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Original Article

Understanding disruption in the social contract between the medical profession and society in India: a tale of mismatched expectations?

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Abstract

A harmonious relationship between the medical profession and the society it serves is essential for any country's health system to fulfill its mandate. Society offers trust, respect, authority, and professional autonomy to doctors, and in return, expects doctors to provide good care and prioritize people's welfare. However, in many parts of the world, we observe growing dissatisfaction, increasingly expressed violently, with the medical profession. Understanding what explains this growing dissatisfaction is necessary to initiate measures to maintain and improve this important social relationship and social contract. Using India as a case, and drawing on insights from qualitative, in-depth interviews with purposively selected doctors, journalists, legal experts, police, patients and patients' rights activists, and social commentators, we demonstrate how a range of mismatched expectations—regarding the organization of the medical profession, the structure of healthcare provision, the status and identity of doctors in society, and fair compensation for care provides—are contributing to the disruption of this critical social relationship. We argue that these dynamics can be meaningfully examined through the lens of the 'social contract' between the medical profession and the society it serves. Our analysis also shows how these mismatched expectations are highly contentious and how they are rooted in the increasingly market-logic-based organization of healthcare. For researchers across the world, our study offers a novel approach to researching the relationship between the medical profession and society, and, for policy makers and health system leaders in India, our findings offer practical entry points to develop policy interventions to help restore, recalibrate, and secure this important social contract.

Keywords: health systems; human resources for health; medical profession; doctors; India

Key messages

- A harmonious relationship between the medical profession and society is critical.
- Harmony is based on shared and agreed expectations—a 'social contract' of sorts.
- Violence against doctors in India points to a breakdown of this social contract.
- This breakdown is due to a mismatch in expectations between doctors and society.
- The market-logic dominating the health system is at the heart of these mismatches.

Introduction

Historically, society has granted medical professionals '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' (Cruess and Cruess 2004: p.185). These societal expectations of the medical profession can be understood within the frame of a social contract (Welie 2012). A well-functioning social contract and a harmonious relationship between the medical profession and the people it serves are essential for any country's health system to fulfill its mandate. In India, however, this social contract seems to be under serious stress; the rise

in violent attacks on doctors (Pai 2015, Nagpal 2017, Singh 2017), especially in the last 10 years, suggests that it is breaking down.

Across the world, transformations in the social contract with the medical profession have been examined from different perspectives, with some talking about 'the end of the golden age of doctoring' in the West (McKinlay and Marceau 2002), while others highlight the struggles for redistribution of power and financial control between professionals and managers (Kurunmäki 1999, Kocher and Sahni 2010, Chamberlain et al. 2018). Phrases like de-professionalization, proletarization, democratization, or corporatization are often used to denote the various facets of the changing social contract between the medical profession and society (Calnan 2020). There is a wealth of literature that discusses, especially from a Western perspective, how the social contract between medicine and society has shifted from an institutional perspective, especially around teaching, accreditation, regulations, etc. (McKinlay and Arches 1985, McKinlay and Marceau 2002), the shift which is also instrumental in challenging the paternalistic norms governing the medical profession.

The shifts in patient–doctor relations altering the paternalistic dynamics have also been viewed as a functional democratization of relations between patients and doctors, amidst broader social reconfigurations, and reducing information asymmetries (Kurunmäki 1999, Kocher and Sahni 2010). There is also a vast body of global literature on changes in the doctor–patient relationship within different healthcare systems (Sorenson 1974, Merkel 1984, Shortliffe 1993, Morgan 2008, George 2010, Lipworth et al. 2013, Berger 2014, Yellowlees et al. 2015, Adams et al. 2018, Dunn 2019). While this literature does highlight the centrality and importance of expectations (Calnan 1988) in this relationship, to our knowledge, only Cetin et al. (2012) have conducted an explicit empirical examination of the expectations patients have of their healthcare providers. However, they do not examine the expectations that healthcare providers have of patients, or of wider society.

In this paper, we present an analysis of the evolving nature of expectations within the relationship between the medical profession and society in India, with the aim of understanding the relational rupture underlying this critical social relationship. In India, the traditional relational arrangement between medical professionals and their patients has been characterized as 'paternalistic', whereby medical professionals derive authority and respect from the specialized nature of the profession's knowledge base (Tripathi et al. 2019). However, emerging research suggests that this paternalistic dynamic is changing in India. The nature of patients' dependence on doctors is now qualitatively different due to the doctor–patient relationship evolving into a service provider–consumer relationship. Scholars have also pointed to the neoliberal turn in how the health system functions in India (Baru 2003, Nandi et al. 2020). They highlight the role of the expanding for-profit private health sector in filling service and coverage gaps left by the under-funded public sector as well as in producing starkly different working conditions, organizational cultures and values and aspirations among medical professionals (Baru 2005). The capital-intensive nature of private healthcare and the increasing role of technology in care affect provider behaviour and, in turn, affect the cost and quality of health services (Bhat 1999). We contend that this, together with the rising demand for private healthcare by the growing middle classes, and the increasing emphasis on efficiency, competition, and reduced public spending, has helped establish 'market logic' as the central institutional logic (Friedland and Alford 1991, Thornton and Ocasio 1999) in the Indian health system.

Table 1. Details of participants.

Participants	Numbers
Doctors, including those who had experienced violence ($n = 7$)	21
Lawyers	06
Journalists and key social informants	04
Aggrieved patients	08
Senior police investigating officers	03
Total	42

This context enables us to situate our findings by examining and analyzing the deeper societal processes at play. This analysis also requires a shift in perspective—one that moves beyond the conventional victim-perpetrator binary, which offers only a superficial understanding of the phenomenon. While we reference the phenomenon of violence against doctors (Jain et al. 2021, Chakraborty et al. 2022, Jain et al. 2023) as a backdrop, our focus here is not on these violent incidents. Rather, we seek to examine and reveal the relational imbalances and disharmony between the medical profession and the society it serves, specifically, by unpacking the underlying structural processes at play. We argue that this approach offers more nuanced and comprehensive insights to help repair and strengthen this important social relationship.

Methods

Over eighteen 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 as victims, perpetrators and associates), had witnessed such incidents, or were uniquely placed to reflect on these incidents. We drew on our long-standing links within the study area to recruit study participants and also used a snowball sampling approach. Authors 1 and 2 conducted the majority of the fieldwork, accompanied sometimes by authors 3, 4, and 6.

We approached the inquiry with no preconceptions about who was a 'victim' or who a 'perpetrator'. This conscious positionality allowed us to consider the perspectives of all actors. Our participant pool included both doctors who had directly experienced violence and those who had not. They ranged in age from approximately 25 to 70 years and were predominantly male, with one female respondent, from diverse socio-economic backgrounds. The sample included practitioners from both urban and peri-urban areas in Maharashtra, working across diverse healthcare settings—including corporate hospitals, public health facilities, and private clinics. Respondents also included patients/patients' relatives who had resorted to violence, journalists, social commentators, lawyers who had represented doctors or had represented those who had resorted to violence, police who had investigated such incidents, and elected local government officers. We interviewed doctors working at government/public hospitals, small private hospitals (commonly named nursing homes),

and corporate hospitals. Table 1 presents an overview of these forty-two study participants. All participants provided written informed consent. The Institutional Ethics Committee of the authors' institution (Anonymised) in India, has approved this study.

Interviews were recorded and transcribed. Detailed notes outlining the circumstances, settings, and other non-verbal elements of all interviews were also taken, as well as reflections about these interviews during and after the fieldwork. A thematic analysis was carried out. It was iterative, with interviews and analysis being carried out in tandem with several debriefing sessions among the researchers. This also involved repeated listening and reading of interview transcripts to generate insights, identify patterns, and gain a deeper understanding of the data. The transcripts were coded using NVivo software. A portion of transcripts were coded inductively using open coding and then were grouped as codes and sub-codes, creating a coding framework. This framework was then used to code all the transcripts. Two researchers independently applied a coding framework to the data—the coding framework is included in Supplementary File S1. The coding process was conducted simultaneously with and was complemented by regular, detailed debriefing sessions involving the entire research team. These discussions facilitated the identification of emerging themes and insights, which in turn helped refine both the ongoing field inquiry and the coding process.

Findings

Early on in our fieldwork, we encountered a mismatch between the ideas and understandings of doctors and wider society regarding how the medical profession functions (and how it ought to) and how healthcare provision occurs (and how it should). In this section, we present our analysis across four domains where we found that expectations were mismatched: the communication context; the increasingly complex nature of medical treatment; tensions around notions of profit and expectations of altruism; and notions of morality relating to doctors' social identity. In each sub-section, we present findings concerning the historical roots of these expectations, followed by an account of the current state of the expectations, and the possible reasons underpinning the mismatch.

Navigating the ambiguities of communication

Communication between healthcare professionals and patients is influenced by many factors, including the formation of expectations around communication itself. While studies have aimed to delineate and elucidate the diverse array of communication-related expectations (Lee and Garvin 2003, Ha and Longnecker 2010), few have engaged with the potential tensions and mismatches in these expectations.

Easier access to and the increasing democratization of difficult-to-access, expert medical knowledge has, perhaps paradoxically, complicated the expectations in the doctor–patient relationship, leading to tensions. As awareness and access to knowledge expand (notably through the internet), patients increasingly seek more comprehensive communication from their physicians regarding their health and treatment. Our study participants highlighted that while knowledge asymmetry between medical professionals and patients remains, patients now expect frequent updates and more information regarding treatment options, health status, progress, expected outcomes, and complications of treatment.

When discussing changes in patients' expectations due to increased access to medical knowledge, doctors, however, seemed to view patients as a homogeneous group. They seemed surprisingly unaware that this better access to medical knowledge may only apply to those from more educated and privileged backgrounds, and not to those from lower socio-economic backgrounds. For example, we found that those from lower socio-economic backgrounds were often unaware of and uninformed about the treatments they were receiving and only realized the poor quality of communication when something went wrong. As the following quote from an interview with a patient from a lower socio-economic background —who lost his father during treatment—illustrates, doctors' inability to meet diverse communication-related expectations emerges as another significant source of tension in the doctor–patient relationship.

> What stayed with me the most was not just the grief of losing my father, but the deep sense of helplessness that surrounded the entire experience. I didn't fully understand what was happening medically—no one really explained it to us in a way we could grasp. There was no clear or transparent communication about his treatment, and that silence left us confused and anxious. Coming from a modest background, I often felt powerless in that hospital setting, as if our questions didn't matter. After waiting for nearly 6–7 hours during his surgery, we were told he didn't survive. The shock of his death was compounded by unanswered questions. In that void of information, doubts crept in—were his kidneys taken? Could something have gone wrong that we weren't told about? (Patient)

Doctors also pointed out that nowadays, patients and their relatives expect a 'guaranteed' full recovery. They pointed out that people consider communication to be good only if it involves positive news or updates. Tensions arise when doctors make patients aware of reality and present more realistic but less positive scenarios, but also and/or when doctors *fail* to communicate what to realistically expect and/or fail to make patients aware of risks. The following quote from a specialist physician encapsulates what our data revealed.

> Nowadays, patients don't want to hear unpleasant news. They expect the doctor to tell them everything will be just fine. But at the same time, they are not ready to accept unexpected results! (Specialist Physician)

In cases where patients (or their family members) only expect positive outcomes, some doctors see it as their professional duty to clearly lay out the right expectations. However, doctors felt that the wide knowledge asymmetry means a lot of time needs to be invested in this communication—and as the following quote illustrates, and as we discuss further later, often, neither doctors nor patients have this time or the patience.

> I consider my role as a 'good' doctor is to crush all (unrealistic) expectations of instant and permanent relief and provide realistic advice. This (act of explaining and counselling) requires time, which we do not have … and

patience, which patients lack. (Specialist Physician practicing in a semi-urban area).

The doctor further argued that while workload did play a role in the level and quality of communication and conduct, there was also a significant element of 'learned behavior' in both these worlds as practices and behaviours were learned from observing 'seniors'. Here, he offered an account of societal changes over time which were also shaping expectations, emphasizing how the practices and behaviours of the 'seniors' were a remnant of the now outdated paternalistic relationship.

> In the past, it was different. Patients and society as a whole had different expectations. Roughly 20 or 30 years ago, the societal approach toward healthcare varied greatly. People didn't expect doctors to dedicate as much time talking to patients. (Cardiologist)

Our findings point to multiple sources of tensions or disconnects that lead to a mismatch in communication-related expectations between doctors and the people they serve. These include an asymmetry of medical knowledge and information, lack of time in public facilities, differential expectations based on the type of institution amongst patients and doctors alike, and communication practices assimilated through and embedded in routines, social and professional norms, and material contexts.

The complexities of medical treatment: market logics, specialization, defensive medicine, and high expectations

Another important and changing context in which patients' expectations are framed has been the growing market logic that underpins the care encounter in the increasingly dominant for-profit private healthcare sector in India—when one pays for a service, one expects results! One of our participants, a senior newspaper editor, explained this by first pointing out that people today are not only aware of the availability of cutting-edge technology but, as a result of commercialization of medical services, they are keen on the use of what they see as the best technology when it comes to the care of their loved ones. The high costs of care, driven among other things by the availability of, demand for, and use of, high-tech diagnostics and procedures, amplifies expectations of recovery and cure. What then follows is that people expect guaranteed results because they have 'paid for a service'. Many participants, mainly doctors, expressed that tensions arise between doctors and patients because these expectations are unrealistic; unlike many other services, doctors cannot guarantee a result (cure). The following statement by a newspaper editor hints at the sky-high expectations that people have from doctors today.

> Today when someone is seriously ill and they go to a hospital, they say things like … 'do whatever it takes' … 'our patient must be saved' … 'we are ready to pay' … 'we don't care about the bills (costs)!'. When people pay, their expectations are sky-high. Paying for healthcare is increasingly seen as (paying) for a guaranteed cure … people expect recovery to be assured because they have paid for it. (Editor of a Major Local Newspaper in India)

While discussing the historical roots of these mismatched expectations, almost all study participants, including some doctors, invoked the notion of a past ideal of 'family doctors'. This notion of a family doctor refers to a local, very accessible go-to doctor, used typically by the urban middle and upper classes, who knew the family history, listened and communicated well, ministered medicine and served as a social confidante. As we have argued elsewhere, while family doctors were limited to a few privileged families, it has always been presented as a universal phenomenon and ideal in the mass media, particularly in films (Samant et al. 2024). All study participants rued the disappearance of these 'family doctors', and the rise of specialist medical practice, which could not offer such patient-centered practice, arguing that this has led to a certain level of dysfunction in the health system. In contrast, however, some participants, including doctors, also consistently said that people expected advanced and specialized health care from the medical profession, which family doctors could not provide. So, the argument that if family doctors had continued to be the norm, the declining state of the social contract between society and the medical profession would have been mitigated does not hold. To us, this lamentation for the 'loss of family doctors' thus appears to be more of a nostalgia trope than a genuine explanation.

Another explanation for growing mismatches in expectations is a shift towards evidence-based medicine. Our participants talked about how patients today are no longer satisfied with their physician's clinical judgment and expect sophisticated investigations. They discussed at length how doctors are expected to adhere to guidelines and standards, including using sophisticated tests and investigations to confirm their diagnoses, and also to shield themselves from growing litigation risks. A common refrain that followed these 'talks' was that when patients are requested to undergo additional investigations or tests (as part of evidence-based medicine), they are often suspicious that they are being asked to do unnecessary tests (for money). The following excerpt illustrates patients' contradictory expectations and the dilemmas that doctors face.

> In the past, upon hearing a patient's complaint of chest pain, I would have relied solely on my clinical judgment, promptly administering the appropriate medicines. However, today, I hesitate to take such a course of action. Instead, I find myself inclined towards recommending further tests despite my awareness that they are unnecessary. We are burdened by the pressure to adhere to guidelines (Cardiologist).

We found that these professional and legal pressures to follow evidence-based care guidelines were at odds with patients and their family members' suspicions about the appropriateness and necessity of the tests and interventions being ordered (for which they are expected to pay). This suspicion, our doctor participants argued, primarily arises from people's misunderstandings about the costs of care and who is expected to shoulder these.

Rising expectations about the quality of both clinical aspects of medical care and service-related aspects of medical care were also a source of tensions. One participant delved into these different categories of expectations and their effects on the interactions between doctors and patients.

Distinguishing between those linked to clinical care and those to service-related aspects, he highlighted how tensions arise not only from changes occurring within these categories but also from the common conflation of service-related expectations with clinical ones. Other study participants added that because people have been exposed to or have seen 'hotel-like' services in corporate hospitals, they now have high service-related expectations from the health system generally. In the past, patients expected mainly clinical proficiency from their doctors. However, as the following except illustrates, now expectations have grown to extend beyond medical expertise to better non-clinical services and amenities,

> Patients at public hospitals were earlier fine with sitting on the ground in the waiting area, but after being exposed to corporate-style services, they are no longer satisfied with basic facilities. Nowadays, patients often harbor expectations akin to those of a five-star hotel experience: air-conditioned waiting rooms, luxurious amenities in their accommodations, and even requests for nurses to attend to non-medical tasks like cleaning their infants. However, they fail to understand the financial implications of such demands. (Gynaecologist)

This argument by doctors has some basis: societal changes and images of good quality private hospitals mean there are higher expectations about service-related quality, and information asymmetries (albeit narrowing due to easy access to expert knowledge and second expert opinions in the Indian context) can mean poorer service-related aspects can overshadow any good clinical care quality provided.

The traditional social contract assumes patients will be compliant with, and trusting and accepting of, doctors, whereas in reality, modern patients are skeptical and impatient and expect results. Our research found this shift to be particularly stark in small-town environments. In a small town, a paediatrician reminisced about her father-in-law, who used to manage her clinic in the past (till 15 years ago). She said,

> In the past, in small towns (anonymized), patients placed such profound trust in doctors' judgments that they would often accept fatalities resulting from medical errors without any questions. However, today's patients exhibit a marked contrast. Factors such as high exposure to social media, expanded access to healthcare resources, and greater availability of information have cultivated impatience and skepticism. Patients are becoming more and more impatient now. Due to changing lifestyles and increasing life pressures, they expect speedy and guaranteed recovery. They are willing to spend more, but they want a guaranteed recovery. (Pediatrician)

The excerpt illustrates how broader societal changes alter and are reflected in patients' attitudes and expectations of the nature of medical care and how these shifts are central to the mismatches in the expectations being examined here.

Walking a tightrope: navigating the tension between profit and altruism

Almost all patients in our study were critical of the profit-driven attitudes of certain doctors, highlighting that they have serious ethical concerns about the state of the medical profession. This viewpoint raises important questions about the balance between financial incentives and the commitment to patient-centered care within the health system broadly. As the following excerpt from a patient reveals, while many healthcare providers prioritize patient well-being, a minority may focus excessively on financial gain. This can manifest in various ways, such as recommending unnecessary procedures, overprescribing medications, or prioritizing high-paying patients.

> Doctors today are so much after making money and improving their (own) standards of living that they have drifted away from their core values and principles. (Patient)

Commercialization and discourses around profiteering thus collide with historically embedded discourses of altruism and trust in the medical profession to complicate the terrain of expectations. Even though all professions are about making money, there remains the expectation (as part of the social contract) that medical professionals prioritize the profession's historic, service-oriented core ethics and altruistic values over making money. A senior lawyer summed it up as follows,

> 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 say 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. (Senior Lawyer)

The literal essence of the Marathi expression *seva* denotes selfless service. Invoking the notion of *seva* has moral, affective, pragmatic, and sometimes political undertones (Srivatsan 2006, Dyahadroy 2009, Ciotti 2012). As some recent literature on care work in India shows (Kleinman and van der Geest 2009, Mishra and Santosh 2024), in healthcare settings, too, invoking *seva* carries moral, affective, and pragmatic implications. Not only do our participants invoke the expectation of *seva*, they go further when they articulate commonly used idioms like '*Rugnaseva hich Ishwar seva*' which translates to 'serving patients is akin to serving god'. Offering *seva* (service) traditionally elevates the recipient to a higher position; it invests the one seen as doing *seva* with both morality and responsibility. But this invocation of *seva* can operate both as a moral compass, and as a moral straitjacket or burden.

We found that doctors are struggling to carry this moral burden of expectations, not least because of the market structure and logic within which they are expected to carry it. The following excerpt from a surgeon echoes a predicament widely experienced and shared by doctors in our study—a predicament that has conflicting expectations at its heart.

> My father established a hospital not to generate profit but to instill in me the ethos of providing exemplary service to those in need. He emphasized that our focus should always be on delivering quality care to the community. However, upholding such noble principles has become increasingly challenging in today's market-driven commercial environment. (Orthopedic Surgeon)

Rising commercialization engenders pressures to run healthcare facilities as 'businesses'—a logic clearly at odds with the long-standing expectations of altruistic *seva*. These tensions around profit are central to doctors' struggles in navigating the delicate tightrope of care provision, which involves balancing altruistic values with the survival imperatives imposed by the market logic of healthcare organization in India. During an interview, a surgeon who has an independent private practice said in exasperation, effectively voicing the struggles of all our doctor participants:

> 'Now, this has become a business. We talk of health 'care'—but in fact it is a health 'industry' … everything is industrialized'.

From the godly healer to the mere 'service provider'

Exploring the dynamics of societal expectations intertwined with the social identities of medical professionals unveils a crucial analytical juncture. The fact that these identities are dynamic, multiple, and evolving further complicates doctor–patient relationships. Our research highlights the different, sometimes conflicting identities that doctors have to embody and invoke. This interplay often engenders a mismatch of expectations. This offers further insights into the causes of mismatched expectations and the ensuing tensions within the social contract.

Our data revealed that the construction of moral identity within the medical profession plays a pivotal role in creating mismatches in expectations and fostering tensions. Societal ideas and expectations regarding what it means to be a doctor, a doctor's conduct and responsibilities underpin these mismatches. Across the board, our participants highlighted how doctors continue to be assigned a revered position akin to gods; doctors consistently found this assignation problematic. Doctors consistently expressed discomfort with their deification and the unrealistic and unsolicited burden of expectations that came with it, advocating instead for being treated as fallible beings deserving of empathy. A young doctor said that perhaps 'It was time to officially declare that medicine is no longer a noble profession'. (Cardiologist)

However, we also encountered an inherent contradiction in this process of identity navigation. While deliberating on tensions around expectations regarding their identity, many doctors criticized the fact that the medical profession is included under the Consumer Protection Act (CPA). The doctors viewed this inclusion as labelling them merely as any other 'service provider' within the 'market', ignoring their unique and difficult service role, which is driven by the motive to promote well-being but with no guarantees of a successful service outcome. The incorporation of the medical profession into the Consumer Protection Act (CPA) therefore emerged in our findings as a contentious arena where tensions surrounding identity manifested. Divergent moral stances taken by different participants, particularly doctors, regarding this inclusion, underscore the messiness of 'identity' and the consequent mismatched expectations. The following excerpt underscores the concerns voiced by many doctors in our study regarding the adverse implications of their inclusion under the Consumer Protection Act (CPA), along with the challenges of adopting the identity of a 'mere service provider' imposed by the competitive market logic inherent to this inclusion.

> Although the inclusion of the medical profession under the Consumer Protection Act (CPA) may promote stricter oversight of healthcare services, it has also led to an investigation-driven approach to safer practices and an increase in referral cases, resulting in a challenging and often perplexing environment for medical professionals. (Senior Doctor, Hospital Administrator)

We contend that this process of juggling and reconciling multiple, often contradictory identities is at the heart of the stresses experienced by the social contract between the medical profession and society in India and also serves as the bases for mismatched expectations and tensions between the medical profession and society.

In the following section, we discuss these findings by situating them within the context of the state of the medical profession in India and research from other parts of the world. We also reflect on the policy and societal implications of these strains or breaches of the social contract between the medical profession and society.

Discussion

Our findings reveal how expectations around how healthcare ought to be organized and delivered are central to the growing dissatisfaction, and are contributing to disrupting the relationship between the medical profession and society in India. Crucially, the doctor–patient/medical profession-society relationship, including people's expectations, are disproportionately influenced by the 'market logic' which shapes all aspects of how healthcare is organized and delivered in India, to the dissatisfaction of all involved. Marketisation of medicine is a global trend, and its many problems are widely recognized, including how it shapes the medical profession–society relationship, and problematically colours the expectations people have from doctors (Hsiao 1994, McKee and Stuckler 2012, Feiler et al. 2018). Research that has looked at expectations within the doctor-patient interactions and the medical profession-society relationship broadly (Lateef 2011, Cetin et al. 2012, Mudiyanse et al. 2015, El-Haddad et al. 2020) has found that patients expect common social courtesies such as greetings, friendly smiles, offering seats, using simple language, allocating sufficient time, summarizing information, showing empathy, and being treated with dignity, and also that doctors recognized these expectations as reasonable and legitimate. While much of the current research is focused on measuring patients' expectations, there are some qualitative inquiries (Cetin et al. 2012, El-Haddad et al. 2020) that seek to identify and analyze expectations to inform clinicians and healthcare managers abilities to deliver and oversee patient-centered care. However, studies have yet to capture the dynamic and evolving nature of expectations. The expectations that healthcare providers have, about what patients and society can reasonably expect of them, and about how they themselves should be treated by patients and in society, i.e. expectations as they relate to the social contract between the medical profession and society, have also received little scholarly attention thus far.

In this section, we discuss our findings along two broad lines: One, in light of the evolving state of the medical profession globally and in India, and second, in terms of the shifting dynamics of the social contract between the medical

profession and society, in India and globally. We argue that these two analytical lines allow a nuanced discussion of the broader societal processes at play and enable us to better understand nature and drivers of expectations within this important social relationship.

The state of the medical profession

There is a large body of literature from across the world that examines the state of the medical profession and especially the changes it has been undergoing. The classical sociological writings on professions, which put forth a particular notion of professions as 'experts in the service of public interest', have greatly shaped perceptions about physicians as an important occupational class committed to advancing public welfare (Hafferty and Light 1995: p.134). Hafferty and Light (1995) also underline the structures of power embedded in professional work that is manifested through the paternalism inherent to doctoring. Foregrounded by this view of looking at the medical profession as a power-exercising profession, and with the realization of the growing institutional, economic, and cultural power of medicine during the 1950s and 1960s, critical studies from the US declaring the 'end of the golden age of doctoring' began to surface (McKinlay and Marceau 2002). Pescosolido (2013) concluded that this was a story of three D's: de-professionalization, decline, and distrust.

While these works provide us with the broader context in which to locate our findings around possible mismatches of expectations, in India, the issues are primarily about the third D—distrust that 'undermines expectations that medical institutions and providers will act in accordance with the interests of the individuals and calls into question physician's credibility, allegiance to altruism, efficacy in the medical encounters and ultimately treatment encounters' (Pescosolido 2013, p.187). However, our findings, including earlier research (Kane et al. 2015, Kane and Calnan 2017), suggest that patients in India have not necessarily become more distrusting but that there is a shift from assumed trust to critical trust where patients expect trust to be earned, not taken for granted. Trust may have become more fragile due to the rising commercialization of health care and the ambiguities surrounding qualities such as 'integrity' and 'benevolence'.

A significant body of literature on 'health systems responsiveness' (de Silva 2000, Valentine et al. 2003, Mirzoev and Kane 2017) explores an area that also shapes the state of the medical profession, particularly in relation to people's expectations of their healthcare system. A key concept in this literature is that of 'legitimate expectations' (Lakin and Kane 2022), which suggests that individuals frequently have unrealistic expectations from health systems. Consequently, there must be a shared understanding—sometimes explicit, but often tacit—of what can legitimately and reasonably be expected from healthcare systems. This discussion naturally leads us to our second analytical lens: the concept of social contract. We argue that the notion of legitimate expectations within this literature is intrinsically linked to the very idea of the social contract between the healthcare system and society.

Strained social contract

Every society fashions its agreements, explicit or tacit, about the rights and duties of different members. These agreements are necessary for the smooth conduct of social life and relations within societies. This 'contract' involves an agreement amongst members of society to uphold and abide by some basic social rules, laws, institutions, and principles of conduct. A reading of the works of key social contract theorists, i.e. Hobbes, Locke, and Rousseau, suggests that this agreement amongst citizens and institutions within a society is arrived at through tacit and explicit deliberations towards establishing the bases for diverse groups with different expectations and diverse social statuses to cooperate, negotiate, and agree (Cruess and Cruess 2006). The bases can vary widely. They are often related to notions of fairness, morality, propriety, reciprocity, and rationality but can equally be about power, privilege, and domination. The social contract with the medical profession is built on the same reciprocity. In this relationship, doctors are expected to be competent, moral, altruistic, and to keep patients' interests above their own. In exchange, society grants medical professionals respect, financial rewards, autonomy of practice, and the privilege of self-regulation (Cruess and Cruess 2004).

Throughout its various political, economic, sociological, and psychological conceptualizations, the idea of a consensus on normative expectations remains at the core of the social contract (Rubin 2012). Owing to technological and institutional changes, these norms and expectations between different stakeholders of the health system are also in a state of constant flux. These mismatches of expectations impact the social contracts both spatially and temporally (Rubin 2012, Rougier et al. 2025). A detailed discussion about the various expectations and obligations, as they pertain to medicine and society, can be seen in the works of Cruess and Cruess (2008). Since these deliberations about the social contract are about agreeing to and then following certain social rules, laws, institutions, and/or principles of conduct, if some of those involved strongly disagree about certain things, the process can sometimes become very fraught, even violent (Riley 1982).

Social contracts are dynamic entities and tend to be in a perpetual state of negotiation and flux. While elaborating on its implications in healthcare settings, Pescosolido (2013) argues that 'every society fashions its medical social contract' (p. 190). For a social contract to function, not all expectations need to match all the time. However, the social contract can come under strain and begin to break down, firstly, if most expectations do not match most of the time, or secondly, when the broader assumptions that underpin a social contract change in a way to make the functioning of the contract untenable. Our findings suggest that both these conditions are true in the Indian context, and therefore, the contract is under strain (Dutta et al. 2025). While in some ways a process of refashioning the social contract between the medical profession and society is already underway from the societal side in India, it is time for the medical profession to more deliberately and thoughtfully engage with this process. We contend that the rise in violence against doctors in India and globally (Liu et al. 2019, Kumari et al. 2020, Njaka et al. 2020) is a form of expression of this demand by sections of society and is merely the most visible aspect of a broader issue. and deserves careful attention by researchers and health systems leaders alike.

Conclusion

The social contract between the medical profession and society is increasingly under strain in many parts of the world.

Using India as a case, we have shown how this strain is the result of disconnects and mismatches in expectations and ideas about the nature of the social contract. Our findings show the value of systematically understanding the deeper societal processes—such as the mismatch of expectations—that are disrupting this important social contract. This systematic exploration of the current state of expectations society and the medical profession have of each other, and the drivers of and reasons for changes to these expectations is novel and it allows researchers and policy makers to move beyond the conventional victim-perpetrator binary often used to frame the phenomenon of violence against doctors. In highlighting the disconnects and mismatches in expectations around the organization and practices of the medical profession in India, the structure of healthcare provision, doctors' status and identity in society, and the question of how doctors should be compensated for their work, our study offers valuable insights for researchers and health system leaders alike. For researchers globally, this study offers a novel lens through which to explore the evolving social contract between the medical profession and society. For policymakers and health system leaders, it identifies critical entry points for designing interventions aimed at restoring, recalibrating, and refashioning this foundational relationship. In particular, the findings point to the need for institutional mechanisms that encourage self-reflexivity among medical professionals, especially in relation to improving communication and fostering trust.

By foregrounding issues such as power asymmetries, professional status, privilege, and broader structural and institutional dynamics, this approach moves beyond individual doctor–patient interactions to highlight systemic conditions that shape and strain the social contract. As such, it holds important implications for policy reforms that seek not only to strengthen accountability and transparency within healthcare systems, but also to rebuild public trust in medical institutions.

Supplementary data

Supplementary data is available at *Health Policy and Planning* online.

Author contributions

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

Reflexivity statement

A diverse team of researchers have conducted this research. The first author is a female mid-career researcher based in an LMIC country. The second and fourth authors are early-career female researchers from an LMIC who are presently pursuing higher education in HIC institutions. The third author is a male early-career researcher based in an LMIC country. The fifth and sixth authors are senior academics based in the global north. The sixth author, who is also the corresponding author, hails from an LMIC country. Authors are also from diverse disciplinary backgrounds. The first, fourth, and fifth authors are sociologists. The second and third authors are from a development studies background, eventually specializing in public health and urban health, respectively. The sixth and corresponding author is a medical doctor with research at the intersection of social sciences and health systems.

The paper is based on fieldwork conducted in an LMIC country (India) by the authors, who were from the region and thus were familiar with the social, cultural and linguistic nuances of the respondents. Working on a traumatic and violent event was challenging, as many respondents were reluctant to revisit the events. Having a medical doctor within a team of sociologists helped us establish credibility. Moreover, we began with senior doctors in the community (who may not have been our ideal respondents initially) and created familiarity with the research team and the topic, which helped us gain more insightful responses later in the data collection process. We had expected that having early- and mid-career researchers from a non-medical background involved in interviewing medical doctors would be a potential problem, but this assumption turned out to be wrong and doctors were very willing and open to discussing the problems faced by the medical professions and by themselves. While consciously avoiding a victim-perpetrator dichotomy in our inquiry enabled a broader and deeper analysis, we realize that it has (and will) displeased some respondents who were (and are still) hoping that our findings would be more overtly sympathetic to the doctors' 'cause'.

Ethical approval

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

Conflict of interest

On behalf of all authors, the corresponding author states that there is no conflict of interest.

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Data availability

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 (this was understandable given that the data contained some personal identifiers related to participants' roles). Revealing this in the public domain or to third parties 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.

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