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Miscommunication as a Cause of Disputes in the Relationship Between Doctors and Patients in Hospitals

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Abstract

This study aims to analyze how miscommunication between doctors and patients in medical services can lead to medical disputes. Employing a sociolegal research approach with qualitative methods, data was collected through in-depth interviews and participatory observations in educational, government, and private hospitals in Semarang City. Patient samples were randomly selected, while doctors were chosen using purposive sampling. Data analysis followed the interactive model of Miles and Huberman, involving data reduction, data presentation, and conclusion drawing. The results reveal that miscommunication often stems from the gap between patient expectations and the reality of medical services, exacerbated by cultural and language differences. Factors such as a

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lack of openness, empathy, and humanistic two-way communication also contribute. In conclusion, miscommunication is a primary cause of disputes between doctors and patients, highlighting the crucial role of improved communication in preventing conflict and fostering a more trusting and effective healthcare environment.

KEYWORDS *Miscommunication, Relationships, Doctors, Patients..*

Introduction

The interaction relationship between doctors and patients utilizes communication to correspond with each other in health services. Patients express their complaints about their illnesses, and doctors respond by immediately treating the patients according to what causes them pain or discomfort. In this line of communication, both verbal language and symbols can be used to express willingness or refusal.

In medical services, communication between health workers, patients, and families is inevitable. In most scenarios, patients will come to complain about their illness, and then the doctor listens and responds to the complaint. Patients who come to get treatment for their illness are hopeful they will get better, while doctors are obligated to provide the best treatment. Such communication concerning health and wellness between health workers and patients previously adopted a paternalistic pattern that placed the doctor in a higher and more dominant position than the patient. Yet, this communication pattern has changed into a two-way communication where doctors and patients are put in an equally valued position. Such effective communication will have a profound impact on improving health, patient comfort, and satisfaction, reducing the risk of malpractice and discomfort between doctors and patients.[1]

The interaction between doctors and patients is an interpersonal relationship between one individual and another. Herbert Blumer, a modern figure in symbolic interactionism theory,[2]

1 Cut Khairunnisa, Mohd Zamre Mohd Zahir, and Muhammad Hatta, "The Role of Communication in Health Services in Indonesia," Cendekia: Jurnal Hukum, Sosial Dan Humaniora 1, no. 3 (2023): 246–58.

2 Steve Bruce and Herbert Blumer, "Symbolic Interactionism: Perspective and Method," The British Journal of Sociology 39, no. 2 (1988), https://doi.org/10.2307/590791.

explains that humans translate and define each other's actions, not just mere reactions from one person's actions towards another. A person's response is not constructed directly because of another person's actions but is based on the meaning given to the other person's actions. These could be discerned in interaction between individuals, whether symbols are used or not, interpretations, or merely by trying to understand each other's intentions. Thus, human interactions are not immediate, where the stimulus automatically and directly causes a response. The actor carries out an interpretation process between the stimulus received and the response that occurs afterward. It is apparent that such an interpretation process is a human-exclusive trait, the ability to possess a thinking process. The interpretation process that mediates between stimulus and response occupies a crucial position in symbolic interactionism theory.

In this study, the basic assumption used is that the relationship between doctors and patients in the provision of medical services in hospitals has occurred so far; there exists an observed relationship of dependency from patients to doctors. Doctors hold control over patients who lack knowledge in the medical field, and the position of doctors is inclined to be higher than that of the patients. This is also due to the fact that patients almost never doubt the expertise and prowess of doctors in the medical field, and almost all decisions are in the hands of the doctor. The higher position of doctors is generally based on the factors of patients' trust in the doctors' ability to give treatment and competence regarding health, patients' lack of knowledge in the medical field in particular, the solidarity among fellow doctors, and an isolating attitude towards other professions. In addition, in the process of treatment and care conducted jointly with other medical workers, doctors are considered to be the parties who play a central role.[3] In recent years, communication between doctors and other healthcare professionals has played a crucial role in maintaining patient trust. According to Prentice et al. (2020), 51% of respondents reported experiencing at least one emotional impact; 57% reported avoiding the doctor or facility involved in the error; and 67% reported

3 Soerjono Soekanto, "Hubungan Dokter – Pasien Ditinjau Dari Hukum Perikatan," Kompas, 1987.

a loss of trust. The level of open communication varied, with 34% stating there was no communication at all, while 24% reported experiencing five or more elements of open communication. After controlling for the severity of the error, those who reported the most open communication were significantly less likely to experience persistent sadness (OR = 0.17, 95% CI: 0.05–0.60, p = 0.006), depression (OR = 0.16, 95% CI: 0.03–0.77, p = 0.022), or feelings of abandonment/betrayal (OR = 0.10, 95% CI: 0.02–0.48, p = 0.004), compared to those who reported no communication. Open communication was also significantly associated with reduced avoidance of specific doctors or facilities, though it was not linked to general avoidance of medical care or overall trust in the healthcare system.[4]

The public perception of the medical profession today indicates that a portion of society feels dissatisfied with the healthcare services provided by doctors. This dissatisfaction generally stems from patients' unmet expectations, resulting in a mismatch between the high hopes of patients and the actual care they receive. This suggests that doctors' service and dedication need improvement to better align with societal expectations. Previous studies highlight the critical role of communication between doctors and patients.[5]

Disputes between doctors and patients could be discerned as an iceberg that occurs too often. Yet, only a tiny area of the iceberg is apparent due to how those disputes are able to be resolved peacefully. This brings the Indonesian Medical Association to light, as their role as a professional organization and consumer agency represents patients' interests in conflict resolution. The Indonesian Medical Association also plays an integral part in filtering conflicts that do not have substantive reasons before one party chooses the legal route. This is due to the fact that conflicts between doctors and patients are caused mainly by differences in perception and

4 Julia C. Prentice et al., "Association of Open Communication and the Emotional and Behavioural Impact of Medical Error on Patients and Families: State-Wide Cross-Sectional Survey," *BMJ Quality and Safety* 29, no. 11 (2020), https://doi.org/10.1136/bmjqs-2019-010367.

5 Kevin Purba and Turnomo Rahardjo, "Pengelolaan Hubungan Antara Dokter Dan Pasien Dalam Konteks Komunikasi Terapeutik," Interaksi Online 8, no. 4 (2020): 154–66.

communication problems in terms of providing medical services.

For example, research by Rifka et al,[6] points out that communication errors can lead to medical disputes that end up in court, although this study lacks quantitative data on communication and legal health regulations. Meanwhile, Prakoeswa et al,[7] emphasize that effective communication is key to enhancing healthcare quality and building patient trust, which positively affects hospital reputation and revenue. However, hospitals still fall short in fully meeting patient expectations, especially in complaint handling. Research by Liu et al,[8] in China reveals that despite doctors being seen as highly skilled professionals, medical disputes frequently occur, reducing patient trust. This shows that conflicts between doctors and patients are often due to miscommunication or misunderstandings rather than malpractice.

Overall, conflicts often arise from differences in perception and ineffective communication rather than solely medical errors. Therefore, improving communication in medical services is essential to reduce disputes and increase patient satisfaction. Additionally, cultural factors and changing times influence public views of doctors. In the past, doctors were highly respected and almost revered, but now patients tend to be more critical and sometimes less patient in receiving explanations. Negative perceptions also arise from unethical practices, such as pharmaceutical company influence or unnecessary use of medical devices for profit, which erode public trust. Consequently, some people turn to alternative treatments or traditional healers due to cost, friendliness, and cultural reasons. From a quantitative perspective, Indonesia still faces a shortage of doctors compared to WHO standards, with a doctor-to-population ratio far below the ideal.

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6 Rifka, Bambang Fitrianto, and T Riza Zarzani, "The Role of the Indonesian Doctors Association (IDI) in Providing Legal Services for Doctors Suspected of Making Mistakes in Health Services (Study of the Indonesian Doctors Association, West Kalimantan)," *Asian Journal of Multidisciplinary Research and Analysis* 1, no. 2 (2023), https://journal.berpusi.co.id/index.php/Ajomra/article/view/589.

7 Cita Rosita Sigit Prakoeswa et al., "Patient Satisfaction, Perception-Expectation Gap, and Costumer Satisfaction Index in Annual Survey 2021 at Dr. Soetomo General Academic Hospital," *Folia Medica Indonesiana* 58, no. 2 (2022), https://doi.org/10.20473/fmi.v58i2.34550.

8 Xiaofan Liu et al., "The Influence of Doctor-Patient Communication on Patients' Trust: The Role of Patient-Physician Consistency and Perceived Threat of Disease," *Psychology Research and Behavior Management* 17, no. null (December 31, 2024): 2727–37, https://doi.org/10.2147/PRBM.S460689.

This adds challenges to providing equitable and satisfactory healthcare. In conclusion, public dissatisfaction with doctors' services is largely influenced by unmet expectations, poor communication, and cultural factors. Enhancing doctor-patient communication, professionalism, and cultural sensitivity is crucial to boosting patient trust and satisfaction and reducing conflicts that may lead to legal actions.

Method

This study was conducted using a non-doctrinal approach (sociolegal research). The population in this study included doctors (general practitioners, surgical, and non-surgical specialists) who work in sample hospitals as well as outpatients and inpatients who receive treatment at educational, government, and private hospitals in Semarang City. Considering the large number of patient respondents taken as samples, the sampling technique for patients used a random technique; meanwhile non-random sampling (purposive sampling) was used for doctor respondents.

This study uses both primary and secondary data. Data was collected through field studies, in-depth interviews, participatory observations, and literature studies. The data was then processed qualitatively by describing it as thoroughly as possible and telling the story of the occurring social reality.

This research's data analysis will follow the interactive model proposed by Matthew B. Miles and A. Michael Huberman. This model requires that the research move in three (three) cycles of activity: data reduction, data presentation, and drawing conclusions or verification.

Communication in Doctor-Patient Interactions

Etymologically, the word communication stems from the Latin word *communicare,* which is derived from the word *communis,* which means sharing or belonging together, namely an effort that has the aim of togetherness or ordinary meaning.[9]

Communication is an instrument used between individuals to interact and exchange messages during daily activities. Hence, the line of communication must be conveyed clearly between one individual and another. The occurrence of differences in understanding and improper delivery of messages is what is called miscommunication[10]

9 Dasa Liow, Meyti Himpong, and Grace Waleleng, "Peran Komunikasi Antara Dokter Dan Pasien Dalam Pelayanan Medis Di Klinik Reci Desa Sinisir Kecamatan Modoinding," Acta Diurna Komunikasi 2, no. 1 (2020).

10 Ariesha Meivia Anggraini, S Ikom Qoni'ah Nur Wijayanti, and M Ikom, "Analisis Pengaruh Miskomunikasi Dalam Suatu Hubungan," Jurnal Media Akademik (JMA) 2, no. 1 (2024).

A proper line of communication between doctors and patients in health services is undeniably vital. With the appropriate words and tone, a doctor can dig for the correct information from the patient to fully understand the patient's needs and complaints, this acivity called *anamnesis*. Hence, this skill of communicating must be mastered properly by doctors. This could influence the success rate of the patient's health problems. Thus, effective communication is the key to reducing patients' doubts about the medical actions they will receive. Both doctors and patients must gain benefits in that line of communication, for this will obtain the optimal results of the medical action that will be performed to cure the patient.[11]

Interpersonal communication, by definition, is face-to-face communication between two individuals or more, which allows for direct reactions from other people, both verbally and non-verbally. Conversely, other experts have stated that interpersonal communication is considered to be the most effective method to change a person's attitudes, opinions, and behavior because of its dialogic nature in the form of conversations so that the feedback is direct.[12]

Health-related communication generally covers messages and media that promote health and well-being, disease prevention, treatment, as well as advocacy, including several variations in situations, structures, messages, relationships, identities, goals, and strategies for influencing society. The health-related communication theory encompasses various communication levels in such a broad social context. The primary levels of analysis of health-related communication consist of intrapersonal, interpersonal, group, and organizational communication. Studies related to intrapersonal communication in health focus on the mental and psychological processes associated with healthcare, involving self-awareness, perception, expectations, as well as beliefs, values, and attitudes about health.[13] Self-awareness helps individuals understand how their feelings and beliefs about health influence their behavior. An individual's perception of disease risks or treatment benefits also

11 Liow, Himpong, and Waleleng, *op.cit.*
12 Ilona Vicenovie Oisina, "Komunikasi Dokter Yang Berpusat Pada Pasien Di Masa Pandemi," MEDIALOG: Jurnal Ilmu Komunikasi 4, no. 1 (2021): 130–41.
13 Khairunnisa, Zahir, and Hatta, *op.cit.*

influences their decisions, often shaped by their beliefs and values. Expectations, which are future-oriented, motivate individuals to achieve their health goals by planning to adopt a healthy lifestyle. Beliefs, values, and attitudes about health significantly influence their intrapersonal communication, affecting how individuals process health information and respond to it. Overall, intrapersonal communication plays a crucial role in influencing health behaviors and individual decisions through complex mental and psychological processes.

Indisputably, proper communication is a part of professionalism that is demonstrated based on knowledge, skills, abilities, attitude, or behavior. A doctor's professionalism shows his commitment to professional ideas and careers. Excellent communication skills between doctors and patients significantly impact treatment efforts, namely during the examination process, in order for doctors to help solve patients' problems[14].

Several factors could influence the effectiveness of communication. De Vito's interpersonal communication theory proposes several factors that exert influence on communication effectiveness, including openness, empathy, supportiveness, positiveness, along with equality. In addition, Suranto AW, in his book, also summarizes the elements of effective communication with the acronym REACH, which stands for Respect (having regard for others), Empathy (putting yourself in someone's shoes), Audible (can be heard and understood well), Clarity (clear and precise), and Humble (being modest). Considering those factors, it can be concluded that openness is a crucial factor since it is the factor that initiates effective communication between the doctor and the patient. And yet, if openness doesn't or barely exists in the communication between a doctor and a patient, there would be a probable result in miscommunication, which could lead to disputes.[15]

Hayes and Bautista, on the other hand, view communication in the interaction between patient and doctor as a negotiation process.[16] John Stoeckle (1988) discerns this line of communication

14 Oisina, *op.cit.*
15 Liow, Himpong, and Waleleng, *op.cit*
12 David E Hayes-Bautista, "Chicano Patients and Medical Practitioners: A Sociology of

in a different light, for he sees how doctor-patient interactions are inseparable from the interests of institutions, the use of technology, as well as socialization.[17] David Mechanic (1981) regards trust in doctor-patient interactions as having five dimensions: technical competence, fiduciary responsibility, control, confidentiality, and disclosure.[18] Technical competence covers education, credentials, competence, and intellect. Fiduciary responsibility, or the responsibility based on trust, is the doctor's ability to provide health services to patients. Control is the doctor's freedom and ability to control the medical actions that will be performed. The concept of confidentiality and disclosure in healthcare involves two important aspects that complement each other. On the one hand, confidentiality is the principle that keeps patient information safe and confidential from the public, except in certain situations permitted by law or with the patient's consent. This is crucial for building trust between patients and healthcare providers. On the other hand, disclosure involves providing clear and accurate medical explanations to patients to ensure they understand their condition and treatment. This disclosure not only builds patient trust in doctors and healthcare organisations, but also enables patients to make informed decisions about their own care. The balance between maintaining confidentiality and making appropriate disclosures is crucial in healthcare practice, ensuring that patients feel safe and confident in sharing their personal information, while also ensuring that they receive appropriate and well-informed care.

EJ Imanuel and LL Imanuel suggest that there are four models of interactions between doctors and patients. They regard these interactions as a conflict between patient autonomy and health workers or between the values held by patients and the values held by doctors. The models, as suggested by EJ Imanuel and LL Imanuel,

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Knowledges Paradigm of Lay-Professional Interaction," *Social Science & Medicine. Part A: Medical Psychology & Medical Sociology* 12 (1978): 83–90, https://doi.org/https://doi.org/10.1016/0271-7123(78)90033-0.

17 Howard Waitzkin, "John D. Stoeckle and the Upstream Vision of Social Determinants in Public Health," *American Journal of Public Health*, 2016, https://doi.org/10.2105/AJPH.2015.302936.

18 David Mechanic and Sharon Meyer, "Concepts of Trust among Patients with Serious Illness," *Social Science and Medicine* 51, no. 5 (2000), https://doi.org/10.1016/S0277-9536(00)00014-9.

are as follows: [19]

A. Paternalistic: The doctor acts like a good parent and chooses what is best for his patient. This model is identical to the active-passive model proposed by Szasz and Hollander.
B. Informative: The doctor provides information to the patient about his/her condition and what medical action will be taken. This model is also the same as guidance and cooperation from Szasz and Hollander.
C. Interpretative: The doctor acts as a counselor or advisor who provides thorough explanations to patients.
D. Deliberative: The doctor provides explanations and helps the patient choose the best action for him/her. In this situation, the doctor acts as a friend to his patient.

Northouse suggests several elements influence communication between health workers and patients, including empathy, control, trust, self-disclosure, and confirmation. It must be noted here that Northouse emphasizes communication between health workers and patients, where the context of communication that occurs is different from communication in general. Here, health workers, generally doctors, need to control the communication process to obtain quality information. The medical diagnosis process is a systematic series of steps taken by doctors to accurately identify a patient's health condition. Doctors begin by gathering information through anamnesis, which involves interviewing the patient to understand their medical history and symptoms. Additionally, physical examinations are conducted to obtain further data about the patient's body condition. Following this, doctors utilize various diagnostic tests such as blood tests, X-rays, or MRIs to strengthen the diagnosis.[20] By combining all this information, doctors can determine the correct diagnosis and plan appropriate treatment tailored to the patient's condition. This process requires meticulousness and careful analysis to ensure that patients receive

19 Ezekiel J. Emanuel and Linda L. Emanuel, "Four Models of the Physician-Patient Relationship," *JAMA: The Journal of the American Medical Association* 267, no. 16 (1992), https://doi.org/10.1001/jama.1992.03480160079038.

20 Katherine H. Schiavoni et al., "How Primary Care Physicians Integrate Price Information into Clinical Decision-Making," Journal of General Internal Medicine 32, no. 1 (2017), https://doi.org/10.1007/s11606-016-3805-0.

effective and timely care.

Effective communication between doctors and patients is a crucial foundation in modern healthcare. More than just an exchange of medical information, this communication builds a bridge of trust that is essential for accurate diagnoses, adherence to treatment plans, and ultimately, patient healing. Doctors who can communicate clearly, empathetically, and openly create an environment where patients feel heard, valued, and motivated to actively participate in their own care. Conversely, failures in communication can lead to misunderstandings, anxiety, non-compliance, and even poor health outcomes. Therefore, continuous development of communication skills for medical professionals, as well as promoting awareness of the importance of good communication among patients, is an important investment in improving the quality and effectiveness of the healthcare system as a whole. [21]

Doctor-Patient Interactions

Doctor-patient interactions mainly stem when a patient enters the examination room, gets encouraged to explain the symptoms that they feel of their illness, and has the doctor respond. Here occurs an interaction between the doctor and the patient related to the diagnosis of the disease, and the therapy to be performed on the patient must be with the patient's consent. This causes the rise of a legal relationship between the doctor and the patient, where the doctor and the patient have reciprocal rights and obligations. In health-related communication, doctors must be able to make a clear and thorough explanation with generally simple vocabulary so as not to confuse patients. Additionally, doctors also should be able to explain the potential risks that might occur from the medical action that will be performed.

The legal relationship between a doctor and a patient doesn’t begin from where a patient enters the examination room, as the general public expected. Yet, it begins from how the doctor expresses his willingness to treat the patient, which is stated verbally (oral statement) or implied by showing an attitude or action

21 Liu et al., “The Influence of Doctor-Patient Communication on Patients’ Trust: The Role of Patient-Physician Consistency and Perceived Threat of Disease.”

that concludes willingness; such as accepting registration, giving queue number, providing and recording the patient's medical records and so on. In other words, a therapeutic relationship also requires a doctor's willingness to treat the patient. This is in accordance with the principles of consensual and contractual.[22]

Negligence in medical care can occur in a variety of ways, such as medication errors, failure to respond to patient complaints, misdiagnosis, surgical errors, or neglect of patient safety-such as patient falls. Such negligence can have far-reaching effects, not only on the physical and emotional health of patients and their families, but also on the reputation of hospitals, the accountability of individual nurses, and the integrity of the nursing profession. From an ethical standpoint, negligence is considered a violation of the fundamental principles of nursing, including autonomy, justice, and non-maleficence. Therefore, such cases often pose ethical dilemmas that require careful and professional resolution.

To address legal conflicts involving medical professionals, Health Law No. 17 of 2023 emphasises alternative dispute resolution methods before resorting to litigation. Mediation is the recommended first step, offering a space for open dialogue between patients and healthcare providers facilitated by a neutral mediator. If mediation fails to result in an agreement, arbitration may be the next option, offering a faster and less formal process with a binding decision. If both approaches are unsuccessful, litigation becomes the last resort. Regardless of the method used, it is crucial for health workers facing legal issues to get the right legal support. Ultimately, the resolution process aims not only to resolve disputes but also to restore relationships, prevent future incidents, and improve the overall quality of healthcare. [23]

The relationship between doctor and patient is *inspanningverbintenis*, an agreement that makes treatment efforts the object of the agreement. This often results in miscommunication and misperception between doctors and

22 Joko Febriantoro, "Relasi, Interaksi Dan Komunikasi Interpersonal Dokter-Pasien Dalam Pelayanan Kesehatan," CoMPHI Journal: Community Medicine and Public Health of Indonesia Journal 1, no. 1 (2020), https://doi.org/10.37148/comphijournal.v1i1.3.

23 Rifka, Fitrianto, and Zarzani, "The Role of the Indonesian Doctors Association (IDI) in Providing Legal Services for Doctors Suspected of Making Mistakes in Health Services (Study of the Indonesian Doctors Association, West Kalimantan)."

patients because patients assume that treatment is the object of therapeutic transactions. Nevertheless, the doctor must be wise and prudent in elucidating the diagnosis and medical actions to be taken, and it must be explained that the doctor is giving his most effort in treatment. The presence of the patient is required so the patient is able to understand the explanation from the doctor so that the interaction between the doctor and the patient can be established well.

Informed Consent

By definition, informed consent is the approval given by the patient or the patient's closest family after receiving a thorough and detailed description of the medical actions that will carried out by the doctor.[24] Informed consent demands doctor-patient interactions where doctors must give an explanation about the diagnosis and treatment to be carried out for the patient, as well as its objectives, risks, and potential complications. There is a possibility that medical actions are performed to help in curing the patient. Hence, the doctor's simplicity in words is necessary for the patient to be able to understand. On the other hand, the patient could either accept or refuse the proposed medical actions, as the patient has the right to do so.

The application of informed consent in Indonesia starts with a therapeutic agreement between the doctor and the patient. This agreement is made in terms of informed consent and must be signed by both the doctor and the patient or the patient's family. A therapeutic agreement doesn't require the doctor to treat the patient fully, as the doctor can't guarantee treatment results. However, every doctor will try his best professionally to perform treatment according to his knowledge and experience, so the doctor must strive to cure the patient and not just focus on the "results".[25]

Kashur R., in his previous study, states that patients who give verbal consent have equal knowledge with those who give written consent. This is due to the fact that most patients don't thoroughly read and comprehend the written information in the informed

24 Peraturan Menteri Kesehatan Republik Indonesia Nomor 290/MENKES/PER/III/2008 Pasal 1

25 Khairunnisa, Zahir, and Hatta, *op.cit.*

consent sheets, as they generally rely on the verbal explanations given by the doctors. That being said, the function of written informed consent has shifted and is aimed more at administrative needs and as proof that the doctor has provided an explanation to the patient.

Five (5) conditions must be met for the validity of Informed Consent based on the instructions of The Medical Defense Union in the book "*Medicolegal Issues in Clinical Practice," and those conditions are as follows:*[26]

1. *Given freely;*
2. *Given by an individual who is able to create an agreement;*
3. *Has explained the form of medical action to be taken so that the patient can understand why the action needs to be taken;*
4. *Concerning something that is typical;*
5. *The medical action was also carried out in the same situation.*

In addition to the above requirements, two absolute requirements are met in a legal relationship: material and formal requirements. Material requirements are necessary because there can't be an agreement on medical action without them. After all, this is a requirement for a legal relationship between a doctor and a patient. Material requirements consist of the existence of a medical action carried out according to the rules applicable in medical science, as well as the patient's consent.

Meanwhile, the formal requirements for the validity of an informed consent are the same as the requirements for the validity of an agreement, namely those contained in Article 1320 of the Civil Code, namely:

1. *There must be consent of the individuals who are bound thereby*
2. *There must be the capacity to conclude an agreement*
3. *There must be a specific subject*

26 Inas Syadza Ikhsan and Hwian Christianto, "Urgensi Informed Consent Sebagai Pencegahan Tindak Pidana Oleh Dokter," Jurnal Hukum Dan Kenotariatan 6, no. 2 (2022): 1201–15.

4. *There must be an admissible cause*

Informed consent based on Article 7 of the Regulation of the Minister of Health of the Republic of Indonesia No. 290/Menkes/Per/III/2008 concerning consent for medical action consists of a diagnosis of the disease, the action to be taken, the purpose of the action, the risks and complications of the action, the prognosis of the action, the cost of the action, and alternative actions that can be chosen if the patient and family refuse the action along with the risks if the action is not taken. The regulation then underwent slight changes in the latest Law number 17 of 2023 concerning Health, where the cost of the action is not included in the contents of the informed consent given by the doctor. Article 294 explains that the explanation regarding the cost of the action is the responsibility of the health service facility.[27]

In the Nuremberg Code of 1947, patient autonomy is fundamentally regulated through Rule 1, which emphasizes the moral values of allowing patients to make their own decisions based on complete and accurate information. This principle is rooted in the concept of informed consent, where patients have the right to self-determination in the doctor-patient relationship. The Code stipulates that voluntary consent from the human subject is absolutely essential, ensuring that individuals have the legal capacity to give consent, are free from coercion, and possess sufficient knowledge to make an informed decision. The Nuremberg Code was established as a response to the unethical medical experiments conducted during World War II, highlighting the need for ethical standards in human experimentation. By requiring informed consent, the Code respects the autonomy of individuals, allowing them to control their own bodies and make decisions about their health care based on full disclosure of the risks and benefits involved. This principle has become a cornerstone in medical ethics, extending beyond research to general medical practice, where patients are empowered to make informed decisions about their treatment

27 Candra Istiningsih Dwi Wahyuni, Batari Laskarwati, and Noer Muthmainnah Al Qulub, "Informed Consent in Health Services: How Are the Patients' Rights Protected?," Journal of Law and Legal Reform 1, no. 4 (2020): 591–604.; Undang-Undang Nomor 17 Tahun 2023 tentang Kesehatan

options. In essence, the Nuremberg Code's emphasis on informed consent has transformed the doctor-patient relationship by prioritizing patient autonomy. It ensures that patients are treated with respect and dignity, recognizing them as individuals with the right to make decisions about their own health care. This shift has contributed significantly to the development of modern medical ethics, where patient-centered care is paramount.[28]

The principle of patient autonomy is deeply rooted in the concept of upholding human dignity, which is a fundamental aspect of several key international human rights declarations and conventions. The Universal Declaration of Human Rights (1948) sets the foundation by affirming the inherent dignity and rights of all individuals, emphasizing equality and freedom from discrimination. The International Covenant on Economic, Social and Cultural Rights (1966) and the International Covenant on Civil and Political Rights (1966) further reinforce these principles by recognizing the right to self-determination and ensuring that individuals have access to essential rights such as healthcare and education.[29] The European Convention on Human Rights (1950) also plays a significant role in protecting human dignity by safeguarding rights like privacy and freedom from inhuman treatment.[30] Additionally, the European Convention on Human Rights and Biomedicine (1997), also known as the Oviedo Convention, specifically addresses the application of biology and medicine, emphasizing informed consent and the protection of human dignity in medical contexts. These documents collectively underscore the importance of respecting patient autonomy as a means of upholding human dignity in healthcare settings. In practice, patient autonomy is manifested through the principle of informed consent, which requires that patients be fully informed about their treatment options and have the right to make decisions about their own healthcare without coercion.[31] This

28 Khairunnisa, Zahir, and Hatta, *op.cit*.

29 "International Covenant on Economic, Social and Cultural Rights - Manual for Human Rights Education with Young People," accessed March 14, 2025, https://www.coe.int/en/web/compass/international-covenant-on-economic-social-and-cultural-rights.

30 "The Oviedo Convention and Human Rights Principles Regarding Health - Human Rights and Biomedicine," accessed March 14, 2025, https://www.coe.int/en/web/human-rights-and-biomedicine/the-oviedo-convention-and-human-rights-principles-regarding-health.

31 "Universal Declaration on Bioethics and Human Rights - Legal Affairs," accessed March

principle is essential for ensuring that patients are treated with respect and dignity, and it is supported by various international legal frameworks that prioritize human rights and dignity.[32]

Informed consent is a manifestation of the patient's right to self-determination. The final decision regarding self-determination can be made if the decision maker has obtained complete information and the advantages and disadvantages of the decision if it is taken.[33] Providing informed consent is a bridge between the doctor and the patient, which is a communication process that determines the best treatment and therapy for the patient.[34]

Not all information that needs to be conveyed through informed consent is given or fully understood by the patient. Research in India shows that, in general, the information that needs to be conveyed through informed consent is only conveyed by 75.4%. The interesting thing about the study is that all patients felt they had been informed about their current medical condition, but only 34% of respondents answered that they had been informed of the risks of the actions to be taken.[35] This is one of the critical issues that can lead to medical disputes between doctors and patients.

Some key elements of informed consent are:[36]

1. Providing information: the doctor provides information to the patient about the disease, the medical procedure to be performed, the risks, and the benefits of the medical procedure.
2. Understanding: the individual must have an adequate understanding of the information provided. Medical language or terms must be explained in simple language that the patient can understand.
3. Voluntary: The patient must give consent voluntarily, without

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14, 2025, https://www.unesco.org/en/legal-affairs/universal-declaration-bioethics-and-human-rights.

32 *Ibid*

33 Anggun Rezki Pebrina, Johni Najwan, and Evalina Alissa, "Fungsi Penerapan Informed Consent Sebagai Persetujuan Pada Perjanjian Terapeutik," Zaaken: Journal of Civil and Business Law 3, no. 3 (2022): 468–86.

34 Dewangga Primananda Susanto, Bramantya Surya Pratama, and Tuti Hariyanto, "Analisis Faktor-Faktor Yang Mempengaruhi Pemahaman Pasien Terhadap Informed Consent Di Rumah Sakit," Jurnal Manajemen Kesehatan Indonesia 5, no. 2 (2017): 74.

35 H Vikas et al., "How Informed Is the Informed Consent?," Journal of Family Medicine and Primary Care 10, no. 6 (2021): 2299–2303.

36 Dea Febrina, Irwansyah Irwansyah, and Dinda Agus Tantri, "Pentingnya Informed Consent Dalam Perspektif Hukum Islam," Jurnal Ilmiah Wahana Pendidikan 10, no. 20 (2024): 178–83.

pressure or coercion, because the patient has the right to refuse or consent without any negative consequences.
4. Ability to give consent: if the patient is unable to give consent due to their health condition, then the closest family can be appointed to give consent.

There are two types of informed consent, namely implied and expressed consent. Implied consent is an agreement to an action that is obtained only through signals or movements made by the patient, such as offering your hand when blood is being drawn, nodding as a sign of agreement, etc. Meanwhile, expressed consent is an explicit agreement given by the patient, either verbally or in writing.[37]

Informed consent is not required in emergencies as long as the doctor takes action to save the patient's life or prevent disability.[38] In some conditions, especially in emergencies where a patient comes in a less competent condition so that he loses his ability to make decisions and is unable to make rational decisions due to decreased consciousness to the point of unconsciousness, he will lose the right to accept or refuse medical treatment. In this case, consent to the action can be stated as implied consent, where the emergency condition itself is a "symbol" for the patient to need immediate help from a doctor.

Regulation of the Minister of Health of the Republic of Indonesia No. 585 of 1989 concerning Consent to Medical Action states that medical information must be provided whether or not requested by the patient. Patients do not have complete medical knowledge, so their rights and obligations must be explained in detail, including the advantages and disadvantages of medical actions at both the diagnostic and therapeutic stages. If the patient does not agree to the medical treatment recommended by the doctor, they have the right to refuse and choose other alternative

37 Dian Fitriana, "The Role of Informed Consent as Legal Protection for Doctors in Conducting Medical Procedures," Sinergi International Journal of Law 1, no. 3 (2023): 235–45.

38 N M R Trismayanti and Setiawan P A H Ismai, "Persetujuan Tindakan Kedokteran Oleh Orang Tua Terhadap Anaknya Sebagai Wujud Pemenuhan Hak Anak," Simbur Cahaya, Palembang. Hal 190 (2022).

treatment methods.[39]

In medical practice, informed consent can be given verbally, in writing, or even impliedly. However, Law No. 29 of 2004 requires informed consent to be given or made in writing. In high-risk medical procedures that have the potential to cause death to the patient, informed consent must be made in writing.[40]

Informed consent is very much needed in medical procedures, especially those categorized as extraordinary means, because it has a legal dimension. [41] In the criminal code, several articles eliminate punishment for perpetrators of criminal acts, namely Article 44 (mentally ill), Article 48 (because there is an element of coercion), Article 50 (implementing provisions of the law), and Article 51 (implementing office orders). This law is generally applicable to the medical profession. However, there are still unique factors that occur in the medical profession and do not occur in generally applicable law, namely:

1. Risk of treatment: namely, the risk of allergies and complications in the patient's body. There is always an inherent risk in medical procedures where the doctor has acted carefully and followed SOP and professional standards, but side effects (risks) still occur. In this situation, the doctor cannot be blamed because he has acted according to the SOP.
2. Medical accident or misadventure: This is entirely unpredictable. For example, during cardiac catheterization, the guidewire used to guide the catheter broke inside, so it took more time to remove it.
3. Non-negligent error of judgment: clinical judgment error. In this situation, the adage errare humantum est applies, meaning mistakes are human. In medicine, another doctrine applies: "A doctor is not considered negligent if he has chosen one of the common treatment methods in the medical world."
4. *Volenti non fit inura*: this doctrine states that if someone has known that there is a risk and is willing to bear the risk voluntarily, and the risk occurs, then he can no longer sue. In the medical

39 Khairunnisa, Zahir, and Hatta, “The Role of Communication in Health Services in Indonesia.”
40 *Ibid*
41 Henny Saida Flora, “Fungsi Informed Consent Bagi Dokter Dan Pasien Dalam Tindakan Medis,” Fiat Iustitia: Jurnal Hukum, 2024, 101–12.

world, several operations carry very high risks, for example, kidney transplants from living donors. Therefore, this risk is inherent in the donor and recipient. If the risk occurs, then the doctor cannot be sued.

5. Contributory negligence: namely, the unreasonable attitude of the patient that results in loss or injury to himself. For example, if a patient has been explained to undergo surgery but the patient refuses and asks to go home by force, if an injury occurs or the disease worsens, the doctor cannot be sued.

In implementing the informed consent doctrine, there is a misconception that signing the consent form will eliminate the legal right to sue or sue a doctor who makes a mistake or negligence in medical procedures. Therefore, the patient has the right to sue the doctor even though he has signed the informed consent.[42]

In emergency situations at hospitals, the application of the principle of voluntariness or informed consent often faces significant challenges. Although hospitals strive to uphold this principle by providing explanations that are easy for patients or their families to understand, the urgency of emergency conditions often makes it difficult to obtain written consent. In cases where the patient is unconscious and there is no accompanying family member, doctors may proceed with medical treatment without prior written consent, taking full responsibility for the action. This illustrates that the principle of voluntariness is still applied, but with flexibility tailored to the emergency context.[43]

Another important issue is the extent to which patients truly understand the contents of the consent form they sign. Research indicates that while patients generally understand the concept of a therapeutic relationship with medical professionals, the information provided must be communicated clearly and in an accessible manner to ensure the consent given is truly informed.[44] Not all forms

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42 Cut Sidrah Nadira and Cut Khairunnisa, "Kedudukan Informed Consent Dalam Pelayanan Kesehatan Di Indonesia," Cendekia: Jurnal Hukum, Sosial Dan Humaniora 1, no. 1 (2023): 28–38.

43 Anwar Musyadad, "Praktek Perlakuan Dokter Terhadap Pasien Dalam Informed Consent (Studi Terhadap Pasien Umum Dan Anggota TNI Beserta Keluarganya Di Rumah Sakit Pusat Angkatan Udara Dr. S. Hardjolukito)" (Universitas Islam Indonesia, 2015).

44 Muh Amin Dali and Warsito Kasim, "Aspek Hukum Informed Consent Dan Perjanjian Terapeutik," *Akademika* 8, no. 2 (2019), https://doi.org/10.31314/akademika.v8i2.403.

of consent must be written; some may be implied or explicitly stated verbally. Therefore, medical personnel play a crucial role in ensuring that patients or their families fully comprehend the medical procedures being proposed.

The argument around whether weak consent is a major cause of legal disputes also deserves further attention. Incomplete or invalid consent can indeed be a major contributing factor in legal conflicts, particularly from a legal standpoint. Disputes often arise when medical procedures are carried out without sufficient information or without valid consent from the patient or their family, especially in non-emergency situations. Inconsistencies in consent procedures or unclear communication can lead to malpractice claims and allegations of patient rights violations. Consequently, weaknesses in the implementation of informed consent especially in terms of completeness and legal validity are key factors in the emergence of legal disputes in healthcare services.

To improve the quality of informed consent,[45] hospitals need to implement several strategic measures focusing on effective communication, responsive services, and the use of technology. First, medical professionals must establish clear and understandable communication with patients, using simple language and providing complete explanations about the patient's condition, procedures, risks, benefits, and available alternatives. They must also patiently address any questions to ensure patients fully understand the information provided. Furthermore, fast and efficient service is essential to prevent patients from feeling rushed or confused when making decisions. Proper queue management and increasing the number of medical staff can help create a more supportive environment. In addition, adopting digital systems such as information apps and electronic consent documentation can help patients access information easily and give informed consent consciously, while also supporting hospitals in evaluating the quality of care. Medical professionals must also continually enhance their

45 See Yeni Triana et al., "Informed Consent Berdasarkan Hukum Perjanjian," *Jurnal Pendidikan Dan Konseling (JPDK)* 5, no. 1 (2023); Pebrina, Najwan, and Alissa, "Fungsi Penerapan Informed Consent Sebagai Persetujuan Pada Perjanjian Terapeutik"; Kastania Lintang, "Tinjauan Yuridis Terhadap Pelaksanaan Informed Consent Dalam Perjanjian Terapeutik," *Jurnal Hukum Lex Generalis* 2, no. 4 (2021), https://doi.org/10.56370/jhlg.v2i4.73.

communication skills and understanding of informed consent ethics to ensure they can deliver information comprehensively and respect patients' rights, including the right to seek a second opinion. Finally, post-treatment follow-up through surveys or direct communication can help ensure that patients understand the process they have undergone and provide valuable feedback for service improvement.

The principle of voluntariness remains applicable in emergency situations, albeit with necessary adjustments. However, improving patient understanding of consent forms through effective communication is essential. Furthermore, weaknesses in the informed consent process particularly in non-emergency cases remain a primary trigger for legal disputes in medical practice.[46]

Miscommunication as a cause of disputes between doctors and patients

Lawsuits are a medical risk that often threatens doctors who work in hospitals. However, this does not arise because the service process does not follow standards and procedures but because the patient's condition is indeed beyond saving. However, patients or their families often assume that the medical actions taken do not meet standards and procedures, which indicates a breach of contract or even malpractice because the patient's condition worsens after medical intervention, causing disability or death.[47]

The risk of legal lawsuits increases significantly if a patient or their family claims they did not receive adequate information or did not consent to a medical procedure. This risk is further exacerbated if the consent documentation is incomplete, as it can make it difficult for doctors to defend themselves in medical disputes. In such cases, patients can file a medical malpractice claim alleging lack of informed consent, which can lead to both civil and criminal charges, including gross negligence and battery.To establish a claim for lack of consent, patients must prove that they would not have

46 Read more Edward Etchells et al., "Bioethics for Clinicians: 4. Voluntariness," *CMAJ. Canadian Medical Association Journal*, 1996.

47 Putu Agus Prawira Eka Putra, I Gusti Ayu Putri Kartika, and R A Tuty Kuswardhani, "The Role of Informed Consent in Medical Disputes at State University Hospitals," Unram Law Review 8, no. 2 (2024).

undergone the procedure if they had been fully informed about the risks and benefits. This often requires demonstrating that a reasonable patient would have declined the treatment if properly informed. Incomplete documentation can hinder a doctor's ability to demonstrate that they obtained proper consent, making it harder to defend against such claims. In legal proceedings, courts typically use two standards to determine whether consent was adequately obtained: whether a competent doctor would have disclosed the risks, and whether a reasonable patient would have chosen not to undergo the procedure if informed. The absence of thorough documentation can complicate these assessments, potentially leading to adverse outcomes for healthcare providers. Therefore, it is crucial for doctors to ensure that all medical procedures are well-documented and that patients have given informed consent before any medical action is taken.[48]

The higher the level of public awareness of the importance of health along with the development of science and technology, especially in the medical field, the higher the public's demand for better medical services. Patients are increasingly aware and more critical in responding to their relationship with their doctors by demanding information about what the doctor will do.

Patient dissatisfaction with medical care services is easy to understand if we look at the relationship between the two parties, namely the doctor who provides the service and the patient as the recipient of the doctor's services. As recipients of medical care, patients have expectations, and the size of these expectations depends on their personal experience and information about the doctor's care that they have heard, seen, or read. These expectations remain in the patient's mind when dealing with a doctor. The patient's expectations will be even greater if the patient has read or seen on television or in films about how a good doctor works with complete dedication. Meanwhile, for those who have never seen or read about good medical care, of course, their expectations are also smaller or lower. On the other hand, doctors, as care providers, also have very varied abilities or behaviors. Some doctors behave extremely materialistic, some are idealistic, some

48 Ibid

have abilities above professional standards, some have abilities according to professional standards, and there may also be doctors whose abilities are substandard.

Communication problems that arise in the therapeutic relationship between doctors and patients are caused by the failure to create an exchange of messages. There is still no good communication between doctors and patients in the health service process. Another problem that often occurs due to communication between doctors and patients is a lack of understanding due to medical terms that are often used that are less understandable to patients. This is worsened by communication that tends to be one-way from the doctor to the patient because the patient tends to be passive.[49]

Barriers to the clarity of information in Informed Consent include matters concerning socio-culture, time of information provision, finances, and intelligence of the patient and family, making it difficult for the patient to accept and understand what has been explained. The results of the study also indicate that there is a meaningful relationship between aspects of patient characteristics such as age, education, employment, marital status, and explanations or information from the doctor.[50] Therefore, communication from the doctor is needed so that the patient can understand and comprehend the information before the patient consents to medical procedures.

The same study also showed that only 24-26% of patients felt that they were given an understanding of alternative actions and the risks and benefits of these actions. Providing information regarding alternative actions remains essential in the informed consent process. Providing information about alternative actions allows patients to weigh the pros and cons of an action, not just feel forced because the action is the only way to be taken. Millum J and Bromwich D, in their article, state that the act of providing an incomplete explanation can be classified as fraudulent disclosure and can threaten the validity of informed consent.[51]

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49 Purba and Rahardjo, "Pengelolaan Hubungan Antara Dokter Dan Pasien Dalam Konteks Komunikasi Terapeutik."

50 Batara Yuda, "Tingkat Pemahaman Pasien Terhadap Informed Consent: Literature Review," Juristic, Semarang. Hal 231 (2021).

51 Joseph Millum and Danielle Bromwich, "Informed Consent: What Must Be Disclosed and

The Expectancy Violation Theory (EVT) is a communication theory that explains how individuals have expectations regarding the behavior of others in social interactions. Developed by Judee K. Burgoon in the late 1970s,[52] this theory focuses on how these expectations influence interactions, particularly in the context of nonverbal communication. People hold expectations about how others should behave in a given interaction, which can be predictive (what is anticipated to happen) and prescriptive (what should happen). When someone's behavior does not align with these expectations, a violation occurs. Violations can be assessed as positive or negative depending on how the violator is perceived by others. If the violator is viewed positively or has a good relationship with others, the violation may be accepted or even considered favorable. Conversely, if the violation is deemed negative, the interaction may become tense or uncomfortable. Examples of expectancy violations can be seen in situations such as inappropriate conversational distance or unexpected verbal communication. In both cases, reactions to these violations can significantly impact the dynamics of social interactions. The Expectancy Violation Theory helps explain how individuals respond to unexpected behaviors and how these responses can influence interpersonal relationships. In the context of communication, this theory emphasizes the importance of understanding social expectations and how violations of these expectations can affect interaction outcomes. By recognizing that expectations can be learned and influenced by culture and prior experiences, individuals can manage their social interactions more effectively. Therefore, this theory provides valuable insights into building and maintaining better relationships through effective communication.

A large gap between patient expectations and the reality obtained after the action is taken is a predisposing factor. However,

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What Must Be Understood?," The American Journal of Bioethics 21, no. 5 (2021): 46–58.

52 Judee K. Burgoon, "Interpersonal Expectations, Expectancy Violations, and Emotional Communication," Journal of Language and Social Psychology 12 (1993), https://doi.org/10.1177/0261927X93121003; Judee K. Burgoon and Stephen B. Jones, "Toward a Theory of Personal Space Expectations and Their Violations," Human Communication Research 2, no. 2 (1976), https://doi.org/10.1111/j.1468-2958.1976.tb00706.x; Surti Sunanto, "Pelanggaran Ekspektasi Komunikasi Dalam Negosiasi Bisnis Internasional Di Indonesia," Communicology: Jurnal Ilmu Komunikasi 4, no. 1 (2016), https://doi.org/10.21009/communicology.041.01.

the real source of conflict can be caused by differences in perception (for example, about the nature and purpose of medical efforts), ambiguous communication (for example, specific terms have different meanings for other individuals), and a person's style (for example the doctor's arrogant attitude or the patient's temperamental nature). Conflicts between doctors and patients are often caused by communication errors, which are influenced by several factors, including cultural and language differences. Cultural differences between doctors and patients can lead to misunderstandings in communication. Different cultural norms and values can affect how information is conveyed and received. For example, some cultures may prefer more formal or informal communication, which can influence the dynamics of doctor-patient interactions. Language differences between doctors and patients are also a source of conflict. If there is no adequate interpreter, important information may not be communicated correctly, leading to misunderstandings and dissatisfaction. The language used in medical communication is often technical and requires clear explanations for patients to understand. Additionally, ineffective communication can be caused by various factors, including the use of medical jargon that patients do not understand, lack of time to explain information properly, and high work pressure on doctors.

Conflicts arising from communication errors can have a significant impact on the doctor-patient relationship.[53] Patients may feel insecure or dissatisfied with the care they receive, which can affect treatment outcomes and overall patient satisfaction. Furthermore, conflicts can also cause stress and burnout in doctors, which in turn can affect the quality of care provided. Therefore, it is essential to improve doctors' communication skills and ensure that information is conveyed clearly and effectively. Using interpreters or language resources can help address language differences, and understanding and respecting cultural differences is also crucial in building a better relationship between doctors and patients.[54]

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53 Ashok Mittal et al., "A Study of Patient-Physician Communication and Barriers in Communication," International Journal of Research Foundation of Hospital and Healthcare Administration 3, no. 2 (2015), https://doi.org/10.5005/jp-journals-10035-1040.

54 Mohanad Omar Darwish Alhelo, "Medical Consultation and Communication with A Family Doctor from The Patients' Perspective: A Review Article," Egyptian Journal of Hospital

Disputes between doctors and patients are often caused by miscommunication. Research involving 900 inpatient and outpatient respondents across various hospitals (government, educational, and private) indicates that miscommunication is a primary factor. This is also confirmed by interviews with 90 doctors as respondents in the same locations, which indicate a communication gap between doctors and patients.

Causes of Disputes Between Doctors and Patients
Respondents: Patients

No.	Cause of Doctor-Patient Dispute	Educational Hospital	Government Hospital	Private Hospital
		Respondents	Percentage	Respondents
1.	Doctor communication	105	35%	108
2.	Doctor's attitude	54	18%	73
3.	Doctor breaks promise	22	7.3%	19
4.	Doctor makes a mistake	119	39.6%	102
	Total	300	100%	300

Source: Interviews with 900 inpatient and outpatient respondents.
Location: Government Hospitals, Educational Hospitals, and Private Hospitals (sample).

Causes of Doctor-Patient Miscommunication
Respondents: Patients

No.	Cause	Educational Hospital	Government Hospital	Private Hospital
		Respondents	Percentage	Respondents
1.	Difference in doctor and patient perception	154	N/A	98
2.	Patient doesn't understand medical	15	N/A	11

	terms			
3.	Patient is shy to ask	10	N/A	10
4.	Doctor doesn't explain in detail	67	N/A	105
5.	Doctor promises a cure	54	N/A	76
	Total	300	100%	300

Source: Interviews with 900 inpatient and outpatient respondents.
Location: Government Hospitals, Educational Hospitals, and Private Hospitals (sample).

Causes of Doctor-Patient Miscommunication
Respondents: Doctors

No.	Cause	Educational Hospital	Government Hospital	Private Hospital
		Respondents	Percentage	Respondents
1.	Difference in doctor and patient perception	21	70%	19
2.	Patient doesn't understand medical terms	6	20%	7
3.	Patient is shy to ask	3	10%	4
	Total	30	100%	30

Source: Interviews with 90 doctors.
Location: Government Hospitals, Educational Hospitals, and Private Hospitals (sample).

The Role of Language and Culture in Doctor-Patient Communication

Cultural differences have an impact on the quality of communication between doctors and patients. From the doctor's perspective, research shows that doctors tend to dominate communication when dealing with patients with different cultures, whereas doctors only involve patients a little in decision-making.

Doctors find it difficult, have many problems, and often cause misunderstandings in communicating with patients from different cultures and languages. Gao, Burke observed videotaped consultations and reported white American physicians as having a biomedical focus and predominantly one-sided conversations with Chinese, Hispanic, and African American patients.[55]

On the other hand, patients also experience obstacles in interacting with doctors from different cultures. Patients find it difficult to express their complaints to doctors, so they often become passive. Another problem is also felt by doctors who treat female immigrant patients. These patients tend to be closed and can only communicate through their husbands, so communication is not smooth, and doctors find it challenging to ask sensitive things directly to female immigrant patients.[56]

This occurs not only in the interaction of doctors and patients with different ethnicities and countries of origin but also due to cultural differences and beliefs. Research in the city of Magelang shows that one of the factors that influence the interaction between doctors and patients is that the local community still adheres to the Javanese culture and still considers the disease suffered as not a medical matter.[57]

Doctors find it difficult to communicate with patients who speak different languages. These language differences are considered a barrier to the communication process and approach to patients and can be a source of misunderstanding. This is especially common in Indonesia due to the many regional languages spoken by various ethnic groups. This becomes a problem if the doctor is not from that area, where patients are often only able to use their regional language, so the doctor cannot understand them.[58]

Miscommunication as a cause of disputes occurs not only in doctor-patient communication but also in miscommunication between health workers. A study suggests that errors in

55 Mohammad Alkhamees and Ibrahim Alasqah, "Patient-Physician Communication in Intercultural Settings: An Integrative Review," Heliyon 9, no. 12 (2023).
56 *Ibid*
57 Grace Sinthike Kewas and Rini Darmastuti, "Strategi Komunikasi Antarbudaya Dokter Kepada Pasien Dalam Proses Pelayanan Kesehatan Di RSU Raffa Majenang," Scriptura 10, no. 2 (2020): 60–76.
58 Alkhamees and Alasqah, *op.cit.*

communication cause 49% of malpractice claims. As many as 53% of claims resulting from communication errors occur in communication between doctors and patients, while the other 47% are actually due to communication errors between health workers. The study also explains that information that is often miscommunicated is related to backup plans, diagnoses, and patient severity.[59] Communication between health teams, both medical and non-medical, can reduce patient safety issues. Good communication between various professions is essential to providing comprehensive, effective, and efficient health services. According to the 2017 Minister of Health Regulation on patient safety, effective communication also aims to ensure patient safety.

Language barriers are not only caused by differences in the regions of origin of doctors and patients. Another obstacle in doctor-patient communication is the language of the medical terms themselves. Terms in the medical world generally use Latin, which has been explained in Indonesian. However, these terms need to be translated into local languages, and in the process, it can often cause differences in perception.

Language barriers in communication between doctors and patients can be overcome with a translator. However, providing professional translators is undoubtedly complex and requires additional costs that are not small. In addition, research states that the patient's examination time also becomes longer with the presence of a translator, thus reducing the efficiency of the examination time.[60] Research shows that online translator applications can be an alternative to help doctors interact with patients. Online translator applications are revolutionizing the way doctors interact with patients, especially in situations where language barriers exist. These tools provide instant translations, allowing healthcare providers to communicate effectively with patients from diverse linguistic backgrounds. For instance, a doctor can use an app to translate medical instructions into the patient's native language, ensuring that they fully understand their treatment

59 Kate E Humphrey et al., "Frequency and Nature of Communication and Handoff Failures in Medical Malpractice Claims," Journal of Patient Safety 18, no. 2 (2022): 130–37.

60 Hilal Al Shamsi et al., "Implications of Language Barriers for Healthcare: A Systematic Review," Oman Medical Journal 35, no. 2 (2020): e122.

plan. This not only improves patient satisfaction but also enhances the quality of care by reducing misunderstandings.

In practice, these applications have proven to be invaluable in real-world scenarios. For example, a doctor at a busy hospital once faced a challenging situation when a patient who spoke only Spanish was admitted. Fortunately, the hospital had recently introduced an online translator application that could translate speech in real-time. The doctor used the app to communicate with the patient, explaining the condition and the necessary steps for recovery. The patient felt relieved and understood the treatment plan clearly, thanks to the effective use of technology. This experience highlighted the potential of online translators to bridge language gaps in healthcare settings.

The integration of online translator applications in healthcare is not just beneficial; it is imperative. These tools can significantly enhance patient outcomes by ensuring that language barriers do not hinder the delivery of quality care. By adopting such technology, hospitals and clinics can improve patient satisfaction, reduce errors due to miscommunication, and ultimately provide more equitable healthcare services. Moreover, these applications can help reduce costs associated with hiring interpreters and improve the efficiency of medical consultations. Therefore, it is crucial for healthcare institutions to invest in and utilize online translator applications to bridge the communication gap between doctors and patients from diverse linguistic backgrounds.

In the context of regional language barriers, most health facilities generally rely on families from the area of origin as intermediaries between doctors and patients who can speak Indonesian. Thus, these family members can be intermediaries to explain information from doctors to patients regarding the disease and the actions to be taken. They can also provide explanations to doctors regarding complaints related to the patient's disease.[61]

Expectations of human behavior can be learned. This assumption refers to the first assumption that leads both people involved in communication to learn their expectations through a broad cultural context, which the individual will display.

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61 Husni Mubarak, "Analisis Variasi Bahasa Pada Pelayanan Rumah Sakit Umum Daerah Kotabaru," CENDEKIA: Jurnal Ilmiah Pendidikan 8, no. 1 (2020): 32–43.

In the context of therapeutic transactions, particularly in doctor-patient relationships, nonverbal behaviour plays a very important role in shaping interactions and outcomes. Individuals often make predictions about others based on their nonverbal cues, such as body language, facial expressions and tone of voice. This assumption shows how one's nonverbal behaviour can influence others in forming interpretations and predictions about their intentions or emotions.

Nonverbal communication is crucial in the doctor-patient relationship as it can help build rapport, create trust, and increase patient satisfaction. Nonverbal cues exhibited by doctors, such as maintaining eye contact, using positive facial expressions, and adopting an open posture, can convey empathy and support, which are crucial for effective treatment. Conversely, negative nonverbal cues, such as showing disinterest or annoyance, can undermine trust and reduce patient satisfaction.

In the therapeutic setting, understanding and managing nonverbal behaviour is critical. Clinicians must be aware of their own nonverbal signals in order to be perceived as caring and attentive. Meanwhile, patients use these cues to assess the doctor's interest and empathy, which in turn can affect their adherence to the treatment plan as well as overall health outcomes. This dynamic interplay in nonverbal communication underscores how important nonverbal communication is in building a positive and effective therapeutic relationship.

Patients have expectations of doctors' verbal and nonverbal behavior to fulfill their patients' rights. The assumption of this theory explains that there are two types of expectations, namely pre-interactional and interactional expectations. Then, it becomes the main factor in the relationship between doctors and patients in therapeutic transactions, where patients assume that doctors know everything related to their health. Therefore, doctors must be able to act according to the expectations imposed by patients in order to care for patients.

Language and culture are critical factors that often lead to miscommunication in the medical field, especially in diverse countries like Indonesia, where numerous regional languages are

spoken.[62] For example, doctors who use Bahasa Indonesia, the national language, may face challenges communicating with patients who are more fluent in regional languages such as Javanese or Sundanese. These language differences can hinder the accurate exchange of medical information, affecting diagnosis and treatment. Additionally, cultural differences significantly influence communication styles and perceptions between healthcare providers and patients. Each culture has unique norms, symbols, and ways of expressing messages—both verbal and nonverbal—which, if misunderstood, can result in ineffective interactions and misinterpretations.[63]

Cultural beliefs also play a role in shaping patients' understanding of illness and treatment.[64] For instance, some cultures prioritize sharing information about serious illnesses with the patient's family rather than the patient directly, which can conflict with practices emphasizing patient autonomy. Similarly, preferences for traditional remedies or religious restrictions may lead to non-compliance with prescribed treatments or mistrust toward medical recommendations. Miscommunication can also stem from implicit biases or stereotypes held by healthcare providers, potentially resulting in misdiagnosis or inappropriate care.

Language barriers further exacerbate these issues when patients lack proficiency in the dominant language used by healthcare professionals. This can make it difficult for patients to express their symptoms or understand medical advice. Professional interpreters are crucial in bridging these gaps to ensure clear communication and reduce misunderstandings. Moreover, noisy environments, hurried attitudes of doctors, and the use of complex medical jargon can aggravate communication problems.

To address these challenges, healthcare providers must cultivate cultural competency by respecting diverse norms, values,

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62 Nabi Fatahi, "Language and Culture Are Two Potential Misunderstanding Sources in Cross-Cultural Clinical Encounters," *Biomedical Journal of Scientific & Technical Research* 23, no. 2 (2019), https://doi.org/10.26717/bjstr.2019.23.003862.

63 O. B. Rojak and Y. Handayani, "The Correlations between Language Barriers and Occupational Safety and Health Communication: A Descriptive Study in Indonesia," *International Journal of Occupational Safety and Health* 13, no. 3 (2023), https://doi.org/10.3126/ijosh.v13i3.49980.

64 V. M. Aziz, "Cultural Aspects of the Patient-Doctor Relationship," *International Psychogeriatrics*, 2009, https://doi.org/10.1017/S1041610208008119.

and traditions. This involves engaging in open dialogue with patients about their cultural needs and tailoring treatment plans accordingly. Using simple language and providing interpreters can also enhance communication effectiveness. By overcoming language and cultural barriers, healthcare services can improve significantly, ensuring better patient outcomes and safety.

Conclusion

Miscommunication between doctors and patients could indisputably lead to disputes. This is generally caused by the discrepancy between high expectations and the reality received by patients, cultural differences, as well as language differences. Every patient hopes to be free from the illness that he or she suffers, but in reality, it is indefinite whether the illness can be cured entirely. There are a number of causes of why this occurs, namely the initial condition when the patient comes for treatment and if the patient is allergic to certain medications. This discrepancy is also exacerbated by the doctor's explanation, which is indigestible to the patient and leads to miscommunication. Cultural and language differences between doctors and patients could also influence this wholly misunderstood information.

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