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# Who really benefits under MICRA?

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Here are two simple questions the medical community and its dark money source (the medical malpractice insurance industry) can't and won't answer: Why is the life of a child killed by medical negligence worth $250,000? And if $250,000 made sense in 1975, why doesn't its functional equivalent after decades of inflation make sense today?

Almost 40 years ago, the state Legislature capped medical malpractice noneconomic damages under the Medical Injury Compensation Reform Act, or MICRA, in response to an alleged "insurance crisis" that turned out to be manufactured by an insurance industry in a down cycle after hefty stock market losses. The centerpiece of MICRA remains a $250,000 cap on noneconomic damages. Just to be clear, the life of a child, a senior citizen or a non-income producing spouse is worth a mere $250,000. And left unchanged 40 years from now the same life will still only be worth $250,000.

To put this into proper perspective, what was $250,000 in 1975 is worth about $56,000 in 2014 - and it will continue to shrink. MICRA has never been adjusted to account for inflation or increased costs of living. Let's not mince words; the reality is that in 2014 MICRA has created near blanket immunity for doctors who kill children, seniors and anyone who doesn't earn a living. It is also virtually impossible to sue a doctor for disfiguring injuries, lost limbs, or any other harm caused by medical negligence where there are no future economic losses. Yet no one on the other side of the issue will talk about it.

They also don't want to talk about how the practice of medicine is radically different than it was in 1975. "Institutional medicine," "corporate hospitals," "HMOs," "PPOs," and "Primary Care Physicians" were not part of our daily vocabulary when Gerald Ford was president. People do not have the Marcus Welby warm-and-fuzzy feeling about physicians or medical care anymore. While most Californians generally trust their doctors, people are very wary of the medical industry as a whole. That leads to a deeper concern for patient safety. Preventable medical errors kill 440,000 people every year, according to a recent study in the authoritative Journal of Patient Safety, making negligence the third leading cause of death in the U.S.

In my capacity last year as the president of the Consumer Attorneys of California (CAOC), we tried to negotiate with the insurers, hospitals and doctors who support MICRA to adjust the $250,000 cap. The medical community refused to come to the table. This year California Senate President pro Tem Darrell Steinberg attempted to broker a deal; again, the same cast of characters would not negotiate. Their recalcitrance continued right up to the last day a negotiated deal could happen.

CAOC was left with no choice but to rally behind the Troy and Alana Pack Patient Safety Act of 2014 - named for children who died after being struck by a driver under the influence of illegally obtained medication. This initiative, which has qualified for this November's statewide ballot, puts the legal rights of medical malpractice victims in the hands of the California electorate. This initiative is sponsored by Robert Pack, the father of Troy and Alana, and Consumer Watchdog.

The Troy and Alana Pack Patient Safety Act has three components designed to

safeguard patients from medical malpractice and offer fairer relief should they become victims of medical malpractice. Those protections are: (1) mandatory drug and alcohol tests for doctors who have hospital privileges, and required peer-reporting of any suspected abuse or negligence; (2) a prescription database for controlled substances; and (3) an increased cap for noneconomic damages for victims of medical malpractice to adjust for inflation as measured by the Consumer Price Index.

The reasoning behind these three components makes sense and is hard to argue against when your safety is at stake. First, while studies show that alcohol abuse rates among doctors mirror alcohol abuse rates in the general population, the same cannot be said for drug abuse rates. Doctors naturally have better access to prescription drugs that can and are abused. These same doctors are the ones who treat patients in the ER and perform serious operations at all hours of the day. Yet no mandatory drug and alcohol testing exists for doctors, as it does for pilots, bus drivers, and others in safety-sensitive occupations. Drug and alcohol tests, as well as mandatory peer-reporting of any abuse or negligence, would easily filter out those doctors whose judgment may be impaired by drug abuse. The outcome will be increased patient safety in hospitals.

Similarly, a requirement that physicians use an existing prescription drug database for controlled substances would lower the risk of medical malpractice by corralling doctors who make a practice of over prescribing as well as those patients who may "doctor shop" to gain access to multiple, high-abuse-risk prescriptions such as oxycodone, Vicodin and other opioids. The database would allow doctors to see exactly what drugs patients are taking and thus lower the risk of over-prescribing - which would potentially lead to unintentional overdoses - or prescribing a drug that may fatally interact with one the patient is already taking. States that have implemented such mandatory checks of a prescription drug database have seen a huge cutback in over prescribing; in California, the savings on Medi-Cal prescriptions could save state and local governments more than $400 million a year.

Finally, increasing the $250,000 cap to reflect modern dollar amounts would provide a safety net to those patients who unfortunately become victims of medical malpractice. It would also provide incentive to medical practitioners to be more careful when treating patients because being careless could result in a more serious financial blow. Currently, the medical community is practically immune from the legal system because it knows the worse that could happen when committing malpractice is a slap on the wrist, no matter how egregious the act. Think about it: A doctor would be limitlessly liable if he ran over a child on the street, yet if he negligently injures or kills a child during a routine operation, the worst that would happen is a $250,000 award, regardless of a sympathetic jury to the victim’s family.

Opponents of the Troy and Alana Pack Patient Safety Act may scoff and point to "greedy lawyers" wanting to change the law for a big pay day. But the act does not remove the limitations of the sliding-scale attorney fees already in place under state law. They have argued in the past that MICRA helps keep low income community health clinics open yet didn’t bother to check that recent changes to federal law means that 90 percent of all clinics are defended and indemnified by the U.S. government for medical malpractice under the federal Tort Claims Act if they receive any federal funding.

Opponents may also argue that MICRA as it currently stands protects patients by keeping insurance premiums down, thus allowing greater access to health care. Patients, however, are not protected by medical malpractice caps; only medical providers and their insurance companies are. Moreover, insurance premiums would not increase rapidly if the law changes; 1988’s Proposition 103 already prevents ridiculous hikes by insurance companies by giving the insurance commissioner the power to regulate malpractice insurance rates. One of Dave Jones’ first acts when he became insurance commissioner in 2012 was to return more than $52 in overcharged insurance premiums to the doctors.

The only people who truly benefit from the current law are insurance companies and big-time medical practitioners like hospitals. The less noneconomic damages that patients can recover for medical malpractice, the more premium money insurance companies keep in their already-deep pockets and the less cautious practitioners have to be when treating patients. A balance between access to justice and access to healthcare can and must be achieved, and it can be delivered by passing the Troy and Alana Pack Patient Safety Act of 2014.

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