

Stewardship & governance of the medical profession & the salience of trust: Comparing the UK & India

Trust has been recognised as significant for effective healthcare provision across health systems and provider contexts; unless citizens can trust the health system that serves them, population level health outcomes cannot be improved.

Trust is a multi-layered concept, but primarily it involves the trustee having either positive or negative expectations about the trustor's intentions and competence. Trust varies from blind and assumed trust to more earned and conditional or critical trust, and there seems to be a shift from the former to the latter due to the dangers of blind trust embedded in high trust cultures where there is a lack of vigilance and a risk of corruption, exploitation, or domination particularly of those with a lack of resources.

One of the key mechanisms for enhancing trust relations is effective stewardship and regulation. According to the World Health Organisation, stewardship involves oversight and trusteeship and may be defined as '*the careful and responsible management of something entrusted to one's care*' (p9). It includes regulation of professional practice, management of performance and oversight of professional conduct and values.

Drawing on published evidence from various studies that have been conducted on this subject in the United Kingdom and India over the last eight years, we present a historical and comparative reflection and analysis of the regulatory approach to professional medical practice in the United Kingdom and India, which have distinctly different health systems in different socio-political and cultural contexts.

We analyse if and how the policy approaches have differed or have been similar in the two countries and what has influenced the shape of these policies. Recognising the centrality of trust in the social compact with the medical profession, we reflect upon the tensions entailed in regulating the profession using a control-based approach. The international comparison helps reveal key policy implications and opportunities for the regulation of professional medical practice, in the two countries and beyond.

Regulation of the medical profession in the United Kingdom

The traditional, self-regulatory approach to governance adopted by the medical profession in the UK began to change during the early part of this century and medical practices became increasingly responsive to collegiate (i.e., the professional bodies that oversaw the practice of medicine – the various Royal Colleges) and managerial mechanisms of control. This shift appeared to be in response to a mixture of policies associated with a series of scandals which had in part been fuelled by the media coupled with the continued emphasis on the new public managerialism such as audit and performance targets.

The traditional self-regulation form of governance adopted by the medical profession was associated with a culture of high trust and limited state involvement whereas this shift in approach has cultivated a culture of low trust with greater state sponsored managerial intervention. In the light of pressure from the government to modernise there was a recognition by the profession of a need for a '*strengthened professionalism*' and a promise of a more effective, inclusive, accountable, transparent General Medical Council (the GMC is an independent regulatory body that is responsible for ensuring good and ethical medical practice) with increased lay membership which was seen as a means of securing public trust whilst at the same time safeguarding the independence of the profession in the face of threats of external control. The 'safeguarding of independence' being from the powerful managerial imperatives and pressures (e.g., to increase efficiencies and cut costs—an imperative often at odds with the professional judgments of the medical professionals), business interests, and also the government (e.g., decisions around rationing of care, allocation of resources are often at odds with professional judgments).

The judicial inquiry known as the Shipman Inquiry (2004) proposed reforms to the GMC to address concerns with how doctors are regulated and their fitness to practice monitored. Consequently, the GMC was reconstituted to reduce the dominance of the medical profession and gained powers to oversee not just professional misconduct but poor performance. More recently, the 2008 Health and Social Care Act introduced significant changes to the regulation of the medical profession and the performance management of doctors through the introduction of the performance appraisal tool revalidation. This process was further defined by the

Responsible Officer (ROs) Regulations 2010 and 2013. Revalidation involves a thorough assessment of a doctor's fitness to practice using a mixture of appraisals, patient feedback and continuing professional development. Attaining and maintaining public trust was seen as one of the key criteria in this assessment:

'Maintaining trust - doctors must show respect for patients ... treat patients and colleagues fairly and without discrimination ... and must act with honesty and integrity' (GMC,2013).

This move away from self-regulation-based governance was dramatic—not least because the changes clearly involved the curtailment of the profession's powers. Curiously, there was not much resistance from the profession to this reconfiguration and evidence suggests a general acceptance by clinicians of the need for stronger regulation as a means of reassuring the public. The evidence so far, seems to support an explanation that aligns with sociologist Eliot Freidson's thesis of the medical profession undergoing a restratification of sorts—i.e., the emergence of a distinct group of regulatory elites from within the profession, who oversee practice and performance. While the policy changes led to some erosion of the medical profession's power, evidence suggests that the profession may have yet retained a substantial degree of self-regulatory power—although in their role of surveyors of professional practice the priority for these regulatory elite (the Responsible Officers) is not necessarily the protection of clinical discretion (and by extension, independence). If this is so, how might one understand the situation from a trust perspective—a common concern and justification for all these changes?

The distinction made by scholar Zoey Spendlove between embodied trust which is part of self-regulation and enforced trust is useful here. Spendlove shows the challenges associated with implementing mechanisms of enforceable trust, such as revalidation, was not taken over by the organisational and regulatory elites, or wider government structures as anticipated. As a result, medical professionals were able to, directly and indirectly, influence the implementation and management of revalidation and thereby maintain self-regulatory power. Moreover, this indicated that the existing debate regarding enforceable trust, through top-down governance, does not, as Donald Light has also argued, adequately consider the impact of organisational factors and professional countervailing power upon the contemporary profession state regulatory power struggle.

Spendlove has also shown that implementing mechanisms of enforced trust, such as revalidations and performance assessments is very difficult and cannot be fully taken

over by government bodies. Others still have argued that this control-oriented approach to stewardship is paradoxically fostering a culture of distrust within the UK health system—with falling levels of trust across all relations between doctors, managers, and the public. We have therefore recently argued that a form of stakeholder governance and stewardship model that fosters mutual trust with an emphasis on explicit accountability and transparency is the optimal way forward. Some have however suggested that the dominance of the new public management perspective founded on neo-liberal values of marketisation, and individualism has, at least in the past, provided little space for the incorporation of the stakeholder model with doctors putting more value on individualistic trust relations with patients than institutional trust.

Regulation of the medical profession in India

In India, the medical profession has historically enjoyed immense social status. This privilege was reflected in the right to self-regulate being accorded to the profession in modern India. For the better part of the last century this traditional, self-regulatory approach worked reasonably effectively, and the medical profession was able to generally govern itself such that society's expectations were being met (as broadly assessed based on the absence of major scandals of the kind and scale that have been seen in recent times). Things however began to change from the late nineties; the first decade of this century saw the health system and the medical profession in India mired in numerous scandals involving corruption and abuse of entrusted power. At the heart of this crisis was the Medical Council of India (MCI), a public institution whose mandate was to ensure medical practice in accordance with the professional code of ethics, and to oversee the quality of medical education. These scandals threw into sharp relief the limits of the self-regulation-based governance of the medical profession and prompted a high-level committee of parliamentarians from across India to conclude that the MCI 'can no longer be entrusted with that responsibility in view of its massive failures'. These failures of trust received extensive coverage in the popular media, and in some instances were also sensationalised.

The situation triggered a series of measures by the Government of India to curtail the medical profession's privileges to self-regulate, and a move towards more broad-based mechanisms of control and oversight of the profession. While the changes

have occurred incrementally, their most recent manifestation, the most significant has been the dismantling of the MCI (the autonomous self-regulatory body formed during the pre-independence era, in 2019) and establishment of the National Medical Commission (NMC), a new regulatory body with, among others, increased lay membership. Large sections of the medical profession in India see these shifts and the dismantling of the MCI as attempts by the political and bureaucratic establishment to usurp professional discretion, authority, and power.

Over the last ten years the profession has, and continues to, vigorously contest these measures. On the other hand, and while the doctors' association vehemently disagrees, the Government of India and civil society actors see this move, as a step towards more effective, inclusive, accountable, and transparent regulation of the medical profession. The Government and civil society see it as a necessary step towards restoring and re-establishing public trust in the medical profession, the doctors' association views it as a threat to the independence of the medical profession.

While at first glance it appears, and it can be argued, that these shifts are/were in response to the many scandals and failures of trust, it is possible to understand these shifts as also emerging from the many changes in the social, economic, and political landscape of India. If the latter were so, these shifts can also be understood as indications of the traditional self-regulation-based governance arrangements as no longer being in harmony and alignment with the changing nature of Indian society and polity, and no longer being appropriate for the evolving economic realities of healthcare provision in India. Irrespective of whether these emerging shifts in the regulation of the medical profession in India have their antecedents in the many scandals or in the broader changes afoot in the society and economy of healthcare provision, they are underpinned by and have implications for trust relations between the medical profession and Indian society.

In India, the traditional social compact and thereby the accordement of the privilege of self-regulation was associated with and contingent upon a historical culture of high trust in the medical profession, acceptance of professional autonomy, and agreement that state involvement was best kept limited. It depended upon and was based upon the fulfilment of the three attributes that allow a trustee to sustain the trust reposed by trustors—the assurance of competence, benevolence, and integrity. The many big and small scandals involved a breach of this social compact, and fuelled by the media, created conditions where people could no longer be sure about

the benevolence and integrity of the medical profession. In parallel, the trend towards commercialisation of healthcare provision and medical education since the early nineties, and more recently the entry of big corporate entities in these spaces, also created conditions where the public could no longer be sure about the benevolence of the medical profession or of their ability to maintain their integrity in the face of growing marketisation and corporatisation of care. These sentiments are/were again pushed by the mainstream media and were further amplified through social media - so much so that (institutional) trust in the medical profession in India, as the following quote suggests, is at an all-time low. The Parliamentary Standing Committee tellingly noted that “respect for the profession has dwindled and distrust replaced the high status the doctor once enjoyed in society” (p.110). If one goes by the parliamentary proceedings and the media coverage around the dismantling of the MCI and promulgation of the NMC Act, the media, civil society, the all-powerful public bureaucracy, the elected leaders, and the populace at large seem to have little trust in the medical profession’s ability as an institution, to regulate itself. However, concomitant evidence continues to suggest that in India people’s confidence in medical professionals’ abilities and competence remains robust, and perhaps paradoxically, people tend to be very trusting of and sure about the competence, benevolence, and integrity of ‘their’ doctor.

This scenario of low institutional trust in the medical profession with high interpersonal trust in individual medical professionals, presents unique challenges for the newly formed regulator NMC. On one hand, given that the NMC has its origins in public distrust in the medical profession and is expected to regulate the profession such as to control for and prevent future failures, it would be remiss if it were to not leverage and build upon the high levels of interpersonal trust people have in ‘their’ doctors.

The question is how the NMC might go about this delicate, difficult balancing act across multiple axes. If, like in the UK, the NMC takes a control-based approach with greater state sponsored managerial intervention, it is likely to further fuel a culture of low trust—also possibly undermining the islands of interpersonal trust. On the other hand, the NMC has no choice but to rely on the medical profession to fulfil its mandate and enforce regulations. Would this reliance lead to, as Freidson has argued, and is being observed in the UK, a restratification of the medical profession with the emergence of a distinct group of hybrid professionals who, in nexus with and support from the state (the NMC), form a governance elite and oversee professional practice. While there existed such a governance elite within the earlier

self-regulation-based regime, their priority then was the protection of clinical discretion, professional autonomy, and power—they always supported the medical profession and that was part of the problem, and they were a part of the problem. There is little reason to be confident that the new regulatory regime spearheaded by a new agency, the NMC, would be able to do any better.

Discussion and conclusion

Despite the well-known differences in health systems, sociocultural values, and levels of resources across the two countries, developments in the regulation of the medical profession have shown similar trends which in some respects might reflect the influence of their past colonial links.

Both countries have however clearly experienced a shift away from a traditional self-regulation-based model, fuelled, at least in part, by scandals about performance and practices which appeared to have had significant implications for institutional trust. The evidence from the UK with its managerialist approach points to the challenges associated with implementing mechanisms of enforceable trust, and the difficulties the organisational and regulatory elites or wider government structures have had in taking over the regulation of the medical profession. In the UK, the medical professionals have been able to directly, or indirectly, influence these regulatory processes and thereby maintain some degree of self-regulatory power. How might this evolve and develop in India? Would Spendlove's observations about how this has panned out in the UK - that enforceable trust, through top-down governance, cannot adequately consider the impact of organisational factors and professional countervailing power upon the contemporary profession state regulatory power struggle, also apply to the Indian context? Would observations from the UK - that control-focused governance, in fact fosters greater distrust, also hold true in the Indian context? Might, for the NMC to fulfil its regulatory mandate while still maintaining and engendering trust in the medical profession, developing a stakeholder governance-based implementation approach which fosters mutual trust with an emphasis on explicit accountability and transparency, be the most effective approach? Might this be the better policy option in the UK too given the difficulties in implementing a control focused regulatory strategy, and the problems in sustaining relational trust relations that it creates?

Such policy discussion now also will have to consider the impact of the Covid-19 pandemic on the relationships between governments, the medical profession, and

the public. Health care workers in the UK have received considerable public support although the relationships between the government and the medical profession have been less concordant. The pandemic led to the suspension of revalidation and appraisal in the UK with the priority placed on clinical safety and workload. This is seen by some as an opportunity to reassess the value of these procedures which are argued to have conflicting priorities and are claimed to be not evidence based.

This moment could however also be an opportunity for the introduction of performance assessment processes with greater emphasis on the voice and interests of the patient i.e., a form of co-production. There has also been increasing criticism from within the medical profession, stemming from a series of cases, in relation to the GMC's competence in performing its regulatory function and the promotion of a blame culture suggesting it was no longer a respected or trustworthy institution. This is at a time when there has been an increase in violent incidents particularly against general practitioners. The latter pattern appears to be in evidence in India too; although the situation in India, if one goes by the ongoing reportage in the popular media, is much more muddled with the medical profession being simultaneously lauded and condemned for how it has conducted itself. Nevertheless, the moment we are in also offers opportunities for India. For the Indian state to reflect upon how it engages with the medical profession, including how it regulates the profession, and, as we have argued not so long ago, for the Indian medical profession to 'collectively, seriously reflect upon the state of their profession, its priorities and its future direction'.

In India and the United Kingdom alike, the time is right to begin a conversation on a new regulative bargain between the state, the medical profession, and the public - a regulatory bargain which is focused on enhancing and maintaining trust.

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