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Benjamin Otsen , Xin Zheng , Ren Chen * , Shuo Ding

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Exploring the Ethical Challenges of *"Go to Court if Not Satisfied"* Language in Healthcare Communication

Benjamin Otsen [1,2], Xin Zheng [2], Shuo Ding [2] and Ren Chen [2,*]

[1] Directorate of University Health Services, University of Cape Coast, Cape Coast, Ghana
[2] School of Health Services Management, Anhui Medical University, Hefei 230032, China
* Correspondence: chenren2006@hotmail.com

Abstract

Healthcare communication during crisis moments imposes profound responsibilities on providers, extending beyond clinical disclosure to encompass the psychosocial and ethical dimensions of patient interaction. The statement, *"Go to Court if Not Satisfied,"* commonly deployed in institutional responses to adverse medical outcomes, raises serious ethical concerns that transcend mere legal defensibility. This paper argues that such language violates core bioethical principles of beneficence, nonmaleficence, and patient autonomy, while simultaneously reflecting a broader culture of defensive medicine that undermines therapeutic relationships. Drawing on the case of missing twins at the 37 Military Hospital in Ghana, we critically interrogate the ethical dimensions of adversarial language in bad-news delivery, foregrounding its psychological harm to already-vulnerable patients and relatives. Beyond existing critique, this paper offers a novel analytical framework: positioning the *"Go to Court"* discourse as an institutional manifestation of power asymmetry and defensive communication culture, antithetical to the values of patient-centred care. We propose that open disclosure frameworks, therapeutic alliance theory, and the *patient-is-always-right* principle together offer a more ethically robust alternative. The paper calls on healthcare institutions to move from legally motivated damage-limitation communication toward accountability-driven, empathic engagement.

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Introduction

The communication of bad news in healthcare settings is one of the most ethically demanding obligations placed on care providers. Bad news encompasses any information that fundamentally and adversely alters a patient's or family's understanding of their present or future health and life prospects (Alelwani & Ahmed, 2014; Warnock et al., 2017). The potency of such news to inflict psychological harm, compounding the clinical adversity already endured, makes the manner of its delivery a matter of both ethical urgency and practical consequence (Lino et al., 2011).

Contemporary scholarship has produced several structured communication frameworks to support empathic bad-news delivery. The SPIKES protocol (*Setting, Perception, Invitation, Knowledge, Empathy, Strategy*) equips providers with a stepwise approach to address patients' emotional and informational needs (Buckman, 2005). Similarly, the BREAKS protocol (*Background, Rapport, Explore, Announce, Kindling, Summarise*) reinforces the relational and supportive dimensions of disclosure (Narayanan et al., 2010). At the theoretical level, Smith and Pettegrew's (1986) mutual persuasion model envisions healthcare communication as a collaborative, bidirectional negotiation where neither party is passive or marginalised (Smith & Pettegrew, 1986). These frameworks collectively

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underscore that effective bad-news delivery is not merely informational but fundamentally therapeutic.

Despite widespread recognition of these frameworks, institutional responses to adverse events frequently deviate from them. A particularly troubling linguistic pattern, observed in various healthcare contexts, is the directive to *"Go to Court if Not Satisfied."* This paper interrogates this language through the lens of bioethics, communication ethics, and mental health theory. Using a documented case from Ghana as its central reference point, we argue that this language is not merely insensitive but constitutes an ethically untenable exercise of institutional power that actively harms patients' mental health and erodes the foundational trust undergirding the therapeutic relationship.

Case Reference: The Missing Twins Saga

In January 2023, multiple Ghanaian media outlets reported that a patient at the 37 Military Hospital in Accra had received two consecutive ultrasound reports—at 20 and 31 weeks of gestation—both confirming a twin pregnancy. The delivery outcome, however, was a singleton. The hospital's subsequent investigation attributed the discrepancy to erroneous ultrasound reports from both the private diagnostic facility and the hospital's own imaging department (Ghanaian Times, 2023; Peacefmonline.com, 2023).

At the meeting convened between hospital officials and the affected family, the Chief of Staff apologised and acknowledged medical error, but added: *"I have gone through the report thoroughly, and I'm convinced nothing untoward happened. However, if you are unsatisfied, you may go to court… but we're a human institution; such errors are bound to occur and would be guided by this going into the future."* This statement—simultaneously conceding error, minimising culpability, and deflecting resolution to the adversarial legal domain—serves as the analytical centrepiece of this paper.

Perspective

1. Defensive Medicine Culture and the Roots of Adversarial Language

To understand why the *"Go to Court"* language persists, it must be situated within the broader culture of defensive medicine. Defensive medicine refers to clinical and communicative practices motivated primarily by fear of litigation, rather than by patient welfare (Studdert et al., 2005). Summerton (1995) documented that a significant proportion of physicians alter their clinical and communicative behaviour in response to the threat of malpractice claims, often to the detriment of the patient relationship. In institutional settings, this defensive posture manifests in crisis communication that is legally scripted, designed to limit liability rather than to provide psychological support.

This is precisely the communicative logic that underlies the *"Go to Court"* directive. Far from being a neutral legal suggestion, it reflects a calculated institutional strategy to discharge accountability through litigation channels rather than through direct, empathic engagement. Kachalia and Mello (2011) observe that institutions caught in adversarial communication cycles often exacerbate patient harm and paradoxically increase litigation risk—findings that invert the very purpose of defensive communication. The irony is that the attempt to avoid legal liability through adversarial language often precipitates it.

2. Ethical Analysis: Violations of Core Bioethical Principles

The bioethical framework articulated by Beauchamp and Childress (2019) establishes four foundational principles: autonomy, beneficence, nonmaleficence, and justice. The *"Go to Court"* language offends each of these.

Autonomy. Respect for patient autonomy requires that patients be empowered to make informed decisions free from coercion, intimidation, or power-laden pressure (Entwistle et al., 2010). Directing a grieving family to court instrumentalises a formal, expensive, and psychologically draining adversarial process as the principal avenue for redress. Far from supporting autonomous decision-making, this framing leverages the inherent power asymmetry between institutional authority and individual patients. Faden and Beauchamp (1986) argue that genuine autonomy requires not merely the absence of coercion but the presence of conditions that enable meaningful choice. Referring a vulnerable family to litigation as a default response does not meet this threshold.

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Beneficence and Nonmaleficence. The principle of beneficence requires that providers act in the best interests of patients, while nonmaleficence demands the avoidance of harm (Varkey, 2021). The *"Go to Court"* language fails on both counts. Grief and trauma research confirms that adversarial contexts amplify psychological harm. Martin (2019) identifies that bereaved individuals require acknowledgement, validation, and support to progress through grief; adversarial redirection obstructs these processes. Furthermore, Lazare (2005) argues that genuine apology in medicine—one that includes acknowledgement of wrong, expressed remorse, and commitment to remedy—has measurable therapeutic effects on patients. The hybrid statement delivered in the Ghana case, which simultaneously apologised and redirected to court, negated any therapeutic benefit the apology might otherwise have conferred.

Justice. Healthcare justice demands equitable treatment and accountability. For patients in low- and middle-income countries (LMICs) such as Ghana, directing grievance resolution to the courts imposes a prohibitively high practical and financial barrier. Horwitz et al. (2019) note that socioeconomic factors significantly determine patients' capacity to pursue legal redress, meaning the *"Go to Court"* directive disproportionately disadvantages already-marginalised populations. This represents a justice violation embedded within the communicative act itself.

3. Power Asymmetry and the Silencing of Vulnerable Patients

A distinctive and under-examined dimension of the *"Go to Court"* language is its function as a silencing mechanism operating within a deeply asymmetrical power relationship. Patients approaching healthcare institutions following adverse outcomes are in a state of profound psychological vulnerability. They are grieving, disoriented, and dependent on institutional actors for both information and emotional support. Within this context, the invocation of legal action as the prescribed pathway for dissatisfaction constitutes what Lukes (2012) might characterise as a third-dimensional exercise of power: one that shapes the very parameters of what the patient perceives as possible or permissible.

This dynamic is compounded by what Charles et al. (1997) describe as the paternalistic model of medical communication, in which the provider exercises unilateral authority over clinical information and decision-making, reducing the patient to a passive recipient. While contemporary healthcare ethics has largely repudiated paternalism in favour of shared decision-making (Elwyn et al., 2012), the *"Go to Court"* language signals a regressive return to provider-dominated communication, weaponised in the specific context of institutional crisis management.

4. Psychological Harm and Mental Health Consequences

The mental health sequelae of adversarial healthcare communication deserve particular attention. Patients and families who have experienced adverse medical outcomes already carry a substantial psychological burden, including shock, grief, and, frequently, post-traumatic stress symptoms (Tenzek & Depner, 2017). Kroenke et al. (2010) have demonstrated that the quality and empathy of provider communication significantly modulates these psychological outcomes; conversely, cold or adversarial communication is independently associated with heightened patient anxiety, depression, and reduced treatment engagement.

Applying a trauma-informed care lens, US Department of Health Human Services (2014) emphasises that trauma-informed communication must prioritise safety, trustworthiness, and empowerment. The *"Go to Court"* directive violates all three of these pillars: it signals institutional hostility rather than safety, destroys trust through adversarial redirection, and disempowers patients by channelling grievance into a system that is structurally weighted against them. Furthermore, Shapiro and Hayburn (2024) found that patients who reported experiencing dismissive or adversarial communication following medical errors exhibited significantly higher rates of post-traumatic stress disorder (PTSD) symptoms and prolonged psychological recovery. The mental health cost of adversarial language is therefore not merely rhetorical but clinically measurable.

5. Medical Error, Institutional Accountability, and Open Disclosure

The *"Go to Court"* response must also be assessed against emerging international standards for open disclosure of medical error. Extensive evidence documents the frequency of medical errors: the

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Institute of Medicine Committee on Quality of Health Care in America (2000) conservatively estimated that 98,000 hospital deaths annually in the United States are attributable to medical errors, while a 2016 analysis substantially increased this figure (Makary & Daniel, 2016). The Joint Commission's Sentinel Event Database attributed approximately 66% of such errors to communication failures (Joint Commission, 2016). These data contextualise the inevitability of adverse outcomes and reinforce the imperative for humane, accountable institutional responses.

Open disclosure frameworks, now adopted in several jurisdictions, represent the ethical counterpoint to defensive communication. The Australian Commission on Safety and Quality in Health Care (ACSQHC) (2013) defines open disclosure as an honest, empathic conversation with patients and families about an adverse event, including an explanation of what happened, an apology, and a commitment to remediation. Research demonstrates that open disclosure reduces patient distress, increases satisfaction, and—paradoxically—decreases litigation risk (Gallagher et al., 2003; Iedema et al., 2012). This evidence fundamentally undermines the legal rationale that purportedly motivates adversarial communication: institutions that communicate openly and empathically are, in fact, better protected than those that resort to defensive language.

6. Towards an Ethically Grounded Alternative: Therapeutic Communication and Accountability

The *"Go to Court"* language must be replaced, not merely rhetorically but structurally, through institutional commitment to therapeutic communication principles. The therapeutic alliance model, originally developed in psychotherapy (Bordin, 1979), has been productively extended to general healthcare contexts, where it characterises the quality of the collaborative bond between provider and patient as itself a healing mechanism. Applied to crisis communication, this model demands that providers prioritise rapport, empathy, and shared meaning-making even—and especially—in moments of institutional failure.

Crew Resource Management (CRM) training, adapted from aviation safety culture, further supports this orientation by developing providers' capacity for error acknowledgement, non-defensive communication, and collaborative problem-solving (Pizzi et al., 2001). CRM-trained teams demonstrate greater willingness to acknowledge fallibility and communicate transparently, qualities directly antithetical to the *"Go to Court"* posture.

Adopting the *patient-is-always-right* principle—adapted from service quality theory into healthcare communication ethics—would further institutionalise an orientation in which provider responsibility is assumed rather than contested. Berkey et al. (2018) outline specific communicative behaviours consistent with this orientation: building rapport, choosing appropriate settings for disclosure, employing empathic validation, and acknowledging patients' emotional realities without minimisation. These practices enact beneficence and nonmaleficence in the communicative domain and are entirely consistent with the mission of healthcare institutions. The mutual persuasion model (Smith & Pettegrew, 1986) and patient-centred communication research (Street et al., 2009) collectively reinforce that such approaches also yield better clinical outcomes, greater patient adherence, and reduced conflict.

Conclusion

This paper has argued that the *"Go to Court if Not Satisfied"* language represents far more than a clumsy communicative choice. It is a symptom of a defensive medicine culture that subordinates patient welfare to institutional self-protection and legal risk management. Ethically, it violates the principles of autonomy, beneficence, nonmaleficence, and justice. Psychologically, it actively harms patients already in states of acute vulnerability. Institutionally, it undermines the very accountability norms that could protect healthcare organisations from the adverse legal and reputational consequences they seek to avoid.

The novelty of this paper's contribution lies in its reframing of the issue: rather than treating the *"Go to Court"* directive as an isolated lapse in communication etiquette, we have situated it as a manifestation of structural power asymmetry, defensive institutional culture, and communicative

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violence against vulnerable patients. This reframing has practical implications. It demands not simply that individual providers speak more kindly, but that healthcare institutions reform their crisis communication culture—adopting open disclosure frameworks, trauma-informed communication standards, therapeutic alliance principles, and CRM-informed training as systematic replacements for defensive language.

Future research should examine the prevalence of adversarial language patterns in healthcare crisis communication across diverse national and institutional contexts, the psychological outcomes for patients exposed to such language, and the institutional factors that enable or constrain its use. Such research would provide the empirical foundation for evidence-based communication policy reform, ensuring that the therapeutic mission of healthcare is protected at its most ethically critical moments.

Declarations

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