Do Poor People Sue Doctors More Frequently? Confronting Unconscious Bias and the Role of Cultural Competency

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Published online: 25 February 2012
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Abstract

Background There is a perception that socioeconomically disadvantaged patients tend to sue their doctors more frequently. As a result, some physicians may be reluctant to treat poor patients or treat such patients differently from other patient groups in terms of medical care provided.

Questions/purposes We (1) examined existing literature to refute the notion that poor patients are inclined to sue doctors more than other patients, (2) explored unconscious bias as an explanation as to why the perception of the poor being more litigious may exist despite evidence to the

contrary, and (3) assessed the role of culturally competent awareness and knowledge in confronting physician bias.

Methods We reviewed medical and social literature to identify studies that have examined differences in litigation rates and related medical malpractice claims among socioeconomically disadvantaged patients versus other groups of patients.

Results Contrary to popular perception, existing studies show poor patients, in fact, tend to sue physicians less often. This may be related to a relative lack of access to legal resources and the nature of the contingency fee system in medical malpractice claims.

Conclusions Misperceptions such as the one examined in this article that assume a relationship between patient poverty and medical malpractice litigation may arise from unconscious physician bias and other social variables. Cultural competency can be helpful in mitigating such bias, improving medical care, and addressing the risk of medical malpractice claims.

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All ICMJE Conflict of Interest Forms for authors and *Clinical Orthopaedics and Related Research* editors and board members are on file with the publication and can be viewed on request.

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Introduction

Some physicians believe low-income patients, as a group, tend to sue their physicians more often than other patients. For example, a 1995 survey of general practitioners in California found the perception of an increased risk of being sued was cited by 57% of physicians as important in the decision not to care for Medicaid patients and by 49% of physicians in not caring for uninsured patients [13]. However, studies show the poor, in fact, sue their physicians less often than other patients [4, 18]. Although no studies have determined the current prevalence of the physician misconception that economically disadvantaged patient groups are prone to sue, the potential negative

effects of this mind-set on the doctor-patient relationship make it worthy of investigation.

We address the perception that poor patients are generally more litigious toward their doctors than other patients by reviewing the results of studies that have addressed this subject. We also examine the factors that discourage lawyers from filing medical malpractice lawsuits on behalf of low-income clients on a contingent fee basis, contrary to the perception of increased litigiousness among the poor. We then reflect on how unconscious bias may contribute to this misperception. Unconscious or implicit bias describes thinking and decision making affected by stereotypes without one being aware of it [23]. Such bias can explain why people may consciously believe in a truth, whereas their behavior, affected by subconscious prejudices, is contrary to that truth [23]. We posit unconscious bias could explain why some physicians believe poor patients are more likely to sue, although factual data argue otherwise. We conclude with recommendations that, if adopted, will hopefully improve medical care and decrease the risk of medical malpractice lawsuits by confronting unconscious bias and providing culturally competent care.

Search Strategies and Criteria

A literature survey was conducted using Google Scholar and SCIRUS (for scientific information) online and in Temple University Libraries using the keyword criteria “(medical OR medicine) and (poor OR poverty OR “low income” OR “low socioeconomic”) and (lawsuits OR “law suits” or “law cases”) among a variety of other search terms. References were also used from the authors’ personal collection of articles and books. A formal search strategy and exclusion criteria were not employed due to the vast scope of this topic and the review is consequently selective.

Dispelling the Myth: The Poor, in Fact, Are Less Likely to Sue

Several studies have negated the notion that low-income patients sue their doctor more often than other patient populations. One such investigation concluded the poor are much less likely to bring malpractice claims against their physicians [6]. In this study of 51 hospitals in New York State, investigators looked at the relationship between patient socioeconomic status and the likelihood of filing a medical malpractice lawsuit. Authors found, not only are patients in lower socioeconomic strata less likely to sue on

the whole, but they are also less likely to file nonmeritorious malpractice claims [4].

Another study examined data from the Maryland Health Claims Arbitration Office to compare legal claims filed by Medicaid versus those filed by non-Medicaid patients; no differences in the incidence of claims between these patient populations were found [18]. In this study, 36% of all claims were filed by patients who had enrolled in a Medicaid program only after the alleged medical injury, suggesting the lawsuit-related incident itself contributed to the claimant’s Medicaid eligibility [18]. This suggests patients who have suffered medical injury and lost income and wealth sufficient enough to become eligible for Medicaid may have a special motivation to sue. No other data were found addressing whether or not particular factors could explain differences in litigation behavior among subgroups in the same economic class.

In its 1992 investigation, the federal Office of Technology Assessment (OTA) asked whether or not Medicaid and Medicare enrollees sue more frequently than other patients. The OTA found, although Medicaid patients represented 10% of the population at the time, they filed less than 5% of medical malpractice lawsuits [22]. Second, monetary settlements related to medical malpractice lawsuits in favor of non-Medicaid patients were 5 to 10 times greater than those received by Medicaid patients [22]. Based on these findings, the OTA concluded there was no evidence to suggest Medicaid and Medicare patients sue more frequently than other patient groups [22].

The fear that the poor are more litigious may contribute to physician efforts to support legislatively prescribed measures targeted at immunizing physicians who care for low-income patients against medical liability lawsuits [20]. These good Samaritan laws are designed to encourage medical care services for the poor and the uninsured without the fear of a lawsuit [20]. Such attempts at creating legislative immunity are unsupported by data that provide no justification for creating patient barriers to judicial recourse for medical malpractice in return for necessary medical care. Contrary to popular belief, for example, obstetric patients on Medicaid have a disproportionately lower incidence of medical malpractice claims when compared with other patient populations [8, 12]. In Colorado, a state where many patients have difficulty finding obstetric care, it has been shown Medicaid patients file only 5.5% of all obstetric medical malpractice obstetric claims [8].

Financial Barriers to Litigation

A poor patient wanting to file a medical malpractice lawsuit must find a lawyer willing to represent the patient on a

contingent fee basis and to advance the funds needed to litigate the case. Pro bono legal services are not an option because of restrictions set forth by the Legal Services Corp (LSC) Act limiting free legal services in fee-generating cases [15]. A substantial upfront financial investment is required to preliminarily evaluate the potential merits of a claim, and costs increase substantially if extensive medical treatment is involved. These litigation costs are related to obtaining and reviewing medical records and hiring medical expert witnesses. The typical cost of a relatively simple medical malpractice suit that goes to trial is approximately \$20,000, and complex cases can cost a law firm in excess of \$100,000.

Contingency fee schedules rely on a settlement or an award made on behalf of the client for the lawyer to be compensated for litigation costs [7]. The most common percentage for the lawyer's fee ranges between 33% and 40% of the monetary recovery from the lawsuit; ethical rules and fiduciary guidelines stipulate the fee amounts must be within a reasonable range [3, 7]. If the client loses the case, the lawyer must bear the entire cost of litigation. A loss of one medical malpractice case may prove financially disastrous to a small business, and such costs can be substantial even for established law firms with many cases. The contingency fee financial arrangement operates to dissuade a lawyer from taking on medical malpractice cases that do not have the strong support of a credible medical expert.

Several studies have shown the size of the jury-awarded monetary damages is related to jury perception of whether or not the recipient is deserving of the award [5, 6, 17]. Accordingly, attorneys calculate how jurors will perceive collateral factors that attach to a plaintiff, such as socioeconomic status, lack of employment, limited education, or a criminal record. In the eyes of lawyers, these human factors, such as being poor, can work against the plaintiff in a medical malpractice case, thereby decreasing the odds of a monetary recovery sufficient to recoup the costs of litigation.

Discussion

The medical literature presents many examples of healthcare disparities resulting from physician bias, and it is probable the misconception that the poor are more likely to sue may be related to such bias despite the existence of studies and erected financial barriers to courtroom access that show this belief to be untrue. The Institute of Medicine has identified several patient groups who experienced disparate care due to conscious and unconscious bias on the part of caregivers; among those groups are those of lower socioeconomic status [21]. Acknowledging and addressing

the role of unconscious bias are important to developing solutions to overcoming the misperception, improving care, and reducing lawsuits.

In his book, Groopman [10] has examined the process of physician thinking and decision making and has identified many examples of cognitive errors, which include unconscious bias. Green [9] conducted a study with physicians who regarded themselves to be unbiased toward blacks, only to have bias emerge on an objective Implicit Association Test. In the followup questions, some of the physicians who demonstrated unconscious bias toward black patients also demonstrated disparate care toward the black patients that they were asked to evaluate and treat. This is an experimental demonstration of unconscious bias resulting in healthcare disparities.

Other patient groups also experience similar disparate treatment such as the Appalachian poor [21]. The biases in this context are probably the result of a mix of socioeconomic status and cultural differences. One can envision how these two factors might lead the physician to consciously or unconsciously construct stereotypes of a litigation-prone patient.

Patients with poor literacy levels also provide another illustration of how unconscious bias may be triggered. The Institute of Medicine observed in its 2004 report: "literacy levels are lower among the elderly, those who have lower educational levels, those who are poor, minority populations and groups with limited English proficiency such as recent immigrants" [11]. Illiteracy and poverty are often related, and such patients, much like obese patients, pose a special challenge to physicians in terms of communication and empathy, including those who try hard to provide good medical care to all patients.

The recently published work of Vedantam [23] addresses how the unconscious mind can trick a person to behave in an undesirable way. For example, physicians may have an unconscious desire to avoid treating poor patients out of concerns related to insufficient financial reimbursement. Such physicians might consciously or unconsciously presume poor patients are more likely to sue as an excuse or way of avoiding the presumed difficulty associated with collections from such patients. In this paradigm, the doctor may be biased against poor people for reasons entirely unrelated to the excuse or rationalization that such patients tend to sue more often.

One of the most effective means to overcome unconscious bias is culturally competent care (CCC). This is the ability to treat or relate to a patient who may be different from the treating physician in race, ethnicity, sex, socioeconomic status, and sexual orientation. This strategy can be effective in lessening disparities of care among patient groups [14]. Although the percentage of the minority population is at an all time high of 33%, the percentage of

white male orthopaedic surgeons has ranged from 84% to 89% [19]. This disparity contributes to the need for CCC educational efforts. Many patients perceive they are not being treated appropriately or with respect because of inadvertent mistakes made by providers who are not familiar with their culture. Patients who encounter healthcare providers who do not treat them with cultural sensitivity can be easily turned off and then turn away from the healthcare system. Their tenuous trust of the system is negatively reinforced and they stay away. This results in disparities of care.

The American Academy of Orthopaedic Surgeons (AAOS) Diversity Advisory Board has taken on the following important charges: (1) to increase the diversity of its membership; (2) to educate AAOS members about CCC; and (3) to help lessen disparities of musculoskeletal care [2]. CCC education promoted by the AAOS Diversity Advisory Board efforts has concentrated on promoting awareness of the differences in race, ethnicity, cultural, religious, sex, and sexual orientation. Their programs have been effective, particularly the CCC Grand Rounds project, which concentrates on orthopaedic residency programs [2]. A modified approach to CCC education is to decrease the emphasis on the differences found in the various races and ethnicities. This view concentrates on viewing the patient through a human perspective regardless of racial, ethnic, religious, or cultural background. The hope is to appeal to the heart and compassion of the orthopaedic physician in dealing with whatever patient is encountered once the door to the examination room is opened.

Communication skills are an effective remedy against the risk of litigation. Under the leadership of orthopaedic surgeons John Tongue, MD, and Terry Canale, MD, the AAOS has established the Communication Skills Mentoring Program in conjunction with the Institute of Healthcare Communications. This program has already educated 5,000 orthopaedic surgeons [1]. It teaches that a surgeon or physician who listens to his or her patient and who uses the four skills of engagement, empathy, education, and enlistment will have an enriched patient encounter and diminished liability risk [1]. Physicians and clinicians can learn to provide their patients with opportunities to be a partner in their own treatment and participate in shared decision making [1].

Empowering patients to become active participants in their own health care is contrary to the paternalistic view of physicians shared by many poor and minority patients, especially Hispanics/Latinos. Such patients seldom question physicians, who are instead viewed as a superior, authoritative, or respected fatherly figure [24]. These patients must be encouraged to be proactive and to ask questions about their care [24]. Primary care physicians should counsel patients about what they need to ask their prospective surgeons. Other Hispanic/Latino patients

believe in *curanderos* or a healthcare provider who cures a patient through prayer and the use of herbs [25]. This concept may transfer to their expectations from surgical treatment, resulting in disappointment when the operation fails to cure their problem completely. These beliefs can only be minimized or dispelled with effective communication methods. Patients treated with CCC and with good communication skills will gain the full benefits of medical and surgical care. Healthcare providers must empower their patients to ask questions to be fully informed and participate meaningfully in shared decision making.

In *The Lost Art of Healing: Practicing Compassion in Medicine*, Lown writes: "Malpractice is largely the consequence of depersonalized medical practice. The experience of my medical group, the Lown Cardiovascular Center in Brookline, Massachusetts, provides evidence that when practice is time-intensive rather than technology-intensive and focused on the primary of caring, there need be little worry about litigation. This small group of five doctors has practiced together for approximately 20 years without a single malpractice suit" [16].

Although improving cultural competency skills of doctors and the health literacy of patients will not eliminate medical litigation, the empirical studies and scientific literature explaining human behavior support these strategies in improving communication, addressing physician bias, improving the quality and effectiveness of medical care, and decreasing the likelihood of medical malpractice claims.

The literature on perceptions and reality of litigation behavior, unconscious bias, and CCC must be read together in holistically challenging the misperception that poor patients are more likely to file medical malpractice lawsuits. This belief lacks evidentiary support and serves no constructive purpose. In fact, the data show poor patients are no more likely to sue, and may in fact sue less frequently, than other patient groups. Unconscious biases affect everyone, and physicians so biased may end up perpetuating disparate medical care despite the best of intentions. Confronting unconscious biases, improving education and training for the delivery of CCC, and empowering patients to play more meaningful roles in their healthcare decisions are proven strategies that can positively impact health disparities, the quality of medical care, physician satisfaction, and the incidence of medical malpractice litigation.

Acknowledgment The authors thank Dr. Sonny Bal for his indispensable feedback in putting this article together.

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