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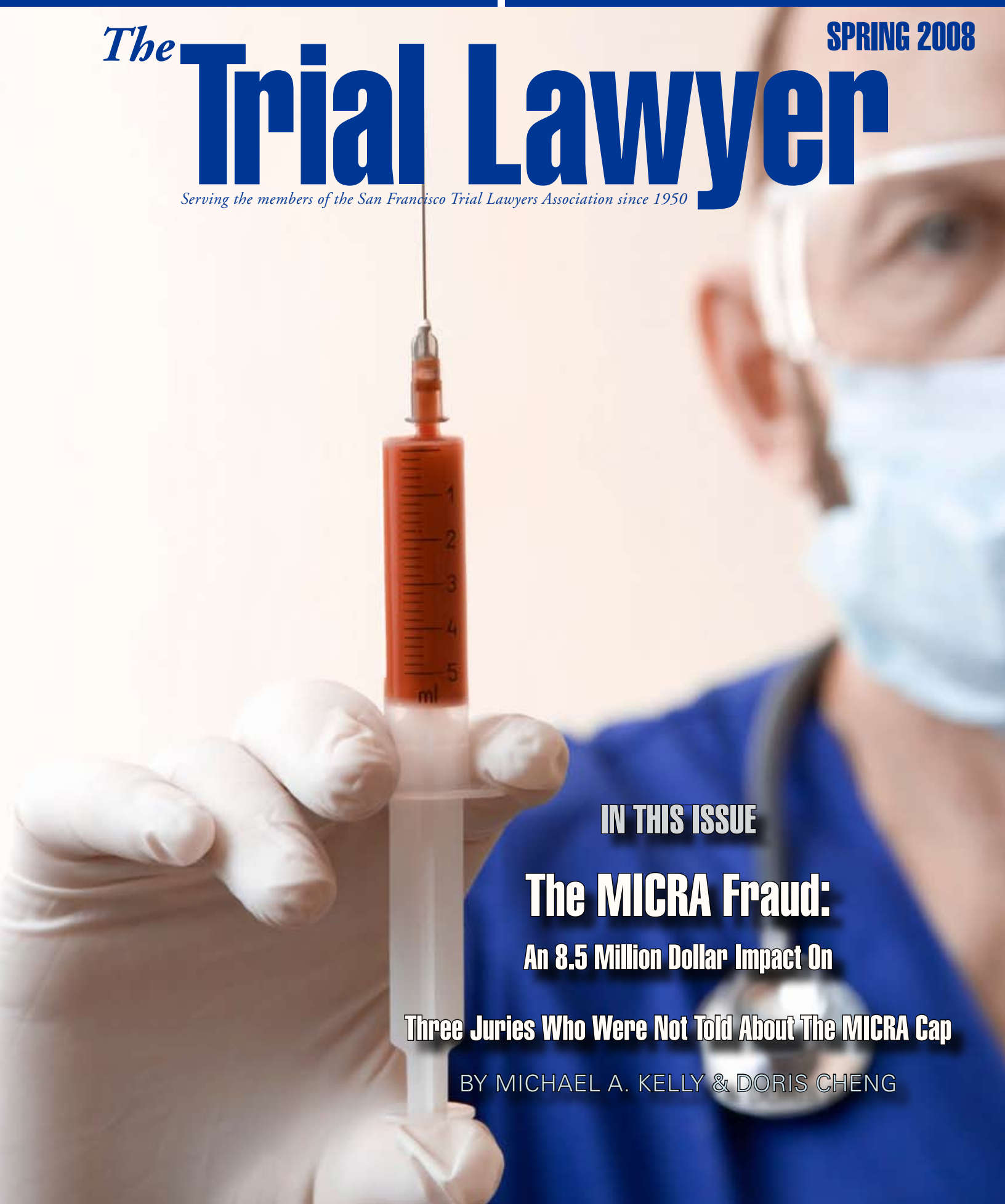

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BY MICHAEL A. KELLY & DORIS CHENG

Welcome to MICRA-world:
A Personal Essay on How MICRA Has Backfired to Hurt Patients

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I recently went through a near-death experience. Oh, actually it was my client who really was dying of bone marrow cancer. I just *felt* like I was dying over the course of two years of mindless litigation, protracted in time and cost because of the way the medical malpractice system (aka MICRA) has been rigged in favor of insurers, doctors and hospitals and against their patients, despite the stated lofty goals in the legislative h istory.

This article is not a MICRA practice treatise, there are many excellent articles and books on that. This article is very personal, and reflects the sometimes visceral reactions I had while I and my law partner wended our way through litigation of a case that you might think should have settled without filing a complaint.

Legislative Background

For the uninitiated, MICRA is the acronym for the Medical Injury Compensation Reform Act of 1975. It includes several different statutes, principally Civil Code ' 3333.2, which sets the $250,000 cap on emotional distress and pain and suffering damages, no matter how badly hurt, maimed or dead a patient is.

In terms of malpractice litigation, in enacting MICRA, the Legislature "attempted to reduce the cost and increase the efficiency of medical malpractice litigation by revising a number of legal rules applicable to such litigation." *American Bank & Trust Co. v. Community Hospital* (1984) 36 Cal.3d 359, 363 364.

Business and Professions Code section 6146, which is a MICRA statute, provides for limits on contingency fees for attorneys who bring actions within the scope of MICRA[1]. As we have stated, one of the purposes of such limits

is to discourage frivolous lawsuits, 'which may be stimulated by potentially huge attorney fee awards if cases are won ....' *Delaney v. Baker* (1999) 20 Cal.4th 23, 29, quoting *Roa v. Lodi Medical Group, Inc.* (1985) 37 Cal.3d 920, 931. This section also requires costs incurred in prosecuting a plaintiff's case to be deducted from the gross settlement *before* attorney's fees are calculated.

The Case

In early October, 2005, plaintiff, a 52-year-old accounting clerk whom I will call Michelle, began to experience back pain and weakness in her legs. Plain X-rays of her spine taken by her family doctor on October 4 were negative. On October 6, her symptoms became much worse: she had extreme weakness and numbness in one leg, and began to have bowel and bladder difficulty. Her family doctor had her admitted to the local hospital, and simultaneously ordered an MRI scan of her lumbar spine (low back) to

rule out a tumor. The family doctor also asked a neurologist, defendant Dr. DOE[2], to consult on the case. Dr. DOE examined her and arrived at a differential diagnosis of either transverse myelitis (spinal cord infection that has similar symptoms to a spinal cord lesion) or a possible tumor in the T-10 area of the thoracic spine (mid-back). Dr. DOE suspected that a tumor at T-10 was compressing her spinal cord because of the nature of the symptoms. Dr. DOE ordered a Athoraco-lumbar MRI ASAP to rule out spinal cord compression.

Both of the MRI orders were placed with the hospital and should have been processed through the hospital's Meditech system, which is a computerized system for transmitting MRI orders to the hospital's radiology department. However, in discovery plaintiff learned that only the lumbar MRI request was actually transmitted. As a result, on October 6 Michelle underwent only the lumbar MRI ordered by the family doctor, and not the thoracic-lumbar MRI order by Dr. DOE. The lumbar MRI was negative for tumor. A hospital chart note written on the MRI report by a registered nurse with 30 years of experience stated that the results were reported to Dr. DOE, on 10/6/05, at 1830 hours. Dr. DOE denied every receiving this call. He testified that at 1830 hours on October 6, he was giving a medical lecture at a restaurant far from his office. Instead, DR. DOE testified that he spoke on the phone sometime on October 7 with a radiologist at the practice group that read the MRI film. This radiologist, whose name Dr. DOE did not recall, told him they had scanned Michelle's spine all the way up and down and found no tumor. Dr. DOE did not chart this conversation. He did chart that the MRI was negative. He admitted that he never read the MRI report, or looked at the films.

Based on the negative oral MRI report , Dr. DOE arrived at the differential diagnosis of transverse myelitis, for which the treatment is time plus medication. By October 11, Michelle had lost all ability to bear weight on her legs and had lost all bowel and bladder function. She was a complete paraplegic, which is not a reversible condition. Dr. DOE saw her every day between October 6 and 25, but never looked at the MRI report or films, and maintained his diagnosis of transverse myelitis.

In late November, Michelle began to have new symptoms in her hands. Another doctor ordered an MRI of the thoracic spine, which revealed a large tumor at T-10. She underwent surgery shortly thereafter to remove the tumor, but she remained a complete paraplegic. Tests also showed that she had Stage 3 multiple myeloma (bone marrow cancer), which is a fatal disease. Her oncologist testified that she had, on average, three years to live, extended by an additional one to two years with stem cell therapy.

What Happened

You might think that a case where the hospital clearly dropped the ball by not taking the correct MRI would settle quickly. Not so in crazy mixed up MICRA-world. While the hospital signaled early on that it would accept some liability, it wanted the neurologist to contribute to settlement because the hospital felt the doctor was negligent as well. Dr. DOE refused. We were thus forced to file suit. This is where it gets interesting, and disillusioning.

Building the Case

There was a raft of initial written discovery by all sides, which basically showed that the hospital was refusing to take a position on whether the doctor committed malpractice, and, significantly, that the doctor blamed the hospital for not taking the MRI. Usually defendants will ally themselves in med-mal cases, so the doctor's blaming the hospital helped the plaintiff.

The deposition of Michelle's oncologist, a well-trained doctor who had attended Harvard and Stanford, revealed that her life expectancy was three to five years from time of diagnosis (with stem cell therapy).

We paid a lot of money to retain a physical medicine doctor, a life care planner, and an economist to work up a life care plan. We had big damages numbers for 24 hour care and for wage

loss. However, these numbers were somewhat "soft" in that an argument could be made that paraplegia did not prevent her from returning to her desk job. Also, there was an apportionment issue about how much of the life care was cancer-related compared to paraplegia-related.

In discovery, we learned that the doctor had a $1 million liability policy, and we served a CCP 998 for that amount. His carrier sent back a snippy letter saying that the doctor had absolutely no liability. His lawyer told us the doctor would never consent to a settlement.

Depositions of hospital personnel established exactly where the ball was dropped in the MRI ordering process, so it was clear that the hospital had failed to process the doctor's request for a Athoraco-lumbar MRI. However, the veteran hospital nurse was firm that she had personally told the doctor about the negative MRI on the telephone, and that she would have read the MRI report exactly, which would have included telling the doctor it was a lumbar MRI.

Chuck Geerhart's MICRA-World article to continue in the upcoming Summer issue of The Trial Lawyer Magazine