doctors, we found, are becoming increasingly disinclined to exercise discretion that is often necessary to achieve good outcomes. Any act of violence against a doctor greatly amplifies this vicious cycle. Consistent with most of our respondents, following excerpt from a Cardiologist illustrates, this 'defensive' turn in how medicine is increasingly being practised,

> In the past I relied quite a bit on my clinical judgment. However, today, I hesitate to take such a course of action. Instead, I find myself inclined to recommend further tests despite being aware that they are often unnecessary. [Cardiologist]

Our respondents noted that due to factors ranging from government regulation and societal expectation, the nature of medical practice is rapidly changing. The lack of trust, as noted earlier, pushes doctors to be defensive in their practice, increasing cost and fundamentally altering the notions of altruism and patients' well-being embedded in doctor-patient relationship. The need for defensive medicine, as we explained earlier, brings the doctors need to be safe above what is the best course of action for the patient, thus shattering a fundamental assumption of the family doctor.

Increasing commercialization further compound this already strained relationship. Even though all professions aim for financial security, the expectation (as part of the social contract) remains that the medical profession's historic, service-oriented core values will be preserved. Market logic and commercialization however exert constant pressure to run healthcare facilities as profit making 'businesses.' This is clearly at odds with the long-standing expectations of selfless service, a cornerstone of the family doctor ideal. These tensions around profit and altruism were central to doctors' struggles as caregiving professionals. The following excerpt from a second-generation private practitioner echoes a predicament widely experienced and shared by doctors in our study.

> My father established a hospital not with the intention of generating profit but rather to serve those in need. He instilled in me the ethos of providing exemplary service … he emphasized that our focus should always be on delivering quality care to the community. However, in today's market-driven commercial environment, upholding such noble principles has become increasingly challenging. [Doctor at his/her own nursing home]

Consumer protection act: challenging uniqueness

As indicated earlier, the inclusion of the medical profession within the ambit of the Consumer Protection Act (AIR, 1996; CPA, 1986) was consistently identified as a watershed moment in the medical profession's relationship with society. For doctors, reducing them to just another service provider, as the CPA does, was a major assault on their assumptive world. The following excerpt from a doctor illustrates the discontent voiced by many of our respondents, predominantly doctors, regarding being labelled as 'service providers' within the 'market'.

> Bringing the medical profession under the Consumer Protection Act is wrong. You cannot treat your patient as a consumer like you treat buyers in any other context. You will not get away with it here as you would in other professions if you make a mistake! [Orthopaedic Surgeon]

Doctors have argued that the CPA contradicts the core ethos of medicine's professional autonomy. This concern highlights the violation of their assumption that the medical profession should be viewed through a distinct lens, one that acknowledges the unique ethical and moral responsibilities inherent to their work. Doctors in our study consistently pointed out that standard CPA guidelines are incompatible with the contextual and contingent nature of medical practice.

> In medicine, we call it 'practice' for a reason – there is no one diagnosis or one pill for everybody. That is why, like in 'law', it is called a practice. It is not that one plus one is two in every case. [Surgeon]

Including the medical profession under the CPA challenges doctors' assumptive worlds in multiple ways. It infringes upon their professional autonomy and the freedom to practice medicine without outside, non-expert, non-professional peer supervision. Doctors in our study consistently expressed bewilderment and annoyance on being subjected to scrutiny from non-medics on medical matters. They seemed to view this undermining of professional autonomy as a loss of prestige and authority. To the doctors in our study, calling patients 'consumers' makes doctors 'service providers', which invokes a very transactional relational arrangement, one significantly different from the relational arrangement and social contract that has historically formed the core of doctors' assumptive worlds.

Evolving assumptions

Doctors in our study consistently expressed discomfort with their deification and the unrealistic and unsolicited burden of expectations that came with it, advocating instead to be treated as fallible beings deserving of understanding. We contend that this sentiment can be understood as a result of the assault on and consequent breakdowns in aspects of the assumptive world, where individuals are trying to reevaluate their position in society. We encountered the contestations between historical notions about the status of the medical profession juxtaposed with doctors' contemporary reluctance to be assigned God-like status.

Doctors acknowledged the need to move past the paradigm of the highly respected, all-knowing, God-like personalities. Our findings show that doctors are coming to terms with how medicine is perceived by society at large. We see their desire not to be put on a pedestal stemming from the shattering of the assumptive world surrounding professional superiority and the ideals of the family doctor. Respondents viewed the shift from paternalistic to a transactional nature as unburdening of responsibility. But this was far from a unanimous position. While many saw medicine as a noble profession, others highlighted that doctors' privileged status was becoming a bane. The following comment by a senior doctor highlights what many felt.

> It (medicine) should be treated like any other profession. We are not gods. We don't want to be gods. It becomes a burden to us. It is a lot of stress. [Gynaecologist]

Historically, doctors have been accorded a very privileged position, and our findings suggest that this history has been instrumental in shaping doctors' assumptive worlds. However, changing circumstances, especially questioning doctors' expertise and the integrity and altruism of their care decisions, necessitate an adjustment to their assumptive worlds. Their perception of the privilege they enjoyed as part of their 'unique' profession is constantly challenged by social hostility. Doctors in our study appear to be reluctantly accepting this new reality where their unique social status no longer exists, or at least has been significantly eroded. The following excerpt from a surgeon poignantly illustrates doctors' discontent with how society views and treats them.

> Everyone could see the hoardings they (a political party) had put up, that said, 'If there are any issues at the hospital, come to us, and we will see to it'. These people (members of a particular political party) would immediately arrive when contacted to throw stones at us. How can a political organisation write this on a hoarding, and nobody talks about it? To me … this reflects deep apathy and hostility of the entire society towards doctors. [Surgeon]

We found that doctors are being forced to confront a reality in which society does not reciprocate their expectations of respect. Their daily encounters with public antagonism, distrust, and abuse have eroded their assumptions of being in a noble and venerable profession. Their assumptions and expectations are clearly at odds with what society is willing to offer. Many doctors in our study had started to see the medical profession not in terms of its unique position and prestige but rather as a site plagued by constant threats, vulnerability, and public discontent. The aspirational aspect of medical profession is being replaced, at least among practicing doctors, with it viewed as a thankless job that they have to constantly balance at a knifes edge. While reflecting on the question of professional satisfaction, a specialist physician said,

> "The joy of practising is gone from the profession. Earlier, we used to enjoy our successes. But now, if the patient is well, he hurls abuses for the high cost of medical care; if he doesn't get well, then he abuses because he didn't get well".

Doctors' disillusionment with their profession stood out as a key finding, as did their stress of coping with regular assaults on their assumptive world. The struggle and stress of constantly revisiting and reshaping their assumptive world to reconcile it with their lived experiences and day-to-day realities was universal, as was the moral pain this inflicted.

Discussion

Our findings show how the assumptive worlds of doctors in India and the various senses in which doctors see these being violated are determined and circumscribed by their changing professional roles and identities in society (Bhugra, 2014), specifically, changes in the prestige, status, respect, and authority of the profession in society. These changes also fundamentally influence the core elements of the social contract (Cruess, 2006; Cruess and Cruess, 1997; 2004) between doctors and patients and, by extension, broader Indian society. As Cruess and Cruess (2004, p. 185) put it, *"Society granted physicians status, respect, autonomy in practice, the privilege of self-regulation, and financial rewards on the expectation that physicians would be competent, altruistic, moral, and would address the health care needs of individual patients and society. This 'arrangement' remains the essence of the social contract."* This relational arrangement, subsumed within the idea of a social contract, lies at the heart of doctors' assumptive world. The assumptions of societal trust, professional autonomy, powers of self-regulation, monopoly over medical practice, and the status that comes from it are all derived from this long-standing social contract. But as we have witnessed throughout the previous section, various countervailing forces are, and have been for some time, altering this social contract in India – much to the dismay of many in the medical profession.

From a global viewpoint, changes in medical practice and the social contract between the medical profession and society in the latter half of the twentieth century are well documented in the Western world. These different social processes have been variously characterised as de-professionalization, restratification, democratization, proletarianization, or corporatisation of medicine (Calnan, 2020). This literature shows how doctors have gradually been divested of or have had to relinquish control over various facets of medical practice, including training, accreditation, regulation, spaces (hospitals), and means of practice (medicine, medical equipment, etc.). Reduced access to these professional inputs has led to a homogeneous degradation of professional control and the eventual proletarianization of doctors (Mckinlay and Arches, 1985). Over time, these developments have led to irrevocably altering the social contract between doctors and society. Light (2007) attributed this to professional dominance itself. Government regulations and various judicial provisions also impacted how doctors performed their duties (Reed and Evans, 1987).

While our data does not allow us to present a thorough analysis, our findings also point to some gendered dimensions of the assumptive world of medicine, a field traditionally regarded as masculine. The various practices and forms of embodiment within the profession are steeped in masculine norms, shaping the core of doctors' 'assumptive world'. However, our findings suggest that significant discomfort and dissatisfaction arise when these doctors, socialized in a gendered environment, enter the marketplace, which acts as a de-masculinizing force. Our findings showed this playing out at the intersection of three major socio-economic trajectories. One, in the healthcare market, doctors are reduced to 'mere service providers', stripping them of the power and authority traditionally associated with their role. Second, the dramatic increase in digital access to hitherto privileged knowledge and the consequent erosion of professional authority. Third, a broader shift in Indian society where one sees greater democratisation and rejection of traditional paternalistic relations that have historically reinforced masculine identities. The gendered aspects of the assumptive world of doctors deserves further in-depth examination, not least to reveal how problematic forms of masculinity might still shape doctors' professional identities and may be hindering the medical profession from reimagining its social contract with society.

Alongside, or perhaps due to these changes in the social contract, the

doctor-patient relationship and social perception of doctors in general have undergone significant change globally. People are more knowledgeable, more demanding, and less deferential towards doctors (Lupton, 1997; McKinlay and Marceau, 2002). Throughout the study, we have found evidence that these changes challenge doctors' assumptive worlds. Violence against doctors is the most overt and extreme manifestation of the disruptions being wrought upon doctors' assumptive world. Doctors in our study appeared to be almost begrudgingly coming to terms with this changing doctor-patient relationship being imposed on them. However, even without such an experience and taking a broader view, several respondents reported experiencing stress due to these changes in the social contract. Respondents highlighted how they find themselves at the receiving end of powerful forces radically changing their world and the social contract they had assumed would continue to hold true. We found the doctors in our study acknowledging the finality of these changes to their assumptive worlds but struggling to come to terms with them, showing reluctant deference to the inevitability of these shifts.

The interviews revealed a sense of melancholy and disappointment. Doctors were socialized and trained to expect a social contract that, perhaps, no longer exists. Many respondents shared their expectation of a further deterioration in the medical profession-society relationship and the collective loss everybody will suffer. Almost all doctors interviewed were disillusioned with the profession and urged future generations not to study medicine. A deep sense of victimhood was evident – our analysis suggests that this has become a key aspect of doctors' identity.

This victimhood and its narrative construction emerged as an important coping mechanism to reconcile themselves with the seemingly uncontrollable and irreversible changes occurring in doctors' assumptive world. Perceptions of victimhood or self-defined victimhood may also arise out of narratives of being wronged, sometimes irrespective of an objective reality (Armaly and Enders, 2021). This is especially true in cases of collective victimhood, where the notion of victimization stems from one's group identity and collective ideas about what is 'just'. In such cases, the sense of being a victim extends to those who did not experience violence directly but identify with the targeted in-group (Noor et al., 2017; Volhardt, 2020). Perception of collective victimhood, in this regard, refers to an intersubjective feeling of injustice in the face of adverse situations, leading to the construction of a 'victim' identity. The position of victimhood is assumed to restore the moral image and present a more sympathetic narrative (in this case for the doctors) vis-a-vis the out-groups (those said to be doing the victimizing) (Young and Sullivan, 2016). This competition for victimhood or the occupation of the victim role is succinctly explained by Noor et al. (2012, p. 352) as "*in a competitive violence state, members of conflicting groups experience a strong wish, and thus also strive, to establish that their in-group was subjected to more injustice and suffering at the hand of the out-group than the other way around.*"

As established previously, doctors, as a profession, possess a strong sense of group identity and a shared assumptive world. Throughout the study, doctors referred to various facets of this assumptive world, invoking it to problematize how society currently treats them and what society now expects of them. These invocations were often tinged with nostalgia for an idealized (past) assumptive world and involved a reiteration of the ethical and moral professional injunctive norms (how doctors perceived they were expected to behave by relevant others and the social sanctions they perceived would be applied if they did not). They were often accompanied by narrations of incidents and experiences that reiterated and reinforced aspects of the idealized assumptive world.

Respondents in our study recognized the changes in societal perceptions about their profession and the rising distrust or criticism they faced, which conflicted with their assumptive world. Most respondents felt the criticism was unfair and borne out of limited understanding and excessive expectations. To most doctors in the study, the social contract they were promised and had assumed is being unilaterally renegotiated for the worse, not just for the doctors but for all parties involved. These changes to their assumptive world, brought about by the changes in the social contract, are perceived as an injustice to the medical community. Doctors feel powerless and under siege by systemic forces like corporatization, political interference, media villainization, and state apathy.

Conclusion

For doctors in India, their assumptive world is being disrupted by various challenges and pressures. The social contract they have long had with society is being unilaterally altered, with society increasingly unwilling to accord them the status, professional autonomy, and prestige that had previously been a given. Doctors in India are understandably struggling to reconcile with this emerging reality. Brown and Perry (2006) have noted that in the face of growing criticism, professions are at risk of groupthink and of foregoing self-reflection in favour of assuming a self-ascribed victimhood position and a siege mentality. We conclude that the medical profession in India should take a measured, realistic, critical, and self-reflective stance and work with the rest of society to repair this important social contract.

Ethical Considerations

The Institutional Ethics Committee of Gokhale Institute of Politics and Economics, Pune, India, has approved this study. All participants provided written informed consent.

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CRediT authorship contribution statement

Sayak Dutta: Investigation, Writing - Original draft preparation, Writing- Reviewing & Editing. **Mayuri Samant**: Investigation, Data curation, Writing- Original draft preparation**. Sanjana Santosh**: Investigation, Data curation, Writing - Review & Editing. **Michael Calnan:** Writing - Review & Editing. **Sumit Kane:** Conceptualization, Methodology, Investigation, Writing - Original draft preparation, Writing-Reviewing & Editing, Funding acquisition, Supervision.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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