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Beyond medical errors: exploring the interpersonal dynamics in physician-patient relationships linked to medico-legal complaints

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Abstract

Background Previous research suggests that medico-legal complaints often arise from various factors influencing patient dissatisfaction, including medical errors, physician-patient relationships, communication, trust, informed consent, perceived quality of care, and continuity of care. However, these findings are not typically derived from actual patients' cases. This study aims to identify factors impacting the interpersonal dynamics between physicians and patients using real patient cases to understand how patients perceive doctor-patient relational problems that can lead to dissatisfaction and subsequent medico-legal complaints.

Methods We conducted a retrospective study using data from closed medical regulatory authority complaint cases from the Canadian Medical Protective Association (CMPA) between January 1, 2015, and December 31, 2020. The study population included patients who experienced sepsis and survived, with complaints written by the patients themselves. A multi-stage standardized thematic analysis using Braun and Clarke's approach was employed. Two researchers independently coded the files to ensure the reliability of the identified codes and themes.

Results Thematic analysis of 50 patient cases revealed four broad themes: (1) Ethics in physician's work, (2) Quality of care, (3) Communication, and (4) Healthcare system/policy impacting patient satisfaction. Key sub-themes included confidentiality, honesty, patient involvement, perceived negligence, perceived lack of concern, active engagement and empathy, transparency and clarity, informed consent, respect and demeanor, lack of resources, long wait times, and insufficient time with physicians.

Conclusions This study identifies and categorizes various factors impacting relational issues between physicians and patients, aiming to increase patient satisfaction and reduce medico-legal cases. Improving physicians' skills in areas such as communication, ethical practices, and patient involvement, as well as addressing systemic problems like long wait times, can enhance the quality of care and reduce medico-legal complaints. Additional training in communication and other skills may help promote stronger relationships between physicians and patients.

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Keywords Physician-patient relationship, Medico-legal complaints, patient dissatisfaction, Communication in healthcare

Introduction and background

Medico-legal complaints often stem from a complex interplay of factors, each exerting varying degrees of influence on patient dissatisfaction [1]. While medical and diagnostic errors are among the most influential factors that contribute to initiating legal actions against physicians, the physician-patient relationship also holds significance in driving patient complaints [2–4]. These factors are important to consider, as research has demonstrated that the risk of Canadian physicians being named in civil legal cases has decreased over time, but the risk of complaints to medical regulators has increased [5, 6]. In the absence of medical or diagnostic error, the lessons to be learned from a medico-legal complaint may require greater reflection on the part of the physician. Research highlights several key factors influencing patient complaints, including communication, trust, informed consent, perceived quality of care, and continuity of care [7–13].

Effective communication is one of the most influential factors; it facilitates patients feeling respected and understood, reducing the likelihood of legal complaints [10, 14–16]. Inadequate communication can lead to misunderstandings and erode trust, potentially resulting in legal action [17, 18].Informed consent is central to upholding patient autonomy, a key issue regarding doctor-patient relationship. Effective informed consent involves not only informing patients of treatment details and risks but also actively ensuring they understand and agree to the course of action. This practice is essential to avoid perceptions of coercion and the subsequent increase in legal disputes. Studies suggest the need for a consent process that genuinely engages patients and respects their decision-making rights, thus fostering trust and reducing medico-legal risks [17, 19, 20].

The perception of care quality also plays a crucial role; patients perceiving substandard treatment or negligence are more prone to seek legal remedies [17, 21, 22]. Ensuring continuity of care strengthens the patient-physician relationship, minimizes the risk of medical issues going untreated or being delayed, and reduces misunderstandings while building trust, which in turn decreases the likelihood of complaints [11]. Prompt and professional responses to concerns, alongside effective resolution mechanisms within healthcare institutions, are key in preventing issues from escalating into formal lawsuits, emphasizing the need for a holistic approach to patient care and communication [10, 16, 23].

Past literature investigated relational factors between physicians and patients impacting medico-legal complaints utilizing various methodologies such as interviews, surveys, theoretical works, reviews, and other methods [23–34]. However, there is little research exploring this research problem utilizing medicolegal complaints. Consequently, the aim of this study is to attempt to identify the factors impacting the interpersonal dynamics between physicians and patients that can result in patient dissatisfaction and, subsequently, provide further impetus for them to file medico-legal complaints against physicians.

Method

The Canadian Medical Protective Association (CMPA) is a mutual defense organization that offers medico-legal support, advice, and education to over 110,000 physician members across Canada. The CMPA conducts safe medical care research using its repository of medico-legal cases, which includes medical regulatory authority (College) complaints.

Data source

The CMPA's approach to coding medico-legal cases has been described in previous work [35]. Briefly, trained registered nurse-analysts routinely summarize and code medico-legal case files, including peer expert opinions and final decisions. Coding includes physician and patient characteristics, and patient health conditions are classified using the International Classification of Diseases, 10th Revision, Canada (ICD-10-CA) codes. Cases coded within the repository are routinely reviewed by the nurse-analysts for quality assurance.

Study population and rationale

We conducted a retrospective study by retrieving and analyzing files from closed medical regulatory authority (College) complaint cases in Canada that closedbetween January 1, 2015 and December 31, 2020 using Statistical Analysis System (SAS) Enterprise Guide 8.3. We included cases that involved a patient who was at least 18 years old; had experienced sepsis or other relevant infection (defined elsewhere [36]) and survived their sepsis episode; thus death from sepsis was an exclusion. Cases were also excluded if the complaint was made by someone other than the patient (e.g. family member or caregiver). Two researchers (MM, JS) manually reviewed the files to remove cases where the complaint was not written by the patient.

Sepsis was chosen as it is a life-threatening medical condition that represents a significant source of stress for patients and with a high morbidity and mortality [37].

We know from prior analyses that patients with sepsis are diagnosed and treated in a variety of clinical settings (e.g. emergency departments, post-operative care units, medicine wards, ambulatory clinics) and by different types of specialist physicians (e.g. family medicine, emergency and critical care medicine, surgery); analysis of complaints from patients who have had sepsis offers insights into a variety of physician-patient relationships. We hypothesized that beyond the survival of the disease, there could be underlying relational dynamics at play, prompting these patients to pursue complaints, making this population an ideal population to investigate the factors impacting the interpersonal dynamics between physicians and patients that can result in patient dissatisfaction and, motivate them to file medico-legal complaints against physicians. Our goal was to understand patients' perceptions, feelings, and the nuances of their encounters with physicians that may have motivated them to file complaints although they survived severe sepsis.

We limited our analysis to College complaints because they generally represent a more accessible and low-cost method for patients to express dissatisfaction with their physicians, often without the need for legal representation. Unlike civil cases, which are heavily influenced by legal strategies and usually with the involvement of lawyers, College complaints are typically written by patients themselves. This approach not only reduces the influence of potential financial motivations but also provides clearer insights into the reasons behind patient complaints and their relationships with their physicians.

Ethics approval

Ethics approval was obtained from the Canadian ethics review panel of the Advarra Institutional Review Board (CR00389884) in compliance with Canada's Tri-Council Policy Statement on the Ethical Conduct for Research Involving Humans (TCPS 2).

Table 1 Patient demographic information ($n=50$)

Variable		Number of Patients (percentage)
Age		
	19–29	5 (10%)
	30–49	16 (32%)
	50–64	13 (26%)
	65–79	13 (26%)
	80+	2 (4%)
	Unknown	1 (2%)
Gender		
	Woman	29 (58%)
	Man	21 (42%)

Analysis

A multi-stage standardized thematic analysis using a phenomenological lens and an inductive method was utilized to analyze the complaint files. We employed a framework presented in the narrative review conducted by the researchers (citation removed due to blind review) as a basis to code the complaint files, while further codes and themes were identified in an iterative process of reading the patients' file, following Braun and Clarke's (2006) approach [38]. We reviewed patient-written complaints, primarily focusing on patients' subjective perceptions.

Two researchers (MM, JS), who had permission to access confidential patients' files, acquainted themselves with a previously-developed framework and identified initial codes [39]. Guided by inductive reasoning, codes were sorted and grouped based on similarity, and similar codes were combined to form overarching themes. Then the researchers reviewed each preliminary theme based on internal homogeneity and external heterogeneity [40], as well as the extent to which the themes related to the data set as a whole. After reaching a consensus, the final themes were named and defined.

The authors coded several cases together to ensure consistency of the coding method before starting to code independently. During this process the statements were assigned to the codes and themes defined by the initial framework. One researcher (MM) had primary responsibility for coding the complaint files (50 files), while the second researcher (JS) served as a duplicate coder for a randomly selected subset, covering two-third of the files (32 files). Cohen's kappa was calculated to evaluated inter-rater reliability [41].

Following an approach used in prior manuscripts [42] we paraphrased patient complaints while ensuring the main message is conveyed and the concerns expressed by the patients is clearly communicated. The paraphrased examples were de-identified by replacing or removing specific references such as names, dates, and places. They/them pronouns were used in place of any existing pronouns and are not intended to represent gender identification.

Results

Utilizing a phenomenological lens and a thematic analysis approach, we thematically analyzed 50 patient-written complaint files meeting inclusion criteria. Applying a phenomenological lens means that the findings in this study reflect and explore the patients' perspectives, which may differ from the perspectives of the treating physician, and the final disposition of the case made by the College.

Table 1 includes basic demographic information about the patients whose complaint files were analyzed in this study.

Thematic analysis

The contents of the complaint cases were coded into four broad themes: (1) Ethics in physician's work; (2) Quality of care; (3) Communication; and (4) Healthcare system/policy impacting patient satisfaction. Each theme had several subthemes. Some of the subthemes were still broad, so they included elements that further clarified what each subtheme entailed. Since two researchers coded the files independently we calculated Cohen's kappa at 0.91, which indicates a very good inter-rater reliability [40]. Table 2 displays the themes, subthemes, and elements.

Theme 1: Ethics in physician's work

Ethics is a cornerstone of the medical profession, ensuring that physicians provide care that is in the best interest of their patients [43]. Three themes were most prevalent from the patient-written complaints relating to ethics in physician's work.

Confidentiality and protecting patients' privacy

Confidentiality and protecting patients' privacy involve keeping a patient's personal and medical information secure and shared only as necessary for treatment or with patient consent [44]. We identified situations where a patient's privacy was perceived to be invaded.

For instance, in one case a physician erroneously suggested that a patient might be a victim of abuse. This error was captured and re-stated in the patient's medical record without the patients' approval, and the patient now routinely faces questions from healthcare providers about possible abuse.

In another example, a patient reported that their treating physician sought information from untrusted sources and shared incorrect information with other physicians

Table 2 Displaying themes, subthemes, and elements

Main themes	Subthemes	Elements
Ethics in physician's work		
	Confidentiality and protecting patients' privacy	
	Honesty	
	Patients' involvement	
Perceived quality of care		
	Perceived negligence	
	Perceived lack of concern	
Communication		
	Active Engagement and empathy	
		Active listening
		Dismissive communication
		Delivery of difficult news
	Transparency and clarity	
		Clearly communicating the condition, treatment plan, and procedure in details
		Informed consent (Clearly communicating and being transparent about the chance of survival and risks of side effects)
		Transparency about any types of medical errors/shortcomings that have occurred
		Giving false hope
	Respect and Demeanor	
		Feeling judged
		Feeling offended
		Labeling
		Disrespect
		Using insensitive language
		Patronizing attitude
		Condescending/rude tone
Healthcare system/policy		
	Perceived lack of resources	
	Long wait times	
	Not having enough time with the physicians	
	Difficulty booking an appointment	

that ultimately affected how the patient was perceived and treated, resulting in a misdiagnosis.

Honesty

In the physician-patient relationship, honesty encompasses transparency regarding medical conditions, available treatment options, all medical procedures, potential risks, and addressing patients' inquiries [43, 45]. A few patients expressed concerns about a perceived lack of honesty in their interactions with their physicians.

For instance, one patient stated that they asked their surgeon multiple times if the surgeon had communicated with the patient's oncologist regarding their care. The patient stated that the surgeon confirmed they had spoken to the oncologist; it was later revealed that no such communication had taken place.

In another example, a patient stated that they were told by their surgeon that an injury that resulted during a laparoscopic surgery was very minimal. However, the patient was later told that it was a significant injury, affecting the small intestine and a major blood vessel. This was verified in the operative report by the surgeon who performed the repair surgery.

Patients' involvement

Actively involving patients in the decision-making process acknowledges the importance of their unique viewpoints, personal values, and preferences in the provision of healthcare services [46]. A few patients reported that physicians sometimes did not consider their preferences in the choice of treatment.

For instance, a patient stated in their complaint that they had told their treating physicians that they did not want to have surgical procedures, which led to laughter from their physicians. One physician asked if this stance was rooted in personal beliefs or something else, further questioning how the person's views might have evolved. The patient expressed significant shame and embarrassment from this encounter.

Theme 2: Perceived quality of care

Patients can have different expectations of the care they are receiving. Within the patients' perceived quality of care, two distinct subthemes were derived: perceived negligence and perceived lack of concern.

Perceived negligence

Perceived negligence by physicians refers to the patient's perception that a healthcare provider has acted without an appropriate level of skill or knowledge to meet the patient's expected standards of care [47]. Patients expressed their perceived negligence about different aspects of care received, in the complaint files.

For instance, one patient stated that their physician had not reviewed their medical chart, which clearly documented an allergy to an antibiotic and an analgesic. The patient had previously been asked about allergies prior to receiving medications, but in the encounter they described their physician was not aware of their allergies and prescribed a medication that they were allergic to.

In another example a patient stated that the examination of a wound showing signs of infection was very brief. The wound was neither cleaned nor swabbed for culture, and the physician offered no medications to treat the patient's pain.

Perceived lack of concern

Perceived lack of concern by a physician refers to a patient's perception that their healthcare provider was not sufficiently attentive, empathetic, or responsive to their medical and emotional needs [48, 49].

In one case example, a patient reported that the physician was not present at the hospital for their scheduled appointment. The patient felt neglected, feeling that their health and well-being were not properly prioritized during a planned hospital transfer.

Another patient felt surprised, exposed, and vulnerable, when their physician suddenly decided to alter their medication in consultation with a psychiatrist who was unfamiliar with the patient's personal history and background.

Theme 3: Communication

Effective communication allows a physician to build a robust therapeutic communication and serves as a conduit for gathering and sharing information crucial to patient care [50]. Communications emerges as our primary and most intricate theme which was divided into several subthemes of active engagement and empathy, transparency and clarity, and respect and demeanor, that each contained additional subthemes.This structure supports communication as one of the essential components of the physician-patient relationship.

Active engagement and empathy denote

In this study, active engagement and empathy are defined as communication skills that include focused attention, understanding, and reflective listening. This approach extends beyond merely hearing the patient's words to encompass a deeper level of comprehension and empathetic interaction [51]. Patient complaints in this theme suggested challenges in cultivating a deeper engagement within the therapeutic relationship. We explored how patients interpreted and described their experiences with active listening, dismissive communication, and the manner in which difficult news was conveyed, as evidenced in complaints.

Active listening Active listening is defined by engaging with the audience by fully concentrating, understanding, responding, and remembering what is being said in a conversation [52, 53].

In several examples, patients' complaints reflected a perception that their physicians were not listening to them. In at least one example, the patient specifically expressed that they felt that their physician was not listening to them or their concerns.

In another example, a patient reported dissatisfaction over the healthcare provider's failure to listen to them and believed that if the physician had listened to them it could have made a big difference in the outcome of their treatment.

In another example, a patient expressed a desire for doctors to prioritize listening to patients, suggesting a need for a more active listening encounter and patient-focused care.

Dismissive communication Dismissive communication in clinical encounters occurs when the physician minimizes or disregards the thoughts, feelings, or concerns of patients [54]. Our analysis revealed that several patients explicitly reported that their concerns and feelings were dismissed. This was another area where patients were very clear in their concerns.

For instance, a patient reported that they shared their worries about their treatment and the complications with their physician, but they seemed to dismiss their concerns.

Similarly, in another example, the patient indicated that they communicated their concerns about their treatment and the challenges encountered to their physician, which resulted in receiving a dismissive attitude from the physician regarding their issues.

Delivery of difficult news Delivering difficult news is a complex task that demands empathy and a sensitive understanding of the emotional state of the recipient [55]. Our analysis suggests that patients' complaints often reflect their perception of a lack of genuine engagement and empathy from physicians when delivering challenging news.

For instance, one patient was told that their finger needed to be amputated immediately; their physician warned that failure to act quickly could endanger their hand. The patient's complaint reflected a feeling that this difficult news was not shared with sensitivity.

Another patient felt that their physician moved too quickly from informing them about the need for an amputation to choosing a surgical date. The patient didn't feel that they had time to process the distressing news, and that they were hurriedly presented with a consent form.

Transparency and clarity

Transparency involves open, honest, and clear communication that empowers patients to make informed decisions about their health [50, 52]. The thematic analysis of these complaints revealed four sub-themes including clear communication, informed consent, transparency, and giving false.

Clear communication Clear communication is closely linked to informed consent and involves providing a detailed and understandable explanation of the patient's medical condition, the proposed treatment plan, and any procedures involved [50, 52]; however, some patients perceived that they were not given sufficient information about their condition or interventions.

For instance, one patient explained that they experienced chest discomfort but felt that their physician was strongly suggesting a referral to see a psychiatrist. They were reluctant to seek clarification from their physician, fearing how their query may be perceived by their physician.

Another patient's complaint reflected a lot of confusion after their diagnosis of sepsis. The patient understood that they had been very ill but sought further information from healthcare providers for more information and clarification, with little success.

In a third example, the patient did not feel that they had been informed that they had been prescribed a high-dose steroid while in hospital. The patient became concerned and refused to continue taking the medication.

Informed consent Informed consent involves a patient's voluntary acceptance of a proposed medical plan after a healthcare provider has disclosed all material information [7, 12]. The thematic analysis of complaint files suggested that when there was a mismatch between patients' understanding of risks before procedures or treatments and the information they received afterwards, the patients expressed that the consent discussion was inadequate. This is an area where perception is essential; physicians may have assumed they had communicated the risks, but from the patient's perspective they may not have been adequately discussed or understood.

For example, it was relatively common for patients to express that the risks of certain procedures were not communicated to them fully. Sometimes there seemed to be disagreement about whether conversations took place. In one case example, the patient stated that the physician claimed that they had thoroughly discussed the risks of the procedure including the risk of developing necrosis; the patient, however, had no recollection of that conversation occurring.

In another example, a patient was not aware until after the surgery that there was a relatively high risk of nerve damage that could impact sexual function.

In another example, the patient stated that they were asked to sign a declaration despite not being informed about the procedure's risks.

There were also several examples where patients felt that information was withheld from them. For example, one patient reported that the informed consent was not provided to them. It remained unclear to the patient whether this omission was accidental or intentional.

Transparency Being transparent about any types of medical errors in clinical interactions entails revealing any mistakes or lapses in care that have occurred during treatment to prevent future consequences [10, 13]. In the analysis of complaint files, several patients perceived that their physicians were not transparent about the medical errors that happened during the interventions.

One example of this was a patient who reported that they discovered years later during a consultation with another physician that their large intestine had been removed. This information had not been shared with them at the time of the procedure.

Giving false hope Giving overly optimistic news or false hopes to patients about treatment outcomes or their current conditions can lead to potential negative consequences [45]. We observed patient complaints about being given false hopes.

For instance, a patient reported that before they were discharged, their physician assured them falsely that their bladder appeared healthy. When the patient later reviewed their imaging results, they learned that there was a recommendation to conduct a follow-up CT cystogram to check for a possible mass.

Respect and demeanor

Respect and demeanor reflect the core values of the medical profession and ensure that patients receive care with dignity and respect [43, 56]. The thematic analysis of the patient complaints revealed six sub-themes under Respect and Demeanor including feeling judged, being labeled, being disrespected/offended, patronizing attitude, using insensitive language, and condescending/rude tone.

Feeling judged Feeling judged in the doctor-patient relationship refers to patients perceiving that their healthcare provider is making negative assessments about them and their intentions without proper evidence [57, 58]. Some patient complaints reflected a perception that the physician was making negative assumptions or evaluations about them or their reasons for seeking treatment.

For instance, one of the patients reported that their physician labeled them as drug-seeking when they sought medication to treat a chronic painful condition. Another patient reported that their physician suspected they were seeking medication to lose weight for cosmetic reasons.

Being labeled In our analysis, we considered labeling a situation in which the doctor assigns a term or diagnosis that simplifies complex patient experiences into a category, which can affect the patient's mental state and how the patient is perceived and treated [59].

For instance, a patient reported in their complaint that they had been labelled as drug-seeking. The patient felt that their physicians did not understand the impact that this label had on the patient's life.

In another example, the patient stated that the assumption made about them being 'one of those seeking drugs' had led to significant harm to their physical health, mental state, and emotional well-being.

Being disrespectful/offended Feeling offended and disrespected in the doctor-patient relationship refers to patients perceiving disrespect or insensitivity from their healthcare provider [58]. We considered an incident as being offensive or disrespectful where patients reflected feeling disrespected or slighted based on any words, actions or attitudes by physicians that devalue the patient's feelings, opinions, or experiences.

For instance, in an encounter with a physician, a patient complained that their physician repeatedly insisted that there was no record of an incident that the patient was referring to, implying that the patient and their spouse were lying.

In another example, a patient felt bullied into undergoing a physical examination that seemed unnecessary to them, given their young age and health condition.

In another example, a patient reported that their physicians' tone changed, and they reacted strongly when the physician mentioned that they were aware of the game patients play, taking medication to lose weight and stay slim.

Patronizing attitude A patronizing attitude in our analysis refers to situations where the physician *treats* the patient in a condescending way, implying the patient's concerns or intelligence are less valid or inferior [60, 61].

For instance, a patient reported that during their visit, it was mentioned that they would receive a tetanus shot and although they declined, stating they didn't want it, the healthcare provider administered the shot dismissively, insisting on its necessity and asking the patient to trust them.

Using insensitive language In our analysis, using insensitive language refers to situations in which a physician employs words or phrases that are thoughtless or lack consideration for the patient's feelings or situation [62].

For instance, a patient stated in their complaint that their physician commented that they seemed to appear more pregnant with each visit.

Condescending/rude tone A condescending tone in our analysis refers to situations where a physician *speaks* in a way that implies superiority, often making the patient feel undervalued or inferior [63, 64].

For instance, a patient indicated that they felt they were bullied and were made to feel foolish for inquiring about their own health and they thought one does not deserve to be treated in such an intimidating manner.

Theme 4: Healthcare system/policy

Healthcare systems and policies significantly influence the frequency and nature of patient complaints [65, 66]. While some of these factors and policies are outside of any individual physician's control, they can impact the physician-patient relationship and contribute to a patient's complaint. Policies that prioritize accessibility, quality, communication, and patient rights can contribute to reducing complaints and improving patient satisfaction; conversely, deficiencies in these areas can lead to an increase in patient complaints [67–69]. The thematic analysis identified three primary sub-themes under healthcare system and policy that contribute to patient dissatisfaction: perceived lack of resources, long wait times and difficulty booking appointments, and insufficient time spent with physicians.

Perceived lack of resources

A perceived lack of resources in hospitals refers to patients' perception that the available resources, such as equipment or personnel, are inadequate to meet the needs of patients and provide quality care. In the analysis of the complaint files, patients expressed dissatisfaction over several instances where they felt there were inadequate resources for proper treatment.

For instance, one patient questioned whether the clinic they attended had adequate equipment to provide a necessary procedure. Another patient was distressed to learn that all available operating rooms were in use, so the procedure was conducted in the patient's hospital room.

Long wait times and difficulty booking an appointment

Long wait times for patients refers to extended periods of time that patients must wait before receiving medical care or services; along the same lines, difficulty booking appointment refers to the challenges patients faced while intending to book an appointment with a physician. Long wait times and difficulty booking appointment with physicians can specifically lead to patient frustration and anxiety, diminishing their perception of the physician's commitment and prioritization of the patient's medical concerns [9].

A few patients complained about how long they had to wait before they could see their physicians, which they felt contributed to their negative health outcomes. In one particular complaint, the patient noted that it was more than two months before they could see their physician in follow-up. Several patients expressed that they were surprised or confused by the long wait times given the severity of their sepsis.

Similarly, the analysis of complaint files revealed that patients were dissatisfied with the difficulty in scheduling follow-up appointments with their physicians, a factor that contributed to their adverse health outcomes.

In one example, a patient complained that they had to repeatedly call their physician's office to request a follow-up appointment after being discharged from hospital, and the appointment was for more than a year later.

Not having enough time with the physicians

This subtheme refers to situations where patients felt that their interactions with physicians were rushed and insufficient. Previous studies suggest that not having enough time with physicians can strain the doctor-patient relationship, leading to reduced trust, satisfaction, and communication [9]. Patients were very explicit about expressing this type of concern and expressed that they are dissatisfied with not having enough time with physicians.

For instance, a patient reported that the physician only spent a very short time with them.

Discussion and limitations

Although previous research has investigated the relational factors that impact the risk of litigation against a physician (e.g., [23–34]), to the best of our knowledge, this is the first study that has used real cases to explore the interpersonal dynamics in Physician-Patient Relationships Linked to Medico-Legal Complaints.

We utilized a phenomenological approachto conduct a thematic analysis. We identified four main themes in relational problems between physician and patients, (1) ethics in physician's work; (2) quality of care; (3) communication; and (4) healthcare system/policy. Each theme had several subthemes with subsequent detailed elements.

Our first theme, ethics in physicians' work, focusing on privacy protection, honesty, and patient involvement, is critical for reducing medico-legal risks. Emphasizing confidentiality, truthful communication, and respecting patient choices is essential to minimize medico-legal

risks and improve care quality, aligning with ethical standards and leading to better patient outcomes.

Our analysis revealed 'Quality of Care' as the second major theme, comprising two critical subthemes: perceived negligence and perceived lack of concern. Existing research suggested that the perceived quality of care significantly influences the dynamics and effectiveness of the physician-patient relationship. This perception affects not only patient satisfaction but also extends to trust, communication, treatment adherence, and overall health outcomes [70]. The examples provided in this theme demonstrate how patients closely observe a physician's attitude, the extent of the physician's attention during visits, and their expression of care and concern. This indicates patients value a physician's attentiveness and care during visits, beyond just following protocols. Genuine empathy and addressing patient expectations are key to improving care and minimizing complaints.

The thematic analysis of patient complaints revealed that communication was the most frequently mentioned theme among all the identified themes, and positively underscores the critical role of effective communication in mitigating medico-legal risks for physicians. This may highlight the pivotal role of effective communication in reducing medico-legal risks for physicians. Key themes were identified as active engagement and empathy, transparency and clarity, informed consent, and respect and demeanor. Active listening and empathy are crucial in understanding patient concerns, while transparency and clarity in explaining conditions, treatment plans, and procedures, alongside ensuring informed consent by clearly communicating material risks and obtaining voluntary agreement, are fundamental in upholding patient autonomy and can empower patients and foster trust. Upholding respect and professional demeanor is essential for fostering respectful interactions with patients and preserving their dignity. Previous work indicates that prioritizing such communication facets can markedly lower the incidence of complaints and improve patient care. It concludes that incorporating effective communication skills into medical practice to proactively address patient concerns can substantially reduce medico-legal risks [10].

Effective communication has been previously identified as significant to mitigating the risk of litigation against physicians [10]. Communication in the physician-patient relationship is not merely a means of exchanging information but a fundamental aspect of delivering high-quality healthcare. It builds trust, ensures understanding, promotes adherence to treatment, enhances patient satisfaction, and ultimately contributes to better health outcomes [71–73]. Our analysis suggests that when patients felt that physicians failed to make a meaningful and satisfactory connection with them, the patients noted this in their complaints. Physicians frequently regard communication as intrinsic to the art of medicine, prompting a devotion to refining this craft through both traditional and novel methods to enhance therapeutic efficacy. Though linguistic precision remains critical in communication skills training, it must enrich, rather than replace, authentic human interaction. Other themes such as ethics in physician's work and quality of care (i.e., showing care and concern) further support these insights. Specifically, the likelihood of patients lodging a medico-legal complaint diminishes when they perceive genuine care and concern, compassion, honesty, and acknowledgment of their preferences and values.

To improve ethics and communication, physicians could benefit from integrating shared decision-making into clinical practice. For instance, models like the "Professionally-Driven Zone of Patient or Surrogate Discretion" and others can be included in physician education to enhance patient engagement and reduce complaints [74].

Our last theme referred to health systems and policy. While this theme might not seem directly related to the relationship between physicians and patients, previous research has shown that systems-level barriers, such as a lack of resources, long wait times, and difficulty booking appointments, can lead to negative emotions and consequences that may drive patients to file complaints [8, 75–77]. It is important to acknowledge that these system factors are generally outside the control of individual physicians. Subsequently, policies that prioritize accessibility, quality, communication, and patient rights can contribute to reducing complaints and improving patient satisfaction. Addressing systems issues effectively requires a holistic review of healthcare structures, suggesting the importance of a comprehensive approach to healthcare improvement. For instance, patients may feel frustrated and abandoned by their physician when they struggle to book follow-up appointments [37, 78, 79].

This study employs a phenomenological approach, effectively capturing participants' perceptions and insights. This methodology is especially relevant given the sparse scholarly work that has employed this approach to explore similar questions. This study identified and categorized factors affecting the physician-patient relationship into themes and subthemes, providing a structured framework for understanding areas where the relationship may be at risk. By organizing these factors, we offer insights for physicians to recognize and address potential vulnerabilities in their interactions with patients. The findings serve as a foundation for developing educational modules aimed at enhancing physician-patient relations. Moreover, this organized categorization invites further research to delve into each theme, facilitating the exploration and enrichment of our understanding of the patient experience and mitigation strategies.

At the same time, we acknowledge the limitations of our study. The retrospective analysis of complaint files restricted our inquiry to the content available in the documents, prohibiting follow-up questions that could deepen our understanding. Moreover, the medico-legal files used represent only a subset of the conflicts between physicians and patients. Future research should further investigate and expand upon the themes identified in this study, exploring their broader impact on patients' motivations to lodge complaints against physicians.

A potential future path could be exploring physician/patient relationships in other medical settings and potentially compare the physician/patient dynamics between patients with a variety of different medical conditions. This would allow researchers to discern whether the interpersonal dynamics and issues leading to medico-legal complaints among sepsis patients are unique to this group or are prevalent across other conditions as well. This targeted approach would deepen our understanding of the factors influencing patient satisfaction and the potential for complaints across different medical scenarios. Another future path could be to investigate the outcomes of complaints to determine how often patient perceptions align with case resolutions, enhancing our understanding of the dynamics that influence potential medico-legal risks.

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Author contributions
MM designed the study protocol, developed the study methodology, coded, and analyzed the data, and prepared the first draft. JS coded and analyzed the data and contributed to and commented on drafts of the paper. JF contributed to the data analysis and commented on drafts of the paper. GG also contributed to the data analysis and commented on drafts of the paper.

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Data availability
We are unable to provide access to this data due to ethical and privacy restrictions.

Declarations

Ethics approval and consent to participate
Ethics approval was obtained from the Canadian ethics review panel of the Advarra Institutional Review Board in compliance with Canada's Tri-Council Policy Statement on the Ethical Conduct for Research Involving Humans (TCPS 2). The Advarra Ethics board waved the need for consent to participate.

Consent for publication
Not Applicable.

Competing interests
The authors declare no competing interests.

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