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The American Medical Association vs. the American Tort System

Jeff Essen
Lisa Aldred
THE AMERICAN MEDICAL ASSOCIATION
VS. THE AMERICAN TORT SYSTEM

JEFF ESSEN* AND LISA ALDRED**

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I. INTRODUCTION

In 1794, a Pennsylvania physician was sued for medical negligence arising out of his treatment of yellow fever victims in what may have been the first American medical malpractice case. The defendant's name was Dr. Benjamin Rush—best known as a signer of our Declaration of Independence. Although malpractice cases were rare prior to World War II, history records that one Illinois physician had the distinction of being defended in 1860 by a vigorous young lawyer named Abraham Lincoln. The right of a patient to sue a physician is not a recent aberration of American law and it is, in fact, well established in our legal system.

Physicians, like all humans, are prone to act negligently from time to time—despite the best of intentions—and that negligence

* B.A. 1974, Duke University, J.D. 1981, University of North Carolina School of Law, recently retired from position as partner in the law firm of McCain & Essen, a firm specializing in medical negligence cases.

** B.A. 1981, Duke University, J.D. 1985, University of North Carolina School of Law, associated with the firm of McCain & Essen.


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will sometimes cause injury to other persons. Our legal system has concluded that as between the innocent victim and the negligent tortfeasor, the cost of injury should be borne by the negligent party. As a democratic country, the United States has attempted to apply this precept in its legal system to all segments of our society—from white-coated physicians to blue-collar truck drivers, and even to pinstriped attorneys. Despite the fact that the viability of medical negligence claims has been established for centuries in our legal system, attorneys have only recently obtained more than occasional success in the courtroom in obtaining recoveries for the victims of medical negligence. Since physicians (like truck drivers, attorneys and other members of society) are generally insured against acts of negligence, most of the debate concerning malpractice has centered on the cost and availability of malpractice insurance.

In the late 1960s, plaintiffs’ attorneys were beginning to successfully litigate medical negligence cases in a few states, and by 1969, a United States Senate subcommittee reported a marked increase in state legislation concerning medical malpractice. By 1975, insurance companies sought significant increases in premiums for medical negligence coverage. In the mid-1970s, the St. Paul Fire & Marine Insurance Company insured over ninety percent of the physicians and surgeons practicing in North Carolina and in September 1975, that company stated that it had decided to cease offering such coverage in North Carolina. The North Carolina Medical Society helped form a competing malpractice insurer—Medical Mutual Insurance Company of North Carolina—and interestingly, St. Paul soon dropped its threats of


5. The following articles are a handful of the many which appeared in the mid-1970's stating the marked increase in insurance premiums: Owens, How Much Have Medical Insurance Premiums Gone Up, MEDICAL ECONOMICS, Dec. 27, 1976, at 102-08; NEWSWEEK, June 9, 1975, at 58; U.S. NEWS AND WORLD REPORT, Jan. 20, 1975, at 53.
leaving North Carolina. Nevertheless, the question of lawsuits against physicians became a highly charged emotional issue in the mid-1970s and in some areas physicians responded to the insurance problems by threatening to close their offices, while hospitals threatened to admit only emergency patients. Indeed, in San Francisco, New York City, Pennsylvania, Rhode Island, Wisconsin and Texas, physicians actually withheld medical services and held public demonstrations.

Commentators and critics disagreed in their assessment of who or what was to blame for the medical malpractice insurance crisis. Proponents of the medical profession and the insurance industry blamed insurance premium increases on the number of medical malpractice actions as well as on larger verdicts in those actions. Various scholars and public interest/consumer rights groups, on the other hand, pointed a sharp finger at the medical profession and the insurance industry. In the mid-1970s, the American Medical Association and the insurance industry lobbied heavily in many states advocating legislative relief in the area of medical negligence.

In North Carolina, a Professional Liability Insurance Study Commission was appointed, and that Commission filed a lengthy report with the General Assembly on March 12, 1976. Interestingly, "the regular voting membership of the Study Commission during its extended deliberations consisted of two doctors, two insurance company representatives, a hospital administrator and a

7. Warren, supra note 1, at 162.
8. Id.
9. For a general discussion of how all groups affected by the medical malpractice problem blame other groups, see Warren, supra note 1, at 462-63.
10. The consumer point of view has been advocated by, among others, the Public Citizen Health Research Group. In a recent report, the Group lambasted the medical profession for not disciplining their members who have committed negligent acts. Public Citizen Health Research Group Report, Medical Malpractice: The Need for Disciplinary Reform, Not Tort Reform (1985) (printed by Public Citizen, Suite 605, 2000 P Street, N.W., Washington, D.C. 20036).
12. STUDY COMMISSION REPORT, supra note 6.
pharmacist."13 Virtually all of the witnesses called by the Study Commission were representatives of insurance companies or the medical profession and, not surprisingly, the Commission made numerous recommendations for legislative change in the area of medical negligence lawsuits.14

Following the Study Commission report, the North Carolina General Assembly enacted the following legislation:

1. A special professional statute of limitations.16
2. A statutory "same or similar communities" standard of care for medical negligence cases intended to stave off judicial adoption of nationwide standards.16
3. An informed consent statute which precludes recovery if a "reasonable person" would have consented if properly informed, regardless of the preferences of the individual.17
4. A statute which precludes an action against a physician on a guarantee unless the guarantee was in writing.18
5. A rule of procedure prohibiting any public ad damnum clause in excess of $10,000 to avoid publicity regarding large claims.19

Interestingly, even before the legislation adopted by the various state legislatures had time to take effect, the clamor of malpractice "crisis" evaporated as quickly as it had formed.20

After the dust had settled, various investigators began to examine the information which had been provided to the North Carolina General Assembly and other legislatures by the insurance industry, the American Medical Association and other medical

13. STUDY COMMISSION MINORITY REPORT, supra note 3, at 20.
14. STUDY COMMISSION REPORT, supra note 6. Although many of the Study Commission recommendations were enacted into statute (see infra note 15-19 and accompanying text) the recommendations for modification of the collateral source rule and for giving trial courts the discretion to award periodic payments did not result in legislation (and these proposals are expected to receive particular attention in the coming legislative discussions).
lobbyists. Essentially, the information which had been provided to the various state legislatures while they were considering tort reform proposals in the mid-1970s tended to support the physicians' claim that they were paying higher insurance premiums and the insurance companies' assertion that they were losing money. The problem with calculating profits for malpractice insurers is that claims are seldom reported or paid the same year in which premiums purchase that coverage, and some investigators asserted that the insurance companies had not provided fair information in their lobbying for legislative reforms. The complaint by the St.

21. See, e.g., infra notes 22-23.


The point is that for lines like malpractice that have a "long tale," where years may pass before final losses are known (auto liability and product liability being two other prime examples), the 'profits' insurers report are little more than guesses; those guesses are often conservative; and the cash that sits around to be invested in the meantime is a gold mine.

In figuring profits—which a company has to do, among other things, to pay taxes—insurers must guess at the "severity" of claims not yet settled. Will they cost, on average, $20,000 or $200,000? Hard enough. But they also must guess at the "frequency" of claims that will be, but have not yet been, made. Will there be 200 claims—or 2,000? By multiplying its guess on the number of claims not yet made by its guess as to how much the average claim will cost, it arrives at an estimate of losses. These "losses"—guesses that you or I might round off to the nearest $10 million, but that the St. Paul and its competitors round off to the nearest dollar—come under the heading 'IBNR.' Incurred But Not Reported. They are treated like any other cost of doing business, as if the cash were actually out the door. IBNR: as much a part of insurance accounting as RBI is part of baseball.

If time proves these estimates to have been conservative, an adjustment will be made and additional profit reported. And taxed. But in the meantime, the insurer has use of the money.

From 1975 through 1978, during the early part of which the nation was suffering a crisis in the availability of medical malpractice insurance because insurers felt they were not being paid adequately for the risk, the St. Paul took in $415 million in malpractice premiums and paid out $27 million in claims and claims-settlement expenses. Even so, in the Fall of 1978, a St. Paul executive told the Conference of Insurance Legislators (an association of state legislators) that St. Paul has lost money in medical malpractice throughout 1975, but that the line had been "generally profitable" during 1976 and 1977. All of this was based on estimates and assumptions, presumably made in good faith, that only time could corroborate. (At the time of the speech, $52.7 million in premiums had been
Paul Insurance Company, through the Study Commission, that it was losing money on malpractice insurance in North Carolina seems to have been more accounting fiction than evidence of a real "malpractice crisis" and one fascinating study of malpractice insurance notes that:

There is some evidence indicating that in recent years the malpractice insurance industry has overstated the reserves set aside for reported claims. For example, in 1974, when St. Paul requested an 82 percent rate increase for North Carolina, a task force from the State Insurance Department made an on-site review of the company's claims files at its home and local offices. Its examination concluded that claims reserves for claims actually paid were overstated by 33 percent, and that 19 percent of all reserves were held for claims which were settled without payment.23

Following the legislative reforms of the mid-1970s in North Carolina, medical malpractice insurance rarely made headlines and the two active medical malpractice insurers—St. Paul and Medical Mutual—seemed to prosper. In 1982, representatives of North Carolina's physician-owned Medical Mutual Insurance Company noted that since the company was formed in 1975, it had actually been able to reduce premium rates so that only with the most recent increases were physicians paying as much as they had been in 1975.24 Another representative of Medical Mutual Insurance Company noted that North Carolina physicians enjoyed the lowest pre-

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23. S. Law & S. Polan, supra note 6, at 182, quoted in Dixon, 63 N.C. App. at 600, 306 S.E.2d at 482.
miums for medical malpractice of any state in the United States.\textsuperscript{25}

During the approximately ten years since the last scramble of intense national debate over medical malpractice actions, the American Medical Association has been quietly planning strategy and raising funds. According to the Federal Election Commission, the American Medical Association's PAC, AMPAC, was the fifth wealthiest political action committee in the United States for the 1983-84 election cycle, posting receipts of $4 million.\textsuperscript{26} In the category of Professional Societies, AMPAC was by far the wealthiest, representing almost one third of the total funding for the top fifty PACs in the Professional Societies category. Indeed, of those top fifty PACs in the Professional Societies category, only one, the PAC of the Association of Trial Lawyers of America, represented the legal profession and the trial bar, while the remaining forty-nine represented medical and dental societies.\textsuperscript{27}

By the mid-1980s, the American Medical Association and the insurance industry were issuing frequent press releases tending to support their contention that a new malpractice crisis had arrived.\textsuperscript{28} Much of the media effort has been aimed at projecting the image that malpractice premiums are responsible for high medical costs in America. However, the A.M. Best Company, which studies the insurance industry, reports that total health care costs in the United States in 1983 were $355.4 billion, and malpractice insurance premiums for that year cost a total of $1.5 billion; in other words, the total cost of medical malpractice claims in 1983 (including monies paid to defense attorneys, plaintiffs' attorneys, insurance company employees and victims themselves) was less than one half of one percent of the cost of health care in the United States. That amounts to only $6.08 for the average citizen for that year.\textsuperscript{29}


\textsuperscript{27.} Id.

\textsuperscript{28.} Beginning in October 1984, the American Medical Association Special Task Force on Professional Liability and Insurance published three heavily publicized reports entitled \textit{Professional Liability in the 80's} (Report I and Report II) and \textit{A.M.A. Special Task Force on Professional Liability and Insurance Action Plan} (calling for an "intensive" public relations campaign), which were the cornerstone for the A.M.A. media campaign.

In attempting to justify large rate increases, insurance companies have projected the myth that large jury verdicts have caused disastrous drains on the assets of insurance companies. Interestingly, as of June 1985, the A.M. Best Company reported that the property/casualty stock index had increased in value 47 percent over the previous 2½ years indicating that Wall Street investors clearly believe that the insurance industry is healthy.

Nevertheless, the American Medical Association and the insurance industry have orchestrated a nationwide lobbying effort for malpractice “reform” legislation intended to promote lower insurance premiums by curtailing the rights of the medical malpractice victim. The 1985 North Carolina General Assembly created a “North Carolina Medical Malpractice Study Commission,” and that Commission is currently considering various proposals advanced by the American Medical Association, including the following:

1. A ceiling, or cap, on non-economic damages (pain and suffering);
2. Limitations on attorneys’ contingent fees;
3. Periodic payments of large damages rather than lump sum awards;
4. Elimination of the collateral source rule.

This article examines these legislative proposals in the context of constitutional challenges and general American tort law.

II.ceilings on Recovery

One goal of American tort law is to fairly and fully compensate the victims of negligence for their injuries. As the North Carolina Supreme Court has expressed, “[t]he plaintiff is entitled to recover the present worth of all damages naturally and proximately result-

30. Id.
ing from defendant's tort."\textsuperscript{33} Much of the clamor over "tort reform" has centered on proposals to put a statutory cap or ceiling on the amount of damages a plaintiff can receive. Although a few proposals limit all damages, the more typical approach is to try to limit non-economic (general) damages.

Out-of-pocket expenses like lost wages and medical expenses can be calculated with some certainty. We simply cannot use an adding machine to calculate the value of a loss of the ability to see our surroundings, to talk to our loved ones, to rise out of bed and walk, to breathe without a respirator, to live free from agonizing pain, or simply to enjoy the myriad of sensations which constitute life. Our jury system has evolved, in part, to allow citizens to place a value on such non-economic damages and other forms of human suffering.

Making the victim whole is a cornerstone principle of all damages law. The suggestion that a certain class of tort victims—namely, the most seriously injured victims of medical negligence—should be deprived of the full monetary recovery which is available to all other members of our society, seems repugnant to the Constitution, our system of tort law, and any concept of fundamental fairness. Nevertheless, the AMA task force and the insurance industry began to press in the mid-1970s for a legislatively imposed ceiling, or cap, on the amount of such non-economic damages which a jury could award.\textsuperscript{34} Indeed, over a third of the state legislatures were persuaded to adopt such ceilings on recovery.\textsuperscript{35}

The various statutes enacted by the state legislatures vary in


\textsuperscript{34} For a general review of limitations on recovery, see Richards, Statutes Limiting Medical Malpractice Damages, F.I.C. QUARTERLY 247 (Spring, 1982).

the types of damages which they limit. Some of the statutes limit the total award to any one victim, even if that award is less than the total amount of economic damages incurred for lost wages, medical expenses, and the like. Other statutes place a cap only on non-economic (general) damages or on non-medical damages. Some statutory schemes place a ceiling on the amount recoverable from any individual health care provider.

Most of the statutes limiting the liability of a health care provider have also implemented a Patient Compensation Fund—a state-sponsored fund to provide for recovery of damages in excess of the health care provider's liability. However, most of these Patient Compensation Funds impose a ceiling on the aggregate amount of recovery available. At least one state has enacted a statute limiting the total amount of damages any individual physician can be held liable for in a single year. In addition to variations in the types of damages covered, the state statutes also differ in the amount of the ceiling which they impose.

36. Among the states placing a limitation on overall recovery in medical malpractice cases are the following: Florida, Idaho, Illinois, Indiana, Louisiana, North Dakota, Ohio, and Virginia. See supra, note 35.

37. Among the states imposing a limitation on non-economic damages in medical malpractice actions are the following: California, Montana, and New Hampshire. See supra note 35.

38. Among the states imposing a limitation on health care providers' liability in medical malpractice actions are the following: Florida, Idaho, Indiana, Louisiana, New Hampshire, Nebraska, Oregon, and Wisconsin. See supra note 35.

39. Of the eight states listed supra, note 38, which have enacted statutes imposing limitations on health care providers' liability, only one, Idaho, does not have some kind of excess liability fund.

40. Wisconsin has enacted as statute which placed an annual aggregate ceiling on a health care provider's liability at $600,000. See Wis. Stat. § 655.23 (Supp. 1985).

41. (a) California: $250,000 on non-economic damages; (b) Florida: $500,000 per claim (escalates by $50,000 each July 1st)/$500,000 per occurrence; (c) Idaho: $300,000 limit on aggregate recovery; (d) Illinois: $500,000 on aggregate recovery; (e) Indiana: $300,000 on aggregate recovery; (f) Louisiana: $500,000 on aggregate recovery; (g) Montana: state not liable for any non-economic damages in a medical malpractice action; (h) Nebraska: $100,000 per health care provider; (i) New Hampshire: $250,000 limit on non-economic damages; (j) New Mexico: $500,000 limit per incident except for punitive damages and medical expenses; (k) North Dakota: $300,000 limit per occurrence; (l) Ohio: $200,000 on general damages in non-death cases; (m) Oregon: limitation on health care provider liability; $100,000 per claim and $300,000 per occurrence; (n) South Dakota: $500,000 limit on general damages; (o) Texas: $500,000 limit on non-medical expenses/damages; (p) Virginia: $1,000,000 limit on total recovery; (q) Wisconsin: $200,000 per practi-
Despite individual differences in the state statutes limiting medical malpractice recovery, they all raise constitutional questions, including equal protection and substantive due process. The constitutionality of ceilings on damages in medical malpractice actions has been challenged in almost every state where such legislation has been passed. The majority of the state courts which have considered the question have struck down the statutes limiting recovery as unconstitutional.

The decisions have generally recognized that ceilings on recovery in medical malpractice actions create at least three discriminatory classifications: (1) the ceilings provide a benefit on health care providers not available to other tortfeasors; (2) the ceilings impose a restriction on victims of medical malpractice not required of other tort victims; (3) the ceilings discriminate against medical malpractice victims whose injuries exceed the specific limitations (who receive only partial compensation) in favor of those victims who suffer relatively minor damages (who are allowed full recovery). In addition to creating discriminating classifications, these ceilings on damages infringe on the medical malpractice victim's right to sue in tort for full recovery guaranteed by the substantive


43. The following states have struck down the statutes limiting medical malpractice recovery: Florida, Idaho, Illinois, Montana, New Hampshire, North Dakota, and Ohio. See supra note 42.

44. See, e.g., Carson v. Maurer, 120 N.H. 925, 931, 424 A.2d 825, 830 (1980).
due process provisions of our federal and state constitutions.\(^\text{45}\)

State courts have evaluated these discriminatory classifications and their infringements on medical malpractice victims' rights under all three judicially recognized levels of scrutiny: strict scrutiny,\(^\text{46}\) middle-tier,\(^\text{47}\) and the rational basis test.\(^\text{48}\) Although the tests have varied, the conclusions have generally been the same. Most of the state courts have declared the statutes unconstitutional because they found the connections tenuous between the underlying legislative goals and the means chosen to implement the goals.\(^\text{49}\)

For example, the New Hampshire Supreme Court acknowledged the legislative goal of decreasing the costs of the medical injury reparations, but held that placing a $250,000 limit on medical malpractice victims' non-economic damages would do little to achieve that goal.\(^\text{50}\) The court recognized that the amount of money paid out in damage awards constitutes only a small part of total insurance premium costs\(^\text{51}\) and noted further that few patients suffer non-economic damages in excess of $250,000.\(^\text{52}\) The court went on to hold:

It is simply unfair and unreasonable to impose the burden of supporting the medical care industry solely upon those persons who are the most severely injured and therefore most in need of recovery.\(^\text{53}\)

An Ohio appellate court similarly rejected limitations on the amount of recovery for medical malpractice victims, writing:

[T]here is no crisis, short of civil insurrection, sufficient to deprive, water down, or make less valuable the right to seek redress of grievances, to a dollar amount fully compensating one for his

\(^{45}\) See, e.g., White v. State, 661 P.2d 1272, 1275 (Mont. 1983).

\(^{46}\) See id.; Simon v. St. Elizabeth Medical Center, 3 Ohio St. 2d 164, 355 N.E.2d 903 (1976).

\(^{47}\) See Jones v. State Bd. of Medicine, 97 Idaho 859, 555 P.2d 399 (1976); Arneson v. Olson, 270 N.W.2d 125 (N.D. 1978).

\(^{48}\) See Baptist Hosp. of Southwest Tex. v. Baber, 672 S.W.2d 296 (Tex. App. 1984).

\(^{49}\) Seven of the twelve states considering the constitutionality of statutes limiting medical malpractice recovery have struck down this legislation as unconstitutional. See supra notes 42-43.

\(^{50}\) Carson v. Maurer, 120 N.H. 925, 944, 424 A.2d 825, 838 (1980).

\(^{51}\) Id. at 940, 424 A.2d at 836.

\(^{52}\) Id.

\(^{53}\) Id. at 942, 424 A.2d at 837.
At least three state courts have upheld some type of limitation on medical malpractice recovery (all under a rational basis test), although one statute only applied to plaintiffs who voluntarily agreed to be bound by an administrative panel and another statute applied only to malpractice claims against the state.

The proposals to limit recoveries are based on convincing legislators that insurance companies are facing a crisis and that large recoveries have a substantial impact on health care costs. As outlined in the introduction to this article, however, insurance companies at the current time are economically healthy and the total cost of malpractice premiums is still less than one half of one percent of the total cost of health care in the United States. Moreover, no one has yet determined what impact malpractice cases have in encouraging responsible medical care and weaning out irresponsible and incompetent practitioners. Thus, there is simply no factual justification for ceilings on recoveries as a means of slashing the total cost of health care in America.

Proposals to place a ceiling on recoveries were made to the North Carolina General Assembly in the 1970s and were rejected.

55. The following states have upheld the constitutionality of legislation placing limits on medical malpractice recovery: California, Louisiana, and Nebraska. See supra note 42.
56. The Nebraska statute sets up a system whereby a medical malpractice plaintiff voluntarily elects to have his or her claim tried by a malpractice panel. If the plaintiff exercises this option, his or her recovery is subject to statutory limitations. In upholding the constitutionality of this legislation placing ceilings on recovery, the Nebraska Supreme Court emphasized the voluntary nature of the statute. See Prendergast v. Nelson, 199 Neb. 97, 116, 256 N.W.2d 657, 669 (1977).
57. The Louisiana statute places a ceiling on medical malpractice recovery only in claims against the state. The Louisiana Supreme Court reasoned that a limitation on the state's liability for medical malpractice actions brought against it was reasonably related to the goal of assuring the availability of affordable public health care to citizens of the state. See Sibley v. Bd. of Supervisors of La. State Univ., 462 So. 2d 149, 157 (La. 1985).
58. See text accompanying notes 29-30, supra.
59. In addition to providing damages to victims, another important goal of tort law is to deter future acts of negligence. To the extent medical malpractice litigation helps curb acts of medical negligence it also reduces the expense of providing nursing and physician care for those damaged victims of medical negligence.
60. Even the 1976 Study Commission refused to endorse this proposal, writing: "Because of the question as to the constitutionality of an absolute limit on
As outlined above, many state court decisions held that similar statutes enacted in the mid-1970s were an unconstitutional denial of equal protection because they singled out the victims of medical negligence. Therefore, the American Medical Association and the insurance industry are beginning to switch strategy and broaden their demands to cover all tort victims—in the hopes of withstanding constitutional challenge if the statutes are passed.61

When negligence leaves a victim to suffer daily for sixty to seventy years, we cannot legislatively reduce that lifetime of torture to some fixed dollar amount proposed by the insurance carrier or the tortfeasor. The concept that a tort victim should be fully compensated for his injuries, to the extent possible by monetary award, is absolutely central to our system of tort law; any attempt to qualify that right is a serious threat to our tort system of transferring the burden of negligent acts from the victim to the tortfeasor. The same rules of law should apply to those persons who suffer minor injuries as to those persons who suffer catastrophic injuries, and it would be unfair and morally unjust to penalize those few negligence victims who suffer catastrophic injuries by legislatively denying them the full protection of law.

III. LIMITATIONS ON CONTINGENT FEES

Attorneys' contingent fees are perhaps the most emotional aspect of malpractice cases in the eyes of many physicians. Unaware of the months and years of pre-trial preparation, and without consideration of the unsuccessful cases which result in no attorneys' fees, these physicians are incensed that an attorney can emerge from a two or three week malpractice trial with a large fee.62 Of course, the fee is deducted from the jury's award to the plaintiff, in accordance with the attorney's employment contract, so there can be no direct savings to the physician or the insurance industry by a statutory prohibition of, or a limitation on, such contingent fees. Consumer groups or malpractice plaintiffs have not been critical of the system of contingent fees, and it is obvious that the medical recovery for malpractice, the Commission does not recommend legislation placing a ceiling on damages.” STUDY COMMISSION REPORT, supra note 6, at 32.


insurance lobbyists are attacking contingent fees as an indirect way of preventing malpractice victims from securing competent representation in pursuing their claims.

The Rand Corporation conducted a study of the impact of contingent fees in personal injury litigation in 1980 at the request of the United States Department of Health, Education and Welfare. The study, written by Professor P.M. Danzon of Duke University, concluded that:

The analysis disputes the allegation that contingent fees result in excessive (above competitive) awards for attorneys. What little empirical evidence is available confirms that, averaging over cases won and lost, the effective hourly earnings of attorneys paid on a contingent basis are similar to the hourly earnings of defense attorneys paid by the hour.

... 

Restriction on contingent fees would also tend to be regressive, deterring low- and middle-income plaintiffs from filing even meritorious suits. Conversely, the common allegation that the contingent fee induces attorneys to bring claims with little legal merit has no basis in logic. The fact that the fee depends on winning provides an incentive to screen out cases with little legal merit—an incentive that is lacking with an hourly fee.

... 

Even if the explicit policy objective were to reduce frequency of suits, size of awards, and expenditure on litigation, it is doubtful that limiting contingent fees is an efficient means of achieving these results.

Nevertheless, at least twenty states have passed legislation limiting contingent fees in some respect.


64. Quoted in Self-Preservation of a Privileged Class: An Analysis of the Florida Medical Association's Proposals to Further Insulate Medical Doctors from Liability for Malpractice at 11 (The Academy of Florida Trial Lawyers, 1982).

65. States which have passed legislation modifying contingent fees include the following: (a) Arizona [ARIZ. REV. STAT. ANN. § 12-568 (1976)]; (b) California [CAL. BUS. & PROF. CODE § 6146 (1975)]; (c) Delaware [DEL. CODE ANN., tit. 18, §
At present, no state has completely abolished the contingent fee system in medical malpractice actions or in personal injury actions in general. The statutes which have been passed generally fall into three categories. (1) Some statutes allow the trial court to determine a reasonable contingent fee or, in the alternative, to review the contractually agreed upon contingent fee for "reasonableness." 66 (2) Other statutes establish a fixed percentage for the contingent fee, no matter what the amount of recovery. 67 (3) Several states have adopted a sliding scale contingent fee system, whereby the percentage of fee taken by the attorney decreases as the total amount of the award increases. 68

All statutes which limit contingent fee contracts between medical malpractice victims and their attorneys raise serious constitutional questions. Possible equal protection violations occur, since the limitations create classifications which discriminate against (1) those tort victims who are injured by medical malpractice, (2) those attorneys who represent medical malpractice plaintiffs, and (3) those victims of medical malpractice who cannot afford to pay attorneys up-front on an hourly basis. 69 Whether judged under a

66. Statutes allowing trial courts to determine or review "reasonableness" of contingent fees have been enacted in the following states: Arizona, Florida, Hawaii, Iowa, Kansas, Maryland, Nebraska, and Washington. See supra note 65.

67. Statutes imposing fixed percentage limitations on contingent fees have been enacted in the following states: California, Delaware, Indiana, New York, Oregon, Pennsylvania, Tennessee, and Wisconsin. See supra note 65.

68. Statutes implementing sliding scale schemes with regard to attorney contingent fees have been enacted in the following states: Florida, Illinois, New Hampshire, and New York. See supra note 65.

69. The New Hampshire Supreme Court held that a statute imposing a scale on attorneys' fees in medical malpractice actions violated equal protection guarantees. See Carson v. Maurer, 120 N.H. 925, 945, 424 A.2d 825, 839 (1980). The court determined that the statute unfairly burdened medical malpractice plaintiff attorneys. By making medical malpractice claims less attractive to attorneys, the statute also burdened medical malpractice victims, making it more difficult for
strict scrutiny, middle tier or rational basis test, the validity of such statutes under an equal protection challenge depends, in large part, on the degree to which such statutes are effective in reducing health care costs and promoting the availability of good medical care.

As noted above, the total cost of malpractice insurance premiums constitutes less that one-half of one percent of the total cost of health care in America and therefore, it is difficult to see how the fee arrangement between malpractice victims and plaintiff's attorneys could have any significant impact on total health care costs. Further, common sense reveals that an attorney's fee which is contingent upon a successful recovery will discourage attorneys from pursuing non-meritorious cases while a fee structure involving hourly charges, regardless of the outcome, would invoke no economic disincentives to the attorney for pursuing non-meritorious claims. 70 There is no logical or rational relationship between limitations on attorneys' contingent fees and achieving better health care for our citizens and there is simply no legitimate state interest furthered by such a limitation.

Restriction of plaintiff's attorneys' contingent fees in medical malpractice cases also raises substantive due process issues under both the United States Constitution and the "law of the land" that "courts shall be open" requirements of the North Carolina Constitution. 71 Any statute which tends to impinge upon the right of an injured person to seek redress of his grievances by preventing him

them to obtain legal representation. The court then reasoned that the reapportionment of damage awards was unlikely to reduce medical malpractice insurance rates. Therefore, the discriminatory classifications were not justified in terms of obtaining the legislative goal.

However, a Florida appellate court upheld a statute which made attorney contingent fees subject to review for reasonableness. See Florida Medical Center, Inc. v. Von Stetina, 436 So. 2d 1022, 1030 (Fla. 1983) The appellate court held that the statute did not offend equal protection because it created a reasonable classification which bore a reasonable relationship to a permissible legislative objective.

The Supreme Court of California held that specific statutorily imposed limits on contingent fees did not offend equal protection guarantees. See Roa v. Lodi Medical Group, Inc., 37 Cal. 3d 920, 695 P.2d 164, 211 Cal. Rptr. 77 (1985).

70. See also Reder, Contingent Fees in Litigation with Special Reference to Medical Malpractice, in The Economics of Medical Malpractice 218 (Rottenberg ed. 1978) (discussing a study which indicates that over 400 attorney hours are spent on the average malpractice case which results in a "zero recovery" after trial).

71. N.C. Const. art I, § 18.
from freely contracting for the employment of an attorney of his choice may run afoul of these constitutional guarantees.\textsuperscript{72} The United States Supreme Court has consistently held that the right of access to the courts can only by restricted where necessary to achieve a compelling state interest.\textsuperscript{73}

Restriction of attorneys' contingent fees has also raised other constitutional problems. At least one state court has overturned the legislatively imposed restrictions on the basis that they interfered with the judiciary's province to regulate attorney conduct.\textsuperscript{74} Another state court has specifically stricken such a statute as a violation of the constitutionally protected freedom of contract.\textsuperscript{75}

In 1976, the North Carolina Professional Liability Insurance Study Commission rejected any suggestion of controls on contingent fees, as follows:

After hearing various medical, legal and insurance people, the Commission saw no problems concerning, or evidence of, abuse of contingency fees, and therefore it does not recommend legislation to regulate attorneys' fees in malpractice actions.\textsuperscript{76}

As a practical matter, the contingent fee system is essential for victims in most personal injury cases to have any chance of recovery.

\begin{itemize}
\item \textsuperscript{72} Statutes imposing limitations on attorney contingent fees restrict a negligently injured victim's right to redress of grievances in a number of ways. Because contingent fees are limited only in medical malpractice cases and since the costs to the attorney are much lower in general personal injury, the plaintiff bar is likely to abandon the medical malpractice field. \textit{See Chief Justice Bird's dissent in Roe}, 37 Cal. 3d at 944, 695 P.2d at 180, 211 Cal. Rptr. at 93. Those lawyers who do continue to take medical malpractice cases may still be forced to exclude certain plaintiffs with valid claims. In states which impose a fixed percentage limitation, there may be no incentive for attorneys to take smaller claims. In states where there is a sliding scale contingent fee limitation, attorneys may be dissuaded from taking the more complicated and time-consuming actions.
\item \textsuperscript{73} The right of access to the courts for the resolution of civil disputes between private parties is encompassed by the right of petition protected by the first amendment. \textit{See United Transportation Union v. Michigan Bar}, 401 U.S. 576, 578 (1971).
\item \textsuperscript{74} The right of access to the courts for the resolution of civil disputes between private parties is encompassed by the right of petition protected by the first amendment. \textit{See United Transportation Union v. Michigan Bar}, 401 U.S. 576, 578 (1971).
\item \textsuperscript{75} \textit{Carson v. Maurer}, 120 N.H. 925, 945, 424 A.2d 825, 839 (1980).
\item \textsuperscript{76} \textit{Study Commission Report}, \textit{supra} note 6, at 34.
\end{itemize}
Hourly legal fees are simply prohibitive for most citizens in any type of substantial dispute. Restrictions on attorneys' contingent fees could have an impact on the number of medical negligence actions which are filed, but only at the cost of depriving the victims of legitimate claims under their right to seek compensation.

IV. COLLATERAL SOURCE RULE

The common law collateral source rule is based on the policy belief that when an injury has been caused by negligence, the tortfeasor (or his insurer) should bear the cost rather than the victim, or his insurer, or some third-party benefactor. Any other rule would create a windfall for the tortfeasor (or his insurer) and would unfairly penalize the victim who gave wage concessions or paid his own insurance premiums in order to generate the "collateral source." Even if a tort victim had not paid any insurance premiums and even if the victim's insurance coverage was unrelated to his employment, an exclusion of recovery on collateral source payments would require third-party benefactors or the public to subsidize the negligence of the tortfeasor. The abolition of the collateral source rule would require the public and the victim to underwrite the cost of malpractice and would reduce economic incentives for removing bad doctors from the practice of medicine.

The argument for abolition of the collateral source rule is that the rule affords plaintiffs a "double recovery." Initially, this argument fails to recognize that the third-party payer is often entitled to reimbursement out of the medical negligence recovery. For example, health insurance contracts often include a subrogation clause entitling the insurance company to such reimbursement. Of course, the concept of a "double recovery" for a tort victim is hollow, when one considers that litigation is an expensive proposition and the costs of attorneys' fees and litigation expenses must be deducted from the amount which a jury has determined to be a

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77. The following studies conclude that most middle and lower income Americans do not have the means to hire a lawyer for a personal injury case on an hourly basis: Schwartz & Mitchell, An Economic Analysis of the Contingent Fee in Personal Injury Litigation, 22 STAN. L. REV. 1125, 1125-26 (1970); Reder, supra note 70, at 231.


79. Under existing law, if a patient receives medicaid or medicare payments which are later recovered from a tortfeasor, the appropriate government agency is entitled to reimbursement of those payments out of the recovery.
fair compensation for the victim's injury. 80

Despite the sound policy behind the collateral source rule, many state legislatures have abolished or largely modified the rule in medical malpractice actions. 81 Some states have abolished the collateral source rule except with regard to collateral sources that the tort victim has paid to receive. 82 Other states have abolished the rule to the extent that no right to subrogation exists. 83 Alternatively, some states have abolished the rule while prohibiting such subrogation rights. 84

The states abrogating or modifying the collateral source rule vary in the procedure used to calculate damages. Some allow the jury to calculate the amount of recovery by determining damages, then subtracting the amount of funds received from collateral sources. 85 Under other statutes, the jury simply determines the total amount of damages and the trial court then subtracts the

80. Generally, fees and costs account for a substantial proportion of the recovery in medical malpractice actions. See Report of the Secretary's Commission on Medical Malpractice, supra note 2, at 983.


82. States abolishing the collateral source rule except to the extent of collateral sources the victim has paid to receive include the following: New Hampshire, New York, and Tennessee. See supra note 81.

83. States abolishing the collateral source rule to the extent that no right to subrogation exists include the following: Florida, Illinois, and South Dakota. See supra note 81.

84. States abolishing the rule while prohibiting subrogation rights include the following: Arizona, California, and Pennsylvania. See supra note 81.

amount received from collateral sources.\textsuperscript{86} Other states simply allow evidence of funds paid to the tort victim by collateral sources to be considered by the jury.\textsuperscript{87}

In the mid-1970s, many of the statutory modifications of the collateral source rule were limited to medical negligence cases. Such statutes raised equal protection problems similar to those discussed above, in the context of ceilings on recovery and limitations on contingent fees; at least three states have held such statutes to be a violation of equal protection,\textsuperscript{88} while at least one state has upheld such a statute under an equal protection challenge.\textsuperscript{89} Substantive due process problems\textsuperscript{90} and the constitutionally protected "right to contract"\textsuperscript{91} are also raised in some cases.\textsuperscript{92}

\textsuperscript{86} The Florida statute allows the jury to determine the total amount of damages to be awarded and directs the trial court to subtract collateral sources. \textit{See} FLA. STAT. § 768.50 (Supp. 1986).

\textsuperscript{87} States allowing evidence of collateral funds include the following: Arizona, California, Delaware, New Hampshire, Rhode Island, South Dakota, and Washington. \textit{See supra} note 81.

\textsuperscript{88} The following states have held that statutory modifications of the collateral source rule in medical malpractice actions violate equal protection guarantees: (a) Illinois: Wright v. Central DuPage, 63 Ill. 2d 313, 347 N.E.2d 736 (1976); (b) Kansas: Wentling v. Medical Anesthesia Services, 237 Kan. 503, 701 P.2d 939 (1985); (c) New Hampshire: Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980). These opinions have reasoned that abolition of the collateral source rule in medical malpractice actions deprives victims of medical negligence of the benefits of the rule bestowed on other tort victims. This discrimination is not rationally related to alleviating the medical malpractice problem. There is no guarantee health care liability insurers would reduce their premiums if they were not responsible for amounts paid by collateral sources. Furthermore, even if health care providers' insurance rates were reduced, the cost of insurance for the public, as potential victims of medical negligence, would increase.

\textsuperscript{89} The California Supreme Court held that a statutory modification of the collateral source rule in that state did not offend equal protection. Fein v. Permanente Medical Group, 38 Cal. 3d 137, 695 P.2d 665 (1981).

\textsuperscript{90} Abrogations and modifications of the collateral source rule infringe on medical malpractice victims' rights to seek full compensation. The Supreme Court of North Dakota held that a statute abolishing the collateral source rule in medical malpractice actions violated substantive due process. \textit{See} Arneson v. Olson, 270 N.W.2d 125 (N.D. 1978). The Supreme Court of California held, on the other hand, that modifications of the collateral source rule in medical malpractice actions did not violate substantive due process. \textit{See} Fein v. Permanente Medical Group, 38 Cal. 3d 137, 695 P.2d 665 (1981).

\textsuperscript{91} An impairment of contract argument was raised in the Nebraska case of Prendergast v. Nelson, 199 Neb. 97, 256 N.W.2d 657 (1977). In \textit{Prendergast}, the statute in question provided that credit be given with respect to the non-refundable insurance benefits, less all premiums paid by or for the claimant. The court
In light of the trend to find such statutes unconstitutional when limited to medical negligence victims, it is expected that the current wave of legislative proposals will aim towards eliminating the collateral source rule as to all tort victims. Indeed, abolition of the collateral source rule has been identified by some physicians as their number one legislative priority. Essentially, consideration of the collateral source rule rests on a policy decision as to whether the full costs of negligent acts should be borne by the tortfeasor, directly or indirectly through insurance, or whether those costs should be spread throughout the rest of society.

V. PERIODIC PAYMENTS

One incentive for insurance companies toward the settlement of large, valid claims is the prospect of negotiating a structured settlement which allows periodic payments to the injured person over a specified period of time. In negotiating such installment payments, patients and their attorneys are aware that money received in the future is worth only a fraction of money received in the present and plaintiffs’ attorneys typically calculate the “present-value” of such offers before presenting them to a client for consideration. Of course, if a case goes through trial, a jury is instructed to award the present value of all damages—past, present and future.

Various periodic payment schemes advocated by the insurance industry attempt to engratify the installment payment plan onto a jury verdict—which has already been reduced back to present value by the jury—providing double savings to the insurance carrier. Such proposals would serve to reduce incentives for settle-

rejeced the impairment of contract argument. Of course, since the statute dealt solely with non-refundable medical insurance benefits, arguably there was no contract involved in the first place. However, other statutory schemes present the question of impairment of contract more squarely.


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ment and would simply act as a direct subsidy to the insurance industry—perhaps an "exclusive emolument" proscribed by the North Carolina Constitution.95 Insurance companies have already learned that they can make huge profits by appealing large jury verdicts just because the legal rate of interest they must pay on the verdict during pendency of the appeal is less than the rate of their investment return.96 Legislatures should be moving towards plugging this loophole by raising the legal rate of interest rather than creating a new incentive against settlement by offering the insurance companies an interest-free installment option of paying the verdicts they lose.

Several states have implemented such mandatory periodic payment schemes in the past.97 Some of these statutes simply provide for periodic payments of awards regardless of the amount of the award, the kind of damages, or other factors.98 Other statutes mandate periodic payments only where the award exceeds a certain dollar amount.99 Still others require periodic payments only on "future damages."100 Some statutes specify that periodic payments will cease upon the injured person's death while others pro-

95. N.C. CONST. art. I, § 32 holds: "No person or set of persons is entitled to exclusive or separate emoluments or privileges from the community but in consideration of public services." Other state constitutions have similar provisions.

96. In Song v. Smatko, 208 Cal. Rptr. 300 (Cal. App. 1984), the California Court of Appeals awarded attorneys' fees plus additional damages to the plaintiff, finding that the defendant in a medical malpractice case had pursued a frivolous appeal simply to incur investment of profits on the amount of the jury award during the pendency of the appeal.


98. The following states have enacted this kind of periodic payment statute: Kansas, Maryland, and Washington. See supra note 97.

99. The following states have enacted statutes mandating periodic payments if the recovery is over a specified amount: Alabama, Arkansas, California, Florida, New Hampshire, New York, and Wisconsin. See supra note 97.

100. The following states have enacted legislation mandating periodic payments of future damages: Arizona, Arkansas, California, Delaware, Florida, New Hampshire, New York, and Wisconsin. See supra note 97.
vide that the remaining amounts shall be paid to the family of the deceased.\textsuperscript{101} To the authors' knowledge, no statute requires that the payment plan be extended if the injured person outlives his life expectancy, a proposal which seems to be the natural corollary of reducing the award if the injured person dies sooner than expected. The majority of state courts deciding the constitutionality of the various periodic payment plans have held them to be unconstitutional.\textsuperscript{102} Such a result has been reached on equal protection grounds,\textsuperscript{103} substantive due process grounds\textsuperscript{104} and "separation of powers" grounds.\textsuperscript{105}

The human effect of legislatively mandated periodic payments is demonstrated very poignantly in \textit{Florida Medical Center, Inc. v. Von Stetina}.\textsuperscript{106} In that case, a young, attractive woman was hospitalized after an auto accident, and was placed on a respirator.

\textsuperscript{101}. States which have enacted statutes specifying that periodic payments will cease upon the injured party’s death include the following: Arkansas, Delaware, Florida, New Hampshire, and Wisconsin. States which have enacted statutes specifying that periodic payments will go to the injured party’s survivors upon death include the following: Alabama and California. \textit{See supra} note 97.

\textsuperscript{102}. The constitutionality of mandatory periodic payments of medical malpractice recoveries appears to have only been addressed by courts in New Hampshire, North Dakota and Florida. Both New Hampshire and Florida held the involved statutes were unconstitutional. Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980); Florida Medical Center, Inc. v. Von Stetina, 436 So. 2d 1022 (Fla. 1983). On the other hand, the North Dakota Supreme Court upheld the constitutionality of mandatory periodic payments. Arneson v. Olson, 270 N.W.2d 125 (N.D. 1978).

\textsuperscript{103}. In Carson v. Maurer, 120 N.H. 925, 424 A.2d 825 (1980), the New Hampshire Supreme Court held that a statute mandating that any future damages in excess of $50,000 be paid periodically and stopped upon the plaintiff’s death violated equal protection guarantees. The court reasoned that this statute unreasonably discriminated against health care defendants and unduly burdened seriously injured malpractice victims. A similar Florida statute mandating payment of future damages in periodic payments was also held to violate equal protection guarantees. \textit{See Florida Medical Center, Inc. v. Von Stetina.}, 436 So. 2d 1022 (Fla. 1983).

\textsuperscript{104}. The court in \textit{Von Stetina}, 436 So. 2d 1022, held that a statute mandating periodic payments violated substantive due process guarantees. The court reasoned that the statute subverted its own purpose of alleviating the medical malpractice crisis by discouraging good faith settlements.

\textsuperscript{105}. The \textit{Von Stetina} court also held that the state’s periodic payment statute violated the constitutional “separation of powers” clause. As the opinion stated, “[i]t is settled that a trial court with constitutional jurisdiction to render a final judgment has the ‘inherent power . . . to enforce collection of its judgments.’” \textit{Id.} at 1025.

\textsuperscript{106}. 436 So. 2d 1022.
parently because of negligence, the patient’s air supply was interrupted and irreversible brain damage ensued, condemning the plaintiff to a 40 year life expectancy as a pathetic, half-blind, hopelessly bedridden, pain-wracked incompetent who nevertheless can recognize people and respond to sounds, love, and touch. In the poetic words of her counsel, “She is a prisoner in her own helpless body and must experience the ultimate nightmare every waking moment of the remainder of her tragically destroyed life.”

In present money value, the jury found that the plaintiff required approximately $188,400 per year simply to meet her necessary expenses for medical and nursing care. The Florida Periodic Payment Statute, however, limited the payout per year to $100,000, an amount which the court noted was “insufficient to keep her alive,” and thus found the statute unconstitutional.

Our jury system has been trusted for centuries with a responsibility of determining reasonable compensation for the victims of negligence. The jury is instructed to give an award which is reduced to present value and it would be manifestly unfair to further reduce that award by allowing the defendant or his insurer to retain the judgment amount (essentially as an interest-free or low-interest loan) while paying the victim under a legislatively mandated periodic payment scheme.

VI. CONCLUSION

Each of the proposals discussed above—ceilings on recoveries, limitations on contingent fees, abolition or modification of the collateral source rule, and mandated periodic payments—has its own visceral attractiveness yet has its own injurious effect. In considering these various proposals now being advanced by the American Medical Association and the insurance industry, the various state legislatures should directly face two questions: (1) Would the enactment of such a proposal significantly reduce the cost of health care in our society and/or improve the quality of that health care? (2) Would the enactment of such a proposal be fair to the injured victims of negligence and protect their rights to receive full compensation for their injuries? Unless the answer to both of these questions is a clear “yes” the proposals discussed above should be

107. Id. at 1024.
108. Id. at 1020.
rejected.

A Rand Institute for Civil Justice study conducted by P.M. Danzon of Duke University reveals that no more than ten percent of all actual instances of medical negligence result in the filing of a claim, and of those, less than half of the claims (representing less than one out of every twenty-five actual instances of medical negligence) are ever paid. Other investigators have reached similar conclusions. If the American Medical Association and our legislatures desire to honestly improve health care in America and promote justice for the victims of medical negligence, then they should be considering proposals quite different from those discussed above.

Physicians and health care commentators across the United States recognize that the primary problem in malpractice litigation is malpractice, itself. In 1985, the Public Citizen Health Research Group published a report entitled "Medical Malpractice: The Need For Disciplinary Reform, Not Tort Reform." That study advocated a number of proposals to decrease the amount of malpractice and therefore the number of malpractice suits, including the following:

(1) Urging that all doctors pay at least $500 per year for their medical license, thus raising about $200 million in state revenues to be used for disciplining doctors.
(2) Passing strong legislation in states to greatly expand the size and strength of the licensing (doctor discipline) function.
(3) Experience-rating of doctors by insurance companies so


A 1976 joint study by the California Hospital Association and the California Medical Association examined the true incidence of actionable injuries as opposed to the number of lawsuits filed. Of an approximate 3 million patients, the study determined that 24,000 had an adverse outcome attributable to medical negligence. During the same year, however, only 4,000 medical malpractice lawsuits were actually filed in California (and, of those, only one-half resulted in payment). See Malpractice Costs: The Pressure for Relief Mounts, MEDICAL WORLD NEWS, July 22, 1985. Obviously, the overwhelming majority of victims of medical negligence are not compensated at all under our present system.

the good doctors stop subsidizing the relatively few with worse performance records.

(4) Requiring attorneys to turn over to state licensing boards information about doctors after patients prevail in a settlement or adjudication of a malpractice suit.

(5) Requiring all other data, such as that collected by professional review organizations (PRO's) concerning doctors' performance in treating Medicare and Medicaid patients to be made part of doctors' files in the state licensing bureaus.\(^{112}\)

Health care can best be improved through better review of physicians' performance and such improvement will ultimately result in lower health care costs for society as a whole.

As a group, American physicians have had the highest mean income of any group of professionals in the world.\(^{113}\) Admittedly, insurance premiums have risen somewhat in recent years, but any consideration of those increases would be incomplete without considering the context of the amount of physicians' incomes. Those physicians who complain that the present state of liability for health care providers represents a new "low" in physician accountability should reflect upon the Code of Hammurabi adopted some 4,000 years ago in ancient Babylon. This early legal code adopted a policy of strict liability for a bad result with non-monetary (and no doubt uninsurable) compensation, as follows:

If the surgeon has made a deep incision in the body of a free man and has caused the man's death or has opened the carbuncle in the eye and so destroys the man's eye, they shall cut off his forehand.\(^{114}\)

With responsibility comes accountability, and physicians, like other members of society, should be fully and fairly responsible for compensating the injured victims of medical negligence. The cost of such medical negligence insurance is a small price for our society to pay for the preservation of our tort system and the continued right of all injured persons to be "made whole" in our democratic society.

\(^{112}\) Id.

\(^{113}\) For example, in 1982, the median gross income for North Carolina physicians was reported to be $153,750 (compared to an average annual insurance premium of $1,400). Briggs, supra note 25, at 4, citing Medical Economics (Feb. 6, 1984).