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Choice-of-Law Problems in Medical Malpractice Actions: Legislative Prescriptions and Judicial Side Effects

David E. Seidelson*

In 1976, in writing an article on lack of informed consent in medical malpractice actions, I began with this language:

I trust that the current controversy over the premium rates charged physicians for professional liability insurance will become the subject of a political resolution which will permit the practice of medicine to continue to be an economically feasible activity. I hope that that resolution will not emasculate either the existing or the emerging body of decisional law governing medical malpractice actions. On the basis of that trust and that hope, I would like to undertake an examination of some of the problems which exist in that decisional law as it applies to informed consent.¹

Well, the practice of medicine does continue to be an economically feasible activity. But the “political solution” turned out to be a series of different solutions or prescriptions attempted by different states and intended to ameliorate what the state legislatures perceived to be a medical malpractice crisis. Some legislated arbitration panels for medical malpractice actions.² Others enacted statutes imposing a ceiling on the total damages recoverable in medical malpractice actions.³ Still others imposed a ceiling on the damages recoverable for pain, suffering and mental anguish in such actions.⁴ Some imposed a ceiling on damages other than those for medical

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expenses. Some a ceiling on damages other than those for medical expenses and punitive damages. Others a ceiling on damages exclusive of medical expenses and lost earnings. Some a repudiation of the collateral source rule. And some require that plaintiff’s counsel file an affidavit asserting that a qualified expert has reviewed the facts and is of the opinion that the defendant deviated from the appropriate standard of care.

What happens when a plaintiff domiciled in a state having none of those provisions brings a medical malpractice action against a defendant who practices in a state that has one of those provisions? The answer is that the court may find itself confronted with a choice-of-law problem. And, indeed, the courts are beginning to confront just such problems. Let’s examine some of those cases and some hypothetical spin-offs.

In *Kaiser-Georgetown Community Health Plan, Inc. v. Stutsman,* plaintiff, domiciled in Virginia, was employed as a nurse in the District of Columbia. “As an employment benefit, . . . she became enrolled as a subscriber to Kaiser’s health plan. Kaiser is a District of Columbia corporation. . . .” It operated a health maintenance organization. Capital Area Permanente Medical Group, also a District of Columbia corporation, pursuant to a contract with Kaiser made available physicians employed by Capital who provided health care in Kaiser’s facilities in the District and surrounding suburbs, including those in Virginia. When Stutsman became pregnant, “she sought prenatal care . . . at the Kaiser facility closest to her home, in Springfield, Virginia.” The care was provided by physicians employed by Capital. Stutsman alleged that she informed the physicians “of a nodule in her right breast. . . .” Relying exclusively on manual palpations, the physicians diagnosed the nodule as benign “despite the increasing size of the mass. . . .” Subsequently, a biopsy “revealed the malig-

7. See, e.g., V.I. Code Ann. Title 27, § 166b (1988 Supp.)
11. Id. at 504-05 (footnote omitted).
12. Id. at 505.
13. Id.
14. Id.
nant character of the mass.” 15 Because of the delay in diagnosis, "the cancer metastasized and [Stutsman's] chances of surviving the disease [were] correspondingly diminished." 16 Alleging that the treating physicians had been negligent, Stutsman sued Kaiser and Capital in the District of Columbia “under a theory of respondeat superior.” 17 She sought damages “in the amount of ten million dollars.” 18 Virginia by statute imposed a ceiling of $750,000 on damages in medical malpractice actions. 19 The District imposed no ceiling on such damages. Of course, the defendants argued that the ceiling should be applied and the plaintiff asserted that it should not.

The District resolves choice-of-law problems through interest analysis. 20 Before reviewing the court's use of that methodology, let's attempt our own application of interest analysis. I should disclose to the reader immediately that I have a rather strong plaintiff-favoring bias in personal injury actions. Perhaps because of that bias, I have a skeptical view of both the medical malpractice “crisis” and the legislative prescriptions intended to ameliorate that crisis. 21 Nevertheless, I shall attempt to restrain both that

15. Id.
16. Id.
17. Id. at 504.
18. Id. at 505.
19. 2 VA. CODE ANN. § 8.01-581.15. After the operative facts of Stutsman had occurred, the ceiling was amended upward to $1,000,000. 2 Va. Code Ann. § 8.01-581.15 (Michie Supp. 1984). In Etheridge v. Medical Center Hospitals, 376 S.E.2d 525 (Va. 1989), the court, dividing 4-3, held that the Virginia ceiling violated neither the federal nor the state constitution.
20. See, e.g., Gaither v. Myers, 404 F.2d 216 (D.C. Cir. 1968); Bledsoe v. Crowley, 849 F.2d 639, 641 (D.C. Cir. 1988):
[T]he District of Columbia... appl[ies] a "governmental interest analysis," which requires a court “to evaluate the governmental policies underlying the applicable conflicting laws and to determine which jurisdiction's policy would be most advanced by having its law applied to the facts of the case under review.” Williams v. Williams, 390 A.2d 4, 5-6 (D.C. 1978);... Rong Yao Zhou v. Jennifer Mall Restaurant, Inc., 534 A.2d 1268, 1270-1271 (D.C. 1987).
Bledsoe is discussed in the text at note 59 infra.
21. That skepticism is not unique to me. In Crowe v. Wigglesworth, 623 F. Supp. 699, 706-07 (D. Kan. 1985) citations omitted), the court, although concluding that the Kansas statute abrogating the collateral source rule in medical malpractice actions was not unconstitutional, nevertheless used this language:
On a more fundamental level, this Court is not at all persuaded this discriminatory legislation is needed or that it will achieve its stated goals. Regarding need, defendants cavalierly refer to the "obvious" medical malpractice crises justifying this legislation. What is apparently so clear to the medical profession, the insurance industry, their respective lobbyists, and the Legislature is a matter of deep and growing concern to this Court as well as a number of commentators and other courts across the
bias and that view in resolving the choice-of-law problem (here and throughout the article) as objectively as I can. How successful I am in that endeavor ultimately must be judged by the reader.

It would seem that the District's law imposing no ceiling on damages has two underlying purposes: regulating the conduct of medical care providers and assuring that victims of medical malpractice do not become indigent wards. By imposing no ceiling, the District hopes to deter negligent medical care. Does that conduct regulating reason for the District's law convert into a significant interest on the part of the District in having its law applied to this case? When a law has a conduct regulating purpose, that reason converts into a significant interest on the part of the state in having its law applied if (1) the conduct intended to be regulated occurred within that state, or (2) the immediate consequences of the conduct occurred within that state, or (3) the ongoing consequences of that conduct will be felt within that state. Here, the

country. In the Legislature's haste to remedy the situation, it has overlooked or, more likely, ignored the fundamental cause of the so-called crisis: it is the unmistakable result not of excessive verdicts, but of excessive malpractice by health care providers. Further, some courts have found that the highly touted malpractice insurance crisis of 1975-76 was limited to that time period, is no longer an "obvious" crisis, and may not now continue to be used to justify imposing separate and unequal treatment on medical malpractice litigants... Others have rightly questioned the complicity of the insurance industry in this situation. Citizens of Idaho were treated to the spectacle of medical malpractice insurers insisting on legislative relief in part because of "abnormally low earnings from investments." [citation omitted] The absurdity of that situation is akin to a products manufacturer requesting and receiving a limitation on liability because of low sales in a previous year. In 1976, the Travelers Insurance Companies faced billion dollar litigation instituted by a physicians' council after Travelers demanded a 486% rate increase; the company ultimately returned 50 million dollars in excess premiums... . . .

Even courts which have upheld such legislation under the rational basis test have expressed doubt about whether the challenged legislation will accomplish the aims of lowering the cost of and assuring the availability of medical care for citizens of the state. . . .

These concerns noted, the Court is of course aware that normally questions regarding the wisdom or likely success of a legislative enactment are not grounds for concluding it violates the Constitution. It is nevertheless possible that in an appropriate case concerning other such legislation the Court could conclude any conceivable "benefits" are sufficiently remote that the statutory discrimination is indeed wholly irrelevant to achievement of the state's ostensible objective.

For discussion of a statute abrogating the collateral source rule in medical malpractice actions in a choice-of-law context, see text commencing at note 158 infra.


Presumably, a state's interest in regulating conduct rests on a desire to avoid the
conduct intended to be regulated or deterred, the negligent care, occurred in Virginia. The immediate consequences of that conduct, the legally cognizable injury to the plaintiff, would seem to have occurred in Virginia where the allegedly negligent care was provided and where the plaintiff was domiciled. The ongoing consequences of that conduct, the diminished likelihood of survival, would seem to be felt in Virginia where the plaintiff was domiciled. Thus, the conduct regulating reason underlying the District's law would appear not to convert into a significant interest on the part of the District in having its no-ceiling law applied to this case.

The second reason for the District's law is to assure that victims of medical malpractice do not become indigent wards. Does that reason convert into a significant interest on the part of the District in having its law applied to this case? Apparently not. The plaintiff was domiciled in Virginia, not the District; thus, should she become indigent, she would become an indigent ward of Virginia and it would be that state, not the District, that would have the onus of providing for her. Apparently, neither reason for the District's no-ceiling law converts into a significant interest on the part of the District in having its law applied to this case.

What are the reasons for the Virginia law imposing a ceiling on damages in medical malpractice actions? There would seem to be two intimately related reasons: to protect the economic integrity of medical care providers and, thereby, to assure the continued availability of medical care at affordable rates. Does either of those reasons convert into a significant interest on the part of Virginia in having its ceiling applied to this case. Presumably, the class of medical care providers whose economic interest Virginia wants to protect would be comprised of Virginia medical care providers. The Virginia physicians who cared for the plaintiff were not defendants in this action. The only defendants were two corporations domiciled in the District. Should they be considered Virginia health care providers? Through their combined operations they did provide physicians to render medical care in Virginia. That suggests that perhaps the two defendants were within the class whose economic integrity was intended to be protected by Vir-

immediate or continuing adverse consequences made possible by such conduct. Consequently, if the conduct occurs within the state, thereby generating its reasonably foreseeable consequences within the state, or the immediate consequences occur within the state, or the continuing consequences will be felt within the state, the state's interest in conduct regulation converts into a significant interest.

Id.
Virginia's law. Should the fact that both defendants were domiciled in the District, not Virginia, serve to remove the defendants from the protected class? I think not. If a physician who practiced in Virginia were domiciled in the District, he probably would be within the protected class. Virginia's concern with protecting economic integrity is focused on the activity, providing medical care, not on domicile. Moreover, as we have noted, that first reason for Virginia's law seems intimately related to, and, indeed, a means of accomplishing, the second: assuring affordable medical care in Virginia. If protecting the economic integrity of the two defendants would contribute to assuring the continued availability of affordable medical care, that would corroborate our conclusion that the defendants were within the class of medical care providers whose economic integrity Virginia wishes to protect. Let's consider that second reason for Virginia's law. Pretty clearly, Virginia's concern is with assuring the availability of affordable medical care in Virginia. If the District defendants were to face potential liability without ceiling, would that be likely to result in higher costs for those seeking medical care in Virginia? I suppose it could be argued that, because the defendants are both District corporations, the possibility of unlimited liability is unlikely to have an adverse effect on medical care costs in Virginia. Still, it should be remembered that the defendants, through their contractual arrangements, provide medical care to subscribers in both the District and Virginia. Should the defendants face unlimited liability, the cost of securing those medical services in both the District and Virginia could be increased. It would seem that the second and ultimate reason for the Virginia ceiling, assuring the continued availability of medical care in Virginia at affordable rates, does convert into a significant interest on the part of Virginia in having its ceiling law applied to this case. Our interest analysis suggests that the case presents a false conflict. Although the laws of the District and Virginia differ, only Virginia has a significant interest in the application of its law to this case. Consequently, interest analysis indicates that the Virginia ceiling on damages should be applied.

Let's go one step further. Having concluded that the District has no significant interest in the application of its no-ceiling law, it may be appropriate for us to determine if the District has some minimal interest in this litigation and, if so, how that minimal interest in the litigation would best be served. Since both defend-

23. See, e.g., 404 F.2d at 224.
ants were domiciled in the District, it would appear that the District does have a minimal interest in the litigation: protecting the economic integrity of its domiciled defendants. Because neither of the two reasons for the District's law, regulating conduct and assuring that District victims do not become indigent wards, converts into a significant interest on the part of the District in having its law applied, the minimal interest of the District is protecting the economic integrity of its defendants can be served without frustrating either of the reasons underlying the District's law. How would that minimal interest in the litigation on the part of the District best be served? Obviously, by the application of Virginia law imposing a ceiling on recovery. Thus, application of Virginia's law, entirely appropriate once determining that the case presents a false conflict with Virginia being the only state with a significant interest in the application of its own law, produces the most nearly perfect result attainable. That result serves both Virginia's significant interest in having its law applied and the District's minimal interest in the litigation.

How did the court resolve the choice-of-law problem? The court wrote:

The District of Columbia has a substantial interest in this litigation. Both defendants are corporate citizens of the District of Columbia. The District has a significant interest, reflected in the fact that it imposes no cap on liability for malpractice, in holding its corporations liable for the full extent of the negligence attributable to them.24

I think that language is intended to refer to the District's concern with conduct regulation, that is, in deterring negligent medical care by subjecting those responsible to the full sting of liability. But the fact that the defendants were domiciled in the District does not automatically convert that conduct regulating reason into a significant interest on the part of the District in having its law applied. The alleged negligence occurred in Virginia, where the plaintiff received the medical care, not in the District. Indeed, the only theory of liability asserted against the defendants was respondeat superior, based on the allegedly negligent medical care provided in Virginia. Moreover, as we have seen, the immediate consequences of that negligent care occurred in Virginia, not the District, and the ongoing consequences of that conduct would be felt in Virginia, not the District. Despite its altruistic ring, the court's implication that the District has a significant interest in imposing unlimited dam-

24. 491 A.2d at 509-10 (footnote omitted).
ages on District defendants irrespective of where the conduct intended to be regulated occurred, where the immediate consequences of that conduct occurred, and where the ongoing consequences of that conduct will be felt, ultimately produces a somewhat hollow sound.

Perhaps that conclusion can be corroborated by a hypothetical case. Let's assume that a physician domiciled in the District vacationed in Virginia. While vacationing, the physician administered emergency care in a negligent manner to a domiciliary of Virginia. Subsequently, the injured victim sues the physician in the District. Would the conduct regulating reason underlying the District's no-ceiling law convert into a significant interest on the part of the District in having that law applied to this case? I think not. The conduct intended to be regulated or deterred, negligent medical care, occurred in Virginia, not in the District. The immediate consequences of that conduct, the victim's injuries, occurred in Virginia, not in the District. And the ongoing consequences of that conduct, the victim's diminished condition, would be felt in Virginia, not in the District. In those circumstances, the District would seem to have no significant interest in imposing unlimited liability on the defendant simply because he was domiciled in the District. Let's amend our hypothetical. Suppose that the same Virginia domiciliary, while visiting the District, received negligent medical care there from the same District physician. In those circumstances, would the District's conduct regulating reason convert into a significant interest on the part of the District in applying its no-ceiling law? Of course. The very conduct intended to be deterred, negligent medical care, occurred in the District. Moreover, the immediate consequences of that conduct, victim's initial injuries, occurred within the District. Either of those facts would afford the District a significant interest in applying its no-ceiling law. As between those two hypotheticals, Stutsman more closely resembles the first than the second.

The court in Stutsman also wrote: "In addition, the District has an interest in protecting a member of its work force who contracts for health services with a District of Columbia corporation within this forum and then is injured by the negligence of that corporation's agents."25 That language implies that the second reason for the District's no-ceiling law, assuring that injured victims of medical malpractice do not become indigent wards, converts into a sig-

25. Id. at 510.
nificant interest on the part of the District in having its law applied. In effect, the language implies that the class intended to be protected from indigence by the District's law is not limited to those domiciled in the District; rather, it encompasses those domiciled anywhere who work in the District. How persuasive is that conclusion?

Once more, the court's language has an altruistic tone. The District is interested in protecting from indigence not only its own domiciliaries but those domiciled anywhere who work in the District. Does that altruism convert into reality? I'm inclined to think not. If the plaintiff, disadvantaged by the application of Virginia's ceiling on recovery, should become indigent, it is Virginia, her domicile, not the District, her workplace, that would feel the economic onus of providing for her. Consequently, I don't think the court's implication that, because the plaintiff was employed in the District, the District's concern with protecting victims from indigence converts into a significant interest on the part of the District in applying its no-ceiling law is very persuasive.

The Stottsman court cited the plurality opinion in Allstate Insurance Co. v. Hague.26 Decedent had been a Wisconsin domiciliary who worked in Minnesota. He died while riding as a passenger on a motorcycle which was rear-ended by a car. The collision occurred in Wisconsin. The motorcycle trip began and was intended to end in Wisconsin. It was unrelated to decedent's employment in Minnesota. Neither the automobile nor the motorcycle operator had liability insurance. Following decedent's death, but prior to the initiation of the action, his widow effected a change of domicile from Wisconsin to Minnesota. Decedent had had a motor vehicle insurance policy covering three vehicles with Allstate. The premium paid to Allstate reflected the fact that the policy covered three vehicles. The policy provided uninsured motorist protection in the amount of $15,000. Plaintiff widow sued Allstate in Minnesota seeking to recover 3 times $15,000 or $45,000. Allstate asserted that its liability was limited to $15,000. Minnesota law permitted the stacking of uninsured motorist coverage sought by the plaintiff; Wisconsin law did not. The trial court, applying Minnesota law, entered judgment for the plaintiff in the amount of $45,000 and the Supreme Court of Minnesota affirmed. Allstate secured review by the Supreme Court of the United States, asserting that the Minnesota court's application of its own law, rather than the law of

Wisconsin, violated the due process27 rights of Allstate and the full faith and credit clause.28 Allstate argued that the choice-of-law result achieved by the Minnesota court was unconstitutional because Minnesota lacked a significant interest in the application of its own law. The Court, by plurality opinion, affirmed the judgment. The plurality identified three bases for a Minnesota interest in the application of its law: (1) decedent had been a member of the Minnesota work force, (2) Allstate does business in Minnesota, and (3) plaintiff was domiciled in Minnesota. The dissent concluded that the first two bases were irrelevant to the decision in the case and that the third, plaintiff's after-acquired domicile in Minnesota, should not have been extended cognizance by the Court. Which was correct, the plurality or the dissenting opinion?

To attempt to answer that question requires us to identify the reason underlying Minnesota's law permitting the stacking of uninsured motorist coverage. Presumably, Minnesota permits such stacking to assure that Minnesota domiciled victims or their dependent survivors do not become indigent wards of that state. Since decedent's having been a member of the Minnesota work force is unrelated to the reason underlying Minnesota law, I am inclined to agree with the dissent that that fact was irrelevant to the choice-of-law issue. Only if Minnesota had been concerned with protecting from indigence those domiciled anywhere who worked in Minnesota, would decedent's employment in that state have been relevant. Clearly, had decedent survived and remained a Wisconsin domiciliary, it would have been Wisconsin, not Minnesota, that would have felt the onus of supporting the indigent victim. The fact that Allstate did business in Minnesota would also seem to be irrelevant to the issue before the Court. Allstate's business presence in Minnesota has nothing to do with that state's desire to protect its domiciliaries from indigence. That leaves only the third basis noted by the majority: plaintiff widow's after-acquired Minnesota domicile. Obviously, that fact is intimately related to the reason for Minnesota's law. By effecting the change of domicile, plaintiff put herself within the precise class of persons Minnesota wishes to protect from indigence. The dissent, however, would have withheld judicial cognizance from the post-litigation fact of a pre-litigation change of domicile. That, I think, would be unwise. To pretend that the plaintiff continued to be domiciled in

27. U.S. Const. amend. XIV, § 1.
Wisconsin, when all (including the Court) knew that she had become a bona fide domiciliary of Minnesota prior to the initiation of litigation, would be to resolve a constitutional issue on the basis of a non-fact, and a non-fact crucial to the question of whether Minnesota had a significant interest in the application of its own law. Ultimately, then, I concur in the result achieved by the plurality opinion in *Hague* because I believe the plaintiff's Minnesota domicile should be noticed and, once noted, it provides the necessary interest on the part of Minnesota. I do not agree with the plurality, however, that decedent's Minnesota workplace provided a constitutionally appropriate basis for the application of Minnesota's law.

It was to that latter point that *Stutsman* alluded in citing *Hague*: "The importance of this contact derives from the fact that 't[he] State of employment has police power responsibilities towards the nonresident employee that are analogous, if somewhat less profound, than towards residents.' *29* But surely those "police power responsibilities" are at best de minimus where the injury sustained has absolutely no relation to the victim's employment, as was the case in both *Hague* and *Stutsman*. The *Stutsman* court attempted to lend the language quoted from *Hague* an *a fortiori* significance by noting: "In this case, in contrast, the relationship between the parties to the litigation grew out of the plaintiff's employment within the District." *30* While it's true that Stutsman's employment (in the District) enabled her to subscribe to the health insurance plan operated by the defendants, her employment was unrelated to the injury she sustained and to the ultimate issue of whether the Virginia ceiling should be applied. Application of the ceiling to any personal injury judgment Stutsman might obtain against the defendants would do nothing to diminish the value of the health insurance offered her and to others employed in the District. To conclude otherwise would require a judicial determination that the value of a health insurance plan can be computed only by determining the amount an insured patient may recover as a result of medical malpractice. Not even the *Stutsman* court suggested that.

The court's emphasis on the District workplace of the plaintiff generates another implication. The first reason we noted for the District's law was conduct regulation: to deter negligent medical care by subjecting the medical care provider to unlimited liability.

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29. 491 A.2d at 510.
30. *Id.*
As we have noted, the conduct to be regulated and the immediate consequences of that conduct occurred in Virginia. But could it be said that the ongoing consequences of that conduct would be felt not only in Virginia, the plaintiff’s domicile, but in the District, the plaintiff’s workplace, as well? If so, that conduct regulating reason for the District’s law would convert into a significant interest on the part of the District in having its law applied. The ultimate answer to that question depends on how broadly the ongoing consequences of the conduct should be defined. I am inclined to characterize those ongoing consequences as the continuing adverse effects that will be felt by the victim and the victim’s family or, in the event of the victim’s death, the victim’s dependent survivors. Should the ongoing consequences be defined more broadly so as to include any disruption occasioned in the workplace of the victim? To answer that question affirmatively would require a determination that the victim’s employer and those served by the victim’s employment were intended beneficiaries of the District’s conduct regulating purpose. Such a determination strikes me as being overbroad, for a couple of reasons. First, as a general proposition, I believe that the ongoing consequences intended to be avoided by a conduct regulating law are those consequences likely to be endured by the victim, the victim’s family, and the (deceased) victim’s dependent survivors. It’s difficult for me to imagine a serious legislative or judicial concern with protecting the victim’s employer or clientele. Second, it seems unlikely to me that, if the victim’s employer or clients were to sue the negligent medical care provider to recover damages for the adverse consequences sustained by them as a result of the victim’s personal injuries, they would be granted a recovery by a District of Columbia court. Neither the employer nor the clients would be likely to be deemed within the class intended to be protected by the District’s conduct regulating law. As a result, I find it difficult to accept the court’s implication that the plaintiff’s being employed in the District gives the District a significant interest in having its no-ceiling law applied.

With regard to the reasons underlying the Virginia ceiling on damages, the court wrote:

Although Virginia undoubtedly has an interest in the welfare of its residents, the [Virginia law] . . . cannot be said to further that interest in these circumstances. . . . [T]he cap on ultimate liability [was] enacted into law by the State with the primary purpose of protecting Virginia health care providers from excessive liability. The statute may also have the effect of lowering malpractice premiums for health care providers operating in Virginia. Thus, Virginia residents may be benefited incidentally by the Act in
that the cost of medical malpractice insurance passed to them through medical fees will be less than it would have been had the statute not been enacted.\textsuperscript{31}

That language, I believe, identifies the two related reasons for Virginia's law that we identified earlier: to protect the economic integrity of Virginia health care providers and, thereby, to assure the continued availability of medical care in Virginia at affordable rates. It should be noted, however, that the court characterized that first reason as "the primary purpose" of the Virginia law and the second reason as merely an "incidental" benefit of the law. With regard to the first reason, the court concluded:

Although the . . . Act applies to all "health care providers" . . . that are licensed to provide health care in the State of Virginia, the State's interest in the application of its statute becomes attenuated when its intended beneficiaries are foreign corporations with principal places of business outside the State. This is so because the financial impact upon foreign defendants of a finding of liability in excess of the statutory cap will not fall most heavily in Virginia . . . Any financial impact that the State is likely to experience will derive not from the liability of these defendants but from the uncompensated injury of this plaintiff.\textsuperscript{32}

Apparently, the court concluded that, (1) because the defendants were domiciled in the District, albeit operated as medical care providers in Virginia as well as in the District, the first reason for Virginia's law, protecting the economic integrity of Virginia health care providers, did not convert into a significant interest on the part of Virginia in having its law applied, and (2) because the plaintiff was domiciled in Virginia, that state was more interested in assuring her unlimited recovery than in protecting the economic integrity of the medical care providers. That first conclusion is at odds with our earlier conclusion that, because the defendants were providing medical care in Virginia (complemented by the fact that subjecting them to unlimited liability seemed likely to result in higher costs for medical care in Virginia), they were within the class of medical care providers whose economic integrity was intended to be protected by the Virginia law. Therefore, we concluded that that first reason for Virginia's law did convert into a significant interest on the part of Virginia in having its ceiling applied.

The second conclusion achieved by the court relates to the second reason for Virginia's law, assuring the availability of medical care.

\textsuperscript{31} \textit{Id.}

\textsuperscript{32} \textit{Id.} at 511 (citation and footnote omitted).
care at affordable rates. On that point, the court wrote:

Virginia undoubtedly has a general interest in the full compensation of its residents for injuries incurred by the negligence of another. Virginia has determined, however, that in the area of medical malpractice, its public policy interest in the limitation of liability of health care provider defendants may outweigh its interest in the full compensation of injured plaintiffs. Thus the [Virginia] Act . . . can in no sense be said to protect the interests of plaintiffs like Mrs. Stutsman.33

The court’s language implies that Virginia’s interest is best served by the application of the District’s law which would permit the plaintiff, domiciled in Virginia, an unlimited recovery. But that can’t be right. Virginia’s law imposing a ceiling on damages in medical malpractice actions is the result of a Virginia determination that as between (1) protecting victims domiciled in Virginia from indigence and (2) protecting the economic integrity of those who provide medical care in Virginia, thereby assuring the continued availability of affordable health care in Virginia, Virginia has elected to prefer the latter concern. One may disagree with the wisdom of that political decision made by Virginia (and, as a matter of fact, I do), but that disagreement neither vitiates the decision nor diminishes Virginia’s interest in having that decision effectuated in an appropriate case. How could the court have concluded that Virginia’s interest was best served by permitting an unlimited recovery which would adversely affect the availability of affordable medical care in Virginia? After setting forth Virginia’s concern with assuring affordable medical care in that state in the preceding excerpts, the court wrote: “Nevertheless, the primary purpose of the [Virginia] Act is to protect Virginia health care providers from claimants who seek to recover damages in excess of the amount the Virginia legislature has deemed to be generally acceptable.”34 The court apparently determined, as noted earlier, that protecting the economic integrity of Virginia health care providers was “the primary purpose of the [Virginia] Act” and that assuring affordable medical care in Virginia was merely an “incidental” benefit flowing from the primary purpose.

That, it seems to me, perverts the priority of Virginia’s concerns. While I agree that Virginia’s law exists in part to protect the economic integrity of health care providers in Virginia, that reason does not exist in isolation. Virginia’s ceiling on damages certainly

33. Id.
34. Id. at 510-11.
does not exist simply to assure the existence of wealthy Virginia health care providers. Rather, Virginia wishes to protect the economic integrity of those health care providers as a means of assuring that they will continue to provide health care in Virginia at affordable rates. That is the ultimate goal of Virginia's law. Protecting the economic integrity of Virginia health care providers is simply one step in accomplishing the ultimate purpose. To characterize that one step as "the primary purpose of the [Virginia] Act" and the ultimate goal as merely "incidental" imputes to Virginia a cynical desire to enrich its medical care providers at the expense of its domiciliaries generally, rather than the more benign goal of assuring its domiciliaries generally the continued availability of medical care at affordable rates.

Moreover, by suggesting that Virginia's interest might be served better by the District's law (permitting the plaintiff a full recovery) than by Virginia's law (imposing a ceiling on damages), the court's opinion indicates a certain confusion between the case actually before the court and a case in which Virginia would have no significant interest in the application of its law. For example, if the medical care had been provided in the District by a private practitioner unaffiliated with either defendant, Virginia would have had no interest in the application of its law. Then the economic integrity of no Virginia health care provider would have been implicated and there would have been no threat of higher medical care costs in Virginia. Since the medical care would have been provided in the District, the District's conduct regulating reason would convert into a significant interest on the part of the District in having its no-ceiling law applied. Given that false conflict, where only the District has a significant interest in the application of its law, it would be entirely appropriate for the court to determine if Virginia had some minimal interest in the litigation and, if so, how that minimal interest would best be served. Because the plaintiff is domiciled there, Virginia would have a minimal interest in the litigation: assuring that its domiciled plaintiff did not become an indigent ward of Virginia. Since no Virginia medical care provider was involved and since full recovery would not threaten the continued availability of affordable medical care in Virginia, that minimal interest in the litigation could be served without frustrating the reason underlying Virginia's law. How would that minimal interest in the litigation on the part of Virginia, protecting its domiciled plaintiff from indigence, best be served? Clearly, by the application of the District law imposing no ceiling on recovery. That re-
suLT, entirely appropriate once concluding that the case presented a false conflict in which only the District had a significant interest in having its law applied, would be the most nearly perfect result attainable, once identifying Virginia's minimal interest in the litigation. But, of course, that was not the case before the court. As our interest analysis indicated, Virginia did have a significant interest in the application of its ceiling law: its concern with protecting the economic integrity of Virginia medical care providers, thereby assuring the availability of affordable medical care in Virginia. It was the District that had no significant interest in the application of its law. The actual case does present a false conflict, but one in which only Virginia has a significant interest in the application of its law.

By suggesting that Virginia's interest would be best served by the application of the District's law, the court did one of two things. First, the court, viewing the case as one presenting a true conflict in which each state had a significant interest in the application of its own law, nevertheless proceeded to identify Virginia's minimal interest in the litigation (protecting the Virginia plaintiff from indigence) and concluded that that minimal interest would best be served by the application of the District's law (permitting an unlimited recovery). That would generate a wholly spurious internal conflict on the part of Virginia. Its law imposing a ceiling on damages demonstrates that Virginia has already decided to favor protecting the economic integrity of Virginia medical care providers, thereby assuring affordable medical care in Virginia, over protecting Virginia victims from indigence. In those circumstances, inquiry into Virginia's minimal interest in the litigation is simply inappropriate. Second, and perhaps more likely, the court, having denigrated Virginia's interest in assuring affordable medical care in Virginia, over protecting Virginia victims from indigence. In those circumstances, inquiry into Virginia's minimal interest in the litigation is simply inappropriate. Second, and perhaps more likely, the court, having denigrated Virginia's interest in assuring affordable medical care in that state to a merely "incidental" benefit arising from Virginia's law and having determined that "the primary purpose" of that law, protecting the economic integrity of Virginia medical care providers, had little to do with a case involving defendants domiciled in the District, may have persuaded itself that Virginia had

35. I would prefer to believe that the Stutsman court, had it viewed the case as one presenting a true conflict, would have recognized that identifying Virginia's minimal interest in the litigation, protecting Mrs. Stutsman from indigency, would create a spurious internal conflict on the part of Virginia. Therefore, I think it more likely that the court viewed the case as one in which Virginia had no significant interest in the application of its ceiling law. Moreover, in Stutsman v. Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., 546 A.2d 367, 374 (D.C. 1988) (Stutsman II), the court characterized Stutsman I as a case "where the court was presented with a false conflict between the District of Columbia and Virginia public policies."
no significant interest in the application of its ceiling law. By extending the conduct regulating reason for the District's law to encompass the case before it, the court found that the District had a significant interest in the application of its no-ceiling law. That would have produced a false conflict, in which case inquiry into whether Virginia had a minimal interest in the litigation and, if so, how that minimal interest would best be served would have been wholly appropriate. But, as our interest analysis indicated, the false conflict arose because the District had no significant interest in the application of its no-ceiling law. Consequently, whichever of those two alternative paths the court pursued, it wound up applying the wrong state's law, in my opinion.

There is a follow-up to *Stutsman: Stutsman II*.36

While the interlocutory appeal [in *Stutsman I*] was pending, [Mr.] Stutsman filed a separate action against Kaiser for loss of consortium due to the physical injuries to his wife. . . . Upon her death in Virginia, [Mr.] Stutsman became the plaintiff in the malpractice action . . . , and that action was consolidated with his action for loss of consortium.

In July, 1985, Stutsman filed a motion to amend the malpractice complaint to add a claim for wrongful death under the Virginia Wrongful Death Act . . . , since the District’s Wrongful Death Act . . . applied only to [death producing injuries] occurring in the District of Columbia. [The trial court] denied the motion . . . on the ground that under *Stutsman I* District of Columbia law applied to the malpractice action and thus precluded Stutsman’s reliance on Virginia law as the basis of his wrongful death action. . . .

In April, 1986, the consolidated survival/loss of consortium action went to trial. The jury awarded Stutsman $401,482 on the survival claim and $250,000 for loss of consortium. . . . Kaiser appealed the award of damages for loss of consortium. . . . Stutsman did not cross-appeal.37

Because Stutsman failed to file a cross-appeal, the appellate court concluded that he was precluded from arguing that the trial court

36. *Stutsman v. Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.*, 546 A.2d 367 (D.C. 1988). Although the defendant-favoring law in *Stutsman II* is not one generated by a perceived medical malpractice crisis, textual consideration of *Stutsman II* is appropriate, I believe, for a couple of reasons. First, having examined *Stutsman I* in some detail, my sense of propriety and completeness suggests a similar treatment for *Stutsman II*. Second, and more important, the lower court’s conclusion in *Stutsman II* that the application of District law in *Stutsman I* compelled the application of District law to the discrete issue in *Stutsman II*, properly repudiated by the appellate court in *Stutsman II* by its recognition of the propriety of decapage, suggests an important message: when a medical malpractice action represents two choice-of-law issues, failure to analyze the issues separately may well produce an imprecise and incorrect conclusion. That problem also existed in *Blakesley v. Wolford*, 789 F.2d 236 (3d Cir. 1986), discussed in the text at note 102 infra.

37. 546 A.2d at 369 (footnote omitted).
had erred in denying a motion to add a wrongful death action. That issue "ha[d] become moot." That left for appellate review only the propriety of the judgment for Stutsman for his loss of consortium.

The District permits recovery for loss of consortium by the spouse of the immediate victim of the defendant's negligence. Virginia does not. The defendant argued that Virginia's law was applicable. Unlike the trial court in its reaction to the plaintiff's motion to add a wrongful death action pursuant to Virginia law, the appellate court recognized that, simply because the District's no-ceiling law had been applied to the damages issue, it did not necessarily follow that Virginia law could not be applied to the consortium issue.

[T]he issue-by-issue approach of interest analysis makes it far more likely that the law of one jurisdiction will be found to govern one aspect of a case while the law of another jurisdiction will control another aspect of that case. . . . This process of applying the law of different states to determine different issues in the same case is known as depecage.

As we did with Stutsman I, let's attempt our own interest analysis with regard to whether the District's law, permitting recovery for loss of consortium, or Virginia's law, precluding such recovery, should be applied.

Presumably, the District permits recovery for loss of consortium in order to protect the economic integrity of the spouse of the immediate victim. By permitting such damages, the District allows the spouse to realize compensation for the loss of sex, services, and society sustained. I think it would be unrealistic to assert that the District is interested in protecting the spouse from indigence. No matter how severe the loss of consortium may be, the spouse of the immediate victim is unlikely to be reduced to indigence. Not having sustained any direct physical injuries, he is likely to retain his preexisting capacity to be self-supporting. Therefore, this reason for the District's law would be a concern with affording the spouse domiciled in the District with a limited form of economic protection. Because Mr. Stutsman was domiciled in Virginia, rather than the District, he would seem not to be within the class intended to enjoy that limited economic protection. Consequently, that reason for the District's law would not convert into a significant interest

38. Id. at 372.
39. Id. at 373. For a discussion of depecage, see R. Weintraub, Commentary on the Conflict of Laws 71 (3d ed. 1986).
on the part of the District in having its law applied. There may be another reason for the District's law: preserving marriages domiciled in the District.\textsuperscript{40} The District may believe that the spouse denied the sex, services, and society of the immediate victim may be less likely to abandon the marriage if he has the opportunity to recover damages for that denial. However, because the Stutsman marriage had been domiciled in Virginia, rather than the District, that reason would not convert into a significant interest on the part of the District in having its law applied. Neither of the reasons underlying that law converts into a significant interest on the part of the District in having its law permitting recovery for loss of consortium applied to \textit{Stutsman II}.

Why does Virginia preclude recovery for loss of consortium? Presumably, Virginia wishes to protect the economic integrity of Virginia domiciled defendants by immunizing them from a type of damages that Virginia finds to be superfluous, potentially duplicative,\textsuperscript{41} or simply insufficiently critical to be afforded legal recognition. Because both defendants were domiciled in the District, rather than Virginia, the reason for that law would not convert into a significant interest on the part of Virginia in having its law precluding recovery for loss of consortium applied to \textit{Stutsman I}. But wait. Earlier on, in discussing \textit{Stutsman I}, we concluded that the defendants, although domiciled in the District, should enjoy the benefit of Virginia's law imposing a ceiling on medical malpractice damages. Is there an inconsistency between that determination and our present conclusion that the defendants were not within the class intended to be immunized from consortium damages? I think not. Our earlier conclusion rested on the combined facts that

\[\text{\hspace{1cm}40. In a footnote, the court in \textit{Stutsman II} wrote: "[W]hile the District's interest in protecting marriages may be aided by the maintenance of alienation [of affections] lawsuits, the same is not equally true of consortium lawsuits..." 546 A.2d 375-76 n.15. The Court's language, I believe, is simultaneously ambiguous and incomplete. By saying that "the same is not equally true of consortium lawsuits," the language could be read as suggesting that consortium actions serve a similar but less pronounced purpose. If the language is intended to suggest that consortium actions serve no such purpose, the court should have indicated why. In the text, I have attempted to indicate why consortium actions could serve to preserve marriages.}\\\[\text{\hspace{1cm}41. Prosser & Keeton on the Law of Torts 933 (5th ed. 1984).}\\\[\text{[O]ne of the chief problems in the consortium claim is the concern to avoid duplicative or impermissible damage awards. So far as damages are based on intangible losses of society and affection, there is some risk that a jury hearing the husband's claim will consciously or not, include something in the verdict for the wife's loss as well, and vice versa.}\\\[\text{Id.}\]
the defendants were providing medical care in Virginia and subjecting them to unlimited liability would threaten the continued availability of affordable medical care in that state. Virginia's law precluding consortium damages, unlike its law imposing a ceiling on medical malpractice damages, wasn't directed precisely at Virginia medical care providers and wasn't intended to assure affordable medical care in that state. Rather, the law precluding consortium damages was intended to protect the economic integrity of Virginia domiciled defendants generally. Moreover, even if the *Stutsman II* defendants were deemed vulnerable to consortium damages under the District's law, they would still enjoy the overall ceiling on damages in medical malpractice actions pursuant to Virginia law, if that ceiling were deemed applicable as suggested by our interest analysis in *Stutsman I*. Therefore, there is no inconsistency in our conclusions that the defendants should have enjoyed the benefit of Virginia's law imposing a ceiling on damages in medical malpractice actions, but should not be immunized from consortium damages pursuant to Virginia law. Virginia simply has no significant interest in having its law precluding consortium damages applied to these District defendants. We seem to be left with a negative standoff: the District has no significant interest in the application of its law permitting consortium damages and Virginia has no significant interest in the application of its law precluding such damages. What's a poor judge to do now?

Earlier, in our discussion of *Stutsman I*, we considered the possibility of a false conflict: a situation in which, while the laws of the two states differ, only one of the states has a significant interest in the application of its own law. In those circumstances, we concluded that it would be appropriate to determine if the state having no significant interest in the application of its own law had some minimal interest in the litigation and, if so, how that minimal interest would best be served. Having concluded in *Stutsman II* that neither state has a significant interest in the application of its own law, it may be appropriate to determine if each state has a minimal interest in the litigation and, if so, how each state's minimal interest would best be served. Because the defendants were domiciled in the District, the District would seem to have a minimal interest in the litigation: protecting the economic integrity of

its domiciled defendants. Obviously, that minimal interest is best served by the application of Virginia law precluding any recovery for loss of consortium. Neither the identification of that minimal interest in the litigation on the part of the District nor the application of Virginia law to serve that minimal interest of the District would generate any internal conflict on the part of the District. Because we have already determined that neither reason for the District’s law permitting consortium damages converts into a significant interest on the part of the District in having its law applied, application of Virginia’s law to serve the District’s minimal interest in the litigation would frustrate no other interest of the District. Because the plaintiff was domiciled in Virginia, that state would seem to have a minimal interest in the litigation: protecting the economic integrity of its domiciled plaintiff. Obviously, that minimal interest is best served by the application of the District’s law permitting recovery for loss of consortium. Neither the identification of that minimal interest in the litigation on the part of Virginia nor the application of the District’s law to serve that minimal interest of Virginia would generate any internal conflict on the part of Virginia. Because we have already determined that the reason for Virginia’s law does not convert into a significant interest on the part of Virginia in having its law applied, application of the District’s law to serve Virginia’s minimal interest in the litigation would frustrate no other interest of Virginia. Consequently, each state would seem to have a minimal interest in the litigation best served by the other state’s law. What had been a negative standoff at the level of each state’s interest in the application of its own law has been converted into a true conflict. The District has a minimal interest in the litigation best served by the application of Virginia law, and Virginia has a minimal interest in the litigation best served by the application of the District’s law.

Now we must decide which state’s minimal interest in the litigation is the more significant and then apply that law which will best serve that interest. The District’s minimal interest in protecting the economic integrity of its defendants is of limited concern. Even assuming an adverse choice-of-law result, one permitting recovery for loss of consortium, it is highly unlikely that such limited liability exposure would result in the bankruptcy of the defendants. Similarly, Virginia’s minimal interest in protecting the economic integrity of the Virginia plaintiff is of limited concern. Even assuming an adverse choice-of-law result, one precluding recovery for loss of consortium, it is unlikely that the plaintiff would become an
indigent ward of the state. After all, the plaintiff, having sustained no direct physical injuries, is likely to retain his capacity to be self-supporting. Perhaps, in determining which state’s minimal interest in the litigation is the more significant, it would be helpful to ask this question: Which litigant would have been in the better position to have acquired protective insurance? The obvious answer would be the defendants. Any liability insurance obtained by them would almost certainly have included an obligation on the part of the insurer to defend and indemnify the insureds with regard to damages for loss of consortium. On the other hand, the plaintiff would have found it difficult, if not impossible, to have acquired insurance protecting him from the loss of the sex, services, and society of his wife. Consequently, application of the District’s law permitting recovery would seem to frustrate the District’s minimal interest in protecting the economic integrity of the defendants less than would the application of Virginia’s law precluding recovery would frustrate Virginia’s minimal interest in protecting the economic integrity of the plaintiff. Therefore, I conclude that Virginia’s minimal interest in the litigation was the more significant, apply the District’s law which best serves that minimal interest, and affirm the consortium judgment for the plaintiff.

How did the court resolve that choice-of-law problem? With regard to the reason underlying the District’s law permitting recovery for loss of consortium, the court wrote: “[T]he District certainly has an interest in holding its corporations liable for negligent acts attributable to their agents.”


The imposition of . . . liability . . . involves at most an increased economic exposure which . . . is a foreseeable and coverable business expense. . . . Given the fact that Nevada has chosen to engage in governmental and business activity in this state, the necessary acquisition of additional insurance coverage to protect itself during such activity is an entirely foreseeable and reasonable expense.

44. Stutsman II, 546 A.2d at 374. The excerpt quoted in the text is followed immediately in the Stutsman II opinion by a citation to similar language that appeared in Stutsman I. See text at note 24 supra. The apparent conclusion in Stutsman I that the District had a significant interest in the application of its conduct regulating law seems to have been adopted and applied to the District law permitting consortium actions in Stutsman II.
That language implies that one reason for the District’s law permitting such recovery is conduct regulation, and that that reason converts into a significant interest on the part of the District in having its law applied. I find that implication difficult to accept, for a couple of reasons. First, it seems to me unlikely that conduct regulation is a reason for the District’s law permitting recovery for loss of consortium. I am willing to assume that a law exposing the culpable actor to liability to the immediate victim of that culpable action has a conduct regulating purpose. But it is difficult for me to accept the court’s implication that liability for loss of consortium is also intended to have a conduct regulating effect. That implication suggests that a potential defendant (an all-encompassing class), deterred from negligence by the prospect of liability to the immediate victim of such negligence, will be further deterred by the prospect of additional liability for a loss of consortium sustained by the potential spouse of the immediate victim. Such an *interrorem* effect seems to me to be painfully strained. Second, even assuming that conduct regulation is a reason for the District’s law permitting recovery for loss of consortium, there would remain the question of whether that reason converted into a significant interest on the part of the District in having its law applied. The conduct to be regulated, provision of medical care, occurred in Virginia. The immediate consequences of that conduct, whether characterized as the injury to Mrs. Stutsman or the loss of consortium sustained by Mr. Stutsman, occurred in Virginia where Mrs. Stutsman was injured because of the delayed diagnosis and where the Stutsman marriage was domiciled. The ongoing consequences of that conduct would be felt in Virginia where Mrs. Stutsman, her husband, and the marriage were domiciled. Thus, even assuming that conduct regulation is a reason for the District’s law, that reason would not convert into a significant interest on the part of the District in having its law applied in *Stutsman I*. The court, however, simply identified the conduct regulating reason and assumed that it converted.

With regard to the reason underlying Virginia’s law precluding consortium actions, the court wrote: “[Virginia] has an obvious interest in regulating the legal rights of married couples domiciled in Virginia.” 45 Despite its surface appeal, that language is troubling to me. If Virginia’s law permitted recovery for loss of consortium, I could comprehend the relationship between that law and the mari-

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45. *Id.*
tal domicile in Virginia for exactly the same reasons noted in our discussion of the District law permitting such damages: such a law exists to protect the economic integrity of the spouse and to preserve the marriage. But Virginia's law precludes consortium actions. That law, I believe, is aimed at protecting the economic integrity of Virginia defendants rather than "regulating the legal rights of couples domiciled in Virginia."

The court traced the history of Virginia law which "eliminated the common law restrictions on a married woman's capacity to sue" and "gave a married woman the exclusive right to sue for damages for her personal injuries." Simultaneously, the court wrote, Virginia "retained the prohibition on the husband's maintenance of any action for loss of consortium." None of that, however, supports the court's conclusion that Virginia's law, precluding consortium actions, was intended to "regulat[e] the legal rights of married couples domiciled in Virginia." In those states permitting consortium actions, married women have been given a similar capacity to sue and a similar capacity to maintain actions for personal injuries sustained by them. Such capacity is not inherently antithetical to recognition of consortium actions by husbands. The two concepts may, and in most states do, coexist. Therefore, I find it difficult to accept the court's conclusion that Virginia's law precluding consortium actions was aimed at regulating the legal aspects of Virginia marriages.

Having concluded that the District had a significant interest in the application of its law permitting consortium actions (based on conduct regulation) and that Virginia had a significant interest in the application of its law precluding such actions (based on the regulation of Virginia marriages), the court found that "we confront a real conflict between the policies of the two jurisdictions." Ultimately, the court determined that "Virginia has the more significant interest in the application of its law." Consequently, the court reversed the judgment for plaintiff in the consortium action. What led the court to that conclusion?

First, the court cited precedents: *Felch v. Air Florida, Inc.* and

46. *Id.*
47. *Id.*
48. *Id.*
49. *Id.*
50. *Id.*
Choice-of-Law

Linnell v. Sloan.\(^52\) In both cases, the courts determined the availability of an action for loss of consortium pursuant to the law of the marital domicile. Neither case, however, provides persuasive precedential support for the result achieved in Stutsman II. Both cases were in federal court on diversity grounds. Thus, each court was making an educated guess as to what the highest appellate court of the District of Columbia would decide.\(^53\) In those circumstances, the diversity court results, while possibly persuasive, are not binding precedents for the District of Columbia Court of Appeals. Moreover, in Linnell, the domicile law applied permitted consortium actions, unlike the Virginia law in Stutsman II which precluded such actions. As we have noted, there is an appropriate relationship between marital domicile and a law in that domicile state permitting such actions. In Felch, the question was whether to permit a claim for loss of consortium where claimant and immediate victim had cohabited absent marriage. The court noted that such a claim was not recognized in either Virginia or the District.

Second, the court found that, because the Virginia law precluding consortium actions existed in a statute "tailored to the specific cause of action asserted here,"\(^54\) Virginia's interest in having that law applied was enhanced. But the Virginia statute precluded consortium claims in all personal injury actions, not just medical malpractice actions. Thus, the Virginia statute was distinguishable from the Brazilian statute in Tramontana v. S.A. Empresa De Viacao Aerea Rio Grandense\(^55\) which imposed a ceiling on recoveries in personal injury and wrongful death actions arising out of airplane accidents. That Brazilian statute evidenced a sharply focused concern on the part of Brazil in protecting the economic integrity of its national airline.\(^56\)

52. 636 F.2d 65 (4th Cir. 1980).
53. In Linnell, [Plaintiffs] originally brought this diversity action . . . in the United States District Court for the District of Columbia. . . . Pursuant to [28 U.S.C. § 1404(a)], that court transferred the action to the United States District Court for the Eastern District of Virginia. . . . [In those circumstances, the transferee court must] apply[y] the choice-of-law rules of the District of Columbia, the original forum. . . .
636 F.2d at 66.
54. 546 A.2d at 374.
56. Id. at 471 (footnote omitted):
. . . Varig is a Brazilian corporation which, as a national airline, is an object of concern in terms of national policy. To Brazil, the success of this enterprise is a matter not only of pride and commercial well-being, but perhaps even of national security. . . . The Brazilian limitation in terms applies only to airplane accidents. . . . The
Third, the court relied on another aspect of the *Tramontana* opinion. In *Tramontana*, the court, finding a true conflict between Brazil and Maryland, concluded that Maryland's interest was diminished because a Maryland court hearing a similar action would, through *lex loci delicti*, apply the Brazilian ceiling even to the economic jeopardy of the Maryland domiciled dependent survivor.\(^{57}\) In *Stutsman II*, the court noted that Virginia, utilizing *lex loci delicti*, would apply Virginia's law precluding consortium actions, thus evidencing an enhanced Virginia interest. While I think that aspect of the *Tramontana* opinion can be helpful to an interest analysis court confronted with a true conflict in which the competing interests are rather evenly balanced,\(^{58}\) I'm not sure it should have been given significant weight in *Stutsman II*. Once the court found that the reason underlying the District law permitting consortium claims was conduct regulation, as the court apparently did, and once the court concluded that that reason converted into a significant interest on the part of the District in having its law applied, as the court apparently did tacitly, the court had fashioned a District interest aimed at protecting and preserving human life. That interest, I would think, would be clearly superior to (the court's perceived) Virginia interest in regulating the marital relationship, even assuming that a Virginia court would apply Virginia law through *lex loci delicti*.

The result achieved in *Stutsman II* disturbs me for a couple of reasons. The first goes to the underlying reasons for each state's law as identified by the court. I think it strains credulity to suggest that the District's law permitting consortium actions was intended to regulate conduct, that is, to deter negligence. I also think it unrealistic to suggest, as the court did, that Virginia's law precluding consortium actions is a necessary concomitant of affording married women the right to sue for their own injuries. Given those dubious reasons for the two laws, I think the court's interest analysis was skewed from the outset. Second, even accepting the underlying reasons identified by the court, its ultimate conclusion that Virginia's interest was superior seems to denigrate the (judicially perceived) District interest in conduct regulation. Consequently, I find myself in disagreement with both *Stutsman I* and *Stutsman II*. In the first case, I believe Virginia's ceiling on damages in medical

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\(^{57}\) *Id.* at 473-75.

malpractice actions should have been applied, and, in the second case, I believe the District’s law permitting consortium actions should have been applied.

Let’s examine another case, one in which the United States Court of Appeals for the District of Columbia, exercising diversity jurisdiction, was confronted with a choice-of-law problem involving the District’s law and Maryland’s law. In Bledsoe v. Crowley,59

. . . Theodore Bledsoe, a medical doctor, brought suit in the District Court against Dr. Brian Crowley and Dr. Sylvia Friedman, alleging negligence in their failure to diagnose his brain tumor during the twelve years they treated him for psychiatric disorders. Bledsoe first consulted Dr. Crowley, a psychiatrist, in 1969, because of “occasional inability to control impulsive behavior.” He underwent psychoanalysis with Crowley for the next eleven years. In 1979, Crowley referred Bledsoe to another psychiatrist, Dr. Friedman, with whom he engaged in group therapy for two and one-half years. In 1984, some time after Bledsoe had discontinued therapy with both doctors, he was admitted to St. Elizabeth’s Hospital in Washington, D.C., where a CAT scan revealed a brain tumor. According to the complaint, the tumor had been present and growing for many years. While Bledsoe’s condition improved following removal of the tumor, he allegedly suffered permanent brain damage and loss of vision, which prevented him from pursuing his practice of radiology.60

Plaintiff was domiciled in the District and the two defendants were domiciled in Maryland. The psychiatric treatment had been provided in Maryland. By statute, Maryland provides that . . . medical malpractice claims . . . must be submitted initially to an arbitration panel. . . . Either party is free to reject the arbitration award, but in such a case the award is admissible in a subsequent court action as the presumptively correct judgment. The party rejecting the award bears the burden of rebutting the presumption and must pay court costs if the verdict ultimately obtained is not more favorable than was the arbitration award. The statute provides . . . that “[a]n action . . . of [the type covered by the statute] may not be brought or pursued in any court of this State except in accordance with this subtitle.”61

The District has no such requirement. Plaintiff had not initiated an arbitration proceeding in Maryland prior to bringing his diversity action in the District. Defendants, asserting that Maryland law was applicable, moved to dismiss the complaint. Plaintiff, arguing that the District’s law should apply, resisted the motion. The court, recognizing its obligation under Klaxon Co. v. Stentor Elec-

59. 849 F.2d 639 (D.C. Cir. 1988).
60. Id. at 640.
61. Id. at 640-41.
tric Mfg. Co., 62 noted that it was required to resolve the choice-of-law problem precisely as it would be resolved by the highest appellate court of the forum state. Since the District of Columbia Court of Appeals would utilize interest analysis, so too did the diversity court.

Once again, let's attempt our own application of interest analysis. The reason underlying Maryland's arbitration law is to assure the continued availability of medical care within that state at affordable rates. 63 It was Maryland's belief that the arbitration process would make the defense of medical malpractice actions less expensive, thereby "assuring the availability of malpractice insurance at reasonable rates," 64 thus assuring the availability of affordable medical care in that state. Does that reason convert into a significant interest on the part of Maryland in having its arbitration law applied to this case? Since the defendants were Maryland practitioners, the answer would seem to be yes. To the extent that the arbitration process would reduce the cost of defending medical malpractice actions, thus resulting in lowered rates for malpractice insurance, the Maryland practitioners would be better able to offer their professional services at affordable rates.

What are the reasons underlying the District's law requiring no arbitration process as a condition precedent to bringing a medical malpractice action in court? One reason presumably would be to assure that victims of medical malpractice domiciled in the District do not become indigent wards. The absence of a mandatory arbitration process whose results become presumptively correct, assures such District victims that they will not be disadvantaged by an arbitration result that awards them less than their claim is worth. Does that reason convert into a significant interest on the part of the District in having its law applied? Of course. The plaintiff, domiciled in the District, is precisely within the class intended to be protected by that law. Were he to be disadvantaged economically by an arbitration result, he could become an indigent ward of the District. A second reason for the District's law would seem to be conduct regulation. By subjecting those charged with medical malpractice to the judicial process, unshielded by a prior arbitration process, the District intends to have those found guilty of malpractice feel the full sting of liability, thus deterring medical mal-

62. 313 U.S. 487 (1941).
64. Id. at 312, 385 A.2d at 79 (footnote omitted).
practice. Does that conduct regulating reason for the District’s law convert into a significant interest on the part of the District in having its law applied? The conduct intended to be regulated occurred in Maryland, where the defendants treated the plaintiff, not in the District. The immediate consequences of that conduct, the undetected growth of the tumor, could be said to have occurred in both Maryland, the place of treatment, and the District, the plaintiff’s domicile. The ongoing consequences of that conduct, plaintiff’s generally diminished capacity and his inability to pursue his profession, certainly will be felt in the District, the plaintiff’s domicile. Clearly, that conduct regulating reason for the District’s law converts into a significant interest on the part of the District in having its law applied. Interest analysis indicates a true conflict: each state has a significant interest in the application of its own law. That requires us to determine which state’s interest in the application of its own law is the more significant and then to apply that state’s law.

We have noted that the sole reason for Maryland’s law converted into a significant interest on the part of Maryland in having its law applied and that both reasons for the District’s law converted into significant interests on the part of the District in having its law applied. Does that mean that the District wins 2 - 1? Of course not. Interest analysis requires a qualitative, not a quantitative, weighing of the competing interests. We must determine qualitatively which of the two jurisdictions has the more significant interest in the application of its own law.

In weighing Maryland’s interest in assuring the continued availability of affordable medical care in that state against the District’s interest in assuring that its domiciled victim does not become an indigent ward of the District, I am inclined to conclude that the Maryland interest is the more significant. Absent a mandatory arbitration process producing a “presumptively correct judgment,” the likelihood of increased litigation costs, increased insurance premiums, and, therefore, increased fees for medical care in Maryland, seems fairly high. On the other hand, subjecting the District plaintiff to such an arbitration process seems unlikely in fact to result in his indigence. If the plaintiff is disappointed by the arbitration result, he may challenge that result judicially. While the plaintiff would bear the burden of rebutting the propriety of that result, and would be required to pay court costs if he failed to do so, it seems likely that, if the arbitration process produces an award for the plaintiff in so low an amount that plaintiff’s indi-
gence becomes likely, plaintiff would be able to rebut the propriety of such an award. An arbitration finding of liability in favor of the plaintiff coupled with an award of damages so low as to threaten the plaintiff with indigence, would seem almost by definition to be inappropriate and vulnerable to successful rebuttal. Therefore, as between Maryland’s interest in assuring the availability of affordable medical care in that state and the District’s interest in assuring that the plaintiff does not become an indigent ward of the District, I believe the former interest prevails.

Let’s consider the District’s second interest, deterring negligent medical care. How does it weigh against Maryland’s interest in assuring affordable medical care? Ordinarily, I believe a conduct regulating reason is entitled to great weight. After all, laws having a conduct regulating reason are usually aimed at protecting and preserving human life. And, indeed, the District’s interest in deterring negligent medical care is directed toward that very purpose. There can hardly be a more significant interest than protecting and preserving human life. Yet, Maryland’s interest, assuring affordable medical care in that state, is also affiliated with protecting and preserving human life. Presumably, the availability of affordable medical care in Maryland will tend to protect and preserve human life by assuring an enhanced likelihood that those requiring medical care will be financially able to seek and receive it. How should that rather evenly balanced conflict be resolved?

I think that Maryland’s interest in assuring the availability of affordable medical care should prevail. If Maryland’s arbitration law is applied, the defendants and their professional liability insurance carriers may enjoy the benefit of a less expensive defense of the medical malpractice claims. That does not necessarily mean, however, that an ultimate award entered for the plaintiff and against one or both defendants will be in an amount so low as to have no deterrent effect with regard to negligent medical care. An award for the plaintiff in the arbitration process is likely to have some efficacy in deterring future negligent medical care. And should the arbitration process produce an award for the plaintiff in an amount substantially below his expectations, plaintiff could exercise the right to have that award reconsidered judicially. While it is true that the plaintiff would be required to rebut the presumption of propriety of the arbitration award in that judicial proceeding, it is possible that he could do so successfully. Of course, if the plaintiff’s effort to rebut the presumption of propriety fails, he will bear the onus of paying court costs. Arguably, that onus could
dissuade the plaintiff from judicially challenging the arbitration award. Even then, however, it would not necessarily follow that the arbitration award would be inadequate to deter negligent medical care. Moreover, the greater the disparity between the arbitration award and the plaintiff's expectations, the more likely it would become that the plaintiff would attempt to rebut the presumption of propriety of the award judicially, even at the risk of incurring court costs if unsuccessful. Consequently, applying Maryland's law would accomplish Maryland's goal of reducing the cost of the defense of medical malpractice actions and thereby assuring affordable medical care in Maryland without necessarily destroying the District's interest in deterring negligent medical care through the sting of liability. On the other hand, if the District's law, aimed at deterrence, were applied, Maryland's interest in assuring the availability of affordable medical care would necessarily be frustrated. The defendants and their professional liability insurance carriers would automatically be deprived of the opportunity of the less expensive defense available in the arbitration process. Therefore, it seems to me that, in this rather evenly balanced conflict, Maryland's interest in the application of its law is more significant than the District's interest in the application of its law; thus, interest analysis points to the application of Maryland's arbitration process.

How did the diversity court resolve the conflict? It arrived at the same conclusion suggested by our application of interest analysis: Maryland's law was applied. The court, however, seems to have been less sensitive to the reasons underlying the District's law and, therefore, to the significant interest of the District in having its law applied, than were we. The court wrote:

[Plaintiff] contends that the District government's silence on the question of malpractice reform does not necessarily . . . indicate a lack of interest in the question, for it could equally well support an inference that the District wished to assure its citizens the full remedies of traditional tort law. In the absence of further documentation of the District's putative interest, this argument remains speculative. Even were we to give it full credence, however, we would conclude that Maryland is the jurisdiction with the stronger

65. *Bledsoe*, 849 F.2d at 640. “We find, contrary to appellant's argument, that District of Columbia choice of law principles require application of Maryland law in this case.” The court, however, did not order the action dismissed. Rather, because the plaintiff initiated an arbitration proceeding in Maryland after initiation of the judicial action, the court ordered that the judicial proceeding be stayed “pending completion of the arbitration process currently underway in Maryland.” *Id.* at 646 (footnote omitted).
The court seems to have accepted the reason for the District law on an arguendo basis and, even on that basis, identified only one aspect of that reason: "the District wishes to assure its citizens the full remedies of traditional tort law." As our analysis indicated, that reason, assuring that District victims do not become indigent wards, is certainly one of the reasons for the District's law. But how about conduct regulation? Surely, the District's law is intended to deter negligent conduct, and, as we have found, that reason too converted into a significant interest on the part of the District in having its law applied. Indeed, that conduct regulating reason, aimed at protecting and preserving human life, would seem to be the more significant of the two interests the District had in having its law applied. How did the court overlook that reason for the District's law?

I think the answer may lie in the court's arguendo acceptance of the reason underlying the District's law. That limited acceptance seems to have resulted in giving short shift to the District's interests. And that limited acceptance, in turn, seems to have arisen from the Court's somewhat skeptical recognition of "the District's putative interest" because of "the District government's silence on the question of malpractice reform." That raises two connected questions. First, should the fact that the District simply retained its common law (not requiring prior arbitration of negligence actions) inherently diminish its internal interests underlying that common law? Second, should the fact that Maryland enacted an arbitration statute specifically applicable to medical malpractice actions enhance its interest in the issue vis-a-vis the District's interest? I think the first question should be answered no and the second question yes.

Simply because the District retained its common law should not result in a diminution of the reasons underlying that law or of the significance of those reasons as viewed by the District. To hold otherwise, would be to tell the District and every other state desirous of retaining any aspect of its common law that it should act legislatively to codify its common law or face a judicial denigration of the reasons underlying that common law. That would be equivalent to sending each legislative body on a fool's errand. To codify all of a given state's common law would be a horrendous legislative undertaking. Moreover, it seems almost inevitable that

66. Id. at 642 (footnote omitted).
such a process would produce inadvertent changes in the common law or at least legislative wording or history that would invite counsel to argue that such changes had been effected. No court should send that message to any legislative body. Consequently, notwithstanding the fact that the District’s law consisted of a retention of that jurisdiction’s common law, I believe that the court should have made an assiduous effort to identify each of the reasons underlying that common law and to determine which of those reasons converted into significant interests on the part of the District in having its law applied.

At the same time, I think the court should have been sensitive to the fact that Maryland’s arbitration law was a legislative reaction to a specific problem, the perceived medical malpractice crisis, and that the Maryland statute, limited to medical malpractice actions, evidenced that state’s clearly focused concern with a particular aspect of the problem. The Maryland statute was analogous to the Brazilian statute in Tramontana: the focus of the enacting state could hardly have been clearer. Therefore, as in Tramontana, I believe the court in Bledsoe should have been influenced by Maryland’s clearly focused concern with assuring lower professional liability insurance premiums, thereby assuring affordable medical care, when weighing that Maryland interest against the District’s interests. Indeed, I am inclined to think that in every choice-of-law problem in which one state has reacted specifically to some aspect of the medical malpractice crisis and the other state has retained its preexisting law, the former state will enjoy an advantage based on its clearly focused concern when the competing state interests are weighed judicially.

In an effort to avoid the application of Maryland’s arbitration statute, plaintiff argued that the statute was “procedural.” According to the court, that argument was predicated on this statutory language: “An action or suit of that type may not be brought or pursued in any court of this State except in accordance with this subtitle.” The court, relying on opinions of the Maryland Court of Appeals and the Fourth Circuit, in a diversity case brought in Maryland, rejected the argument. The court concluded that the

67. Id. at 644.
68. Id. at 643.
70. Davison v. Sinai Hospital, 462 F. Supp. 778 (D. Md. 1978), aff’d, 617 F.2d 361 (4th Cir. 1980).
statutory language quoted above "was only meant to exclude minor claims [having a dollar value beneath that set forth in the statute] filed in state district courts [having a limited dollar jurisdiction] from the arbitration requirements." In further support of the "procedural" nature of the statute, plaintiff asserted this language in the statute: "The provisions of this subtitle shall be deemed procedural in nature . . . ." The court expressed "some difficulty comprehending the precise nature of [plaintiff's] argument." To the court, plaintiff's "procedural" argument led to the conclusion that the Maryland statute would be applied by a diversity court sitting in Maryland but not by a diversity court sitting elsewhere, for example in the District. The court found that "This is a strange argument indeed. . . . Once it has been determined . . . that Maryland law governs, a D.C. federal court would apply Maryland law no differently than would a Maryland federal court."

I'm not sure that plaintiff's argument was quite so "strange" as the court concluded. It's conceivable that one reason for Maryland's statute may have been to preserve the integrity of the judicial process in Maryland by assuring that potentially spurious malpractice actions were not brought in those courts. Presumably, the arbitration process would winnow out such spurious claims, thus diminishing the likelihood that Maryland courts would have such claims imposed on them. Let's assume for the sake of discussion that thus protecting the integrity of the judicial process in Maryland was the only reason for the arbitration statute. Would the arbitration statute then be potentially applicable in a diversity court sitting in Maryland and confronted with a plaintiff's argument that the law of some other state having no such statute (the District of Columbia, for example) should be applied? I think the answer is yes. Obviously, a Maryland state court confronted with a similar choice-of-law problem would be justified in finding that Maryland's desire to protect the integrity of the judicial process in that state converted into a significant interest on the part of Maryland in having its statute applied by a Maryland court. Indeed, that interest could lead the state court to apply the Maryland statute. A diversity court sitting in Maryland and confronted with the same choice-of-law problem, cognizant of its Klaxon obligation, might very well conclude that the same Maryland purpose con-

71. 849 F.2d at 643.
72. Id. at 644, n.8.
73. Id. at 644.
74. Id.
verted into a significant interest on the part of Maryland in having its statute applied by a diversity court sitting in Maryland. Otherwise two adverse consequences would arise: the diversity court might resolve the choice-of-law problem differently than the Maryland state court, thus violating the spirit if not the letter of *Klaxon*, and the Maryland statute could be circumvented in every diversity case brought in Maryland. Consequently, the diversity court could conclude that Maryland’s interest in protecting the integrity of the judicial process in that state extended to diversity courts sitting in that state. If, on the other hand, the action were brought in a diversity court sitting in some state other than Maryland (the District, for example), that court would be entirely free to conclude that Maryland’s desire to protect the integrity of the judicial process in Maryland simply did not convert into a significant interest on the part of Maryland in having its law applied by this diversity court. It would be officious on the part of Maryland to attempt to impose its notions about the appropriate means of protecting the judicial integrity of courts, state or federal, sitting in some state other than Maryland. That non-application of the Maryland statute would not constitute an inappropriate circumvention of the statute; rather, it would be the product of a reasoned judicial conclusion that Maryland simply had no significant interest in the statute’s application. In those circumstances, there would be nothing “strange” about “a federal court sitting in Maryland . . . apply[ing] the arbitration statute, [while] a federal court sitting in another state could not do so.” Such a situation could very well exist. Consequently, I think the language used by the court in rejecting plaintiff’s “procedural” argument, perhaps appropriate to the actual case before the court, may have been too sweeping in scope.

The concurring opinion in *Bledsoe*, although agreeing “wholeheartedly” with the “excellent [court] opinion,” “consider[ed] an additional element in the choice of laws problem.” The concurrence noted: “In the medical malpractice context, with which we deal here, there are systemic interests in (1) states’ being able to develop coherent policies governing medical malpractice liability and (2) individuals’ being able to take advantage of medical ser-

75. *Id.*
76. *Id.* at 646.
77. *Id.*
78. *Id.*
ervices outside their home jurisdictions." To help deal with those "systemic interests," the concurring opinion invoked the Restatement (Second) of Conflict of Laws, "to which District of Columbia courts often turn for guidance." The Restatement . . . lists as the first relevant "factor" in interest analysis "the needs of the interstate system[]." The "needs of the interstate system" when applied to the "systemic interests" noted, led the concurrence to consider two possible general resolutions: (1) application of the law of the state where the medical services had been rendered or (2) application of the law of the patient's domicile.

In order to serve Maryland's interest in "reduc[ing] medical costs by reducing the burden of malpractice liability," the state "must be able to assure providers that the state's rules will actually apply to all (or virtually all) cases."

For example, if Maryland places limits on malpractice recoveries but its medical providers are exposed to liability under the laws of states without such controls, the charges of persons providing medical services in Maryland will rise to carry the burden of expected liabilities to out-of-staters. This result thwarts not only the ability of each state to establish a policy and secure whatever benefits it may offer, but also the system's capacity to conduct and evaluate experiments in liability policy.

On the other hand,

[a]pplying the rule of the patient's domicile might at first blush seem easily reconciled with the interest in state development of liability policy. If courts apply the law of the patient's domicile, medical associations can be expected to promptly inform Maryland providers, who in turn can reject would-be out-of-state patients. By contrast, potential out-of-state patients may not so readily learn that use of Maryland providers entails special malpractice rules.

Ultimately, the concurrence opted for application of the law of the state where the professional services were rendered. It did so for two reasons. First,

[for medical providers to screen out incoming patients altogether would completely destroy individuals' ability to seek out expert medical help

79. Id.
80. Id.
81. Id.
82. Id.
83. Id.
84. Id.
85. Id.
86. Id. at 646-47.
87. Id. at 647.
throughout the United States. The Mayo Clinic in Minnesota is simply the most prominent of many providers whose reputation draws patients from the entire country. A system depriving the ill of these benefits would seem a tragic waste. 88

Second,

[w]hile medical associations can readily communicate with members as to liability hazards, and alert them to possible responses, patients are inherently on notice that journeying to new jurisdictions may expose them to new rules. The maxim “When in Rome do as the Romans do” bespeaks the common sense view that it is the traveler who must adjust.89

The conclusion that the law of the state where the medical services had been rendered should be applied left the concurrence with an awkward problem. As the concurring opinion noted, the diversity court deciding Bledsoe was, under Klaxon, “act[ing] only as [a] surrogate[] for the District of Columbia courts, and the District’s [then] only case on conflicts in medical malpractice law [Stutsman I] rejected the law of Virginia, where the services were provided.”90

Of course, the diversity court and the concurrence in Bledsoe lacked the freedom we enjoyed to characterize the result achieved in Stutsman I as mistaken. Instead, both the court’s opinion and the concurrence sought to distinguish Stutsman I. The concurrence noted that, in addition to the court opinion’s “amply distinguish[ing]”91 Stutsman I in a footnote, that case was further distinguishable in several respects.92 First, in Stutsman I, “no one even brought the systemic values to the attention of the court.”93 Second, in Stutsman I, the court “assumed Virginia’s primary interest lay in benefitting providers as opposed to consumers.”94

88. Id. at 647.
89. Id.
90. Id.
91. Id. The court opinion distinguished Stutsman I in the following manner:
The court’s decision was based largely on three factors: (1) the two defendants were District of Columbia corporations, and the District therefore had a significant interest in holding them fully liable for their negligence; (2) the plaintiff was employed in the District, the health plan under which she was treated was a benefit of that employment, and, therefore, the District’s interest in the protection of its workforce was implicated; and (3) Virginia’s interest in imposing a liability cap was primarily in protecting Virginia health care providers, and that interest was weaker where the defendants were foreign corporations with their principal places of business outside Virginia. . . . In the present case, none of these factors would point to a stronger interest for the District of Columbia.
849 F.2d at 643 n.6.
92. Id. at 647.
93. 849 F.2d at 647.
94. Id.
Third, as a result of that failure and that assumption, the Stutsman I court "ignore[d] the systemic interest in states' being able to adopt policies reducing health care costs for consumers" and (my words) overemphasized the significance of the District domicile of the two defendants.

The second and third distinguishing characteristics identified by the concurrence closely track our own interest analysis in Stutsman I. We, like the concurrence, found that Stutsman I had unduly emphasized Virginia's interest in protecting the economic integrity of medical care providers while unduly diminishing its interest in assuring the availability of affordable medical care. What remain are the concurrence's "systemic interests," and its decision that those interests can best be served by applying the law of the state where the medical care was provided. How persuasive is that interest and that decision?

To the extent that the court opinion and the concurrence in Bledsoe wound up applying Maryland's arbitration statute, both arrived at the same conclusion achieved by our interest analysis. But the concurrence apparently would go further. Moved by the "systemic interests" it identified, the concurrence would apply the defendant-favoring law of the state where the medical services were rendered "to all (or virtually all) cases." That conclusion troubles me for two reasons, one pragmatic and the other philosophical.

My pragmatic concern arises out of two of the assumptions underlying the concurring opinion. The first assumption is that, if the defendant-favoring law of the state where the medical service is provided is not applied, medical care providers in that state would "screen out incoming patients" domiciled in states having plaintiff-favoring laws. How valid is that assumption? To make the assumption somewhat more specific (and to utilize the concurrence's example), we might ask: How likely is it that the Mayo Clinic would decline to accept patients from states having plaintiff-favoring laws? For me, merely to ask the question virtually compels the answer, not very likely. The reputation of the Mayo Clinic rests in substantial measure on its acceptance of patients from all over the country and indeed all over the world. To accept the assumption that the Clinic would jeopardize that reputation by declining to accept patients from a significant portion of the country imputes

95. *Id.*
96. *Id.* at 646.
to the Clinic a skewed view of its interest in its reputation, its professional competence, and its economic well-being. One reason for the historically extraordinary diagnostic competence of the Clinic is its acceptance of an extraordinary number of patients and its meticulously maintained and cumulative patient files. The more patients examined the more competent the Clinic becomes in its historic specialty of diagnosis. Enhanced competence leads to enhanced reputation which leads to enhanced economic stature. But let’s leave the unique status of the Mayo Clinic and look to the facts before the court in Bledsoe where a District domiciliary sought and received medical care in Maryland. To anyone familiar with the relationship between the District and its suburbs in Maryland (and Virginia), and indeed to anyone familiar with similar relationships around the country, it would seem highly unlikely that a medical care provider in a state having a defendant-favoring law would decline to accept a patient from a contiguous state having a plaintiff-favoring law. To indulge in the assumption that the medical care provider would so decline would be to impute to the provider a skewed sense of his own professional competence, reputation, and economic well-being. Medical care providers in such circumstances depend in substantial measure on a continuing flow of patients from both their own and the contiguous states to assure their professional competence, reputation, and economic well-being. Anyone doubting that need only look to the Yellow Pages where he will find quarter- and half-page advertisements for hospitals in contiguous and geographically proximate states and somewhat more modestly sized but attention-grabbing advertisements for physicians in contiguous and geographically proximate states. Indeed, the District of Columbia Yellow Pages\(^97\) are full of such ads under Hospitals\(^98\) and under Physicians\(^99\) with many of the advertisers offering medical care in Maryland and Virginia, both of which, as we have seen, have defendant-favoring laws. Consequently, I find some difficulty in accepting the concurrence’s first assumption that such medical care providers will turn away out-of-


\(^98\) Among the listings under Hospitals, there are 28 offering medical care in Maryland or Virginia whose listings are in larger than normal type size.

\(^99\) Among the listings under Physicians, there are dozens offering medical care in Maryland or Virginia whose listings are in larger than normal type size. Of those, many offer medical care in Maryland and the District, or Virginia and the District, or Maryland, Virginia, and the District.
state patients absent a choice-of-law rule that will invariably apply the defendant-favoring law.

The second assumption of the concurring opinion is that “patients are inherently on notice that journeying to new jurisdictions may expose them to new rules. The maxim ‘When in Rome do as the Romans do’ bespeaks the common sense view that it is the traveler who must adjust.” I find that assumption difficult to accept, for several reasons. First, I don’t understand why it is “inherently” more reasonable for the patient who travels from the District to Maryland for medical treatment to contemplate “new rules” than it is for the Maryland practitioner who accepts a patient from the District to contemplate “new rules.” Certainly, as between the two, it is the medical care provider who is more likely in fact to be aware of the difference in rules. Second, it is not unusual for the provider to offer care in both jurisdictions. (Take another look at the Yellow Pages.) And it is certainly not unusual for the patient to opt for that facility nearer his home or that facility nearer his place of employment, either of which facility may be in a state other than patient’s home. To make the choice-of-law result turn on the option of the patient, where provider invites the exercise of such an option, isn’t very persuasive. Third, the patient’s choice of medical care provider is often the practical result of a referral by patient’s primary physician. Anyone familiar with the geography of the District, Maryland, and Virginia, and anyone familiar with similar geographical proximity among other states, knows that such a referral may be to a medical provider in a state other than the patient’s domicile. In such circumstances, where the patient’s choice of a medical care provider (whether physician or hospital) is impelled by the referral, to make the choice-of-law result turn on the locale of the referred provider seems inappropriate. Consequently, I find it difficult to accept the concurring opinion’s second assumption that “it is the traveler who must adjust.”

Beyond those pragmatic considerations, I am concerned philosophically with the concurrence’s suggestion that the defendant-favoring law of the state where the medical care is provided should apply in “all (or virtually all) cases.” Even absent such a general conflicts rule, interest analysis is likely to point to that defendant-favoring law more often than not. Two of the reasons for that conclusion became apparent in our interest analysis of Bledsoe. Ap-
cation of the Maryland arbitration statute would not entirely frustrate the District’s interests, but application of the District’s law would frustrate entirely Maryland’s interest in assuring affordable medical care. That relationship is likely to exist in most such choice-of-law cases and, as in Bledsoe, it will point to the defendant-favoring law. Moreover, the defendant-favoring law, enacted as a legislative response to a perceived medical malpractice crisis, will evidence a more sharply focused concern on the part of the state having the statute than exists on the part of the state whose common law would apply. That too will point to the defendant-favoring law. Thus, the site of the medical care having such a defendant-favoring law will enjoy a decided inherent advantage over the other state in a choice-of-law context. That advantage is likely to be dissipated only in that unusual case where the defendant-favoring law (or combination of laws) is so egregious in its effect on the patient and his domicile state that the forum concludes that the interests of the latter state should prevail. That existing state of the law exercises a certain therapeutic inhibiting effect on those states having or contemplating crisis-generated defendant-favoring laws. It informs them that, if their crisis-generated statutes go too far, those statutes may not be applied in interstate cases. The concurring opinion’s suggested general rule that the defendant-favoring laws be applied in “all (or virtually all) cases” would, I believe, have an unfortunate impact on that presently existing therapeutic effect. For that reason, too, I find it difficult to acquiesce in the concurrence’s suggestion. However, in specific result, both the court’s opinion and the concurring opinion in Bledsoe seem to have produced the correct choice-of-law resolution: application of the Maryland arbitration statute.

Let’s move from the District of Columbia to Pennsylvania and Blakesley v. Wolford. Plaintiff, domiciled in Pennsylvania, suffered injury to her right lingual nerve during the extraction of her wisdom teeth. That nerve damage left her with “numbness and ‘electric-shock like’ sensations on the right side of her tongue.” Two Pennsylvania surgeons suggested to the plaintiff that she should have the defendant, “a Texas oral surgeon expert in the repair of nerve damage, examine [the plaintiff] during his next scheduled visit to and speaking engagement in the Lancaster

102. 789 F.2d 236 (3d Cir. 1986).
103. Id. at 237.
Pursuant to that advice, the plaintiff arranged to be examined by the defendant in Pennsylvania. Following the examination,

[Dr.] Wolford advised Blakesley that nerve graft surgery might alleviate her distress. Specifically, Wolford suggested the removal of the neuroma on her lingual nerve and the grafting of a section of the greater auricular nerve located in her neck below her left ear to replace the damaged nerve. . . . Wolford informed her that removal of the portion of the greater auricular nerve would leave “a small area of numbness in [her] temple area and possibly part of [her] ear,” but that other patients who had undergone similar surgery “had not had any problems with that.”

Blakesley asked if Wolford could perform the surgery in Pennsylvania but Wolford told Blakesley “that the operation ‘would have to be done in Texas.’”106 Wolford then gave Blakesley one of his cards, suggesting that she contact him after deciding whether to have the surgery performed. On the back of the card, Wolford wrote the following “description of the proposed surgical procedure:[]

Secretary — Linda
DX [presumably, Diagnosis]: Neuroma [with] paresthesia of right lingual nerve
TX [presumably, Treatment]:
1. Resection of neuroma
2. Greater Auricular nerve graft to lingual nerve
Time: 4 hr.107

Subsequently, Blakesley decided to proceed with the surgery and met with Wolford in his hospital office in Dallas, Texas. “During that 45-minute meeting, Wolford explained the proposed surgical procedure, essentially repeating what he previously had told Blakesley at the Lancaster, Pennsylvania consultation. Following that discussion, Blakesley signed the hospital’s standard operative consent form for the surgery.”108 The surgery was performed the next day. “However, instead of using Blakesley’s greater auricular nerve as the donor nerve for the nerve graft, as Blakesley had been informed, Wolford . . . grafted an alternate nerve from her neck onto her damaged lingual nerve in her tongue.”109 The operation

104.  Id.
105.  Id.
106.  Id.
107.  Id. at n.2.
108.  789 F.2d at 237.
109.  Id.
was not a success. Not only were the numbness and electric shock-like sensations in Blakesley's tongue not eliminated but, in addition, she experienced "highly unpleasant sensations of strangulation and choking upon the slightest touch to the area of her neck from which the donor nerve had been removed." Moreover, "Blakesley experienced pain and discomfort in her ear and jaw joint, purportedly caused by her jaws being propped open" during the nearly seven hours required by the operation because of the use of the alternate donor nerve, rather than the four hours originally contemplated. Blakesley, asserting that Wolford had not secured her informed consent to perform the alternate surgery, sought damages. The case presented two choice-of-law problems.

Under Texas law, the doctor's duty to disclose risks to the patient in order to secure the patient's informed consent was defined by the professional standard of disclosure. Under Pennsylvania law, the physician must disclose all risks that would be significant to a reasonable person in the patient's circumstances. In addition, Texas by statute imposed a ceiling on damages in malpractice actions in the amount of $500,000 plus past and future medical expenses. Pennsylvania imposed no ceiling on damages in such
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actions. Blakesley sued Wolford in a federal district court sitting in Pennsylvania and exercising diversity jurisdiction. We have already noted that, pursuant to \textit{Klaxon}, the diversity court must resolve choice-of-law problems precisely as they would be resolved by the highest appellate court of the forum state. The Third Circuit concluded that the Supreme Court of Pennsylvania would resolve the choice-of-law problems by "combin[ing] the approaches of both Restatement II [Conflict of Laws] ... and 'interest analysis.'"\footnote{115. 789 F.2d at 239, \textit{quoting} Melville v. American Home Assurance Co., 584 F.2d 1306, 1311 (3d Cir. 1978). It may not be entirely clear whether the Supreme Court of Pennsylvania would utilize interest analysis (my guess), the Restatement (Second) of Conflicts, or a combination of the two (the \textit{Blakesley} court's guess). See Seidelson, \textit{Interest Analysis or the Restatement Second of Conflicts: Which is the Preferable Approach to Resolving Choice-of-Law Problems?}, 27 Duq. L. Rev. 73, 94 & 94 n. 94 (1988).}

As we did with \textit{Stutsman I} and \textit{II} and \textit{Bledsoe}, let's attempt our own application of interest analysis with regard to each of the choice-of-law issues and let's begin with the appropriate duty of disclosure. Why did Texas define the physician's duty to disclose risks by the professional standard of disclosure? The Supreme Court of Texas indicated that there were two reasons underlying that law: (1) to protect the integrity of the judicial process in Texas and (2) to protect the economic integrity of physicians practicing in Texas.\footnote{116. Wilson v. Scott, 412 S.W.2d 299, 302 (Tex. 1967) (\textit{quoting} Fisher v. Wilkinson, 382 S.W.2d 627, 632 (Mo. 1964)).} With regard to the first reason, the Texas court concluded that, not to apply the professional standard of disclosure, would be to invite jurors to "resort[] to conjecture and surmise or set[] up an arbitrary standard of their own."\footnote{117. \textit{Id.}} Apparently, in the view of the Texas court, that would create an unacceptable threat to the integrity of the judicial process in that state. Does that reason convert into a significant interest on the part of Texas in having its professional standard of disclosure applied in \textit{Blakesley}? I think not. \textit{Blakesley}, after all, was brought before a diversity court sitting in Pennsylvania; that proceeding could pose no threat to the integrity of the judicial process in Texas. That con-
cern with jurors establishing and applying an arbitrary standard of disclosure of their own implies the second reason for the Texas law, protecting the economic integrity of Texas practitioners. Apparently, the Texas court wished to shield such practitioners from liability based on (in the court's view) an arbitrary standard. Does that reason for Texas' utilization of the professional standard of disclosure convert into a significant interest on the part of Texas in having its law applied in *Blakesley*? I think the answer must be yes, since the defendant was a Texas practitioner.

What are the reasons underlying Pennsylvania's law which requires the physician to disclose all risks that would be significant to a reasonable person in the patient's circumstances? The Pennsylvania court has identified two reasons for that law: (1) to protect the patient's right of self-determination and (2) to protect the patient from the "community of silence" that might make it difficult or impossible for the patient to find a physician willing to testify that the defendant's disclosure was not consistent with the professional standard of disclosure.\(^\text{118}\) Does either of those reasons convert into a significant interest on the part of Pennsylvania in having its law applied in *Blakesley*?

Because the patient was domiciled in Pennsylvania, she would seem to have been precisely within the class whose right of self-determination was intended to be protected. What does that right of self-determination encompass? Obviously, it is intended to protect the patient's right to control her own destiny, to decide for herself what will or will not be done to or with her body. Almost as clearly, that right of self-determination is intended to enable the patient to decide for herself what risks or hazards she will or will not undertake. That aspect of the right of self-determination implicates conduct regulation. The physician is not to engage in any conduct that may adversely affect the patient without the patient's informed consent. Because the patient was domiciled in Pennsylvania, that state would have a significant interest in having its law applied to protect the patient's right of autonomy. In addition, because the conduct intended to be regulated, the disclosure to patient, occurred substantially in Pennsylvania, and because the ongoing consequences of that conduct, patient's continuing and exacerbated disability, will be felt in Pennsylvania, her domicile, Pennsylvania would have a significant interest in the application of its disclosure law with regard to its conduct regulating function. In

addition, because the plaintiff was domiciled in Pennsylvania, she would seem to be precisely within the class intended to be protected from the "community of silence." Pennsylvania wishes to assure that patients domiciled in that state do not become indigent wards of that state because of injuries sustained by unconsented to treatment and the victims' inability to find medical experts willing to testify against their professional colleagues. Interest analysis has produced a true conflict: each state, Texas and Pennsylvania, has a significant interest in having its law defining the physician's duty to disclose risks applied to Blakesley. Texas' interest rests on protecting the economic integrity of the Texas defendant. Pennsylvania's interest, on preserving the patient's right of autonomy and thereby regulating the conduct of the physician, and in assuring that the injured victim does not become an indigent ward of Pennsylvania. Which state's interest is the more significant?

To me, the answer is fairly apparent: Pennsylvania has the more significant interest in the application of its law. If we were to weigh each state's economic interest, Texas' interest in protecting the economic integrity of the defendant and Pennsylvania's interest in assuring that the injured victim does not become an indigent ward, it would seem that the Pennsylvania interest would prevail. Given an adverse choice-of-law result, the indigence of the injured victim, no longer as capable of being self-supporting as she was before sustaining the injuries, seems more likely to eventuate than the bankruptcy of the defendant who retains his preexisting capacity to be self-supporting. When we add Pennsylvania's interest in protecting the patient's right of self-determination and the concomitant conduct regulating concern, the scales would seem to tip clearly in Pennsylvania's favor. As we have already suggested, a conduct regulating interest aimed at protecting and preserving human life, almost by definition, appears to be of greater moment than a competing interest in protecting economic integrity. Interest analysis seems to point clearly toward Pennsylvania's law requiring the physician to disclose all risks that would be significant to a reasonable person in patient's circumstances.

But how about the Restatement (Second) of Conflicts? The Third Circuit concluded that the Supreme Court of Pennsylvania would employ both interest analysis and the Restatement. Earlier on, in discussing the concurring opinion in Bledsoe, we noted that it was one subsection of the Restatement that stimulated the

119. "[T]he factors relevant to the choice of the applicable rule of law include . . . the
concurrency’s attention to “systemic interests.” Now we must attempt to apply the totality of the Restatement’s approach to Blakesley.

Section 6 of the Restatement, headed Choice-of-Law Principles, reads as follows:

(1) A court, subject to constitutional restrictions, will follow a statutory directive of its own state on choice of law.
(2) When there is no such directive, the factors relevant to the choice of the applicable rule of law include

(a) the needs of the interstate and international systems,
(b) the relevant policies of the forum,
(c) the relevant policies of other interested states and the relative interests of those states in the determination of the particular issue,
(d) the protection of justified expectations,
(e) the basic policies underlying the particular field of law,
(f) certainty, predictability and uniformity of result, and
(g) ease in the determination and application of the law to be applied. 120

Subsection (1), requiring the court to apply an applicable statutory conflicts rule of the forum state if such a law exists and its application would produce a constitutional result, is uncontroversial but inapplicable. No such statutory conflicts rule existed in Pennsylvania. Subsections 2(b) and (c), referring to the policies of the forum and other interested states and their relative interests in the determination of the particular issue, seem fairly consistent with the interest analysis we have already applied. Subsection 2(e), the basic policies underlying the particular field of law, would seem to be inapplicable since the policies of the interested states, Texas and Pennsylvania, are not “largely the same”121 with only “minor differences between their relevant local law rules.”122 That leaves subsections 2(a), (d), (f), and (g).

I confess to being unclear about the significance intended for “the needs of the interstate . . . system[],” subsection 2(a), and the relevant Restatement Comment does little to enlighten me.123 It was that factor that led the concurring opinion in Bledsoe to conclude that the law of the state in which the medical care was provided should be applied where that state’s law “is directed at

needs of the interstate . . . system[]. . . .” Restatement (Second) of Conflict of Laws § 6(2)(a) (1969) (hereinafter Restatement (Second)).
120. Restatement (Second) § 6.
121. Id. § 6(2)(e) comment h.
122. Id.
123. Id. § 6(2)(a) comment d.
reducing the total costs of medical malpractice liability.” The con-
currence was led to that conclusion by its determination that a
contrary result would stimulate medical care providers in that
state to turn away patients from outside the state. I found it diffi-
cult to acquiesce in that determination. More germane to Blake-
sley, however, is the fact that Texas’ law applying the professional
standard of disclosure, unlike Maryland’s arbitration law in Bled-
soe, is not directed at reducing the total costs of medical malprac-
tice liability. The Texas law, although intended to protect the eco-
nomic integrity of Texas practitioners, is intended to afford that
protection from arbitrary, unguided standards imposed by a jury
which might engage in “conjecture and surmise.” The Texas law,
unlike the Maryland law, is not aimed at the possibility of elimi-
nating protracted and expensive judicial proceedings by subjecting
the claim to a mandatory arbitration process. Consequently, “the
needs of the interstate . . . system[]” seems to provide little guid-
ance in Blakesley.

“[T]he protection of justified expectations,” subsection 2(d), is
an elusive factor when applied to Blakesley. The Comment to 2(d)
provides:

There are occasions, particularly in the area of negligence, when the parties
act without giving thought to the legal consequences of their conduct or to
the law that may be applied. In such situations, the parties have no justified
expectations to protect, and this factor can play no part in the decision of a
choice-of-law question.124

Since Blakesley was a negligence action, the Comment suggests
that 2(d) may be inapplicable. I suppose, however, that we should
attempt to determine whether Blakesley and Wolford in fact had
“justified expectations to protect.” Their first meeting was in
Pennsylvania. It was there that Wolford first examined Blakesley,
diagnosed her condition, indicated the procedure he contemplated,
the time that procedure would require, the risks inherent in the
procedure, provided Blakesley with his card, and invited Blakesley
to contact him when she had decided whether to have the proce-
dure performed. It was in Texas where the two next met and where
Wolford “essentially repeat[ed] what he previously had told Blake-
sley” in Pennsylvania, and performed the surgical procedure on
Blakesley. In those circumstances, it seems to me, the parties had
no justified expectations to protect with regard to which state’s law
would define the doctor’s duty to disclose.

124. Id. § 6(2)(d) comment g.
That leaves subsections 2(f), "certainty, predictability and uniformity of result," and 2(g), "ease in the determination and application of the law to be applied." The Comment to 2(f) provides: "Predictability and uniformity of result are of particular importance in areas where the parties are likely to give advance thought to the legal consequences of their transactions." Since we have already concluded that the parties had no justified expectations to protect, it would appear that 2(f) lacks significance. With regard to 2(g), the Comment provides: " Ideally, choice-of-law rules should be simple and easy to apply. This policy should not be overemphasized, since it is obviously of greater importance that choice-of-law rules lead to desirable results. The policy does, however, provide a goal for which to strive." My reaction to that "now you do, now you don't" comment is that 2(g) has little significance. Apparently, the factors listed in section 6 most germane to Blakesley are those that complement our interest analysis pointing to Pennsylvania's law.

It should be noted, however, that section 6 sets forth general principles applicable to all choice-of-law problems. Section 145, specifically applicable to tort actions, provides:

(1) The rights and liabilities of the parties with respect to an issue in tort are determined by the local law of the state which, with respect to that issue, has the most significant relationship to the occurrence and the parties under the principles stated in § 6.
(2) Contacts to be taken into account in applying the principles of § 6 to determine the law applicable to an issue include:

(a) the place where the injury occurred,
(b) the place where the conduct causing the injury occurred,
(c) the domicile, residence, nationality, place of incorporation and place of business of the parties, and
(d) the place where the relationship, if any, between the parties is centered.

These contacts are to be evaluated according to their relative importance with respect to the particular issue.

Subsection (1), incorporating "the principles stated in § 6," combined with our earlier determination that the factors in section 6 most germane to the issue are those complementing interest analysis, would seem to suggest retention of the conclusion suggested by interest analysis: application of Pennsylvania law. Yet, subsection

125. Id. § 6(2)(f) comment i.
126. Id. § 6(2)(g) comment j.
127. Id. § 145.
2 identifies the "[c]ontacts to be taken into account in applying the principles of § 6." I suppose we must take into account those contacts. Subsection 2(a), "the place where the injury occurred," points to Texas. Subsection 2(b), "the place where the conduct causing the injury occurred," points to Texas. Subsection 2(c), "the domicil . . . of the parties," points to both Texas (the defendant) and Pennsylvania (the plaintiff). Subsection 2(d), "the place where the relationship . . . between the parties is centered," probably points to Texas where, within the doctor-patient relationship, the defendant operated on the plaintiff. Does that mean that Texas wins 4-1? Apparently not, since the conclusion of section 145 admonishes us that "These contacts are to be evaluated according to their relative importance with respect to the particular issue." The only feasible way I know to comply with that admonition is to apply interest analysis and our application of interest analysis indicated that Pennsylvania has the more significant interest in the application of its law to this particular issue. What now?

Section 146 reads as follows:

In an action for a personal injury, the local law of the state where the injury occurred determines the rights and liabilities of the parties, unless, with respect to the particular issue, some other state has a more significant relationship under the principles stated in § 6 to the occurrence and the parties, in which event the local law of the other state will be applied.128

Does that mean that we've slogged through sections 6 and 145 only to arrive at section 146 and a resurrection of lex loci delicti unless . . . ? Apparently so. The Restatement creates an awkward amalgam of interest analysis, territoriality, and mechanical conflicts rules.129 And that amalgam is not inadvertent; it was intended.130

Section 146 and its resurrection of lex loci delicti point to the law of Texas unless. Is the "unless" requirement satisfied in Blakesley? Well, our application of interest analysis indicated that Pennsylvania has the more significant interest in the application of its law to this particular issue. And our examination of section 6, explicitly incorporated in section 146, indicated that the most germane of the factors listed in section 6 were those complementing interest analysis. Consequently, I am inclined to think that the "unless" requirement of section 146 has been satisfied and, there-

128. Id. § 146.
130. Id.
fore, lex loci delicti and its reference to Texas law has been over-ridden in favor of the application of Pennsylvania law. I would conclude therefore that Pennsylvania's law defining the duty to disclose to encompass all risks which would be significant to a reasonable person in patient's circumstances should be applied in Blakesley.

Now we must confront the second choice-of-law issue in that case. Texas law imposed a $500,000 ceiling (exclusive of past and future medical expenses) on damages in medical malpractice actions. Pennsylvania law imposes no such ceiling. The diversity court sitting in Pennsylvania is required by *Klaxon* to resolve that issue precisely as it would be resolved by the Supreme Court of Pennsylvania. The Third Circuit concluded that that highest appellate court of the forum state would utilize a combination of interest analysis and the Restatement. Once again, let's attempt our own application of interest analysis. What is the reason underlying the Texas ceiling on damages in medical malpractice actions? Texas wishes to protect the economic integrity of Texas medical care providers for the ultimate purpose of assuring the continued availability of affordable medical care in Texas. Because the defendant is a Texas medical care provider whose care in that state gave rise to this action, that reason for the Texas ceiling converts into a significant interest on the part of Texas in having its ceiling applied to this case. Absent the ceiling, the defendant's liability and the resultant increase in his professional liability insurance premiums may well have an adverse impact on the availability of affordable medical care in Texas. Why does Pennsylvania impose no ceiling on such damages? There are two reasons underlying that law: (1) conduct regulation and (2) a desire to assure that Pennsylvania domiciliaries injured by medical malpractice do not become indigent wards of that state. Pennsylvania apparently believes that the full sting of liability, unlimited by any arbitrary ceiling, will serve to deter malpractice. Does that conduct regulating reason convert into a significant interest on the part of Pennsylvania in having its law applied? The conduct intended to be regulated, the disclosure of risks, occurred in both Pennsylvania and Texas. The immediate consequences of that conduct occurred in Texas where the plaintiff was injured. The ongoing consequences of that conduct, plaintiff's continuing disability and its accompanying pain and discomfort, will be felt in Pennsylvania, the plaintiff's domicile. It would seem that Pennsylvania has a significant interest in the application of its no-ceiling law based on that law's conduct
regulating purpose. Moreover, because the plaintiff is domiciled in Pennsylvania, she would fall within the class of victims that state wishes to protect from potential indigence. Therefore, that reason too would convert into a significant interest on the part of Pennsylvania in having its law applied. The court is confronted with another true conflict; each state has a significant interest in the application of its own law. Which state’s interest in the application of its own law is the more significant?

The answer to that question in Blakesley is similar to the answer we achieved in Stutsman I. While Pennsylvania’s interest in conduct regulation, aimed at protecting and preserving human life, is compelling, and its interest in protecting the injured victim from indigence is important, I think those interests must yield to Texas’ concern with assuring affordable medical care in that state. That Texas interest is also aimed at protecting and preserving human life by assuring that those needing medical care in that state will be able to afford it and, therefore, will be more likely to secure it. Moreover, even a judgment limited by the Texas ceiling on damages seems likely to have some deterrent effect on medical malpractice. Thus, the application of Texas’ law would not wholly frustrate Pennsylvania’s interest in conduct regulation. Similarly, the Texas ceiling will afford some protection against the victim’s indigence; even a $500,000 judgment (plus past and future medical expenses) would afford some cushion against indigence. Therefore, application of the Texas ceiling would not wholly frustrate either of the Pennsylvania interests. Application of Pennsylvania’s no-ceiling law, however, would wholly frustrate the Texas interest in controlling the cost of medical negligence thereby assuring the continuity of affordable medical care in that state. Consequently, on this issue I believe Texas has the more significant interest in the application of its law.

How about the Restatement approach? This time I shall not attempt to drag the reader through sections 6, 145, and 146. I think it’s fair to say that, since interest analysis points to Texas law, section 146’s reversion to lex loci delicti, which would also lead to Texas law, would govern. Thus, both interest analysis and the Restatement would result in the application of the Texas ceiling on damages. Ultimately, then, I would apply Pennsylvania’s law to determine the defendant’s duty to disclose risks and Texas’ law to determine the maximum judgment recoverable.

How did the court in Blakesley resolve the two choice-of-law issues? The district court applied Pennsylvania law to both issues.
and the jury, instructed pursuant to that law, returned a verdict for the plaintiff in the amount of $800,000. Defendant appealed from the judgment entered thereon and the Third Circuit reversed and remanded for a new trial, concluding that both issues should have been governed by Texas law. What led the Third Circuit to that conclusion?

The Third Circuit combined both choice-of-law issues in a single analysis. The court characterized the competing state interests in this manner:

Pennsylvania's liberal compensation policy and lay approach to informed consent reflect that state's strong interest in protecting patients from the hazards of medical malpractice and in insuring that victims of physicians' negligence are fully compensated for their injuries. Texas' attempted limitation on malpractice damages and its physician-oriented informed consent law represent that state's policy to limit medical malpractice claims within prescribed bounds in an effort to control health care costs and promote the general accessibility of health care in Texas.131

I think it unfortunate that the court lumped together the two issues. That process may have led the court to impute underlying reasons for each state's two laws that, in fact, would more precisely be affiliated with only one of each state's laws. That, in turn, may have led the court to a less precisely considered determination of which state's interest was the more significant with regard to each of the disparate issues.

In identifying Pennsylvania's interests, for example, the court found two: protecting and preserving patients' lives and protecting patients from indigence. In our analysis, we found that Pennsylvania's informed consent law was intended to (1) protect the right of self-determination of patients, (2) protect and preserve patients' lives, and (3) protect patients from indigence. In the process of combining both of Pennsylvania's laws, the court seems to have overlooked that first interest, which, as we noted, although encompassing protection of human life, also includes protecting the patient's right of autonomy. In identifying Texas' interests, the court found one: assuring the availability of affordable medical care. The court then imputed that interest to both of Texas' laws. Our analysis, treating the two Texas laws separately, imputed that reason only to the Texas ceiling law. We concluded that assuring affordable medical care was not a reason for Texas' informed consent law.

131. 789 F.2d at 238.
132. Id. at 240 (footnote omitted).
Once the court combined both Texas' laws in its analysis and imputed that reason to both, it gave Texas a reason for its informed consent law that may not be a reason for that law. Consequently, the court may have attributed a spurious interest to Texas in the application of its informed consent law and then weighed that interest against the (diminished) interest the court found on the part of Pennsylvania in having its informed consent law applied.

The court then proceeded to apply the Restatement approach. The court began with section 145. With regard to "Citizenship of the Parties," the court concluded that, since the plaintiff was domiciled in Pennsylvania and the defendant in Texas, that contact was "neutralized." As to the place where the injury occurred, the court found that Texas was the situs of the injury. The Third Circuit then chastised the district court for having been influenced by the fact that the effects of the injury would be felt in Pennsylvania. To the Third Circuit, "by looking to the place where the injuries are felt, rather than the place where they in fact occurred, the district court gave double weight, which was unwarranted, to Blakesley's state of residence — Pennsylvania." I don't think the chastisement was justified. We concluded that both of Pennsylvania's laws were aimed in part at conduct regulation, protecting and preserving the lives and well-being of patients. We also concluded that the conduct intended to be regulated by Pennsylvania's informed consent law, the disclosure of risks, had occurred in both Pennsylvania and Texas. The Third Circuit mooted that fact by tacitly converting "the place where the conduct causing the injury occurred" into a determination that the defendant "was fully entitled to rely on his home state's law of informed consent." That latter quoted language would seem more germane to section 6 and "the protection of justified expectations" than to section 145 and the place where the injury-causing conduct occurred. When we considered that section 6 factor, we concluded from the facts that the parties had "no justified expectations to protect," with regard to which state's law of informed consent should be applied. Even assuming *arguendo* that the conduct that caused the injury had occurred in Texas, the fact that the effects of that conduct would be felt in Pennsylvania (as the district court concluded) would have significance. Since one reason for Pennsylva-

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133. *Id.* at 241.
134. *Id.*
135. *Id.* (footnote omitted).
136. *Id.* at 243.
nia's informed consent law is conduct regulation, the fact that the ongoing consequences of that conduct would be felt in Pennsylvania would serve to convert that reason into a significant interest on the part of Pennsylvania in having its law applied. That conclusion does not, I believe, give the plaintiff's Pennsylvania domicile an inappropriate "double weight." Rather, it recognizes that Pennsylvania is concerned with protecting its patients from indigence, which converts into a significant interest on the part of Pennsylvania in having its informed consent law applied, and that Pennsylvania is concerned with protecting and preserving the lives and well-being of its patients, which also converts into a significant interest on the part of Pennsylvania in having its informed consent law applied. That conclusion seems to have eluded the Third Circuit. By failing to treat the two choice-of-law issues separately, and thereby failing to identify the reasons underlying each of the two laws of the states, the Third Circuit managed to overlook Pennsylvania's separate interests and, in the process, incorrectly applied Texas' law of informed consent, in my opinion.

Let's examine another case arising out of a legislative reaction to the medical malpractice "crisis." In Hughes v. Mayo Clinic, plaintiffs, domiciled in Illinois, brought a malpractice action against the defendant, domiciled in Minnesota. The action arose "from a surgical procedure resulting in a total hip arthroplasty." The action was brought in a federal district court sitting in Minnesota and exercising diversity jurisdiction. By statute, Minnesota requires that in a medical malpractice action predicated on a deviation from the applicable professional standard the complaint must be accompanied by an affidavit by plaintiff's attorney stating that:

[T]he facts of the case have been reviewed by the plaintiff's attorney with an expert whose qualifications provide a reasonable expectation that the expert's opinions could be admissible at trial and that, in the opinion of this expert, one or more defendants deviated from the applicable standard of care and by that action caused injury to the plaintiff. . . .

That Minnesota statute became effective at "12:01 a.m. on August 137. 834 F.2d 713 (8th Cir. 1987), cert denied, 108 S. Ct. 2857 (1988).
138. Id. at 714.
140. Id. § 145.682(3)(a). In Oslund v. United States, 701 F. Supp. 710 (D. Minn. 1988), the court held that Minnesota's affidavit statute was applicable to a malpractice action brought against the United States pursuant to the Federal Tort Claims Act.
1, [1986].''141 Plaintiffs' complaint was filed in the district court on July 8, 1986. Service of the complaint and summons, however, was not effected "until late afternoon on August 1, 1986."142 Defendant moved for summary judgment based on plaintiffs' non-compliance with the affidavit statute. Plaintiffs argued that, under Federal Rule of Civil Procedure 3, 143 the action had been commenced on July 8, prior to the effective date of the statute. Defendant asserted that "the suit was not commenced under Minnesota law until the summons was served on the defendant."144 The diversity court was confronted with an Erie145-Hanna146-Ragan147-Walker148 problem: Was the Minnesota statute providing that an action is commenced only upon service on the defendant applicable in this diversity action? The district court said yes and granted the defendant's motion for summary judgment. The Eighth Circuit reversed.

It should be noted that the issue in Hughes was not the general question of whether the Minnesota statute requiring an affidavit was applicable in a diversity action filed in Minnesota. Rather, it was the "narrow, singular"149 issue of whether Federal Rule of Civil Procedure 3 or the Minnesota statute requiring service should determine when the action was commenced for the purpose of determining the applicability of the Minnesota affidavit statute. As to that narrow issue, the Eighth Circuit wrote:

There was no forum shopping in this suit, and our holding will not promote forum shopping in the future. Here, as in Walker, there is no evidence that the plaintiffs filed in federal court in order to avoid those service requirements. The plaintiffs could have filed in state court, and, if they were aware of the new legislation, they could have sought an expedited service of process in the state court to assure service of summons before August 1. Furthermore, all suits commenced after August 1 will be governed by the Minnesota statute. Thus, there exists no great policy question concerning future cases.150

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141. 834 F.2d at 714.
142. Id.
144. 834 F.2d at 714.
149. 834 F.2d at 716.
150. Id. In the hypothetical case in the text immediately after footnote 150, I have assumed, contrary to legal fact, that Illinois has no statutory affidavit requirement similar to that of Minnesota. The Illinois statute may be found at Illinois Annotated Statutes ch. 110, para. 2-622 (Smith-Hurd 1988). There are two reasons for that assumption. First, it permits
Let's convert *Hughes* into an interstate choice-of-law problem. We can do that simply by hypothesizing that the plaintiffs sued the defendant in a federal court sitting in Illinois and exercising diversity jurisdiction. Let's assume, too, that the action was commenced after the effective date of the Minnesota affidavit statute and that the diversity court in Illinois has jurisdiction over the Minnesota defendant. Defendant challenges legal sufficiency based on noncompliance with the Minnesota affidavit statute. Plaintiffs assert that Illinois law, not requiring such an affidavit, should apply. How should the diversity court rule?

Under *Klaxon*, of course, the court would be required to resolve the choice-of-law issue precisely as it would be resolved by the highest appellate court of Illinois. For the sake of facilitating an examination of the reasons underlying each state's law, let's assume that Illinois would utilize interest analysis. What are the reasons underlying the Minnesota statute requiring an affidavit? The most obvious reason would be to protect against frivolous or spurious medical malpractice actions. That reason suggests two related concerns: (1) to assure relatively lower liability insurance premium rates for medical care providers by eliminating the expense of litigating frivolous or spurious suits, thus assuring the continuity of affordable medical care in Minnesota, and (2) to protect the integrity of the judicial process in Minnesota by insulating courts in that state from such frivolous or spurious suits and assuring that Minnesota courts are not available as instruments for such undesirable litigation. Does either of those reasons convert into a significant interest on the part of Minnesota in having its affidavit statute apply to our hypothetical case?

Because the defendant is a Minnesota medical care provider and the medical care giving rise to the action occurred in Minnesota, the first reason would so convert. If the defendant's liability insurance carrier were required to litigate this potentially frivolous or spurious claim, the costs of litigation would be charged to the insurer's Minnesota experience, thus creating the possibility of
higher premium rates for Minnesota medical care providers and, ultimately, higher fees for medical care in Minnesota. Because the court is a federal court exercising diversity jurisdiction in Illinois, the second reason for the Minnesota statute would seem not to convert. Hearing this action would in no way threaten the integrity of the judicial process in Minnesota. Since the first reason for the statute does convert, Minnesota would appear to have a significant interest in the application of its affidavit statute to this case.

What are the reasons for the Illinois law not requiring such an affidavit? One reason would be to assure that Illinois victims of medical malpractice are not denied an opportunity to recover by the "conspiracy of silence," thus protecting such victims from becoming indigent wards of the state. Since the plaintiffs are domiciled in Illinois, that reason would convert into a significant interest on the part of Illinois in having its law not requiring such an affidavit applied. A second reason for the Illinois law would be conduct regulation. Illinois may feel that not imposing an affidavit impediment on a malpractice victim may serve to deter medical negligence. Does that conduct regulating reason for Illinois law convert into a significant interest on the part of Illinois in having its law applied? The conduct intended to be regulated occurred in Minnesota where the defendant provided medical care to the plaintiff. The immediate consequences of that conduct, the injury to the plaintiff, occurred in Minnesota. But the ongoing consequences of that conduct will be felt in Illinois where the plaintiff is domiciled. Thus, that reason too converts into a significant interest on the part of Illinois in having its law applied. The case presents a true conflict. Minnesota has a significant interest in the application of its affidavit law in order to assure the availability of affordable medical care in that state. Illinois has a significant interest in the application of its law not requiring an affidavit in order to assure that the victim does not become an indigent ward of that state and in order to deter negligent medical care. Which state's interest in the application of its own law is the more significant?

There is an initial inclination to characterize the Illinois interest as the more significant, for a couple of reasons. First, as we have noted earlier, a conduct regulating purpose aimed at protecting and preserving human life seems of greater moment than any interest based on economic considerations. Second, given an adverse choice-of-law result, the indigence of the injured victim seems more likely to eventuate than does the unavailability of medical care at affordable rates. That initial inclination, however, may be a
We have also noted earlier on that a state’s interest in assuring affordable medical care is directed at protecting and preserving human life. The continued availability of affordable medical care makes it more likely that those in need of such care will seek and receive it. Thus, Minnesota’s interest is not simply economic in nature; it too is related to protecting and preserving human life. Moreover, assuming that plaintiffs’ theory of liability would require at trial expert medical testimony establishing a professional standard different from the defendant’s conduct, the Minnesota statute does not substantially alter the plaintiff’s burden of production. Rather, it accelerates the time when the requirement must be satisfied from trial or during pre-trial discovery to initiation of the action. Moreover, the Minnesota statute provides an escape device for the plaintiff who lacks time to secure such an affidavit because of the imminent expiration of the statute of limitations. The Minnesota statute provides that the affidavit of expert review may be supplanted by an affidavit asserting that

the expert review . . . could not reasonably be obtained before the action was commenced because of the applicable statute of limitations. If [such a supplanting] affidavit is executed . . ., the affidavit [of expert review] must be served on defendant or defendant’s counsel within 90 days after service of the summons and complaint.¹⁵¹

Thus, assuming that plaintiff or plaintiff’s counsel can secure a willing medical expert for testimonial purposes (as required by the theory of liability asserted), Minnesota’s law simply requires that such an expert be secured earlier than would be required by Illinois’ law. That mere acceleration of the time requirement tends to make it unlikely that Minnesota’s law will result in the indigence of an Illinois victim stymied by a “conspiracy of silence.” If the victim truly is so stymied, her action would fail at trial even under Illinois law.

That latter consideration also has significant consequences with regard to the Illinois concern with conduct regulation. Since under either state’s law the victim would be required to present expert medical testimony establishing a professional standard different from defendant’s conduct, application of Minnesota’s affidavit statute is unlikely to frustrate severely Illinois’ interest in deterring negligent medical care. The medical care provider vulnerable to potential liability upon presentation of appropriate expert testi-

mony at trial, and thereby dissuaded from providing negligent care, is hardly likely to be significantly less dissuaded by the affidavit statute which merely accelerates the time when a willing expert must be secured. It would appear that application of the Minnesota affidavit statute would be unlikely to impair seriously either of the Illinois concerns. On the other hand, application of Illinois law subjecting the defendant and its liability insurance carrier to the expense of partially defending a potentially frivolous or spurious claim would seem likely to increase the cost of litigation, thereby generating the potential evils that Minnesota wishes to avoid: higher insurance premium rates for medical care providers passed on to patients in the form of increased medical fees. Consequently, interest analysis would lead me to conclude that the court should apply the Minnesota statute.

What result would the diversity court sitting in Illinois achieve? Under Klaxon, the diversity court would be required to achieve the same result as would the highest appellate court of Illinois. It isn't entirely clear what choice-of-law methodology the Supreme Court of Illinois would utilize. In 1970, the court rejected lex loci delicti and apparently embraced section 379 of the Restatement (Second) of Conflicts, Tentative Draft No. 9. Section 379 of that Tentative Draft, in turn, was supplanted by section 145 of the Official Draft of the Restatement (Second) of Conflicts. The intermediate appellate court of Illinois has generated mixed signals as to that state's choice-of-law methodology. In one case, the court, after quoting sections 6 and 145 of the Restatement (Second), wrote:

However, conflicts analysis under the second Restatement requires more than a mere tallying of contacts in each respective State and a comparison to determine which State has the highest total. Illinois courts have rejected this "contact counting" approach in favor of a more sophisticated "interest analysis" construction of the Restatement.

In another case, the court, citing the Restatement (Second), wrote:

Under Illinois choice of law principles, "the local law of the State where the injury occurred should determine the rights and liabilities of the parties, unless Illinois has a more significant relationship with the occurrence and

153. Restatement (Second) § 145. See text at note 123 supra.
155. 133 Ill. App.3d at 367, 478 N.E.2d at 1050.
with the parties, in which case, the law of Illinois should apply." (Ingersoll v. Klein (1970) . . .) Four contacts are especially important in determining which of two States has the more significant relationship with the occurrence and the parties: (1) place of injury, (2) place of conduct causing the injury, (3) domicile and place of business of parties, and (4) place where parties' relationship is centered.\textsuperscript{157}

That language tracks sections 146 and 145 of the Restatement (Second).

Consequently, it isn't entirely clear whether the Supreme Court of Illinois (and, therefore, under \textit{Klaxon}, the diversity court in our hypothetical) would utilize interest analysis, the Restatement (Second) with an interest analysis emphasis, or the Restatement (Second) without such an emphasis. If interest analysis, the resolution of the choice-of-law problem presumably would be that which we achieved: application of the Minnesota affidavit statute. If the Restatement (Second) with or without an interest analysis emphasis, the resolution would point to the law of the state when the injury had occurred, Minnesota and its affidavit statute. Apparently, the diversity court sitting in Illinois would achieve the same result produced by our interest analysis, whichever of the three paths it might follow.

Let's try one more problem. In \textit{Reilly v. United States},\textsuperscript{158} plaintiffs, a minor and her parents, sued the United States pursuant to the Federal Tort Claims Act.\textsuperscript{159} Because husband had been "on active duty with the Navy,"\textsuperscript{160} his pregnant wife had been "admitted to Newport Naval Hospital"\textsuperscript{161} in Rhode Island. Due to medical malpractice,

Heather Reilly was born with severe, apparently irremediable, brain damage . . . [S]he was left "a helpless individual, 'significantly delayed developmentally' and unable to see; she will never be able to walk, talk, feed or take care of herself in any way.\textsuperscript{162}

From a judgment for the plaintiffs, the defendant appealed, asserting, \textit{inter alia}, that the district court had erred in concluding that the United States was not entitled to the benefits of Rhode Island's statutory exception\textsuperscript{163} to the collateral source rule. Gener-

\begin{footnotes}
\textsuperscript{157} 157 Ill. App.3d at 943, 510 N.E.2d at 970.
\textsuperscript{158} 863 F.2d 149 (1st Cir. 1988).
\textsuperscript{159} 28 U.S.C. §§ 1346(b), 2671 \textit{et seq.} (1982).
\textsuperscript{160} 863 F.2d at 153.
\textsuperscript{161} \textit{Id.}
\textsuperscript{162} \textit{Id.}
\end{footnotes}
ally, Rhode Island applies the common law rule that the defendant may not reduce the extent of his liability by the amount received by the plaintiff from collateral sources.\textsuperscript{164} However, in response to a perceived medical malpractice crisis, Rhode Island enacted a statute permitting a medical care provider to "introduce evidence of any amount payable as a benefit to the plaintiff \ldots"\textsuperscript{165} as a result of law or insurance. Where the medical care provider introduces such evidence, the plaintiff is permitted to "introduce evidence of any amount which the \ldots plaintiff has paid \ldots to secure \ldots any [such] insurance benefits. \ldots"\textsuperscript{166} The factfinder is then "to reduce the award for damages by a sum equal to the difference between the total benefits received and the total amount paid to secure such benefits. \ldots"\textsuperscript{167}

The district court concluded that "because the United States \ldots was not one of the class of defendants (health care providers who purchase malpractice insurance) which [the statute] was designed to assist, the statute had no application in this case."\textsuperscript{168} The First Circuit held that "[t]he FTCA, not the letter of the Rhode Island statute, is the focal point of this inquiry and is determinative of the question."\textsuperscript{169}

The FTCA provides that "[t]he United States shall be liable \ldots in the same manner and to the same extent as a private individual under like circumstances."\textsuperscript{170} Because a medical care provider would be the state law analogue to the United States, the First Circuit concluded that the FTCA required that the Rhode Island statute be available to the United States. However, because the government had failed to present explicit evidence of the benefits payable to the plaintiffs, it had failed to avail itself of the benefits of the state statute. Consequently, the First Circuit affirmed the district court's refusal to reduce the judgment.

Let's convert \textit{Reilly} into a more conventional choice-of-law problem. We can do that by hypothesizing that plaintiff, domiciled in State A, brings a medical malpractice action against defendant, a Rhode Island medical care provider, in a federal district court sitting in Rhode Island and exercising diversity jurisdiction. The al-

\textsuperscript{164} 863 F.2d at 161.
\textsuperscript{165} Id. at 162 quoting R.I. GEN. LAWS § 9-19-34.
\textsuperscript{167} Id.
\textsuperscript{168} 863 F.2d at 162.
\textsuperscript{169} Id.
\textsuperscript{170} Id. quoting 28 U.S.C. § 2674.
legedly negligent medical care was provided in Rhode Island. Pursuant to the Rhode Island statute, the defendant seeks a ruling in limine that evidence to be offered by the defendant of the amounts received by the plaintiff pursuant to insurance secured by the plaintiff be received. The plaintiff opposes the ruling, asserting that State A law which would impose the common law collateral source rule should be applied. How should the court resolve the issue?

I suppose the court could say that the issue presented was one of evidence and, therefore, the forum's law was applicable. There are, however, a couple of problems with that solution. First, if the issue were purely evidentiary, the federal court presumably would apply the Federal Rules of Evidence and disregard the Rhode Island statute. The fact that the court is considering the Rhode Island statute as the forum's law indicates that the statute has an underlying substantive policy reason which suggests its applicability. That same consideration suggests the second problem with that solution. If the issue is one of underlying substantive policy concerns (and I think it clearly is), then State A's policies as well as those of Rhode Island should be considered by the court. In short, I believe the issue confronts the court with a choice-of-law problem.

Confronted with such a choice-of-law problem, the diversity court is required by Klaxon to resolve the issue precisely as it would be resolved by the highest appellate court of the forum state, the Supreme Court of Rhode Island. Apparently, that court has embraced Professor Robert Leflar's "Choice-Influencing Considerations" in resolving choice-of-law problems in tort cases.

[Professor Leflar] articulated the following five [choice-influencing] factors: (1) predictability of result, (2) maintenance of interstate and international order, (3) simplification of the judicial task, (4) advancement of the forum's governmental interests and, by far the most controversial factor, (5) application of the better rule of law. The Leflar factors have proven to be exceedingly flexible in practice, often allowing a court to apply a law which could not be selected under any other modern theory, but which, for any number of reasons, might provide an appropriate rule of decision in a particular case. Unfortunately, the theory is plagued by excessive forum-favoritism. The third and fourth factors will almost never point to the application of foreign law. Moreover, the fifth factor also points to forum law in the great majority of cases, since judges rarely consider their state's own laws to be inferior to those of another state. A final problem with the Leflar test is that

171. 28 U.S.C.A. FED. R. EVID.
the first three factors are totally irrelevant in tort cases and tend to be ignored by judges. This further heightens the significance of the pro-forum fourth factor and the highly subjective fifth factor.\textsuperscript{173}

All of that suggests that the Rhode Island court and, therefore, under \textit{Klaxon}, the diversity court would apply the Rhode Island statute and permit the defendant to introduce evidence of the collateral source benefits received by the plaintiff.

Of course, \textit{Klaxon} neither requires nor permits the diversity court to achieve a choice-of-law result that would be unconstitutional. If Rhode Island had no significant interest in the application of its statute to this case, such a result would violate the due process rights of the plaintiff and, assuming that State A had a significant interest in the application of its law, the full faith and credit clause.\textsuperscript{174} In order to determine the existence of such a Rhode Island interest, we must perform at least a partial interest analysis.

What is the reason underlying the Rhode Island statute? Obviously, it is aimed at lowering judgments in medical malpractice actions, thus reducing the premiums paid for malpractice insurance and thereby assuring the continuity of affordable medical care in Rhode Island. Does that reason convert into a significant interest on the part of Rhode Island in having its statute applied in this case? Of course. Since the defendant provided the medical care in Rhode Island, the amount of any judgment rendered in this case has the potential of affecting the defendant's insurance premium and therefore the cost of medical care in Rhode Island. Consequently, the application of the Rhode Island statute would be constitutionally permissible.

But let's go further and attempt to determine if that constitutionally permissible result is the most appropriate choice-of-law result attainable. To do that, we must complete our interest analysis. What are the reasons underlying State A's common law collateral source rule? The rule would seem to have a couple of underlying reasons: (1) to assure that victims domiciled in State A enjoy an undiminished recovery and thereby avoid indigence; and (2) to deter negligent conduct. The first reason reflects a belief that to the extent that (a) an undiminished recovery would permit a "windfall" to the plaintiff and (b) a diminished recovery would benefit a


wrongdoer by making him a beneficiary of insurance acquired by the victim, (a) is the preferable result. One of the reasons making it preferable may be a pragmatic recognition that the victim’s undiminished recovery will in fact be diminished by a contingent fee agreement. To diminish it further by deducting insurance benefits received by the plaintiff may be to expose the plaintiff to potential indigence. The second reason is aimed at conduct regulation and reflects the belief that the potential of undiminished liability may deter negligence. Does either of those reasons convert into a significant interest on the part of State A in having its collateral source rule applied to this case?

Because the plaintiff is domiciled in State A, he falls precisely within the class intended to be protected from indigence. Should a diminished recovery result in his indigence, it would be State A that would be faced with the onus of his support. How about the conduct regulating reason? The conduct intended to be regulated occurred in Rhode Island where the allegedly negligent medical care was furnished. The immediate consequences of that conduct, the plaintiff’s injuries, also occurred in Rhode Island. The ongoing consequences of that conduct, however, will be felt in State A where the victim is domiciled; therefore, the conduct regulating reason also converts into a significant interest on the part of State A in having its law applied. The case presents a true conflict.

Which state’s interest in the application of its own law is the more significant? I believe the Rhode Island interest is paramount. While State A’s concern with avoiding the indigence of its injured victim is wholly legitimate and its interest in conduct regulation, that is, in protecting and preserving human life, is urgent, analysis suggests that the application of the Rhode Island statute would frustrate State A’s interests less than the application of State A’s law would frustrate Rhode Island’s interest in assuring affordable medical care in that state. Even if the plaintiff’s recovery is reduced by the value of insurance benefits received by him, less the cost to him of such insurance, it seems unlikely that he will in fact become indigent. Consequential damages for pain, suffering, and mental anguish, likely to increase exponentially as the special damages (less diminution) are increased, afford some assurance that the plaintiff will be able to avoid indigence even after deducting a contingent fee from the judgment. In a wrongful death action, consequential damages for loss of guidance, counsel, and companionship would serve a function analogous to damages for pain, suffering, and mental anguish in a personal injury action. As for State
A's interest in conduct regulation aimed at protecting and preserving human life, two aspects of Rhode Island law must be noted. As we have suggested earlier, a law intended to assure the continuity of affordable medical care is also aimed at protecting and preserving human life. To the extent that fees for medical care are contained, more of those requiring such care are likely to seek and receive it. Moreover, the negative effect of Rhode Island's statute on conduct regulation is speculative. A physician less inclined to avoid negligent care because of the extent of his patient's insurance protection would be not only a poor physician but a damned fool. Even a diminished recovery against the physician is likely to have an adverse effect on his professional liability insurance premiums and his professional reputation. Thus, application of Rhode Island's statute seems unlikely to frustrate entirely or perhaps even to impair seriously State A's interest. On the other hand, application of State A's common law and an undiminished judgment against the defendant seem virtually certain to have an enhanced adverse effect on the physician's insurance premiums and therefore on the fees he charges for his medical services. Finally, because Rhode Island's statute is focused specifically on medical malpractice actions, while State A's common law applies across the board, it seems fair to suggest that the former evidences a somewhat sharper, more intense interest. Consequently, I am inclined to conclude that application of Rhode Island's statute would be not only constitutionally permissible but the more appropriate choice-of-law result.

The cases, real and hypothetical, that we have examined suggest a series of conclusions. With the exception of Stutsman I, each of the cases in which the state where the medical care was provided had a statute aimed at reducing the cost of malpractice insurance thereby assuring affordable medical care, and in which the other interested state had no such statute, produced a choice-of-law result applying the cost-containment statute. And even in Stutsman I, our own application of interest analysis produced such a result. For judges and lawyers, the conclusion seems fairly clear. Given the specificity of such statutes, their life-protecting goals, and their less than total frustration of the other states' competing interests, rational analysis (whatever the precise methodology) of such choice-of-law problems will almost invariably point to the statutes' application, and even without the general conflicts rule proposed by the concurrence in Bledsoe. To one skeptical of the medical malpractice "crisis" (as I am), that result is subjectively troubling.
In terms of objective judicial determinations, however, the result seems entirely appropriate. That conclusion suggests another. Because of the inherent advantage enjoyed by such crisis-generated statutes when weighed against competing laws in a choice-of-law context, courts should be assiduous in avoiding the mistaken extension of that advantage to other defendant-favoring laws that were not crisis-generated. The lower court in \textit{Stutsman II}, by failing to recognize the propriety of applying one state’s law to one issue and another state’s law to a second issue, made itself vulnerable to such error, notwithstanding the fact that its apparent unawareness of the propriety of such \textit{depecage} arose out of the \textit{Stutsman I} opinion that the District’s plaintiff-favoring law should be applied. The Third Circuit, in \textit{Blakesley}, by failing to consider the two choice-of-law issues separately, succumbed to such vulnerability by imputing to a non-crisis-generated Texas law a desire to assure the availability of affordable medical care, properly imputed only to the other and crisis-generated Texas law. Another conclusion may suggest itself to state legislatures. To a legislature having enacted a crisis-generated statute, the almost invariable application of that statute in a choice-of-law context may be particularly gratifying. To a legislature contemplating the enactment of such a statute, that result may serve as an additional inducement. That conclusion, however, should be tempered with a certain restraint. The extra-territorial application of such statutes over an extended period of time conceivably could dissuade some out-of-state patients from utilizing medical care providers in states having such statutes. Should that occur, and the local medical care providers experience a resulting diminution of income, those providers might find it necessary or desirable to increase fees to local patients, thus frustrating the core reason for such statutes. In all candor, while I think legislatures should be sensitive to such a concern, I have no illusion that my monody will prove influential either with those legislatures having such statutes or those contemplating their enactment. Legislatures frequently prove themselves more sensitive to short-term than long-term considerations and more susceptible to well-organized, easily identifiable interest groups than to the sometimes more subtle overall public good. Ultimately, whatever the long-term legislative reaction may be, it seems fair to conclude that, so long as such crisis-generated statutes continue to exist and come into conflict with competing state interests in a choice-of-law context, the crisis-generated statutes are likely to prevail.