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From Care to Commerce: Ethical Reconfigurations of Doctor–Patient Relationships in India's Market-Driven Healthcare System

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Abstract: The Indian healthcare system has undergone a noticeable transformation, shifting from a traditionally trust-based model of care to a more market-driven and institutional framework. While the expansion of private and corporate healthcare has improved infrastructure, access, and specialisation, it has also raised concerns about the changing ethical foundations of medical practice. This paper examines how commercialisation has reshaped the doctor–patient relationship in India, particularly the transition from a fiduciary model grounded in trust and duty to a more transactional, service-oriented interaction.

Using a doctrinal and interdisciplinary approach, the study draws on legal frameworks, policy developments, and academic literature to analyse the ethical implications of this shift. It identifies key concerns, including erosion of trust, conflicts of interest in clinical decision-making, inequality in access to healthcare, and the gradual dehumanisation of care within institutional settings. The paper also evaluates the role of regulatory mechanisms, such as consumer protection laws and professional ethics codes, while highlighting gaps in their enforcement. By briefly engaging with comparative perspectives, the study reflects on how other healthcare systems attempt to balance market efficiency with ethical responsibility. It concludes by emphasising the need for stronger ethical accountability, improved regulatory coherence, and greater integration of ethics within medical education, while recognising that maintaining the ethical core of healthcare remains essential in a changing system.

Keywords: Medical Ethics, Commercialisation, Doctor–Patient Relationship, Healthcare India, Bioethics, Health Policy

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Introduction: Shifting Ethics in Indian Healthcare

Background and Context

For a long time, the practice of medicine in India rested on an ethical foundation that was less about contracts and more about trust. The doctor and patient relationship was traditionally understood as a fiduciary one, where the doctor was expected to act in the best interest of the patient, often even beyond strictly professional obligations (Gopichandran, 2013). Care was not merely a service; it carried a moral weight. The language of "duty," "compassion," and even "seva" shaped how healthcare was both delivered and perceived (Marathe et al., 2020). In many parts of the country, particularly in smaller towns and rural settings, this trust-based model continues to hold some relevance, though increasingly under strain.

However, over the past few decades, this landscape has undergone a noticeable transformation. The rapid expansion of private and corporate healthcare institutions, combined with technological advancements and rising healthcare costs, has gradually repositioned healthcare within a market-oriented framework. Large hospital chains, insurance-driven treatment models, and the growing influence of pharmaceutical industries have introduced new dynamics into clinical practice. Healthcare today is not just a site of care but also, undeniably, a sector of economic activity (Jeffery, 2013). This shift has brought undeniable benefits: improved infrastructure, access to advanced treatments, and greater specialisation (Jeffery, 2013). Yet, it has also altered the ethical contours of medical practice in ways that are not always immediately visible. The movement from a personalised, trust-based system to a more institutional and transactional model raises important questions about the changing nature of medical ethics in India.

Problem Statement

The increasing commercialisation of healthcare has created a persistent and often uncomfortable tension between profit motives and patient welfare. While private investment has strengthened healthcare delivery in many respects, it has also introduced financial considerations into spaces that were once governed primarily by ethical judgment. Decisions regarding diagnostics, treatment plans, and hospitalisation are, at times, influenced directly or indirectly by economic incentives.

This raises concerns about the dilution of ethical standards in clinical decision-making. Instances of over-prescription, unnecessary diagnostic procedures, and

extended hospital stays are frequently cited in public discourse, reflecting a broader anxiety about whether patient interests remain central in medical practice. It would be simplistic to suggest that all healthcare providers are driven by profit; however, the structural environment within which they operate increasingly rewards revenue generation alongside, and sometimes over, ethical care. At the same time, patients themselves are no longer seen merely as recipients of care but are increasingly framed as consumers of medical services. This shift, reinforced by legal developments and consumer protection mechanisms, has redefined expectations on both sides. While it has empowered patients in certain ways, it has also contributed to the transformation of the doctor and patient relationship into a more transactional engagement. The core issue, therefore, is not simply the presence of commercialisation, but its implications for the ethical foundations of healthcare. Whether existing legal and regulatory frameworks are capable of addressing these emerging challenges remains an open and pressing question.

Research Objectives

In light of these developments, the present study seeks to:

- Examine the transformation of the doctor and patient relationship in India in the context of increasing commercialisation of healthcare;
- Analyse the ethical implications arising from the shift towards market-driven healthcare delivery systems;
- Evaluate the adequacy and effectiveness of existing legal and regulatory frameworks in addressing ethical concerns within the healthcare sector;
- Explore the tensions between professional medical ethics and economic incentives in contemporary clinical practice;
- Suggest possible reforms aimed at strengthening ethical accountability and restoring trust within the healthcare system.

Research Questions

The following key questions guide this paper:

- Has the commercialisation of healthcare significantly altered the ethical foundations of medical practice in India?
- Can the doctor–patient relationship still be meaningfully understood as fiduciary, or has it evolved into a primarily service-based interaction?

- To what extent can legal and regulatory mechanisms effectively address ethical decline within a market-driven healthcare system?

Literature Review and Conceptual Framework

Existing Scholarship on Medical Ethics in India

The question of medical ethics in India has, for quite some time, been closely tied to the idea of trust. Much of the earlier scholarship tends to view the doctor–patient relationship as inherently fiduciary, which is built on confidence, professional integrity, and an expectation that the doctor will prioritise patient welfare above all else (Gopichandran, 2013, p. 79–82). This understanding draws not only from formal ethical codes but also from long-standing social perceptions of doctors as moral agents, not merely service providers (Gopichandran, 2019). In that sense, ethics was never seen as something external to medical practice; it was embedded within it.

At the same time, more recent literature reflects a noticeable shift in how this relationship is being understood. With the increasing recognition of patients' rights and accountability mechanisms, there has been a gradual move towards framing healthcare within the language of consumer protection (Gopichandran, 2019). Legal developments, particularly the inclusion of medical services within consumer law, have reinforced the idea that patients can question, challenge, and seek remedies for deficiencies in care. This has, in many ways, empowered patients and introduced a degree of transparency that was previously lacking. However, this transition is not without its complications. While the consumer protection framework strengthens accountability, it also subtly reshapes the relationship itself. The doctor begins to appear less as a fiduciary figure and more as a service provider, while the patient assumes the role of a consumer navigating a marketplace of healthcare options (Sukumar, 2023). Some scholars argue that this shift risks oversimplifying medical care by reducing it to a transactional exchange, where outcomes are expected to align neatly with service expectations, something that is not always possible in the inherently uncertain domain of medicine (Medical Council of India, 2002). This is also signified by the Supreme Court of India in the case of *Indian Medical Association v. V. P. Shantha* (AIR 1996 SC 550). There is, therefore, an emerging tension in the literature: between preserving the ethical core of medical practice and adapting to a rights-based, legally enforceable framework of accountability (AIR 1996 SC 550). This tension forms a crucial backdrop for understanding contemporary debates on medical ethics in India.

Commercialisation and Healthcare Markets

Parallel to these developments, a growing body of work has focused on the commercialisation of healthcare and its implications. The expansion of private healthcare in India, particularly since the economic liberalisation period, has been both rapid and transformative. Corporate hospital chains, advanced diagnostic centres, and specialised treatment facilities have become central to healthcare delivery, especially in urban areas (Marathe et al., 2020). These institutions often operate with significant capital investment, sophisticated technology, and managerial structures that resemble those of large business enterprises.

Scholars examining this shift often point out that healthcare is increasingly being treated as an industry, rather than a purely social service. Market logic efficiency, profitability, competition has begun to influence not just administrative decisions but, indirectly at least, clinical ones as well. The integration of health insurance systems has further reinforced this trend, introducing new layers of financial calculation into treatment processes. In such a system, the boundaries between medical necessity and economic viability can sometimes become blurred (Jeffery, 2018). At the same time, it would be inaccurate to portray commercialisation in entirely negative terms. Many studies acknowledge that private investment has significantly improved infrastructure, reduced waiting times, and expanded access to advanced medical technologies. For a large section of the population, especially in cities, private healthcare has become the primary source of treatment (Kennedy, 2015). Yet, the critical concern raised in the literature is about the ethical consequences of this market orientation. When healthcare operates within a profit-driven framework, there is always a risk that, whether realised or not, those financial considerations may influence medical judgment (Pellegrino, 1999). Discussions around over-medicalisation, unnecessary procedures, and differential access based on economic capacity are often situated within this broader context. In this sense, commercialisation is not merely an economic phenomenon; it is also an ethical one (Christiansen, 2017).

Theoretical Framework

To analyse these shifts more systematically, this paper draws on three interrelated theoretical perspectives that help illuminate the changing nature of medical ethics in India.

First, Fiduciary Theory provides the classical foundation for understanding the doctor–patient relationship. Within this framework, the doctor is seen as a trustee of

the patient's well-being, bound by duties of care, loyalty, and good faith. The asymmetry of knowledge between doctor and patient is central; the patient relies on the doctor's expertise and honesty, often without the capacity to independently verify medical decisions (Gopichandran, 2019). Ethical practice, therefore, requires the doctor to act selflessly, placing patient interests above personal or institutional gain. This model has long underpinned professional medical ethics, even if its practical application has varied across contexts (Pellegrino, 1999, pp. 273-274).

In contrast, Commodification Theory offers a lens through which the transformation of healthcare into a market good can be understood. Commodification, in this sense, refers to the process by which something traditionally governed by social or moral values becomes subject to market exchange. Applied to healthcare, it suggests that medical services are increasingly treated as products which are priced, packaged, and delivered within a competitive marketplace. While this can improve efficiency and accessibility in certain respects, it also raises concerns about the erosion of intrinsic ethical values. Care risks becoming standardised and transactional, rather than relational and patient-centred. Finally, the political economy of healthcare situates these developments within broader economic and structural dynamics. This perspective examines how systems of production, capital investment, and institutional incentives shape the delivery of healthcare. It draws attention to the fact that medical decisions do not occur in isolation; they are influenced by organisational structures, financial models, and policy frameworks. From this viewpoint, the tension between profit and care is not simply an ethical dilemma faced by individual doctors; it is embedded within the very design of the healthcare system.

Taken together, these three frameworks allow for a more nuanced understanding of the ongoing transformation. The shift from a fiduciary to a more transactional model of care is not abrupt or absolute; rather, it reflects the interaction of ethical traditions with evolving economic realities (Kennedy, 2015). It is within this space somewhere between care and commerce that contemporary debates on medical ethics in India are unfolding.

Methodology

Nature of Study

This study is mainly doctrinal, but it doesn't stay limited to law alone. Since medical ethics is not just a legal issue, the paper also takes a slightly broader, interdisciplinary view, bringing in ideas from sociology and ethics where needed. The intention is simple: to not just look at what the law says, but also how it actually plays out in real situations within the healthcare system.

Sources of Data

The study is based on secondary sources.

- Relevant statutes have been used to understand how courts deal with issues like medical negligence and patient rights.
- Some policy reports and official documents help in understanding the larger healthcare framework.
- Along with this, academic literature books and journal articles have been used to build the theoretical and ethical side of the discussion.

These sources together give a fairly complete picture, even without primary data.

Analytical Approach

The approach is largely socio-legal, meaning the law is looked at along with the social realities around it. It's not just about rules on paper, but also about how those rules function in practice. At the same time, the paper also takes an ethical perspective. Just because something is legally allowed doesn't always make it ethically sound, especially in healthcare. So, wherever relevant, the analysis tries to look at whether current practices still align with basic ethical principles.

Evolution of the Doctor–Patient Relationship in India

Traditional Ethical Model

For a long time, the doctor–patient relationship in India was largely trust-based. Patients would rely heavily on the doctor's judgment, often without questioning it. There was a kind of unspoken belief that the doctor would always act in the patient's best interest. This is what is usually described as a paternalistic model in which the doctor decides what is best, and the patient follows. In many ways, it worked because medicine was seen more as a profession guided by duty rather than something driven by external pressures. Ethical values like care, honesty, and responsibility were expected to come naturally with the role (Panday & Choudhary, 2020). Even today, in some smaller towns or rural areas, this kind of relationship still exists, though not as strongly as before.

Transition to Consumer Model

Over time, this traditional model has started to shift. Patients are no longer just passive recipients of care; they are increasingly seen, and also see themselves, as consumers

of healthcare services. This change didn't happen suddenly, but it has become more visible in recent years (Government of India, 2019). One important reason for this shift is the growing awareness of patient rights, along with legal developments that allow patients to seek remedies in cases of negligence or deficiency in service. With medical services being brought under consumer protection laws, the relationship has become more formal and, to some extent, transactional (Sukumar, 2023).

This has had both positive and negative effects. On one hand, it has made doctors more accountable and given patients a sense of agency. On the other hand, it has slightly altered the nature of the relationship and trust is no longer assumed in the same way, and interactions sometimes feel more like service exchanges rather than ethical engagements. Medicine, in that sense, begins to look a bit like any other service sector, which is not always a comfortable shift.

Impact of Privatisation and Corporate Hospitals

The growth of private and corporate hospitals has further changed this relationship. Healthcare delivery is now increasingly institutionalised, with large hospital systems, administrative layers, and standardised procedures. The interaction is often no longer just between a doctor and a patient, but between a patient and an entire system.

In such settings, decisions are not always purely individual. There are protocols, financial considerations, and organisational policies that come into play (Marathe et al., 2020). While this has improved efficiency and access to advanced treatments, it has also created some distance in the doctor–patient interaction. Another noticeable change is the issue of reduced personal accountability. In a corporate setup, responsibility can sometimes become diffused. It is not always clear whether the individual doctor, the hospital administration, or the system as a whole should be held accountable in cases of ethical or professional lapses (Marathe et al., 2020). Hence, what we see today is not a complete replacement of the old model, but rather a gradual shift. The relationship has moved from being purely trust-based to something more structured, regulated, and at times, transactional, shaped by legal, economic, and institutional factors.

Commercialisation of Healthcare: Structural Drivers

Growth of Private Healthcare Sector

Over the last few decades, India's healthcare system has seen a steady shift towards the private sector. Government facilities still exist, of course, but for a large section of people, especially in urban areas, private hospitals have become the first point of contact. This

expansion hasn't happened randomly; it is closely tied to broader economic changes and increasing demand for better infrastructure and specialised care.

With this, healthcare has also seen a kind of market expansion. Hospitals are no longer just places of treatment; they operate like organised institutions, sometimes even like business entities, with branding, competition, and service differentiation. Corporate hospital chains, multi-speciality centres, and diagnostic hubs have become quite common (Kamath et al., 2025). Another important factor is the rise of insurance-driven healthcare. More people now rely on health insurance to cover medical expenses, which has changed how treatment is accessed and delivered. While insurance has improved affordability in some cases, it has also introduced a different dynamic where treatment decisions are sometimes influenced by coverage limits, package structures, and reimbursement policies. It's not always very visible, but it does shape the system in subtle ways.

Profit Incentives and Clinical Decision-Making

One of the more debated aspects of commercialisation is how profit incentives may influence clinical decisions. Medicine, ideally, should be guided purely by patient need, but in a system where financial sustainability matters, the lines can occasionally blur. Concerns about over-treatment often come up in this context. There are instances, at least as discussed in public discourse, where patients undergo procedures or treatments that may not be strictly necessary. Similarly, the issue of diagnostic inflation, where multiple tests are prescribed, is frequently pointed out. While it would be unfair to generalise this across all practitioners, the structural environment does create conditions where such practices can occur (Manna et al., 2023). It's also worth noting that doctors themselves operate within these systems. They may not always have complete autonomy, especially in large institutional setups where targets, resource utilisation, or administrative expectations play a role. So, the issue is not just individual ethics, but also the system within which decisions are made.

Role of Pharmaceutical and Insurance Industries

The role of the pharmaceutical industry is another important piece of this puzzle. Medicines are central to healthcare, but the relationship between pharmaceutical companies and medical practitioners has often been debated. There are concerns, sometimes subtle, sometimes more direct, about how marketing practices, incentives, or brand promotion might influence prescription patterns.

Similarly, the growing involvement of the insurance sector has added another layer to healthcare delivery. Insurance companies determine what treatments are covered, to what extent, and under what conditions. This can indirectly affect medical decisions, as doctors and hospitals may need to align treatments with policy terms and reimbursement structures (Manna et al., 2023). All of this points towards what can be described as the financialisation of care, where economic considerations are increasingly intertwined with medical ones. Healthcare, in this sense, becomes part of a larger economic network involving hospitals, insurers, pharmaceutical companies, and patients. While this system brings efficiency and resources, it also raises questions about whether ethical priorities always remain at the centre.

Ethical Implications: From Fiduciary Duty to Transactional Care

The changes discussed so far are not just structural or economic, and they have very real ethical consequences. The shift from a trust-based system to a more market-oriented one has gradually altered how care is perceived and delivered. It would be an exaggeration to say that ethics has disappeared, but it has certainly become more complicated, and at times, a bit strained.

Erosion of Trust

One of the most noticeable outcomes of this shift is the gradual erosion of trust between doctors and patients. Earlier, patients rarely questioned medical advice; today, there is often hesitation, doubt, or even suspicion. News reports, personal experiences, and general awareness have all contributed to this change. Patients now tend to seek second opinions more frequently, sometimes not just out of caution but out of uncertainty about whether the advice given is entirely in their best interest. On the other side, doctors too seem to practice more defensively, possibly due to fear of litigation or complaints. This creates a slightly tense environment where confidence is not as strong as it once was (Bhattacharjee & Mohanty, 2024). Trust, once weakened, is not easy to rebuild. And in a field like healthcare where vulnerability is high, it becomes even more significant.

Conflict of Interest

Another important issue is the growing conflict between financial and ethical considerations. Ideally, medical decisions should be guided purely by what is best for the patient. But in a system influenced by costs, targets, and institutional expectations, this is not always straightforward (Bhattacharjee & Mohanty, 2024).

There can be situations where a treatment option is medically sound but also financially beneficial to the institution. Even if the intention is not unethical, the overlap between financial gain and clinical decision-making creates a grey area (Bhattacharjee & Mohanty, 2024). This is where the idea of conflict of interest comes in. It is important to note that not every such situation leads to unethical conduct. Many doctors continue to prioritise patient welfare despite these pressures. Still, the presence of such conflicts itself raises concerns about how consistently ethical principles can be maintained within a commercial framework.

Inequality in Access to Healthcare

Commercialisation has also brought into focus the issue of inequality in access to healthcare. High-quality treatment is often available but not equally accessible to everyone. Those with financial resources or insurance coverage can access better facilities, while others may have to rely on limited or overburdened public systems (Christiansen, 2017). This raises an ethical question that goes beyond individual conduct: is healthcare becoming a privilege rather than a right? When access depends heavily on one's ability to pay, it creates what can be described as an ethics of exclusion, where certain sections of society are effectively left out of quality care (Christiansen, 2017). The problem is not new, but commercialisation has arguably widened this gap. It forces us to think about whether a market-driven model can truly align with the idea of equitable healthcare (Christiansen, 2017).

Dehumanisation of Care

A more subtle, but equally important, consequence is the dehumanisation of care. In large institutional settings, patients are sometimes reduced to "cases" or "clients", identified more by their medical condition or billing category than by their individual circumstances (Hansson & Fröding, 2021). Time constraints, administrative processes, and standardised treatment protocols can make interactions feel impersonal. The emotional and human aspects of care, such as listening, reassurance, and empathy, may not always receive the same attention as clinical efficiency.

Again, this is not to suggest that compassion has disappeared from medical practice. Many healthcare professionals continue to provide deeply humane care. But the system, as it evolves, does not always make space for it in the way it once did (Hansson & Fröding, 2021). Overall, what emerges is not a complete breakdown of ethics, but a shift in its context. The doctor–patient relationship is no longer defined solely by trust and

duty; it is increasingly shaped by institutional structures, economic pressures, and legal frameworks. The challenge, then, is not just to recognise these changes, but to find ways of addressing them without losing the ethical core of healthcare.

Legal and Regulatory Framework in India

Consumer Protection and Medical Services

Over time, medical services in India have come to be viewed within the framework of consumer protection law. Doctors and hospitals are now often treated as service providers, and patients as consumers who can seek remedies in case of negligence or deficiency in service. This shift has made healthcare more accountable and has given patients a formal legal avenue to challenge malpractice. At the same time, it has also changed the nature of the relationship. Medical care, which was earlier seen as a professional duty, is now partly understood as a service transaction. While this strengthens patient rights, it also adds a layer of legal caution to medical practice.

Role of Medical Councils and Ethics Codes

Regulation of medical ethics in India is primarily handled through professional bodies like medical councils, along with formal codes of ethics that lay down standards of conduct. These codes cover aspects such as professional responsibility, patient confidentiality, and fair practice. However, one of the major concerns is the issue of enforcement. While the guidelines exist, their implementation is often inconsistent. Disciplinary actions can be slow, and in some cases, not strong enough to act as a deterrent. This creates a gap between what is prescribed on paper and what actually happens in practice (Hansson & Fröding, 2021).

Judicial Trends In Medical Negligence

The judiciary has played an important role in shaping the legal understanding of medical negligence. Over the years, there has been a noticeable shift in judicial attitude. Courts have moved from a position of strong deference to medical professionals towards a more balanced approach that considers patient rights more seriously.

At the same time, courts have also been careful not to over-penalise doctors, recognising the complexities and uncertainties involved in medical decision-making.[1] So, the trend is not entirely one-sided, but it reflects an attempt to balance accountability with professional autonomy (Hansson & Fröding, 2021). Overall, the legal and regulatory

framework in India has evolved to address changing realities in healthcare, but certain gaps, especially in enforcement and consistency, continue to remain.

Global Perspectives

Looking beyond India, it becomes clear that the tension between care and commerce is not unique. Many developed healthcare systems have faced similar challenges, though their responses have been more structured and, in some cases, more effective. A brief comparative glance helps in understanding what works and what perhaps does not.

Ethical Regulation in Developed Healthcare Systems

In several developed countries, ethical regulation in healthcare is supported by strong institutional frameworks. Professional bodies are not only responsible for setting ethical standards but are also relatively stricter in enforcing them. Mechanisms for accountability, whether through regulatory agencies, independent review boards, or ombudsman systems, tend to function with greater consistency (Tulchinsky et al., 2015). At the same time, these systems often attempt to balance professional autonomy with patient rights. For instance, clear guidelines exist regarding informed consent, transparency in treatment, and conflict of interest. In some jurisdictions, there is also greater scrutiny over relationships between healthcare providers and pharmaceutical companies, aiming to reduce undue influence (Tulchinsky et al., 2015).

Significantly, even where private healthcare is dominant, there are checks in place to prevent excessive commercialisation from undermining ethical care. This includes standardised treatment protocols, price regulation in certain sectors, and oversight mechanisms that monitor quality and fairness. That said, these systems are not without their own issues. Debates around rising costs, insurance-driven care, and access disparities persist. But comparatively, there is a more visible effort to integrate ethical regulation within the structure of the healthcare system itself, rather than treating it as an afterthought.

Lessons for India: Balancing Market and Morality

For India, the lesson is not to replicate any one model entirely, but to recognise the need for a better balance between market efficiency and ethical responsibility. The growth of private healthcare is unlikely to slow down, nor is it necessarily undesirable. The challenge lies in ensuring that this growth does not come at the cost of ethical integrity.

Stronger enforcement of existing regulations, clearer accountability mechanisms, and greater transparency in medical decision-making could help bridge some of the current gaps. There is also a need to rethink how ethical standards are taught and internalised within the medical profession, rather than relying solely on external regulation. At a broader level, the focus should remain on preserving the core idea that healthcare, even when delivered within a market system, is not just another commodity. It carries a social and moral dimension that cannot be entirely reduced to economic logic. In that sense, the real task for India is not to eliminate commercialisation, but to ensure that it operates within boundaries that still prioritise patient welfare. Striking this balance between market and morality is perhaps the most important takeaway from global experiences.

Re-Imagining Medical Ethics in India

The discussion so far shows that the issue is not simply about decline, but about adaptation. Medical ethics in India is not disappearing, but it is being reshaped under new pressures. The real question, then, is how to respond to this shift in a way that preserves core ethical values without ignoring present realities. Some directions, though not perfect, can still be thought through.

Strengthening Ethical Accountability

One of the immediate needs is to make ethical accountability more effective in practice, not just in theory. Codes of conduct already exist, but their impact depends largely on enforcement. There is a need for clearer, quicker, and more transparent mechanisms to address ethical violations (Atta, 2024). At the same time, accountability should not become purely punitive. If doctors begin to see ethics only through the lens of fear of complaints or litigation, it may lead to defensive practices rather than genuinely ethical ones. So, the focus has to be balanced: ensuring responsibility, but also maintaining professional trust and autonomy. It's a fine line, and not always easy to manage.

Reforming Healthcare Regulation

Regulation in India, as it stands, is somewhat uneven. While laws and guidelines exist, their implementation often lacks consistency. Strengthening regulation does not necessarily mean adding more rules, but rather making existing ones work better. This could involve better coordination between regulatory bodies, more clarity in standards, and perhaps some degree of oversight over pricing and treatment practices, especially in

private healthcare. At the same time, excessive control can also create its own problems, so reforms need to be careful, not over-corrective. The idea is to create a system where ethical practice is supported, not just monitored.

Integrating Ethics in Medical Education

Another important area is medical education. Ethics is usually taught, but often as a separate or secondary component. In reality, it needs to be more deeply integrated into training, not just as theory but as part of everyday clinical thinking. Young professionals entering the field should be able to recognise ethical dilemmas as they arise, not only after something goes wrong. This kind of awareness cannot be developed overnight and definitely not through textbooks alone. It requires discussion, reflection, and exposure to real-world situations. If ethics becomes part of the professional mindset early on, it is more likely to be sustained later.

Towards a Patient-Centric Model

Ultimately, any reform should move towards a more patient-centric approach. This does not mean returning entirely to the old paternalistic model, nor does it mean treating healthcare purely as a service transaction. It lies somewhere in between.

Patients today are more aware and more involved in decision-making, and that is a positive development. But at the same time, care should not lose its human element. Communication, empathy, and respect still matter, perhaps even more in a system that is becoming increasingly complex. A patient-centric model would aim to combine professional expertise with patient participation, without reducing the relationship to mere exchange. It may sound idealistic, but even small shifts in this direction can make a difference. In the end, re-imagining medical ethics is not about going back to what existed earlier, but about finding a workable balance that acknowledges economic realities while still holding on to the fundamental idea that healthcare is, at its core, about care.

Conclusion

The discussion across this paper reflects a broader transformation within Indian healthcare from a system largely rooted in care and trust to one increasingly shaped by commerce and institutional structures. This shift is neither entirely unexpected nor entirely avoidable, given the expansion of private healthcare, technological advancements, and changing patient expectations. However, it has undeniably altered

the ethical foundations on which the doctor and patient relationship once stood. What emerges is not a complete collapse of ethics, but a situation where ethical principles are often under pressure. Issues like declining trust, conflicts of interest, unequal access, and the gradual loss of the human element in care point towards an ethical strain within the system. At times, the balance seems tilted, where efficiency and profitability begin to overshadow the core purpose of healthcare.

That is to say, the solution does not lie in rejecting commercialisation altogether. The growth of private healthcare has brought real benefits, and it remains an important part of the system. The challenge is to ensure that this growth is guided by clear ethical boundaries and effective regulation. Strengthening accountability, improving regulatory mechanisms, and rethinking how ethics is taught and practised are all steps in that direction. Going forward, the aim should be to rebuild a healthcare environment where professional integrity and patient welfare remain central, even within a modern, market-influenced framework. The task is not simple, and there is no single solution. But if approached carefully, it is still possible to move towards a system that manages to hold on to its ethical core while adapting to contemporary realities.

Note

1. https://www.researchgate.net/publication/373281187_Medical_Negligence_and_Evolving_Judicial_Activism last assessed on 22/04/2026.

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