WHO SUES THEIR DOCTORS? HOW PATIENTS HANDLE MEDICAL GRIEVANCES

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This article applies the dispute processing model developed by Felstiner, Abel, and Sarat (1980–81) to disputing between patients and doctors. We conducted interviews with 240 dissatisfied patients to examine the dispute resolution choices they made in response to unsatisfactory medical experiences. Probit models were constructed for each of five resolution choices, incorporating independent variables derived form the Felstiner *et al.* conceptual model. These analyses go beyond previous studies of medical malpractice by (a) presenting a comparative analysis of suers and nonsuers, (b) not relying on closed malpractice case data, and (c) presenting the perspective of aggrieved patients.

In this article we explore patient/doctor disputing using parts of the Felstiner, Abel, and Sarat (1980–81) conceptualization of the disputing process (cf. Miller and Sarat, 1980–81: 554–55). Most prior research on medical disputes has analyzed closed cases of medical malpractice (Danzon, 1984, 1985, 1986; U.S. General Accounting Office, 1986). Because such work has studied only patients who chose to initiate formal legal action, it has not been able to consider the conditions under which patients decide not to complain or not to sue. Because very few grievances are transformed into disputes, and few disputes find their way through the thickets of diversion to become legally framed and resolved, the lawsuits in medical malpractice studies represent only the tip of the iceberg. In this research we investigate the shape of the iceberg and analyze what characterizes the grievances that make their way to the tip visible on the legal docket.

I. THEORETICAL FRAMEWORK

The potential for a medical malpractice claim arises when the patient suspects that "something is not quite right" with the medical care he or she has received. This suspicion is not yet a griev-

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ance (Ladinsky and Susmilch, 1980: 5). It is little more than what Silberman (1977: 3) calls a "violation of expectations." After the problem is "named," that is, evaluated and judged to be negative (Felstiner *et al.*, 1980–81), and the patient places the blame on him or herself, the doctor, someone else, or a combination of all three, a grievance exists.

Faced with a grievance, the patient may or may not take formal legal action. The patient may instead choose to (1) *lump it* and do nothing (Felstiner, 1974; Best and Andreasen, 1977; Galanter, 1974; Danzig and Lowy, 1975); (2) *exit* by changing doctors and thereby avoid the problem (cf. Hirschman, 1970; Felstiner, 1975); (3) make a *claim* by confronting the doctor directly to register a complaint and get some kind of remedy (see Lempert, 1976: 173; Macaulay, 1963); (4) *engage in disputing* by taking the grievance to some nonlegal third-party forum (Nader and Singer, 1976; Cratsley, 1978; Steele, 1977; Hannigan, 1977); and/or (5) *engage in disputing* by first going to a lawyer to initiate a lawsuit but then choosing not to sue. This study explores potential influences on these choices and compares the experiences and characteristics of patients who do and do not decide to sue.

II. SAMPLE AND METHODOLOGY

We conducted face-to-face interviews with a sample of 175 aggrieved patients who ultimately did not file a lawsuit (nonsuers) and a second sample of 65 patients who did file a malpractice suit. We obtained the nonsuers by drawing a sample of 2,050 names from the city directories of two socioeconomically different cities in Wisconsin[1] and identifying those who said they had experienced unsatisfactory medical care in the past two years.[2]

We selected a second sample, consisting of suers, by randomly sampling all medical malpractice cases filed in the State of Wisconsin during the two years prior to the study. In Wisconsin at the time of the study everyone filing a lawsuit against a physician (except physicians employed by the state) had to file with the Wisconsin Patient Compensation Panel Office as a matter of public record. Consequently, we had a nearly complete record of malpractice actions from which to draw the sample. We selected a sample of 150 cases from slightly more than 600 filings, and sent a

[1] Beloit, with a population of approximately 35,000, had an economic base in heavy industry and was predominantly blue collar. The other city, Madison, with a population of about 171,000, had a mixed socioeconomic base concentrated in light industry, service agencies, state government, and higher education.

[2] We mailed a letter to all potential respondents describing the study and informing them that we would be telephoning within ten days. In our follow-up telephone call, we spoke to 1,706 respondents and determined that 198 of them had experienced unsatisfactory care apart from complaints about billing or waiting. Those with complaints were invited to participate in the study, and 175 agreed to be interviewed.

letter to each person informing them of the study and inviting them to participate. A follow-up telephone call to each of these people located 65 for face-to-face interviews. We used the same schedule that we used with the nonsuers.[3]

III. DEPENDENT VARIABLES

We asked all respondents what they had done following their unsatisfactory medical care. First, patients were asked if they had done anything about the problem. Those who said they had not were considered *lumpits*.[4] Those who did take action could choose one or more of the following: they could complain directly to doctors on their own (*claimers*); they could change doctors to avoid further interaction (*exiters*); and they could choose to contact a lawyer to initiate a lawsuit (*lawyer seekers*). They could also actually carry through with a lawsuit (*formal suers*).[5] These five resolution choices represent transformation points in the disputing process (Felstiner *et al.*, 1980–81: 633–36) and they represent the dependent variables in our analyses.[6] Table 1 displays the percentage of suers and nonsuers who used each resolution choice.

IV. INDEPENDENT VARIABLES

We measured five sets of potential influences on resolution choices—(a) audiences, (b) parties, (c) strategic interaction, (d) seriousness of injury experienced, and (e) respondents' general resources at the time of the conflict. Each variable set included one or more indicators constructed from the conceptual model developed by Felstiner *et al.* (1980–81), and each set is used in probit models to explain patients' resolution choices.[7]

A. Audiences

Felstiner *et al.* suggest: "Disputes may be transformed through interaction with audiences. . . . [Audiences help] . . . define the experience as injurious or harmless, encourage or discourage

[3] At the outset, a backup sampling procedures—snowball sampling—was set in place to be used to locate "nonsuers" only in the event that the random sampling procedures did not produce sufficient numbers of respondents given the time, financial, and other resource constraints imposed by the research grant. In the end, only 8 percent of the "nonsuers" came from this backup sampling method.

[4] Each respondent was asked, "Did you contact any of the following persons or agencies to get something done about the inadequate care?" They were then shown a list of options, including the option "none." Lumpits were defined as those who selected "none."

[5] Resolution choices do not include any "nonlegal third party" agencies because virtually no respondents chose nonlegal third parties to resolve their grievances.

[6] Each dependent variable is a dichotomy with the value of 1 if the respondent chose that resolution choice, 0 if not.

[7] For a discussion of probit modeling, see Aldrich and Cnudde (1975).

Table 1. Resolution Choices by Suers and Nonsuers

	Nonsuers (N=175)	Suers (N=65)
Lumpits	26%	(0%)
Claimers	25	31
Exiters	46	85
Lawyer seekers	9	(100)

NOTE: Percentages do not sum to 100 because a patient could choose none or more than one of these resolution strategies.

the expression of the grievance" (1980–81: 644). Audiences are those to whom injured parties might turn to tell their story, seek advice, or get something done—family, friends, acquaintances, or knowledgeable persons who are informally engaged in conversation about the problem.

The significance of audiences has been established empirically by Ladinsky and Susmilch (1983). They identify (p. 7) what they call a system of "brokers" who help make decisions.

> Involved in the disputing process are a variety of persons and organizations we call *brokers* because they act as helping "middlemen" in the defining and managing of problems, grievances, claims and disputes. . . . They may discourage complaints and convince the consumer that he or she does not have a problem or that nothing can be done about it. They may, on the other hand, inspire or persuade the consumer to "voice" rather than "exit," and help in defining the problem and in taking it to a person of more formal authority or position who might further help in the resolution of the problem.

Three measures of audiences are used here. The first indicator measures whether patients believe they have support from family and friends for initiating legal action. Each respondent answered this statement on a five-point Likert scale ranging from "strongly disagree" to "strongly agree": "Given a problem like mine, most of my friends and relatives would support bringing a malpractice lawsuit against the doctor." We hypothesized that perceived support from family and friends regarding legal action would increase the likelihood that patients would change doctors, formally contact a lawyer, and sue.

A second measure of audiences focuses on whether respondents sought *informal* input form lawyer friends.[8] Although law-

[8] Note the emphasis on informal contact. Patients were asked whether they had talked, off the record, with a lawyer friend to help clarify their problem. The focus was specifically on those contacts that were not for the purpose of initiating legal action.

yer friends need not be intimates like family and friends, they are persons who dissatisfied patients trust and from whom they may feel they can informally seek objective advice. Respondents were asked, "When you were trying to decide what the problem was and what could be done about it, did you talk informally to a lawyer?" Those who said they had were asked, "Did s/he think that the doctor had provided inadequate care?" We used the response to this last question as a measure of audience support.[9] We predicted that informal support from a lawyer friend would be positively related to patients' later decisions to formally contact a lawyer and initiate a lawsuit.

A third measure of audience is more general in character. It does not identify a particular audience but rather specifies that the audience contacted was someone who could help decide what to do. We asked respondents: "Once the decision had been made that the doctor was at fault, did you have ideas about who you should talk to about getting something done?" Dissatisfied patients who indicated that they had someone in mind to talk to displayed a clarity, an awareness, and an assertiveness that makes the dispute processing maze a little less formidable, and more accessible to a variety of resolution options. We predicted that they would be more likely to make either a direct claim on their doctors, formally contact a lawyer, or both.

B. Parties

"Audience" refers to actors external to the relationship between dissatisfied patients and their doctors. "Parties" focuses *internally* on the patient/doctor relationship. Parties occupy a prominent theoretical position in the literature on disputing. Yngvesson (1984) asserts that disputants' choices about how they resolve grievances are affected by the nature of past, present, and/or ongoing future relationships (see also Merry, 1979). Upham's (1987) study of law in postwar Japan too demonstrates that relationship networks play a role in dispute resolution decisions and strategies in environmental disputes. Felstiner *et al.* (1980–81: 640) theorize: "The relationship between parties has significance for transformation. . . . [Factors shaping dispute transformations] include . . . the sphere of social life that brings them together . . . their relative status . . . and the history of prior conflict."

Party relationships in unsatisfactory delivery of medical care may be uniquely important. This professional/lay relationship is unlike other conflicted consumer/provider relationships. Much of the dispute-processing literature focuses on conflict between nonprofessional parties (e.g., Best and Andreasen, 1979; Ladinsky and

[9] The interview schedule allowed for respondents to have up to three informal contacts with lawyer friends. Thus the measure for this indicator is an index that ranges from 0 to 3 informal contacts.

Susmilch, 1983; Buckle and Thomas-Buckle, 1982). A few studies (e.g., the Civil Litigation Research Project, 1987; Sarat and Felstiner, 1986) have looked at lawyer/client interactions. But the patient/doctor connection is unique in the "personal" bond that links the parties. The doctor is dealing with the patient's body and health and may literally hold the life of the patient in his/her hands. Obviously, this is an extremely personal matter for the patient. The relationship binds the patient and doctor, providing a context that would seem to discourage the initiation of disputing.

To test the effects of patient/doctor relationships on the dispute transformation process, we wanted to learn two things. First, how did patients perceive that their doctors had related to them as patients and persons? Four measures are used. Patients were asked to evaluate[10] whether their doctors (1) tended not to rush them through medical care visits, (2) showed concern for how their medical care problem affected them personally, (3) informed them during visits about what they (the doctors) were doing and why, and (4) involved them as "partners" in diagnosis and treatment. We also wanted to know how patients evaluated their doctors' professional competence before and up to the point at which they perceived unsatisfactory care. Each respondent was asked, "Was your evaluation of your doctor's competence before you realized there was a problem (a) excellent, (b) good, (c) average, (d) fair, (e) poor?"

Based on the discussion of party relationship in the literature, we predicted that the more patients perceived their doctors as not rushing them, showing personal concern, involving them as partners, and informing them, and the higher they rated their doctors' professional competence, the less likely they would be to change doctors and transform a grievance into a dispute and the more likely they would be to make a claim directly to the doctor.

C. *Strategic Interaction*

Behavior by parties in the course of a conflict may also affect the choices made by an injured party. Felstiner *et al.* (1980–81: 640–41) suggest that "strategic interaction between the parties in the course of a conflict may have a major transformational role. . . . Adversary response may be an important factor in this transformation."

All respondents were asked if they had complained directly to their doctors. Those who said "yes" were then asked what happened, including what they expected to get, whether their doctors responded to their claims, and whether their doctors helped them understand what had happened and what might be done to correct it. Respondents were then asked about their satisfaction with the

[10] We used a five-point Likert scale ranging from "strongly agree" to "strongly disagree."

results of the claim. This question was used to measure patients' evaluation of strategic interaction.[11] We expected that dissatisfaction with the outcomes of their claims would contribute to exiting, to formally contacting a lawyer, and to filing a lawsuit.

D. Seriousness of Injury Experienced

Felstiner *et al.* (1980–81) do not consider the seriousness of the injury when they discuss disputing beyond the blaming stage. They do point out that the way the injury is perceived influences whether a grievance is defined at all. "A grievance must be distinguished from a complaint against no one in particular (about the weather, or perhaps inflation) and from a mere wish unaccompanied by a sense of injury for which another is held responsible" (*ibid.*, p. 635). But seriousness of injury may have further consequences for resolution choices.

Miller and Sarat (1980–81: 547) stress that "[w]hat ones does about a grievance . . . is obviously a function of what is at stake and how much or what kind of damage was done." In instances of unsatisfactory medical care we expect to find that the sense of moral judgment and blame will increase as the negative effects of injury accumulate. The more confident the aggrieved patients are that their attributions of fault are correct, the more likely they should be to exit and to push toward suing. Faced with less serious injuries, injured parties should be more likely to lump it.

The measure used to determine seriousness of the injury is a Seriousness of Injury Experienced Index (SIEI). The index is constructed from respondents' answers to each of the four categories of this question: "Did the unsatisfactory medical care result in (a) physical disability, (b) physical disfigurement, (c) psychological disability, (d) loss of job?"[12] We did not ask respondents to give a global, subjective evaluation of their injuries (i.e., "Do you think this injury is more serious than other patients' injuries"), but rather asked them to identify the specific, objective injur(ies) they experienced.

E. General Resources

Felstiner *et al.* (1980–81: 640) note that the behavior of parties to any conflict "will be a function of personality as it interacts with prior experience and current pressures. Experience includes involvement in other conflicts, contact with reference groups, representatives and officials, and familiarity with various forms of dispute processing remedies." Miller and Sarat (1980–81: 551) add:

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[11] The dichotomous measure of strategic interaction was 1 if the patient indicated dissatisfaction with the results and 0 otherwise.

[12] The SIEI has a range of 0–4, from none of the four choices identified as occurring (=0) to all four identified as occurring (=4). Each item had a response of "yes" and "no." A response of "yes" counted as 1.

"The general resources of a household, such as income or education, may affect its capacity or propensity to make claims. Certain specific resources and experiences are also relevant: previous experience with the kind of problem in question and experience with and access to legal advice."

We measured four types of general resources that patients could have: knowledge about legal professionals' work, previous litigation experience, knowledge about health professionals' work, and social status.

Knowledge About Legal Professionals' Work and Previous Litigation Experience. "Repeat players" know more about the law, use it more, and have more resources at their disposal and are the ones who are most likely to use the law again (Galanter, 1974: 97–98). Although repeat players are usually organized, institutional players (e.g., corporations), they may also be individuals who have more knowledge about and experience in the legal system. At the other end of the user continuum are "one-shotters" (*ibid.*, p. 98). They are usually citizens who have little knowledge and experience with law matters, fewer resources available to them, less ability to play the odds and few options (e.g. personal injury victims, parties to divorce).

Yet there is some evidence that previous experience with litigation may also discourage future use of the law. Engel (1983: 813) describes the reaction to suing of a middle-aged plaintiff who had been disabled because of an allegedly negligent property owner: "In retrospect he viewed the litigation experience as 'disgusting . . . a lot of wasted time.' If he had to do it over again, he would 'just forget it.' " Familiarity may breed hesitancy to get involved in litigation again. Engel concludes: "Because judicial processes in tort cases represented a dramatic discontinuity with nonjudicial values and approaches, litigation tended to underscore the social alienation of tort plaintiffs. . . . The ultimate effect of litigation . . . was therefore a reaffirmation of community norms opposing such claims" (*ibid.*, p. 873).

Many of the patients we interviewed would be one-shotters under Galanter's definition. But some had experience with litigation and had personal relationships with judges and lawyers; some had worked for lawyers and judges. While they were not repeat players, they were "closer" to legal personnel and processes than others. To differentiate the more knowledgeable and experienced, we asked all respondents "Had you (prior to this problem) (a) worked for a lawyer or law firm, (b) a good friend who is a lawyer, (c) a close relative who is a lawyer, (d) worked for a judge or in a court of law, (e) a good friend who is a judge, (f) a close relative who is a judge?" We constructed an index of familiarity of law-related matters from this question. To separate simple knowledge about the world of law and legal professionals from personal expe-

rience with litigation, we asked two additional questions: "Had you (prior to this problem) had occasion to initiate a lawsuit?" and "Have you ever had someone bring a lawsuit against you?" From these questions we constructed an index of litigation experience.[13]

We expected that familiarity with legal matters would be positively related to formally contacting a lawyer, but negatively related to suing. Simple familiarity with legal professionals' work may make going to a lawyer easier and less formidable. But once in the lawyer's office, the patients begin to get a more intricate understanding of the law and its relationship to their case, They may learn that they do not have a case. Past litigation experience may provide that same insight and discourage formal disputing. Patients with past litigation experience have a more direct, working knowledge of the legal system. Thus, because the patients are familiar from prior experience with the complexity of formal disputing, litigation experience should be negatively related both to going to a lawyer and to suing (Miller and Sarat, 1980–81: 552).

Knowledge About Health Professionals and Health Care. Most people know something about health care and the work of health professionals because of occasional visits to a doctor. But fewer people have the inside knowledge that comes from having worked in a health care facility or from knowing health care professionals as family and friends. To differentiate degrees of knowledge on this dimension, we asked respondents, "Had you (prior to this problem) (a) taken a course in health care, (b) worked for a doctor or health care provider, (c) a close friend who was a doctor or other health care provider, (d) a close relative who was a doctor or other health care provider, (e) other kinds of experiences that would give you knowledge of the health care world?" From this question, we constructed an index of knowledge of the health care world.[14]

We predicted that familiarity with the health care world would discourage suing, either because familiarity engenders empathy toward or an appreciation of the complexity of medicine and the human body. More knowledge may also leave dissatisfied patients with a sense of futility about fighting the medical establishment. We thus predicted that familiarity with the health care world would be negatively related to going to a lawyer and to suing. We predicted no systematic effects on whether patients would make a claim on their doctors, but hypothesized that it would be positively related to exiting and doing nothing.

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[13] The index of litigation experience has a range of 0–2, from respondents who have neither litigation experience to those who have both.

[14] This index counts the different ways in which respondents might know about the health care world. The range of the index is 0–5.

Status in the Community. Status[15] is a particularly important variable in studying professional/lay disputing because status differential is more apparent in patient/doctor relationships than in most consumer/provider relationships. Historically, status deference has characterized patients' orientation toward doctors (Parsons, 1951). It is true that the past quarter-century has brought some changes; patients have become more aware of their rights, and their perception of doctors' status has been diminished somewhat (Haug and Lavin, 1978, 1981). Nevertheless, even with these changes, most patients still relate to their doctors quite deferentially.

We predicted a positive relationship between status and claiming, hypothesizing that higher status patients should be more likely to complain in person to their doctors because they have more status commonality with them. We expected lower status patients to avoid this option out of status deference and/or anxiety.

For the low-status patient, the law becomes a means to equalize the status differential. Therefore, we predicted that lower status patients would be more likely to contact a lawyer and to sue. We also predicted that they would be more likely to exit, a low-cost means of expressing dissatisfaction.

V. EXPLAINING AVOIDING, CLAIMING, AND DISPUTING DECISIONS

A. Audience

The decision to sue is significantly associated with all three measures of the audience network: suers make active use of audiences (see Table 2). Among nonsuers, however, the audience network has a less pervasive influence on informal action. Support of family and friends for suing and informal conversations with lawyer friends show no significant relationships with lumping, claiming, exiting, or lawyer seeking. But having an early knowledge of who to talk with is significantly related to three of the four resolution choices for nonsuers. Patients who become lumpits rarely indicate they know who to talk to, while claimers and lawyer seekers express an awareness of who to talk to early in the process.

A portrait of the connection between audience network and nonsuers begins to emerge. Claimers say they know who to talk with about their grievance, and, in claiming, turn to the source of the grievance, the doctor. Claimers do not show any increased tendency to consult with other audiences. While confronting one's doctor is not necessarily easy to do, it does not involve support from family and friends or informal advice from a lawyer friend.

The significant relationship between lawyer seeking and

[15] We measure status using the respondent's education and property ownership.

Table 2. Probit Regression Models of Dispute Resolution Choices

	Dissatisfied Patients (N=175)				Formal Suers (N=240)
	Lumpits	Claimers	Exiters	Lawyer Seekers	
Audiences					
1. Support for suing from relatives friends	−.034 (.138)	.150 (.130)	−.024 (.121)	.211 (.188)	.598** (.130)
2. Informal contact: lawyer friend	.419 (.736)	.792 (.732)	.523 (.793)	1.208 (.871)	1.202** (.341)
Knowing who to talk to about getting something done	−.836** (.235)	.709** (.232)	.206 (.207)	.782* (.397)	.605* (.265)
Parties					
1. Doctor did not rush	−.008 (.124)	−.169 (.119)	−.033 (.109)	−.226 (.182)	.021 (.125)
2. Doctor concerned about personal effects of care	−.143 (.169)	−.209 (.168)	.088 (.148)	−.147 (.285)	−.434* (.206)
3. Doctor informed patient about care	−.057 (.154)	.065 (.161)	.155 (.139)	−.060 (.255)	.077 (.192)
4. Doctor involved patient as "partner"	.036 (.186)	−.236 (.187)	.135 (.167)	.163 (.306)	.142 (.196)
5. Patient evaulation of doctors' competence	.035 (.116)	−.106 (.111)	−.144 (.105)	.004 (.187)	−.430** (.135)
Strategic Interaction					
Patient dissatisfaction with results of claim	—	—	.401 (.261)	1.294** (.389)	−.400 (.307)
Seriousness of Injury	−.078 (.114)	.136 (.110)	−.135 (.106)	.359* (.181)	.499* (.106)
General Resources					
1. Patient owns own home	−.139 (.171)	.154 (.178)	−.218 (.157)	−.770* (.318)	−.300 (.174)
2. Education level	.117** (.044)	.005 (.044)	−.048 (.040)	−.229* (.093)	−.017 (.052)
3. Knowledge of health care world	−.310* (.156)	.246 (.145)	.140 (.134)	.304 (.238)	−.448** (.176)
4. Knowledge of legal professionals world	−.270 (.191)	−.317 (.198)	.088 (.171)	.324 (.306)	−.731* (.296)
5. Previous litigation experience	.163 (.183)	.074 (.178)	.101 (.173)	.003 (.287)	.386* (.185)

* $p < 0.05$
** $p < 0.01$

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knowing who to talk to may have at least two sources. While some patients may know at an early stage that they should seek a lawyer's advice, others apparently become lawyer seekers when they find claiming unsatisfactory. Having failed to resolve the grievance at its source, they turn to a lawyer.

Lumpits, on the other hand, are at bay. Not only do they report that they have no one in mind to talk to about their grievance, they apparently have no systematic connection to others in a larger audience network that would help sort out what to do. It is not surprising that they do nothing under these circumstances.

Overall, the results in Table 2 support our hypotheses about the interaction of audiences and the decision to sue. The decision to sue requires assertiveness and strategy, and suers appear to engage the involvement and discernment of a broad audience network, while nonsuers show little involvement with the audience network measured here. We can only speculate about why this might be the case. Lumpits may be ambivalent at the outset about the nature of their problem, what to do about it, or whether to do anything. But if this were true, they might be more likely to develop an audience network, perhaps one that these measures do not tap. Conversely, of course, lumpits may be quite clear at the outset that they are not going to do anything and therefore may not develop connections with audience. Panel research that traces the evolution of the disputing process prospectively will be required to untangle this causal web.

B. Parties

Among nonsuers, patients' perceptions of the patient/doctor relationship prior to the grievance do not predict resolution choices, nor is there any relationship between resolution choices and patients' evaluations of their doctors' competence. Among suers, however, two factors do appear significant. As we predicted, patients who more negatively evaluate doctors' competence prior to the grievance are more likely to sue. Likewise patients are more likely to sue if their doctors fail to show concern for them personally. These results suggest that while the current trend in medicine stresses the importance of treating patients as active participants in the delivery of medical services, such considerations may have few consequences for disputing. At bottom, only the doctor's perceived competence and attention to the patient's health appear to influence the decision to sue.

C. Strategic Interaction

Strategic interaction between patient and doctor is significantly related to lawyer seeking but not to exiting or suing. One possible explanation for the difference is what we call a slingshot effect. Patients who make a claim and come away dissatisfied are

undoubtedly disappointed, and their grievance looms larger than it did before the claim. Unable to resolve the grievance at its source, they are left frustrated and perhaps even angry, more ready than ever to "get something done." They seek out a lawyer who, they believe, will surely help them.

Yet when the patient reaches the lawyer's office, he or she often discovers that the grievance, at least in the lawyer's eyes, does not merit a lawsuit. The dissatisfied claimer thus pulls back and joins the ranks of the nonsuers. The lawyer has, in effect, played a gatekeeping function at this point, cooling out the dispute transformation process.

D. Seriousness of Injury

Patients who sue are more likely to report serious injuries than are patients who do not sue. Even among nonsuers, perception of a more serious injury is positively related to consulting a lawyer, even when a lawsuit is not initiated. What's at stake does apparently make a difference in the transformation of a grievance into a dispute (Miller and Sarat, 1980–81; 547). Those, therefore, who contend that dissatisfied patients sue for reasons extraneous to the perceived seriousness of an injury can find little confirmation here.

Seriousness of the injury does not show any relationship to the other resolution choices, including exiting. Thus, while the cost of forgoing possible recovery of actual damages may push a patient to seek legal advice and/or sue when severe injury is involved, it does not appear to stimulate informed actions among those who choose not to sue.

E. General Resources

The status measures of education and property ownership do not predict the decision to sue. In contrast, knowledge and experience are significantly related to suing. Patients with greater knowledge about the work of health professionals or legal professionals are less likely to sue, confirming our predictions. However, patients with prior experience in the legal system (Galanter's repeat players) were more likely to sue, apparently not deterred by their prior experience with the legal system.

The choice of informal actions by nonsuers reflects different effects of general resources. As expected, neither first-hand knowledge of legal professionals' work nor prior experience in the legal system is significantly related to any informal resolution choice. Knowledge of health professionals' work, however, does relate significantly and negatively to simply lumping it, a finding we did not expect. Both those who do nothing *and* those who sue are less knowledgeable about the work of health care professionals. Future work is needed to explore why these diametrically op-

posed resolution choices are similarly related to the same indicators.

Finally, the two status indicators (property ownership and education) show few correlations with resolution choices. Both indicators are negatively related to lawyer seeking among nonsuers, and education level is positively related to doing nothing. While the higher status patients are less likely to sue, the indicators of status tell us nothing systematic about claiming and exiting. Apparently exiting does not peculiarly afford lower status patients with a "affordable" grievance resolution, nor are higher status patients more likely to make greater use of direct claims on doctors because the status differential between doctor and patient is reduced.

VI. CONCLUSIONS

Two significant conclusions can be derived from these analyses. First, this study has shown that the theoretical model of Felstiner *et al.* (1980–81) as applied to suing behavior by dissatisfied patients works quite well. A number of variables generated from the Felstiner *et al.* model differentiate suers and nonsuers. Furthermore, some of these variables appear to affect patients' informal resolution choices as well. Most clearly, the 'audience' variable shows much potential for understanding the dispute transformation process and how dissatisfied patients decide what to do. We still need to know more about the intricacies of informal broker networks (Ladinsky and Susmilch, 1983) and reference groups (Felstiner *et al.*, 1980–81: 644), about who develops what brokers, and how they utilize them. Our data show, for example, that virtually none of the dissatisfied patients utilized formal nonlegal resolution mechanisms (e.g., clinic review or ethics boards, state agencies, action lines, etc.) (cf. Ladinsky and Susmilch, 1983; Merry and Silbey, 1984: 151ff.) but extensively utilized a complex informal network.

The "parties" variable, at least as we measured it here, did not assist in understanding how patients make informal resolution choices. Only two of the five measures, perceived doctor competence and concern of the doctor about the personal effect of care, differentiated potential suers from nonsuers. We had not expected this outcome because it is common to hear doctors and their professional organizations claim that improving communication skills will help prevent malpractice lawsuits. Our results tentatively suggest that patients are not affected by many of the procedural niceties of these efforts: involving the patient as partner, informing the patient about care, not rushing the patient's visit, and taking personal care about the patient's medical problem. Second, we have identified a rather distinct set of attributes that characterize suers. Suers extensively seek input from friends and relatives,

lawyer friends, and unnamed confidants in making their dispute resolution choices. They question their doctor's competence and concern about the personal effects of their medical problem, and believe that they have experienced a serious injury. At the same time, they have less knowledge about the health care and legal professionals' world but are more likely to have previous litigation experience. They tend to have fewer of society's resources that provide status and power. The models do not provide as distinctive a picture of "lumpits," "claimers," and "exiters" relative to the variables we have measured in this study. Future analysis should focus on identifying other variables that may help us understand how and why "lumpits," "claimers," and "exiters" make their choices.

The dispute transformation process model holds much potential for unraveling the medical malpractice muddle. So much of the policy related to medical malpractice is primarily designed to suppress the number of lawsuits and the size of the awards and is based too much, we believe, only on the symptoms of a much deeper malaise underlying medical malpractice lawsuits. By approaching the problem within a dispute transformation framework, and from the patient's point of view, we begin to get beyond the symptoms and into the fundamental causes. The next step is to conduct a prospective study that traces the transformations that lead or do not lead to lawsuits.

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