OAJ Medical Malpractice Section Article August 1, 2013

Physician Bias as a Reason for Poor Care

By: Sarah Tankersley

We are all aware that despite this being the 21st century, and an enlightened age with laws to protect people from discrimination, discrimination and prejudices still exist, conscious or unconscious. As it turns out, doctors are not immune from bias, and studies have shown that it can affect their care. In some cases, this can be a powerful tool for us to exploit in creating juror outrage at how our client, the doctor's patient, was treated differently, or not treated at all, based on factors over which she has little or no control, and which have little or no relation to her medical condition.

Some common physician biases to be aware of are bias toward women, bias toward African Americans, bias toward people with mental illness or mental disability, and bias toward people who are overweight.

If you are a woman, you should not have a heart attack, because doctors do not expect it and they will ignore you. Anecdotal case in point: a client a few years back who had a miscarriage and then presented to the emergency room a week later with complaints of chest pain radiating to her back, with an EKG computer-read as consistent with an anterior infarct, age indeterminate. The ER doctor and her primary care doctor two days later both felt she was suffering anxiety due to her miscarriage and prescribed her Ativan and blood pressure meds. She died of a heart attack three days after her ER trip and one day after seeing her primary care doctor, having been assured by both of them that it was not her heart, nor anything else life-threatening. Studies have shown gender based differences in treatment for men and women with peripheral arterial disease, behavioral health issues, stroke, osteoarthritis, coronary artery disease, acute coronary syndrome, acute myocardial infarction, chest pain, organ donation and transplantation, and trauma triage.

Similarly, African Americans are at risk for different or worse care because of their color. Just last month, JAMA reports that black people with critical limb ischemia are 1.77 times more likely than whites to have an amputation rather than revascularization of the limb, even in settings where the resources available are similar or better. We have seen this in action, currently litigating a case where our black client lost her leg above the knee due to failure to re-vascularize. To be fair, though, it is difficult to decide whether the failure was because of her race or because she had the misfortune to clot off her artery in the hospital over a holiday weekend.

Studies also show that people with mental illness are less often properly treated for their co-existing physical illness. As recently as May 2013, survey results of primary care and mental health providers showed that both groups of providers were less likely to refer patients with

stable schizophrenia for weight management programs or sleep study programs, and more likely to involve the patient's family in making medical determinations. Apparently, health care providers are just as likely as the general public to assume that a person with schizophrenia is incapable of following directions, being compliant with recommendations, and managing his own health than people who are not similarly ill, even when there is no evidence to support that assumption. Would your ER client get a better work up if he was not mentally ill?

Finally, there is proven physician bias against people who are obese. Studies show that physicians overall have less respect for obese patients, that discrimination against obese people is rising, and that it is affecting the availability and quality of health care received, especially by obese women. Overweight women are less likely to seek health care in general and cancer screening in particular than women who are not obese. These women feel that they are being shamed and that the equipment is not big enough to be comfortable or useful to them. Further, although 92% of doctors feel obesity is treatable, only about a third feel that a motivated obese patient could lose the extra weight. This leads to an unwillingness to treat obesity, and fosters perceptions that obese people are lazy or unmotivated. When I challenged a defendant doctor as to why he would even do a knee surgery on a 350 pound patient after the client had been told by other doctors that he was not a candidate for surgery due to his weight, I was told that the doctor felt this patient was never going to be able to lose weight and he should just be glad someone was willing to do the knee. To be fair to physicians, it is true and well recognized that obesity is a health issue in and of itself, and is a legitimate factor to consider in many types of diagnosis and treatment. The problem is the physician perception that overweight people are lazy and unmotivated, and less able or willing to comply with instructions, such that doctors fail to even attempt treatment.

For us as Plaintiff lawyers, the takeaway from these reports is that doctors, like everyone else, come with biases and prejudices, and those social factors are going to affect the care they give. Even though we have no duty to prove to the jury why a doctor made a mistake, we also know that we often need to supply a reason why an otherwise competent and trained physician, someone they, the jurors, might see for care, dropped the ball. We point to doctors being in a hurry to leave for the weekend; to doctors latching on to one diagnosis and ignoring conflicting symptoms; to doctors who have simply become complacent over time; to doctors who assume someone else is handling the situation. Why not point to doctors revealing their own inherent biases as well? In the right case, a doctor who lets his black patient lose her leg rather than re-vascularizing, or a doctor who ignores a woman's chest pain as basically hysteria can create a lot of jury appeal.