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The Economics of Injustice: Stratification in Medical Malpractice Claims by Poor and Vulnerable Patients

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ABSTRACT

The legislative wrangling over tort reform often frames the debate in purely economic terms, pitting medical providers against patients perceived to be litigious. The downstream effects of physicians' perceptions of patients' likeliness to sue has insidious consequences for those patients' care, especially when those perceptions do not align with reality. This Note considers the intersections between medical malpractice claims and vulnerable populations of patient groups, and analyzes the effects of misplaced physician attitudes towards those groups on their care.

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I. Introduction

Much of the debate over tort reform has centered on often-competing value systems, such as the benefits of increased patient care versus the spiraling costs of premiums, or the effects of unbridled litigation versus the negative effects on medical communities. This framing often casts medical providers against patients who are perceived to be the most likely litigious; but in fact a host of strategies, such as increased practicing of defensive medicine and proposals for safe harbor rules or communication-and-resolution programs, all aim in some important respects to limit health care providers' liability. The tension between the economical functioning of our health care system and the general welfare of patients is complicated by the fact that doctors' *perceptions* of how likely a patient is to sue for malpractice necessarily has some downstream effects on that patient's care—a concern which is magnified when those perceptions do not align with reality.

Studies have found that many physicians—and advocates of tort reform, however those groups may be correlated—believe that poorer patients are more likely to sue their physicians. However, data confirm that poor and uninsured patients, including those recipients of Medicaid and Medicare, are far *less* likely than the average patient to sue for malpractice. Though there have been no studies to determine the prevalence of physician misconceptions that poor and vulnerable patient groups are more prone to sue, the potential adverse effects on social welfare stemming from those negative attitudes clearly abound. As Studdert et al. have characterized the issue:

> Subjecting physicians to meritless malpractice claims is costly, wasteful, burdensome, and unjust . . . . However, every bit as troubling from a social justice perspective are the many victims of medical negligence who do not file suit and hence are probably never compensated for the economic loss and pain and suffering they experience as a result of their injuries.[1]

This paper aims to explore the intersections between medical malpractice claims and vulnerable populations of patient groups—the poor, the uninsured, and the elderly—and investigate the effects of misplaced physician attitudes towards those groups on their care. Section II discusses physicians' fear of malpractice liability with respect to vulnerable patient groups and the consequences for those patients' care. Section III analyzes the empirical literature on rates of litigation by patient populations. Section IV evaluates strategies for effective and equitable deterrence, and proposes recommendations. Section V concludes.

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1. David M. Studdert et al., *Negligent Care and Malpractice Claiming Behavior in Utah and Colorado,* 38 Med. Care 250, 256 (2000).

II. The Fear of Liability and Patient Care

A. The Standard of Care for Vulnerable Groups

A vast literature has shown that poor socioeconomic status correlates directly with the risk of substandard medical care. To be clear, the factors contributing to health care inequality—beyond the standard of medical care—are myriad: structural conditions predispose the poor to being sick, low-income neighborhoods have disproportionately worse access to quality hospitals, and the costs of insurance and health care create barriers to treatment.[2] But implicit biases also factor into the equation. The Institute of Medicine has identified several patient groups who have experienced disparate health care stemming from conscious and unconscious biases on the part of caregivers—including the poor, the uninsured, and the elderly.[3]

One 1992 multivariate analysis, which reviewed over thirty thousand medical records from fifty-one hospitals in New York state in 1984, and controlled for hospital-level factors, found that uninsured patients were at greater risk for suffering medical injury due to substandard medical care.[4] Other studies have shown that race and insurance status are risk factors for trauma mortality and independently predict outcome disparities.[5] Insurance status in particular appeared to have the strongest association with mortality after trauma.[6]

B. Physicians' Fears of Liability Create Barriers to Care

Physicians' deep-rooted fears about malpractice liability coalesce in socially undesirable ways with fears about the litigiousness of poor and uninsured patients. As discussed below, fears about the claiming patterns of the poor and uninsured turn out to be largely unwarranted. But fears about liability, while psychologically understandable (from, say, an appreciation of the undesirability of reputational harm), are also fundamentally unfounded in many ways. It is unclear, and has not been studied robustly, where and how these misperceptions are developed so systemically. However, studies have shown high levels of malpractice concern among both generalist and specialty practitioners in states where the objective measures of malpractice liability risk are low.[7] This is in part due to the tendency to overestimate "dread risks,"—or those risks misperceived to be more

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2. *See, e.g.*, Kimberly Amadeo, *Health Care Inequality in the US*, The Balance (Jan. 6, 2022), https://www.thebalance.com/health-care-inequality-facts-types-effect-solution-4174842.

3. *See, e.g.*, Brian D. Smedley et al., Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care 1–2 (Brian D. Smedley et al. eds., 2003).

4. Helen R. Burstin et al., *Socioeconomic Status and Risk for Substandard Medical Care*, 268 JAMA 2383, 2383 (1992).

5. Adil H. Haider et al., *Race and Insurance Status as Risk Factors for Trauma Mortality*, 143 JAMA 945, 945 (2008).

6. *Id.* at 947–48.

7. *See, e.g.*, Emily R. Carrier et al., *Physicians' Fears of Malpractice Lawsuits Are Not Assuaged by Tort Reforms*, 29 Health Affs. 1585, 1585 (2010).

threatening because of their sociological dreadfulness—which are not accurate appraisals of genuine risks.[8]

Overestimations of "dread risks" apply to physicians' fears about treating poor and uninsured patients as well. Indirect evidence suggests that general physicians are more likely than specialty physicians to accept Medicaid or uninsured patients, but many still perceive financial and nonfinancial barriers alike to caring for these patients.[9] A study of family physicians in California on the willingness to provide obstetric care for Medicaid patients indicated that the fear of being sued for malpractice (along with the perception that Medicaid patients are noncompliant) was a significant factor in the decision to discontinue obstetric care for those patients.[10] However, that same study noted other literature that has demonstrated that Medicaid obstetric patients do not sue more often than other patients, stating, "[t]hat this misperception exists in any group of potential providers of Medicaid obstetric care indicates that state Medicaid programs could benefit by increasing physicians' awareness of Medicaid patients' true propensity for suing."[11] Even in Colorado, a state where many patients have difficulty finding obstetric care, it has previously been shown that Medicaid patients file only 5.5% of all obstetric medical malpractice obstetric claims.[12]

Another study, which provided a survey of general physicians in California, found that the (misplaced) perception that they were more likely to be sued was cited as an important reason for avoiding poor patients by 57% of the physicians who did not accept Medicaid and 49% of those who did not accept uninsured patients.[13] In focus groups, physicians identified three areas of concern about increased malpractice risk. First, many actually believed Medicaid patients were more likely to bring malpractice suits against their physicians.[14] Second, some were aware that studies had disproven the first proposition, but found the presence of any substantial risk of being sued unacceptable when providing care to patients who were not privately insured.[15] The study quoted one doctor as saying, "I understand that you're actually less likely to be sued by [Medicaid patients]; but you can be sued by them and always really resent it when you're taking care of somebody for essentially nothing and you get nailed."[16] Third, others thought

8. *Id.*

9. *See, e.g.*, Miriam Komaromy et al., *California Physicians' Willingness to Care for the Poor*, 162 WEST J. MED. 127, 127 (1995).

10. Thomas S. Nesbitt et al., *Obstetric Care, Medicaid, and Family Physicians: How Policy Changes Affect Physicians' Attitudes*, 155 WEST J. MED. 653, 653 (1991).

11. *Id.* at 656.

12. Frank M. McClellan et al., *Do Poor People Sue Doctors More Frequently? Confronting Unconscious Bias and the Role of Cultural Competency*, 470 CLIN. ORTHOP. RELAT. RES. 1393, 1394 (2012) (citing M. Gould, *Data Refutes Physician Perception that Poor Sue More*, 86 COLO. MED. 383, 383 (1989)).

13. Komaromy et al., *supra* note 9, at 130.

14. *Id.*

15. *Id.*

16. *Id.*

they were especially vulnerable to exposure to litigation because the difficulty of obtaining tests and consultations for poor patients caused the doctors to provide substandard medical care.[17]

Beyond fear of malpractice liability, however, the study identified poor reimbursement (cited by 88% of participants) as the main reason why physicians did not accept Medicaid patients.[18] The study also noted that psychosocial issues and patient noncompliance were cited as important reasons for refusing to take on Medicaid and uninsured patients.[19]

C. "Dread Risks" Drive Defensive Medicine, Increasing Health Care Costs

What is more, physicians that have previously been sued tend to believe that financial compensation (and not physician negligence) is the primary motivation of patients suing for malpractice. A 1989 study surveyed patients who sued physicians, physicians who had previously been sued, and physicians who had never been sued.[20] Nearly all (97%) of the plaintiffs reported negligence as the reason for bringing their malpractice action.[21] About half of non-sued physicians believed negligence to be the cause of malpractice suits in general.[22] Only a striking 10% of sued physicians, however, thought negligence was the reason for claims against them.[23] While just around 20% of patients reported financial compensation as their motive for suing, over 80% of all physicians surveyed thought this was the reason patients filed suits.[24] That is, the vast majority of physicians believe that medical malpractice plaintiffs are really after the money—and not recompense for harms suffered.

As an empirical matter, jury awards on average do not come close to matching the true economic losses of medical malpractice plaintiffs. On average, malpractice plaintiffs recover just about half of their economic losses.[25] Noneconomic damages constitute less than a quarter of malpractice damage awards.[26] A 1994 study of the characteristics of potential malpractice plaintiffs found that those patients that made a call to a law office to inquire about the validity of their claim did so overwhelmingly because of outstanding medical bills (and actual need).[27] Forty-five percent of 278 potential plaintiffs with earned

17. *Id.*
18. *Id.*
19. *Id.* at 130–31.
20. Robyn S. Shapiro et al., *A Survey of Sued and Nonsued Physicians and Suing Patients*, 149 ARCH. INTERN. MED. 2190, 2190 (1989).
21. *Id.*
22. *Id.*
23. *Id.*
24. *Id.*
25. MICHAEL J. SAKS & STEPHAN LANDSMAN, CLOSING DEATH'S DOOR 69 (2021).
26. *Id.*
27. LaRae I. Huycke & Mark M. Huycke, *Characteristics of Potential Plaintiffs in Malpractice Litigation*, 120 ANNALS OF INTERNAL MED. 792, 792 (1994).

income had outstanding medical bills, and over one-third of those bills made up 50% or more of the potential plaintiff's annual earned income.[28]

And, moreover, physicians do not face widespread financial exposure; a very small number of care providers are responsible for a large portion of claims. A 2019 study found that 2.3% of physicians accounted for 38.9% of all malpractice claims in the United States.[29] But, as a result of these kinds of ingrained physician attitudes, the great majority of efforts to reduce malpractice risk focus on trying to make it more difficult for patients to sue or win large settlements—a consequence that especially disadvantages the poor.

The group of physicians sued in the abovementioned study include physicians who have been sued just to have the case dropped. One reality of the tort system is that plaintiffs' lawyers have to proceed to discovery with imperfect information, and the screening process for cases continues after a suit is filed. In some instances, post-filing investigation reveals the case not to be worth the lawyer's time and expenses to pursue, leading them to drop the action—in which case, "[d]efendant physicians will once again view abandonment without payment as evidence that the case should never have been brought."[30] In other instances, "plaintiffs' lawyers will pursue a case, but only against some defendants, dropping others. The dropped defendants will likely feel that they should never have been named."[31] These realities of litigation perpetuate physicians' misperceptions that much malpractice litigation is frivolous and simply cash-seeking.

The net effect of all these misperceptions—about the risk of being sued, the motivation for being sued, and the patients that are most likely to sue—is an increase in the practice of defensive medicine. And that practice, ordering tests or performing medically unnecessary procedures to stave off perceived risks of facing litigation, drives up health care costs and has not been shown to improve patient outcomes. While a legitimate issue, in some respects the overestimation of defensive medicine costs has been a boon to those advocating for increased tort reform as well, as statistically inaccurate fearmongering about the economic (and social) costs of defensive medicine helps to sway public opinion. In 2010, then-Congressman Tom Price offered one remarkable appraisal: defensive medicine was costing the United States $650 billion per year (or about 26% of every dollar spent).[32] A more accurate 2010 study found that the cost of defensive medicine totaled $45.6 billion annually (in 2008 dollars), accounting for over 80% of the $55.6 billion total yearly cost of the medical liability system.

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28. *Id.* at 795.

29. David M. Studdert et al., *Changes in Practice Among Physicians with Malpractice Claims*, 380 NEW ENG. J. MED. 1247, 1247 (2019).

30. Mohammad Rahmati et al., S*creening Plaintiffs and Selecting Defendants in Medical Malpractice Litigation: Evidence from Illinois and Indiana*, 15 J. EMPIRICAL LEGAL STUD. 41, 43 (2018).

31. *Id.*

32. Margot Sanger-Katz, *A Fear of Lawsuits Really Does Seem to Result in Extra Medical Tests*, N.Y. TIMES (July 23, 2018), https://www.nytimes.com/2018/07/23/upshot/malpractice-lawsuits-medical-costs.html.

In recent years, patients have been increasingly saddled with medical debt. In 2020, collection agencies held $140 billion in unpaid medical bills.[33] That amount owed has become largely concentrated in states that do not participate in the Affordable Care Act's Medicaid expansion program[34] and is disproportionately borne by lower-income communities.[35] In turn, those with unpaid health care bills are far less likely to seek needed care.[36]

In general, defensive medicine responds to overinflated or entirely illusory risks, and tort reform efforts have largely failed to rectify this discrepancy. As Carrier et al. have noted, "the most strongly advocated reform, capping noneconomic damages, was not associated with a significant difference in perceived malpractice risk."[37] Tort reform thus has been successful mostly with respect to stymying patients' recovery in litigation and driving up health care costs. The ultimate form of defensive medicine, however, incurs primarily social costs—it is the refusal to provide care to those patients perceived to be litigious.

III. Are Vulnerable Patient Populations More Litigious?

A. The Poor and Uninsured

Empirical studies have proven physicians' fears—at least with respect to malpractice exposure by poor patients—to be largely unfounded. Using the same dataset of over thirty-one thousand medical records from fifty-one hospitals in New York in 1984 from the 1992 multivariate analysis discussed above, a pioneering 1993 study found that poor and uninsured patients were significantly less likely to sue physicians for malpractice, even after controlling for the presence of medical injury.[38] The authors used a two-staged sampling process to develop a representative sample of 31,429 hospitalization records, which were screened by trained nurses and medical record analysts, then independently reviewed by physicians.[39] To estimate the risk of malpractice claims by age, gender, race, insurance status, and income, the authors conducted a case-control study of claimant cases matched with non-claimant controls.[40]

The cases used in the sample were derived from those nonpsychiatric patients who filed malpractice claims referring to alleged malpractice during a hospital stay.[41] After controlling for severity of medical injury, the study revealed that poor (odds ratio [OR], 0.2; 95% confidence interval [CI], 0.03 to 0.8), uninsured

33. Raymond Kluender et al., *Medical Debt in the US, 2009-2020*, 363 JAMA 250, 255 (2020).
34. *Id.* at 253.
35. *Id.* at 256.
36. *See, e.g.*, Alyce S. Adams et al., *The Impact of Financial Assistance Programs on Health Care Utilization* 3 (Nat'l Bureau of Econ. Rsch., Working Paper No. 29227, 2021).
37. Carrier et al., *supra* note 7, at 1591.
38. Helen R. Burstin et al., *Do the Poor Sue More? A Case-Control Study of Malpractice Claims and Socioeconomic Status*, 270 JAMA 1697, 1697 (1993).
39. *Id.* at 1698.
40. *Id.*
41. *Id.*

(OR, 0.1; 95% Cl, 0.005 to 0.9), and elderly patients (OR, 0.2; 95% Cl, 0.03 to 0.9) were significantly less likely than other patient groups to file claims for malpractice.[42] In addition, poor patients were less likely than other patients to file inappropriate malpractice claims when they suffered no medical injury.[43] One suggested explanation for these results is that lower expected future earnings damages from a poor patient's malpractice claim reduce the expected contingency award, and thus plaintiffs' lawyers' incentives to accept those cases.[44] "Fear of malpractice risk should not be a significant factor in the decision to serve the poor," concluded Burstin et al.[45] "Tort reforms that would protect physicians who serve the medically indigent from malpractice suits may not be warranted."[46]

A similar 2000 study matched malpractice claims data with clinical medical records from Colorado and Utah.[47] A random sampling of fifteen thousand hospital discharges in 1992 (ten thousand from Colorado and five thousand from Utah) were reviewed and matched to insurer claims data through 1996, yielding 161 adverse events with identified substandard care.[48] Among those negligently injured who did not sue, the study found that the poor, the uninsured, the elderly, and Medicaid and Medicare recipients were far less likely to sue than other patient groups.[49] The authors explained, "[t]he elderly and the poor are particularly unlikely to generate income. Moreover, what income they do generate is less likely to be 'lost' because of a decline in physical capacity occasioned by negligent injury."[50]

Direct studies on Medicaid recipients have produced similar findings. In one 1991 analysis, researchers examined data from the Maryland Health Claims Arbitration Office to compare malpractice claims filed by Medicaid patients against those filed by non-Medicaid patients.[51] The study found no difference in the incidence of claims between these patient populations.[52] Thirty-six percent of all claims were filed by patients who had enrolled in a Medicaid program only *after* the alleged medical injury, suggesting the incident forming the basis of the malpractice claim itself contributed to the patient's Medicaid eligibility.[53] Thus, the study suggests, patients who have suffered medical injuries and resulting lost income at levels sufficient enough to become eligible for Medicaid may have a

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42. *Id.* at 1699. For those unfamiliar with the statistical nomenclature, odds ratios are measures of association between a given exposure and an outcome; confidence intervals are measures of the degree of certainty in a sampling method.

43. *Id.* at 1700.

44. *Id.*

45. *Id.* at 1697.

46. *Id.*

47. Studdert et al., *supra* note 1, at 250.

48. *Id.* at 253.

49. *Id.* at 257.

50. *Id.*

51. Mary G. Mussman et al., *Medical Malpractice Claims Filed by Medicaid and Non-Medicaid Recipients in Maryland*, 265 JAMA 2992, 2992 (1991).

52. *Id.* at 2993.

53. *Id.* at 2994.

special motivation to sue. However, this motivation did not correlate to larger awards but in fact the opposite; a national study of 1984 claims found that Medicaid patients received lower average malpractice awards than non-Medicaid patients.[54]

Physicians in many specialties have reported practice changes in response to the threat of malpractice liability, declining services to medically "high-risk" patients—a demographic that includes the poor, the uninsured, and the elderly.[55] In obstetrics, "high-risk" status correlates with poverty—often because maternal low-income status is associated with higher morbidity and mortality for newborns, and therefore statistically, Medicaid obstetric patients more frequently face medical risks.[56] In 1992, the Office of Technology Assessment (OTA) conducted a study at the request of the Congressional Sunbelt Caucus, which asked that OTA examine the available evidence on whether Medicaid and Medicare patients (particularly obstetrics patients) were more litigious than other groups.[57] OTA concluded, "[a]lthough the evidence is sparse, OTA's conclusions are strong: these patients are not more likely to sue and may actually sue less often than would be expected on the basis of their medical risks."[58]

With respect to Medicaid patients, OTA found that the group sued physicians for malpractice "considerably less frequently than would be expected by . . . [those] enrolled in the Medicaid Program . . . .The proportion of malpractice suits initiated by Medicaid recipients ranged from 4 to 9 percent of total claims, and total Medicaid enrollment was 9 to 12 percent of the total populations."[59] In addition, because Medicaid patients often fall below the poverty line, and thus have a correspondingly greater incidence of adverse outcomes during birth, it might be expected that Medicaid patients would have a higher rate of obstetric malpractice suits.[60] However, the data supported the conclusion that Medicaid obstetric patients sue at rates roughly commensurate with non-Medicaid patients.[61]

B. The Elderly

In the same 1992 study, OTA also examined the claiming patterns of Medicare patients (who are generally over sixty-five years old).[62] At the time, only one study in Wisconsin had directly addressed how often the elderly sued their physicians for malpractice.[63] That study found that the elderly filed 10% of the malpractice suits and made up 12.7% of the population in Wisconsin during

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54. ROGER HERDMAN ET AL., OFFICE OF TECHNOLOGY ASSESSMENT, DO MEDICAID AND MEDICARE PATIENTS SUE PHYSICIANS MORE OFTEN THAN OTHER PATIENTS? 3 (1992).
55. *Id.* at 1.
56. *Id.* at 8.
57. *Id.* at Foreword.
58. *Id.*
59. *Id.* at 4.
60. *Id.* at 89.
61. *Id.* at 9.
62. *Id.* at 13.
63. *Id.*

the study years—results which coincided with the 9.9% of all malpractice claims filed by Medicare beneficiaries in a national sample reported by the General Accounting Office (GAO).[64] When a like proportion of the population was used as the comparison group, the elderly sued about as often as expected.[65] When the number of claims was compared to use of health services, however, Medicare patients were far less likely to sue.[66] In 1984, the elderly accounted for nearly one-third of the admissions to hospitals, where over 80% of malpractice injuries occurred.[67] When the researchers compared the frequency of litigation brought by the elderly with their rates of hospitalization and inpatient days, the elderly's rate of filing claims was far lower ($P < .001$) than expected.[68] The study's authors hypothesized that "the difficulty in proving causation (the elderly may have numerous preexisting illnesses), the contingency fee system, and the limited life expectancy of advanced age may combine to limit malpractice litigation and compensation for the elderly."[69]

Other scholarship has compared the effects of Texas tort reform on medical malpractice claims paid out to the elderly.[70] Over the period of 1988–2003, elderly plaintiffs' rates of paid claims had risen from 20% to 66% of the adult nonelderly rate, though elderly claimants were significantly less likely to receive large payouts.[71] The 2003 wave of Texas reforms interrupted these trends and disproportionately reduced payouts to elderly claimants.[72] The authors of the study explain that possible reasons for the adjusted post-2003 elderly claim rate equaling only about half of the adult nonelderly rate include "reluctance by elderly patients to bring suit, especially against physicians; lesser familiarity of medical malpractice lawyers with elderly claims; and lower expected damages for many claims."[73]

Nationally, Medicare patients have fared even worse. From 1985 to 1990, Medicare and Medicaid patients received only about one-fourth of the $2.3 billion of hospital medical malpractice awards, although they represented more than 45% of hospital patients during that period.[74] In 1990, Medicare patients comprised about 32% of hospital discharges and 44% of hospital inpatient days but

64. *Id.*

65. *Id.*

66. *Id.* at 14.

67. *Id.*

68. *Id.* The P-value represents the probability of obtaining results at least as extreme as the observed results of a hypothesis test, taking the null hypothesis as given.

69. *Id.*

70. BERNARD S. BLACK ET AL., MEDICAL MALPRACTICE LITIGATION: HOW IT WORKS, WHY TORT REFORM HASN'T HELPED 123 (2021).

71. *Id.*

72. *Id.*

73. *Id.* at 139.

74. U.S. GEN. ACCT. OFF., MEDICAL MALPRACTICE: MEDICARE/MEDICAID BENEFICIARIES ACCOUNT FOR A RELATIVELY SMALL PERCENTAGE OF MALPRACTICE LOSSES, Report to the Chairman, Committee on Finance, U.S. Senate 2 (1993).

received just 9.6% of all hospital malpractice awards.[75] Medicaid patients' percentage of malpractice losses is only slightly higher than their discharge rate—accounting for 14% of discharges and 13% of inpatient days but receiving 17% of all malpractice awards.[76] To compare, the percentage of malpractice losses paid to other patients with insurance was far higher than their hospital discharge rate, accounting for 54% of discharges, 43% of inpatient days, and 72% of all malpractice losses.[77]

IV. Efficient Deterrence and Equity

There is relatively little data on the issue of the intersection of medical malpractice and vulnerable populations—especially the poor and uninsured. From the literature showing that poor socioeconomic status correlates with the risk of substandard medical care, however, we can assume that there is some overlap between the lack of access to both the health care system and the tort system. Moreover, plaintiffs with small potential recoveries likely have difficulty gaining access to the tort system to vindicate their claims because the cost to litigate such cases may exceed recoveries—especially in jurisdictions with caps on medical malpractice damages. And when Medicaid and Medicare recipients do file claims, their awards or settlements are significantly lower than those for patients with other health insurance, providing another layer of deterrence for those groups to litigate their losses.

Representing the poor and elderly is simply not as profitable for plaintiffs' lawyers as representing those with substantial potential future earnings. The 1993 study discussed above reached the same conclusion nearly thirty years ago, before the aggressive wave of tort reform laws had come into effect.[78] Now with the prohibitive force of damages caps, however, you would be hard-pressed to find a plaintiffs' lawyer in say, Texas, to accept a medical malpractice case on behalf of an indigent patient.

To remedy these growing social ills, health care policymakers at the state level should aim to bring Medicaid reimbursement closer to that of private insurance companies, as that issue is a large factor in physicians' decisions about whether to accept Medicaid patients.[79] More importantly, though, physicians' misperceptions—about the risk of being sued, the motivation for being sued, and the patients that are most likely to sue—must be corrected. All involved (patients, physicians, providers, state Medicaid programs, etc.) would benefit immensely from increasing physicians' awareness of patient groups' true propensity for suing. Implicit bias training should be mandatory, not only in medical schools but in institutions, and not only with respect to factors such as race, but with respect

75. *Id.* at 3.
76. *Id.*
77. *Id.*
78. Burstin et al., *supra* note 38, at 1700.
79. *See, e.g.*, Dylan Scott, *Medicaid Is a Hassle for Doctors. That's Hurting Patients.*, Vox (June 7, 2021), https://www.vox.com/2021/6/7/22522479/medicaid-health-insurance-doctors-billing-research.

to factors such as socioeconomic and insured status as well. More study is needed, and should be conducted, on what shapes physicians' misconceptions about their exposure to liability and the litigiousness of certain patient groups.

On a structural level, state legislatures should not be so brazen as to subvert the common law functioning of the tort system by imposing arbitrary caps on damages for malpractice claims. Assume that physicians' perceptions of the litigiousness of poor, uninsured, and elderly patients are correct—that is, assume those groups *did in fact* sue for malpractice more often. A survey conducted in 1989 and 1990 of 187 Florida malpractice claims found that approximately 22% of birth-injured claimants and 40% of emergency room claimants did not have health insurance at the time of their injury.[80] "The researchers interpreted this lack of insurance as an indication of a larger social problem, namely, that a substantial portion of the U.S. population does not have insurance, and compensation from malpractice cases fills an unmet need."[81]

Ideally, the tort system should function as a kind of safety regulatory mechanism outside the strict control of the legislature, in which the system's participants are steered towards social welfare-promoting directions without eliminating the autonomy to seek just compensation. However, in the ten years after the Texas legislature imposed a cap on medical malpractice damages, resolved malpractice claims and lawsuits dropped by nearly two-thirds.[82] The average malpractice payout declined 22% to around $199,000.[83] This kind of data suggests that tort reforms are having precisely the kind of effect intended: short-shifting plaintiffs' recoveries.

Intuitively, the increased likelihood of being sued should not factor into care decisions. By all accounts, the abovenamed vulnerable patient groups *should* sue more often—they are more often the victims of malpractice.[84] If physicians' perceptions of the reasons why patients sue (primarily to compensate for negligence, not for financial gain) were corrected through educational initiatives, the only reason to be hesitant to take on those patients would be their pre-disposition as "high risk." However, there should be policy limitations to turning down high-risk patients for fear of exposure to liability, so there is truly no valid basis for denial.

V. Conclusion

Economic inequality is, and has been, growing in the United States. This much is largely undisputed. But so is care inequality. Because physicians are less likely to accept poor, uninsured, Medicaid, Medicare, or "high-risk" patients for care, partly motivated by unfounded fears that those patients are more litigious,

80. U.S. Gen. Acct. Off., *supra* note 74, at 10.

81. *Id.*

82. *10 Years of Tort Reform in Texas Bring Fewer Suits, Lower Payouts*, Ins. J. (Sept. 3, 2013), https://www.insurancejournal.com/news/southcentral/2013/09/03/303718.htm.

83. *Id.*

84. *See, e.g.*, Burstin et al., *supra* note 4; Haider et al., *supra* note 5.

many vulnerable patient groups are forced to seek out substandard care or go without care altogether. Moreover, tort reforms have largely been focused on reducing physicians' liability and impeding plaintiffs' abilities to bring claims, not focused on patient protection and access to care. As Jill Lepore has written, "[t]he growth of inequality isn't inevitable. But, insofar as Americans have been unable to adopt measures to reduce it, the numbers might seem to suggest that the problem . . . lies with Congress."[85] The only relevant standard of care, for a plaintiff, is the standard of care that can be enforced.

A vicious cycle ensues in which physicians, fearful of liability, practice more defensive medicine (on one end of the spectrum, ordering unnecessary procedures and tests, and on the other, barring certain patients from receiving care altogether), which in turn drives up health care costs. Poor and vulnerable patients face dire consequences: it is harder for them to receive care in the first place, and when they do, and are the victims of negligence, it is harder for them to seek compensation for the resulting harm. We should have serious public policy concerns not only about these insidious kinds of physician attitudes, but the tort reforms that serve to reinforce them.

85. Jill Lepore, *Richer and Poorer: Accounting for Inequality*, NEW YORKER (Mar. 9, 2015), https://www.newyorker.com/magazine/2015/03/16/richer-and-poorer.