March, 2007

The Constitutional Right to Make Medical Treatment Decisions: A Tale of Two Doctrines

Jessie Hill, Case Western Reserve University

Available at: https://works.bepress.com/jessie_hill/1/
THE CONSTITUTIONAL RIGHT TO MAKE MEDICAL TREATMENT DECISIONS:
A TALE OF TWO DOCTRINES

B. JESSIE HILL*

INTRODUCTION ...........................................................................................................1

I. CONSTITUTIONAL CASES ON A COLLISION COURSE .........................5
   A. “Partial Birth” Abortion and the Health Exception .................5
   B. Medical Marijuana and Medical Necessity .........................14
   C. Summary .................................................................................................20

II. A TALE OF TWO DOCTRINES .................................................................21
   A. The Public Health Cases .................................................................23
   B. The Autonomy Cases ......................................................................32
   C. A Right to Make Medical Treatment Choices? ....................41

III. HEALING THE BODY OF DOCTRINE ..............................................48
   A. Some Non-Explanations .................................................................48
   B. The Right to Make Medical Treatment Choices:
      Preliminary Recommendations ..............................................54
         1. The Existence of the Right ..................................................54
         2. The Problem of Deference .................................................55
         3. Applications ...........................................................................63

CONCLUSION ...........................................................................................................65

* Assistant Professor, Case Western Reserve University School of Law. B.A. 1992, Brown; J.D. 1999, Harvard. A draft of this Article was presented at the Saint Louis University Center for Health Law Studies/American Society of Law, Medicine & Ethics Health Law Scholars Workshop in September 2006. The author would like to thank the participants of that workshop for their incisive and supportive comments, especially Susan Frelich Appleton, Eric Claeys, Wendy Mariner, and Sidney Watson. The author would also like to thank Jessica Berg, Mel Durchslag, Jonathan Entin, David Garrow, Paul Giannelli, Sharona Hoffman, Max Mehlman, and Gary Simson. Deborah Urban provided extensive and outstanding research assistance; Chelan Bliss and Frank Nardulli also provided excellent research assistance. All errors are mine.
THE CONSTITUTIONAL RIGHT TO MAKE MEDICAL TREATMENT DECISIONS: 
A TALE OF TWO DOCTRINES

ABSTRACT

The Supreme Court has taken very different approaches to the question whether individuals have a right to make autonomous medical treatment choices, depending on the context. For example, in cases concerning the right to choose “partial-birth” abortion and the right to use medical marijuana, decided just one year apart, the Supreme Court reached radically different results, based on radically different reasoning. In Stenberg v. Carhart, the Supreme Court recognized an almost absolute right to choose a particular abortion procedure if the procedure is the safest for the woman, refusing to defer to the state’s view of the relevant medical facts. In United States v. Oakland Cannabis Buyers’ Cooperative, by contrast, the Court took a dim view of the claim that patients have a right to access marijuana as a last-resort medical treatment, and the Court deferred to Congress’s finding that marijuana had no medically acceptable use in the face of abundant evidence to the contrary.

These two cases are on a doctrinal collision course: both the “partial-birth” abortion issue and the medical marijuana issue are making their way back before the Supreme Court, as are other cases raising similar issues. In light of this pressing conflict, the goal of this Article is to view all of the constitutional cases touching on medical treatment decisions as one body of doctrine, as no other scholar has done. And indeed, this new perspective reveals that there are in fact two distinct lines of constitutional doctrine touching on the right to make medical treatment decisions: the “public health” line of cases, which emphasizes the police power of the state over individual rights, and the “autonomy” line of cases, which emphasizes individual bodily integrity and dignitary interests. Those lines of cases have grown up in parallel, appearing to represent airtight doctrinal categories while in fact addressing the same fundamental question. In addition, courts have applied varying degrees of deference to legislative determinations of medical fact without any logical consistency, perhaps based on largely superficial determinations about what type of case is before it. This Article concludes that a constitutional right to protect one’s health should be consistently recognized; that the recognition of this right should not be artificially limited by excessive deference to legislative findings of medical fact; and that this right will have to be carefully balanced against the state’s real and legitimate interest in regulating the practice of medicine to protect the public.
THE CONSTITUTIONAL RIGHT TO MAKE MEDICAL TREATMENT DECISIONS: A TALE OF TWO DOCTRINES

INTRODUCTION

In 1958, in a mostly forgotten case, the Fifth Circuit sweepingly pronounced that, under the Fourteenth Amendment, “the State cannot deny to any individual the right to exercise a reasonable choice in the method of treatment of his ills.”¹ The court’s unqualified language may have been overly optimistic, however: nearly fifty years later, it is hardly certain whether, and to what extent, the government can interfere with individuals’ medical treatment choices.

Two recent Supreme Court cases, in particular, highlight the confusion. In cases concerning the right to choose “partial-birth” abortion and the right to use medical marijuana, decided just one year apart, the Supreme Court reached radically different results, based on radically different reasoning. In the first case, the Supreme Court broadly recognized an almost absolute right of a woman to choose a particular abortion procedure when her physician believes, in his or her reasonable medical judgment, that the procedure is safer for the woman than any other available abortion procedures.² Moreover, the Court refused to defer to the state’s finding that the outlawed procedure was never medically necessary, accepting instead the plaintiffs’ expert testimony demonstrating medical need.³ In the second case, the Court took a dim view of the claim that patients have a right to access marijuana as a last-resort medical treatment.⁴ Moreover, the Court deferred to Congress’s finding that marijuana had no medically acceptable use in the face of the plaintiffs’ abundant evidence to the contrary.⁵

These two cases are on a doctrinal collision course. Both the “partial-birth” abortion issue and the medical marijuana issue are making their way back before the Supreme Court: in November 2006,

---

³ Id. at 934-36.
⁵ Id. at 491-93.
the Supreme Court heard oral arguments in the cases of Gonzales v. Carhart\(^6\) and Gonzales v. Planned Parenthood,\(^7\) dealing with the necessity of a health exception in the federal Partial Birth Abortion Ban Act. At the same time, seriously ill patients seeking marijuana for medicinal use have continued to press their claims in the Ninth Circuit in Raich v. Gonzales, with a subsequent petition for certiorari likely.\(^8\) Moreover, many expect that the case of Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach,\(^9\) in which the D.C. Circuit recently recognized a constitutional right to access experimental drugs on the theory that a terminally ill patient has the right “to make an informed decision” regarding medical treatment that she and her doctor believe may prolong her life,\(^10\) though set for en banc review, “will end up before the Supreme Court.”\(^11\)

The question of when the state can dictate that certain forms of medical treatment are off-limits – or, put differently, when the individual has a constitutional right to protect her health by making autonomous decisions about medical treatment – spans a number of doctrinal categories, often themselves considered airtight compartments that are to some extent sui generis. It arises in the contexts of abortion, medical marijuana, right-to-die, and access to non-FDA-approved drugs, among others. Some of those cases obviously invoke clearly established constitutional rights, such as the right to privacy, which require courts to apply heightened scrutiny; others involve important state interests, such as the “war on drugs,” which tend to provoke almost knee-jerk reactions from courts in a rush to defer to legislative judgments. Yet the tendency to see each of these doctrinal categories as unique and self-contained has perhaps obscured the reality that all of them raise the common question of when the government can permissibly intervene in the doctor-patient

---

\(^6\) No. 05-380 (argued Nov. 8, 2006).
\(^7\) No. 05-1382 (argued Nov. 8, 2006).
\(^8\) Raich was argued on remand in the Ninth Circuit on March 27, 2006. Raich v. Gonzales, No. 03-15481; see also http://www.angeljustice.org/ (last visited March 6, 2007).
\(^10\) Id. at 477.
\(^11\) Karen Ertel, Terminally Ill Have ‘Fundamental Right’ to Unapproved Drugs, 42 TRIAL 102, 103 (July 2006); see also Jerome Groopman, The Right to a Trial, NEW YORKER, Dec. 18, 2006, at 44. Several months after Abigail Alliance was decided, the FDA proposed new rules to make experimental drugs more widely available to seriously ill patients. http://www.fda.gov/cder/regulatory/applications/IND_PR.htm (last visited Jan. 19, 2007).
relationship to dictate an individual’s medical treatment decisions.\textsuperscript{12}

The goal of this Article, and one of its principal contributions, is therefore to view the constitutional cases touching on medical treatment decisions as one body of doctrine, as no other scholar has done, to my knowledge.\textsuperscript{13} And indeed, this new perspective elicits some startling inconsistencies and surprising insights. My investigation reveals that there are two distinct lines of constitutional doctrine touching on the right to make medical treatment choices. The first is the “public health” line of cases, beginning with \textit{Jacobson v. Massachusetts},\textsuperscript{14} which dealt with the constitutionality of mandatory vaccination laws. Those cases emphasized the police power of the state over individual rights. The second is the newer “autonomy” line of cases, beginning with \textit{Griswold v. Connecticut},\textsuperscript{15} which emphasized individual dignitary and autonomy interests.

In addition, a careful look at the cases in each of those lines demonstrates that the degree of judicial deference to the government on issues of legislative fact – that is, the extent to which judges accept the government’s view of matters of scientific or medical fact that bear on policy choices – plays an important but largely unrecognized role in explaining the cases’ differing outcomes. Although it is tempting to understand the level of judicial deference as reflecting the nature of the underlying constitutional right or doctrinal category (i.e., whether a right requiring heightened scrutiny, and therefore minimal deference, is involved), I demonstrate that the Court has decided to apply

\textsuperscript{12} I wish to emphasize that, in speaking of medical treatment decisions, I am contemplating only those cases in which both a patient and her physician have agreed upon a course of treatment and the government wishes to prohibit that treatment. Therefore, I am neither arguing that an individual has an unqualified right to do what she pleases with her body, nor am I questioning the authority of the court to forbid the practice of medicine by non-physicians. Rather, my argument relies in part on the constitutional importance of the physician-patient relationship, see \textit{Roe v. Wade}, 410 U.S. 135, 153 (1973); Doe v. Bolton, 410 U.S. 179, 197 (1973). \textit{But see} Planned Parenthood v. Casey, 505 U.S. 833, 884 (1992); Rust v. Sullivan, 500 U.S. 173, 202-03 (1991). Moreover, the physician’s role (which itself incorporates the state’s power to regulate the qualifications of physicians) provides an important check on the individual’s exercise of her right to make medical treatment choices.

\textsuperscript{13} One law review article from 1989 discusses a number of the cases considered here in arguing that the substantive due process right to privacy encompasses a right to make health care decisions. Elizabeth G. Patterson, \textit{Health Care Choice and the Constitution: Reconciling Privacy and Public Health}, 42 Rutgers L. Rev. 1 (1989). Many of the cases discussed in this Article have been decided since 1989, however, and have reshaped the doctrine considerably.

\textsuperscript{14} 197 U.S. 11 (1905).

\textsuperscript{15} 381 U.S. 479 (1965).
deference without any logical consistency, perhaps based on largely superficial determinations about what type of case is before it. Moreover, the deference arises not in weighing the quality of the state interest or balancing it against the individual’s interests, but at the stage of deciding whether the constitutional right to protect one’s health exists at all, where such deference is particularly inappropriate.

I therefore argue that a right to protect one’s health by making medical treatment decisions has already been recognized by the Supreme Court but that its application has largely been clouded by the problem of deference, and I conclude that the deference issue must be confronted directly and considered on its own merits.\footnote{The issue of judicial deference to legislative findings of fact has been extensively covered in legal scholarship. See infra TAN ___. This scholarship does not, however, differentiate between medical or scientific facts and other kinds of fact, such as predictive judgments of social scientific fact, nor does it focus exclusively on the former. Another contribution of this Article is therefore its specific analysis of deference to legislative findings of medical fact.}

The question of deference, in these cases, usually boils down to the question of who decides whether a particular medical treatment has therapeutic merit.\footnote{The notion of a constitutional right to make medical treatment decisions also invokes another question of “who decides” – namely, whether the patient or the doctor decides on the appropriate course of treatment. That question, which is one discussed extensively by bioethics scholars, is beyond the scope of this Article. In this Article, I assume that the doctor and patient have agreed on a particular course of treatment which in turn is prohibited by law.} I argue that legislatures are particularly ill-suited to this task and that judges, while not ideal medical decision-makers, are in a better institutional position to weigh the scientific evidence before them. This does not, of course, mean that individuals will have an unqualified right to obtain any medical treatment they and their physicians deem appropriate, but only that a constitutional right to protect one’s health should be consistently recognized; that the recognition of this right should not be artificially limited by deference to legislative findings of medical fact; and that this right will have to be balanced against the state’s real and legitimate interest in regulating the practice of medicine to protect the public.

Part I of this Article describes and analyzes \textit{Stenberg v. Carhart}, the “partial-birth” abortion case, and \textit{United States v. Oakland Cannabis Buyers Cooperative}, one of the “medical marijuana” cases, in order to demonstrate the conflict at the heart of my argument. Part II then traces that conflict to two opposing lines of constitutional doctrine, both touching on the right to make medical
treatment decisions. Finally, Part III concludes that although the Supreme Court has recognized such a right, legislative fact deference has played a largely unacknowledged role in the inconsistent application of that right. Part III ends with some suggestions as to how the right to make medical treatment choices and the corresponding legislative determinations of medical fact should be handled by courts in the future.

I. CONSTITUTIONAL CASES ON A COLLISION COURSE

This Part considers two recent Supreme Court cases decided in consecutive Terms — Stenberg v. Carhart and United States v. Oakland Cannabis Buyers’ Cooperative — that have taken notably conflicting views of the right to choose appropriate medical treatment. These cases are examined at length not simply because of their importance to this issue, but also because, though decided close to one another chronologically, they are emblematic of the two radically differing approaches the Supreme Court has taken in this area. In particular, as explained at greater length in Part II, United States v. Oakland Cannabis Buyers’ Cooperative represents the “public health” approach, and Stenberg v. Carhart exemplifies the “autonomy” approach. These cases, having grown out of distinct doctrinal lines and resulting in a glaring doctrinal inconsistency, are thus on a collision course, which will eventually force the Supreme Court to decide which approach will prevail.

A. “Partial-Birth” Abortion and the Health Exception

Though it has received relatively little scholarly attention, Stenberg v. Carhart, the so-called “partial-birth abortion” case,

---

18 Aside from a number of student notes, there has been very little article-length scholarship focusing on Carhart in any depth. One exception is David Meyer’s careful analysis of Carhart in Lochner Redeemed: Family Privacy after Troxel and Carhart, 48 U.C.L.A. L. REV. 1125 (2001).

19 I place the term “partial-birth abortion” in quotes, because it is considered by many to be an inaccurate and political term, like “assault weapon.” “Partial-birth abortion” is not a medical term, and in fact did not, at the time states began adopting “partial-birth abortion” bans, refer to any particular procedure known to physicians. The term is clearly intended to have vivid emotional impact, which is why abortion opponents prefer it to a term like “dilation and extraction” or “D&X.” See, e.g., Gail Glidewell, Note, “Partial Birth” Abortion and the Health Exception: Protecting Maternal Health or Risking Abortion on Demand?, 28 FORDHAM URB. L.J. 1089.
arguably effected a radical extension of the substantive due process right to choose appropriate medical treatment. In Carhart, the Court recognized the nearly absolute right of a woman to choose the safest abortion procedure for her, even when other safe methods of abortion exist. Moreover, the Court showed little willingness in Carhart to defer to the state legislature’s findings of medical fact, instead allowing the plaintiffs to challenge and ultimately defeat those findings with their own expert medical testimony. Indeed, the Supreme Court in Carhart recognized a powerful right whose existence it was barely willing to contemplate in the medical marijuana cases considered by the Court almost contemporaneously.

In Stenberg v. Carhart, the Supreme Court considered a challenge to a Nebraska state law purporting to ban a procedure often referred to as “partial-birth abortion,” or more technically and accurately called “dilation and extraction,” or “D&X.”

Nebraska’s ban imposed civil and criminal sanctions for performing an abortion in which the physician “deliberately and intentionally deliver[s] into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the [physician]... knows will kill the unborn child and does kill the unborn child.” The ban contained an exception allowing the procedure to be performed if it was “necessary to save the life of the mother whose life is endangered by a physical disorder, physical illness, or physical injury,” but it contained no exception allowing the procedure to be performed when necessary to preserve the health of the woman in situations that might not qualify as life-threatening.

In a five-to-four decision, the Supreme Court held that the law violated the Fourteenth Amendment right to substantive due process as set out in Roe v. Wade and Planned Parenthood v. Casey, for two


20 Stenberg v. Carhart, 530 U.S. 914, 927-29 (2000). The procedure is also referred to as “intact dilation and evacuation” or “intact D&E.” At the time Carhart was decided, twenty-nine other states had “partial-birth abortion” bans similar to Nebraska’s. See, e.g., id. at 983 (Thomas, J., dissenting).


22 Carhart, 530 U.S. at 921-22.
separate and independent reasons. First, the Court stated that the law was unconstitutional because it lacked an exception allowing the procedure to be performed when it is “necessary, in appropriate medical judgment, for the preservation of the ... health of the mother.” The Court had made clear since Roe v. Wade that such a health exception was required when the state regulates postviability abortions; since the Nebraska ban admittedly applied both previability and postviability, it was a fortiori unconstitutional without a health exception. Second, the Court held the law was written so broadly and imprecisely as to sweep within its reach not only the D&X procedure but also the much more commonly used, second-trimester dilation and evacuation procedure (D&E). The Court held, and indeed the State had conceded, that a law banning D&E imposed an undue burden on the right to choose abortion and was therefore an unconstitutional “undue burden” on the right to abortion under Planned Parenthood v. Casey.

Thus, the Court held that it is an independent constitutional requirement that any law banning an abortion procedure like D&X must contain an exception permitting the procedure when medically necessary. In so holding, the Supreme Court in Carhart noted that

---

23 Carhart, 530 U.S. at 929-30.
24 Id. at 929-31.
25 Carhart, 530 U.S. at 930. Despite the state’s contention to the contrary, the Supreme Court held in Carhart that the Nebraska ban, as written, outlawed not only the D&X procedure, but also the more commonly-used D&E procedure, which may be used as early as 13 weeks gestation. Id. at 924, 938. Yet, even if the ban applied only to the D&X procedure, as the state argued, it would still apply previability, as the D&X procedure may be used as early as 16 weeks gestation. Id. at 927.
26 Id. at 938 (“Nebraska does not deny that the statute imposes an ‘undue burden’ if it applies to the more commonly used D&E procedure as well as to D&X. And we agree with the Eighth Circuit that it does so apply.”).
27 Id. at 929-30 (“The question before us is whether Nebraska’s statute, making criminal the performance of a ‘partial birth abortion,’ violates the Federal Constitution, as interpreted in Planned Parenthood of Southeastern Pa. v. Casey and Roe v. Wade. We conclude that it does for at least two independent reasons.”) (citations omitted); see also id. at 948 (O’Connor, J., concurring) (noting that the “lack of a health exception necessarily renders the statute unconstitutional” but adding that the law is also “unconstitutional on the alternative and independent ground that it imposes an undue burden on a woman’s right to choose to terminate her pregnancy before viability”). Thus, even if the law had been written sufficiently precisely that it outlawed only D&X, and therefore most likely did not impose an undue burden, it would still be unconstitutional if it lacked a health exception.

Some of the Justices argued in dissent that the requirement of a health exception is not itself a separate and independent requirement but rather should be analyzed under the rubric of the undue burden inquiry. Id. at 965-68 (Kennedy, J., dissenting) (arguing that a health exception was not required because the “marginal”
the Constitution protects against abortion regulations imposing “significant health risks,” whether those risks “happen[] to arise from regulating a particular method of abortion, or from barring abortion entirely.”\textsuperscript{28} Thus, a woman has a right not only to access an abortion whenever it is necessary to protect her health but also to access the safest method of abortion for her.

The state had argued that no health exception was required in this particular case, because the D&X procedure was never medically necessary. In support of its view, the state pointed to the testimony of its own medical expert, some \textit{amici}, and an American Medical Association policy statement suggesting that the health benefits of D&X were questionable, or even that D&X might be a riskier procedure than D&E.\textsuperscript{29} There was also testimony to the same effect contained in the legislative history.\textsuperscript{30} Nonetheless, the majority rejected the state’s legislative findings, asserting instead that the record demonstrated that D&X may be safer than the alternatives in some circumstances; at a minimum, the evidence on the medical necessity of D&X was disputed. And in fact, the plaintiffs had assembled an array of expert testimony pointing to myriad circumstances in which D&X might prove safer than the alternative D&E procedure.\textsuperscript{31}

In reaching its conclusion, the Court set out the evidentiary standard that each party must meet in a challenge to a ban on a method of abortion that lacks a health exception. “Where a significant body of medical opinion believes a procedure may bring with it greater safety for some patients and explains the medical reasons supporting that view,” the Court held, the law requires a health exception unless the safety differences between D&X and D&E “do not amount to a substantial obstacle to the abortion right”; \textit{id.} at 1011 n.20 (Thomas, J., dissenting). This view has been rejected by lower courts as well as by the Supreme Court itself, however. \textit{See, e.g., Planned Parenthood Cincinnati Region v. Taft}, 444 F.3d 502, 508 (6\textsuperscript{th} Cir. 2006), citing \textit{Ayotte v. Planned Parenthood of Northern New England}, --- U.S. ----, 126 S.Ct. 961, 969 (2006); \textit{Planned Parenthood v. Wasden}, 376 F.3d 908, 923 (9\textsuperscript{th} Cir. 2004), \textit{cert. denied}, 125 S. Ct. 1694 (2005). The federal Partial-Birth Abortion Ban Act, which is arguably written more precisely to ban only D&X, has nonetheless been struck down due to its lack of a health exception by every court to consider it so far. NAF v. Gonzales, 437 F.3d 278 (2d Cir. 2006); Planned Parenthood Fed’n v. Gonzales, 435 F.3d 1163 (9\textsuperscript{th} Cir. 2006); Carhart v. Gonzales, 413 F.3d 791 (8\textsuperscript{th} Cir. 2005).

\textsuperscript{28} \textit{Carhart}, 530 U.S. at 931.
\textsuperscript{29} \textit{Id.} at 933-36.
\textsuperscript{30} \textit{Id.} at 1015-16 (Thomas, J., dissenting); Floor Debate, Committee on the Judiciary, LB 23 (Neb. Feb. 12, 1997), at 50, 64.
\textsuperscript{31} \textit{See, e.g., Carhart}, 530 U.S. at 932.
state can show “that a health exception is ‘never necessary to preserve the health of women.’” In this case, the Court held, the plaintiffs had met their burden, and Nebraska had failed to refute the plaintiffs’ evidence by showing that the health exception would never be necessary. Thus, Carhart “does not leave it to a legislature . . . to make a finding as to whether a statute prohibiting an abortion procedure constitutionally requires a health exception. On the contrary, [Carhart] leaves it to the challenger of the statute . . . to point to evidence of ‘substantial medical authority’ that supports the view that the procedure may sometimes be necessary to avoid risk to a woman’s health.”

Although the Court’s health exception holding appears at first glance to be a straightforward application of Roe v. Wade, it is in fact quite different from Roe. First and foremost, Carhart is not about the right to choose abortion in the usual sense. For women affected by the D&X ban, their alternative is not to forgo the desired (or required) abortion, but to have an abortion by a method that is, at least arguendo, riskier. Carhart is therefore not about a state intrusion on the constitutional right to choose not to become a parent; it implicates only the right to choose the particular method of abortion, or in my terminology, the right to make medical treatment choices.

Of course, to some extent this bodily integrity right has always been implicated in the abortion decision as well. One might, for example, point to the requirement that any postviability ban on abortion contain a health exception, despite the state’s admittedly compelling interest in the viable fetus, as showing a similar concern with the woman’s right to protect her health. But that situation, too,

---

32 Id. at 937-38. Indeed, the Court added, “the uncertainty means a significant likelihood that those who believe that D&X is a safer abortion method in certain circumstances may turn out to be right. If so, then the absence of a health exception will place women at an unnecessary risk of tragic health consequences. If they are wrong, the exception will simply turn out to have been unnecessary.” Id. at 937.


34 See Akhil Reed Amar, Foreword: The Document and the Doctrine, 114 HARV. L. REV. 26, 109-14 (2000) (noting that the law in Carhart was “quite different” from that in Roe, in that the D&X ban “did not completely conscript women’s bodies or channel them into narrowly circumscribed lives. . . . the law, if narrowly construed, outlawed only a single procedure, leaving other methods of abortion unaffected”).

35 Cf. Eugene Volokh, Medical Self-Defense, Prohibited Experimental Therapies, and Payment for Organs, 120 HARV. L. REV. ___ (forthcoming 2007) (discussing the existence of a “post-viability right to abortion as medical self-defense when pregnancy threatens a woman’s life” as distinct from the “pre-viability right to abortion as reproductive choice”).
is distinguishable. The *Roe* health exception requirement is apparently motivated by the notion that the state cannot force a woman to suffer physical harm in order to serve the state’s interest in the fetus, even a viable fetus.\(^{36}\) The Court explained in *Thornburgh v. American College of Obstetricians and Gynecologists*, for example, that “require[ing] the mother to bear an increased medical risk in order to save her viable fetus” would effect an undesirable “‘trade-off’ between the woman’s health and additional percentage points of fetal survival.”\(^{37}\) Indeed, one might understand *Roe* itself as being fundamentally premised on the notion that, whatever the state’s interest in fetal life, that interest is inferior to the value placed by the Constitution on the woman herself.

In the *Carhart* situation, however, the state’s interest in potential life is not implicated, since the fetus will not survive regardless of the method chosen. Thus, *Carhart* implicates only the woman’s right to choose a particular *method* of abortion, which her doctor has determined to be safest for her, despite the state’s desire to outlaw that procedure for claimed moral, health, or other reasons not related to fetal preservation. Of course, one might argue that the *Carhart* situation is more compelling, not less compelling than the *Roe* postviability health exception requirement: in the *Carhart* situation, there is nothing so compelling as the state’s interest in a viable fetus to offset the woman’s right to protect her health. At the same time, however, it is important to understand that *Carhart* guarantees the right to choose the safest abortion procedure, even when other, presumably safe, procedures are available.


\(^{37}\) *Thornburgh* v. American Coll. of Obstetricians & Gynecol., 476 U.S. 747, 769 (1986) (quoting *Colautti* v. Franklin, 439 U.S. 379, 397-401 (1979)). In *Colautti* v. *Franklin*, the Supreme Court struck down on vagueness grounds a state statute requiring physicians to use the postviability method of abortion most likely to result in a live birth, so long as a different technique was not necessary to preserve the life or health of the woman. *Colautti*, 439 U.S. at 390. The Court also suggested in dicta that such a standard-of-care requirement might endanger the woman’s rights as well. *Id.* at 400. The Tenth Circuit held a similar choice-of-method statute unconstitutional in *Jane L. v. Bangerter*, the court there emphasized that “a woman’s health must be the paramount concern” and that this remains so even after *Casey*. 61 F.3d 1493, 1504 (10th Cir. 1995), *rev’d on other grounds sub nom.* Leavitt v. *Jane L.*, 518 U.S. 137 (1996).
A Tale of Two Doctrines

The closest analogue to Carhart in abortion jurisprudence is Planned Parenthood v. Danforth, in which the Supreme Court reviewed a Missouri law prohibiting, *inter alia*, the saline amniocentesis method of abortion, the most common method of performing a second-trimester abortion at the time the case was decided. The state legislature had adopted a finding stating that the banned abortion method was harmful to a woman’s health. The Court held, however, that the prohibition was tantamount to a ban on all second-trimester abortions, because no other safe method was widely available. While not directly questioning the legislature’s finding regarding the safety of saline amniocentesis, the Court dismissed it on the ground that the legislature, although purporting to outlaw one risky form of abortion, was forcing women either to use forms that were acknowledged to be far riskier or to forgo the abortion altogether.

Although Danforth arguably provides clear precedent for the outcome in Carhart, it is distinguishable for a number of reasons. First, Danforth was decided under the trimester framework of Roe v. Wade, which was rejected in Planned Parenthood v. Casey both as insufficiently protective of the state’s interests and as overstating the physician’s role. Thus, there was reason to think that this holding from Danforth was no longer good law. In addition, one might argue that even the Court in Danforth did not go as far as the Court in Carhart. In Danforth, the Court did not make it clear that a woman had the right to choose an abortion method whenever it was deemed by her physician to be safer for her; rather, in Danforth no comparably safe procedure would be available for women seeking second-trimester abortions if the state’s ban were to stand. The same cannot be said for the women affected by the Carhart ban, who still had the option of an

---

39 Id. at 75-76.
40 Id. at 76.
41 Id. at 77-79. The majority based its decision in large part on the fact that prostaglandin abortions, the assertedly safer alternative to saline amniocentesis, were not yet widely available. This left the alternatives of hysterectomy (removal of the uterus) and hysterotomy (essentially a caesarian section to remove the fetus), both of which are highly invasive forms of major surgery and far riskier than saline amniocentesis. Hysterectomy, in addition, leaves women unable to conceive again.
43 Cf. Meyer, supra note ___, at 1161-62 (noting that Casey took a “more balanced tack” than those pre-Casey cases declaring the unconstitutionality of a “trade-off” between a woman’s interest in her health and the state’s interest in the fetus).
admittedly safe but comparatively riskier procedure (dilation and evacuation). Indeed, Justice Stevens’ concurrence in *Danforth*, while brief and somewhat enigmatic on this point, indicates just this: he stated that “[i]f two abortion procedures had been equally accessible to Missouri women, . . . the Constitution would not prevent the state legislature from outlawing the one it found to be less safe even though its conclusion might not reflect a unanimous consensus of informed medical opinion.”44 Moreover, Justices Stewart and Powell indicated that they agreed with Justice Stevens’ opinion; 45 thus, three of the six Justices making up the Court in *Danforth* suggested that the state need not allow women always to choose the procedure that their doctors believe safest for them in the face of a lack of medical consensus and a legislative finding that the procedure is unsafe. Yet this was precisely what the majority required in *Carhart*.

Despite the majority’s protestations to the contrary, 46 several commentators have thus pointed out that, at least when there is a “significant body of medical opinion” supporting the comparative safety of an abortion method, *Carhart* essentially gives the woman and her physician total discretion to choose the method of abortion they deem most medically appropriate.47 Indeed, Justice Kennedy, in a dissent that can only be described as apoplectic, decried the health exception holding as “award[ing] each physician a veto power over the State’s judgment that the procedures should not be performed” and argued that “it is now Dr. Leroy Carhart [the plaintiff] who sets

44 *Danforth*, 428 U.S. 101-02 (Stevens, J., concurring in part and dissenting in part).
45 *Id.* at 92 (Stewart, J., concurring).
46 “This is not to say, as Justice Thomas and Justice Kennedy claim, that a State is prohibited from proscribing an abortion procedure whenever a particular physician deems the procedure preferable. By no means must a State grant physicians ‘unfettered discretion’ in their selection of abortion methods.” *Carhart*, 530 U.S. at 938.
47 See, e.g., Richard Collin Mangrum, Stenberg v. Carhart: Poor Interpretive Analysis, Unreliable Expert Testimony, and the Immorality of the Court’s Invalidation of Partial-Birth Abortion Legislation, 34 CREIGHTON L. REV. 549, 579 (2001) (arguing that *Carhart* means “any and all attempts to restrict any form of abortion procedures is doomed to failure” and gives physicians “absolute veto power of any abortion legislation”). One circuit court has interpreted *Carhart* somewhat more narrowly, holding that the health exception is required only to obviate significant, as opposed to trivial, health risks. Women’s Med. Prof’l Corp. v. Taft, 353 F.3d 436, 446-48 (2003). At the same time, the Sixth Circuit in *WMPC* failed to explain clearly what constitutes a “significant” health risk beyond saying that it embodies calculations of comparative health risks and excludes cases where “the choice of methods is dictated purely by the preference of an individual physician” and has “nothing to do with the health of the particular patient.” *Id.* at 449-50.
abortion policy for the State of Nebraska, not the legislature or the people.”

Justice Thomas agreed, and opined that the Court cannot possibly mean what it says in Carhart: “For example, physicians are presumably prohibited from using abortifacients that have not been approved by the Food and Drug Administration even if some physicians reasonably believe that these abortifacients would be safer for women than existing abortifacients.”

In addition, Justice Kennedy took the majority to task for what he viewed as a failure to respect the worthy tradition of deference to legislatures on disputed issues of medical fact. Noting legislatures’ “superior factfinding capabilities,” Justice Kennedy argued that the Carhart majority “fail[ed] to acknowledge substantial authority allowing the State to take sides in a medical debate even when fundamental liberty interests are at stake and even when leading members of the profession disagree with the conclusions drawn by the legislature.” To the same effect, Justice Thomas noted that the Nebraska Legislature had before it evidence suggesting that the D&X procedure is unsafe and that it is never medically indicated; citing authority pertaining to the constitutionality of involuntary civil commitment of criminal offenders, Justice Thomas argued that, precisely when there is a division of medical authority, “legislatures have been afforded the widest latitude in drafting such statutes . . . . When a legislature undertakes to act in areas fraught with medical and scientific uncertainty, legislative options must be especially broad.” Carhart is therefore as notable for its nondeferential approach to issues of legislative fact as for its holding that arguably extends Roe beyond its former bounds.

48 Id. at 964-65 (Kennedy, J., dissenting).
49 Id. at 1010-11 (Thomas, J., dissenting).
51 Id. at 1017-18 (quoting Hendricks, 521 U.S. at 369 n.3). In considering the constitutionality of the federal Partial Birth Abortion Ban Act, Judge Straub of the Second Circuit made similar observations in dissent, arguing that the federal government’s factfinding is entitled to deference under the standard set out in Turner Broadcasting System, Inc. v. FCC, 520 U.S. 180 (1997). National Abortion Fed’n v. Gonzales, 437 F.3d 278, 301-05 (2d Cir. 2006).
52 Indeed, not only did the Court definitively recognize such a right for women seeking an abortion in Carhart, it appeared to recognize that right as an absolute one. The Court has not contemplated that any state interest would be sufficient to overcome the woman’s right to protect her health in this context, nor did it mention
B. Medical Marijuana and Medical Necessity

The broad holding and lack of deference to the legislature in Carhart contrasts sharply with the Supreme Court’s analysis and decision in United States v. Oakland Cannabis Buyers’ Cooperative (“OCBC”), 53 decided the following Term. In OCBC as well as the most recent case dealing with medicinal use of marijuana, Gonzales v. Raich, 54 the Supreme Court – while not facing the issue directly – strongly suggested that it would be futile to press a claim of constitutional right to access marijuana as a form of medical treatment.

Although the Supreme Court’s opinion in OCBC did not turn on the question whether individuals have a substantive due process right to choose appropriate medical treatment, the case is highly relevant to that issue for two reasons. First, the defendants had argued throughout the litigation, and the district court ruled on the claim, that the Due Process Clause of the Fifth Amendment protected the right of seriously ill patients to choose marijuana, in consultation with their physicians, to alleviate their suffering. In addition, the Supreme Court’s reasoning in reaching the conclusion that the Controlled Substances Act (CSA) contained no medical necessity defense has levels of scrutiny or standards of review. For this reason, the health exception requirement is difficult to integrate into standard substantive due process doctrine. Of course, it is fair to say that “the Supreme Court’s substantive due process jurisprudence has been anything but a model of clarity.” Marc Spindelman, Are the Similarities Between a Woman’s Right to Choose an Abortion and the Alleged Right to Assisted Suicide Really Compelling?, 29 U. Mich. J.L. Reform 775, 781 (1996); see also Daniel O. Conkle, Three Theories of Substantive Due Process, 85 N.C.L. Rev. 63, 64 (2006); Lois Shepherd, Looking Forward with the Right of Privacy, 49 U. Kan. L. Rev. 251, 251-52 (2001) (“Thirty-five years after the Supreme Court first explicitly recognized a constitutional right to privacy in Griswold v. Connecticut, we are still grappling with understanding and articulating what that right embraces.”). Nonetheless, the apparent per se rule articulated by the Court does not fit clearly into any of the available paradigms of substantive due process review. Cf. Meyer, supra note ___, at 1159-62 (noting that the Court in Carhart treated the lack of a health exception as a “stand-alone defect” rather than a burden to be considered within Casey’s “undue burden” framework and arguing that the Court thus applied a standard similar to strict scrutiny). The Supreme Court does not always articulate a clear standard of review for constitutional claims, however, and has most notably declined to do so recently in Lawrence v. Texas, 539 U.S. 558 (2003). See Laurence Tribe, Lawrence v. Texas: The “Fundamental Right” that Dare Not Speak Its Name, 117 Harv. L. Rev. 1893, 1917 (2004).

54 545 U.S. 1 (2005).
important implications for how the Court might rule on the conceptually similar claim of a right of seriously ill individuals to choose appropriate medical treatment in the form of medical marijuana.

The OCBC litigation arose out of the federal government’s attempts to enforce the Controlled Substances Act’s prohibition on distributing or manufacturing marijuana against the Oakland Cannabis Buyers’ Club, a not-for-profit organization in California that provided cannabis to patients whose doctors recommended it, in compliance with the California Compassionate Use Act of 1996.\textsuperscript{55} The organization defended on several grounds, including that the common law defense of necessity – styled “medical necessity” – precluded enforcement of the criminal provisions of the Controlled Substances Act against them, as well as that the enforcement of the prohibition on medical use of marijuana would violate substantive due process.\textsuperscript{56} The defendants had presented evidence, including expert testimony, demonstrating that cannabis may be the only effective treatment for certain patients for whom other treatments have failed, including some patients suffering from serious conditions such as AIDS, cancer, glaucoma, multiple sclerosis, and quadriplegia.\textsuperscript{57} The government, by contrast, submitted absolutely no evidence to refute defendants’ medical position.\textsuperscript{58}

\textsuperscript{55} Oakland Cannabis, 532 U.S. at 486-87. The federal government had brought suit against the Cooperative and its executive director, seeking an injunction against the Cooperative’s activities. The suit against the Oakland Cannabis Buyers’ Cooperative was one of six suits against cannabis dispensaries in California brought by the federal government and consolidated into one case, captioned United States v. Cannabis Cultivators Club, 5 F. Supp. 2d 1086 (N.D. Cal. 1998), in the district court.

\textsuperscript{56} Cannabis Cultivators, 5 F. Supp. 2d at 1101-03.

\textsuperscript{57} United States v. Oakland Cannabis Buyers’ Cooperative, 190 F.3d 1109, 1115 (9th Cir. 1999); Appellants’ Opening Brief at 13-14, United States v. Oakland Cannabis Buyers’ Cooperative, 190 F.3d 1109 (9th Cir. 1999) (No. 98-16950), 1998 WL 34078848, at *13-14. A number of studies document the safety and potential medical benefits of cannabis. See, e.g., David Baker, et al., The Therapeutic Potential of Cannabis, 2 LANCET NEUROLOGY 291, 294-96 (2003) (benefits for sufferers of neurological and neurodegenerative disease); Donald Abrams, et al., Short-Term Effects of Cannabinoids in Patients with HIV-I Infection: A Randomized, Placebo-Controlled Clinical Trial, 139 ANN. INTERN. MED. 258, 266 (2003) (safety of cannabis for HIV patients); INSTITUTE OF MEDICINE, MARIJUANA AND MEDICINE: ASSESSING THE SCIENCE BASE 159 (Janet E. Joy, et al., eds., 1999) (“Nausea, appetite loss, pain, and anxiety are all afflictions of wasting and all can be mitigated by marijuana.”).

\textsuperscript{58} OCBC, 190 F.3d at 1115; Appellants' Opening Brief, supra note __, at 15.
The district court rejected the defendants’ arguments, including the substantive due process argument. The court held that the defendants had failed to demonstrate the existence of a fundamental right to “a demonstrated and effective treatment as recommended by their physician that can alleviate their agony, preserve their sight, and save their lives.” The district court categorically rejected the notion that individuals have a “fundamental right to obtain the medication of choice,” even on a physician’s recommendation, and even assuming that marijuana was the only effective treatment for the intervenors’ symptoms. The court relied heavily on *Carnohan v. United States* and *Rutherford v. United States*, two circuit court opinions that rejected the claim that individuals had a substantive due process right to access laetrile, a drug made from apricot pits that was not approved by the FDA but believed by some to be a cure or treatment for cancer. According to the court, patients might have a constitutional right to access treatment for pain or illness, but the “selection of a particular treatment, or at least a medication, is within the area of governmental interest in protecting public health.”

By the time the case reached the Supreme Court on writ of certiorari from the Ninth Circuit’s decision allowing the distributors to

---

60 United States v. Cannabis Cultivator’s Club, Nos. C 98-00085 CRB, C 98-00086 CRB, C 98-00087 CRB, C 98-00088 CRB, C 98-00245 CRB, 1999 WL 111893, at *2-3 (N.D. Cal. Feb. 25, 1999) (“If one does not have a right to obtain medication free from government regulation, there is no reason one would have that right upon a physician’s recommendation.”). The district court had initially rejected the defendants’ substantive due process claims partly on the ground that it was inappropriate for the cannabis distributors to raise this argument as a defense to a suit for an injunction to enforce the CSA, suggesting instead that the issue would be better presented by an individual patient. *Cannabis Cultivators’ Club*, 5 F. Supp. 2d at 1103. When four individual patients intervened in the suit and requested a declarator that they had such a right, however, they fared no better. *Cannabis Cultivator’s Club*, 1999 WL 111893, at *2-3.
61 616 F.2d 1120 (9th Cir. 1980).
62 *Rutherford v. United States*, 616 F.2d 455 (10th Cir. 1980).
provide marijuana to those individuals who met the requirements of medical necessity, the case primarily turned on an issue of statutory interpretation: whether the federal courts should recognize a common-law defense of medical necessity to the criminal prohibitions of the Controlled Substances Act, although the language of the Act itself neither expressly provides for nor excludes such a defense.65 The defendants, citing Washington v. Glucksberg,66 had argued in their brief that, if the CSA were construed to contain no medical necessity defense for seriously ill patients, it would be unconstitutional as violative of the patients’ substantive due process right to life and their corollary right to “be free from government interdiction of their personal self-funded medical decision, in consultation with their physician, to alleviate their suffering through the only alternative available to them.”67 The Supreme Court declined to reach that argument, however, noting that the Court of Appeals had not addressed those claims.68 Only Justice Stevens, who concurred in the judgment, obliquely noted that the question whether the medical necessity defense “might be available to a seriously ill patient for whom there is no alternative means of avoiding starvation or extraordinary suffering” – that is, whether the defense might be recognized if a patient rather than a distributor had raised it here – “is a difficult issue that is not presented here.”69

Although the Court declined to reach the issue whether seriously ill patients’ substantive due process rights were implicated by the CSA’s blanket prohibition on marijuana, it seems plausible to draw some conclusions from the Court’s analysis. First, one might suggest that the Court’s refusal to consider the substantive due process claim reflects its view of the merits of that claim. The issue was clearly raised, both in the lower courts and in the Supreme Court briefs, and

69 Id. at 501 (Stevens, J., concurring). Justice Stevens’ concurrence was joined by Justices Souter and Ginsburg. Interestingly, this issue – essentially one of third-party standing – has not been controversial in the abortion context, where physicians and clinics routinely assert their patients’ right to a health exception, which is conceptually similar to the medical necessity defense at issue in OCBC. See, e.g., Stenberg v. Carhart, 530 U.S. 914 (2000) (allowing Dr. Carhart to assert his patients’ constitutional right to a health exception).
the parties had an opportunity to build an evidentiary record, so the Court could – and arguably should – have reached it. Given that the Court found no medical necessity defense to the CSA, it should have considered the defendants’ claim that the substantive due process argument provided an alternative basis for affirming the Ninth Circuit’s decision requiring the district court to modify the injunction against the distributors. Since it brushed this constitutional point aside, it is possible that the Court thought it had no merit and therefore would not have changed the ultimate outcome.

A second way in which the Court’s analysis of the statutory issue is relevant to the constitutional question is in the Court’s treatment of the defendants’ medical evidence, which conflicts sharply with the Court’s treatment of such evidence in Carhart. Despite the defendants’ submission of expert medical testimony showing the medicinal qualities of cannabis, which went uncontradicted by the government, the Court instead deferred to Congress’s finding in the CSA that marijuana “has no currently accepted medical use.” The finding that marijuana lacks medical benefit was key to the Supreme Court’s decision. Moreover, in response to the defendants’ argument

\[\text{[70] The Court suggested that the issue was raised by defendants only as an argument that the Court should avoid constitutional questions in construing the statute, } OCBC, 532 U.S. at 494, but the issue was clearly not only raised in this posture. Brief for Respondents, } OCBC, 532 U.S. 483 (2001) (No. 00-151), at 42-49; see also oral argument at 38-39.

\[\text{[71] Id. at 491 (quoting 21 U.S.C. § 812). The Controlled Substances Act categorizes drugs into different “schedules” according to their usefulness and their propensity for abuse. Kathleen T. McCarthy, } Conversations About Medical Marijuana Between Physicians and Their Patients, 25 J. LEGAL MED. 333, 334 (2004). In order to place a drug in Schedule I, either Congress or the Attorney General, acting on the recommendations of the Secretary of Health and Human Services, must find that the drug “has no currently accepted medical use in treatment in the United States,” that it “has a high potential for abuse,” and that it has “a lack of accepted safety for use … under medical supervision.” 21 U.S.C. § 812(b)(1)(A)-(C); Lars Noah, Challenges in the Federal Regulation of Pain Management Technologies, 31 J.L. MED. & ETHICS 55, (2003). Schedule I drugs therefore may not be prescribed or distributed for any reason. 21 U.S.C. § 841(a). A Schedule II drug is one that has a high potential for abuse, potentially leading to severe physical or psychological dependence, but has a currently accepted medical use. 21 U.S.C. § 812(b)(2). In the case of marijuana, it was Congress that placed the drug in Schedule I. Noah, supra, at 49. Attempts to re-schedule the drug have been administratively pursued but have failed. See infra (Disc of Doblin br.); grinspoon?

\[\text{[72] Raich v. Ashcroft, 248 F. Supp. 2d 918, 929 (N.D. Cal. 2003) (“The main foundation for the Supreme Court’s position in } OCBC rests upon Congress’ findings that marijuana has no currently accepted medical use.”); Noah, supra note __, at 59 (noting that in } OCBC, “the U.S. Supreme Court showed tremendous}
that notwithstanding that finding, marijuana can still be medically necessary for certain patients, the Court simply stated that it was “unable … to override a legislative determination manifest in a statute.” 73 Thus, the Court would also be likely to defer to the legislature’s finding in a challenge based on the substantive due process right to appropriate medical treatment.

Since leaving the question open in OCBC, the Supreme Court has not again addressed whether there is a due process right to access marijuana for medicinal purposes. In Gonzales v. Raich the Supreme Court decided that the CSA, as applied to the intrastate medicinal use of marijuana in compliance with the California Compassionate Use Act, did not exceed Congress’s Commerce powers, but the Court did not address the claim raised by the individual patients that they had a

73 OCBC, 532 U.S. at 493. Interestingly, Justice Stevens seemed troubled by this issue three years later in hearing oral argument in Gonzales v. Raich, 545 U.S. 1 (2005). The following exchange between Justice Stevens and Paul Clement, arguing on behalf of the Attorney General of the United States, is noteworthy:

JUSTICE STEVENS: Do you think there could be any state of facts on which a judicial tribunal could disagree with the finding of Congress that there’s no acceptable medical use? Say they had a – say there was a judicial hearing on which they made a contrary finding. Would we have to ignore that? Would we have to follow the congressional finding or the judicial finding if that happened?

MR. CLEMENT: Well, it depends on the exact hypothetical you have in mind. I think the – the judicial finding that I think would be appropriate, and this Court would not have to ignore in any way, is a finding by the D.C. Circuit that, in a particular case where there’s a rescheduling effort before the FDA, that the underlying judgement of the FDA refusing to reschedule is invalid, arbitrary, capricious. That’s the way to go after the finding that marijuana is a Schedule I substance without a valid medical use in treatment. This is not a situation in – and your hypothetical might respond to a different statute that raised a harder question, where Congress made such a medical finding, and then just left it there without any mechanism to adjust the finding for changing realities. . . .

Transcript of Oral Argument at 20-21, Raich, 545 U.S. 1 (No. 03-1454). It is noteworthy that even the Government’s attorney acknowledged the possibility of a “harder question” where Congress has made a scientific finding unsupported by current scientific evidence. It is not clear, however, why the existence of an administrative process by which parties may seek rescheduling of a drug should make any difference in the degree of deference that courts owe to congressional findings.
substantive due process right to access the drug.\textsuperscript{74} As in \textit{OCBC}, the district court in \textit{Raich} had rejected the patients’ substantive due process claims on the basis of the laetrile cases, \textit{Rutherford} and \textit{Carnohan}.\textsuperscript{75}

C. Summary

While they differ in the specific legal questions presented, \textit{Carhart} and \textit{OCBC} both raise the issue whether individuals possess a constitutional right to noninterference with medical treatment choices made in consultation with a physician. In \textit{Carhart}, the issue was whether a state law prohibiting a particular method of abortion must contain an exception allowing the procedure to be performed when it is, in the opinion of the woman’s physician, the safest method of abortion for a particular woman. In \textit{OCBC}, the issue was whether a federal law prohibiting manufacture, distribution, or possession of marijuana had to be understood to contain an exception allowing an individual to access the drug when it is, in the opinion of the patient’s physician, the only effective or most tolerable method of treating the patient’s illness or its symptoms. Both cases, then, are about the right to access not just medical treatment to relieve pain, but the right to make medical treatment decisions.

Though the cases were decided within less than a year of each other, the Court did not cite \textit{Carhart} in \textit{OCBC}, nor did it appear to think that the approach taken in the former case had any applicability to the latter case.\textsuperscript{76} In \textit{Carhart}, the Court recognized a broad right to choose one abortion procedure when it has safety benefits over other procedures; moreover, in determining whether the procedure might have safety benefits, it allowed the plaintiffs to challenge the state’s view of the medical evidence, ultimately accepting the plaintiff’s “substantial evidence” of health benefits associated with the procedure as sufficient to overcome the legislature’s evidence to the contrary. \textit{OCBC} is something like a mirror image of this paradigm, since the Supreme Court and lower court peremptorily dismissed the claims of

\textsuperscript{74} \textit{Raich}, 545 U.S. at 33. As in \textit{OCBC}, the Ninth Circuit had declined to reach the issue, since it held for the plaintiffs on another ground. Raich v. Ashcroft, 352 F.3d 1222, 1227 (9th Cir. 2003).

\textsuperscript{75} Raich v. Ashcroft, 248 F. Supp. 2d 918, 928 (N.D. Cal. 2003).

\textsuperscript{76} It is also interesting to note that the respondents’ briefs in \textit{Oakland Cannabis Buyers’} and \textit{Raich} did not cite \textit{Carhart}, given that it is arguably the strongest recognition of the right to appropriate medical treatment in all of Supreme Court doctrine.
seriously ill patients to access cannabis for medicinal purposes when no other treatment was availing. Indeed, the Court noted that “the very point of [its] holding is that there is no medical necessity exception to the prohibitions at issue, even when the patient is ‘seriously ill’ and lacks alternative avenues for relief.” The lower courts that considered those claims simply stated that no fundamental right was implicated. Moreover, despite the fact that the patients in *OCBC* presented evidence, unrefuted by the government, that marijuana may have legitimate medical uses and may be the only appropriate treatment for some patients, the Court refused to consider that evidence, finding itself to be powerless to override a conclusory and controversial congressional finding.

II. A TALE OF TWO DOCTRINES

What accounts for the puzzling difference in the Supreme Court’s treatment of women seeking a particular method of abortion for health reasons and a cancer patient seeking marijuana for relief from severe symptoms? In this Part, I argue that the tension between the two approaches to the constitutional right to choose appropriate medical treatment can be traced to the fact that two distinct lines of cases, both implicating the right to make medical treatment decisions, have developed without merging. I describe these two lines of cases as the “public health” cases and the “autonomy” cases.

Both lines of cases consider the right of individuals to protect

---

77 *OCBC*, 532 U.S. at 494 n.7. The modified injunction crafted by the district court after remand from the Ninth Circuit had created an exception for distribution to patients who “(1) suffer from a serious medical condition, (2) will suffer imminent harm if the patient-member does not have access to cannabis, (3) need cannabis for the treatment of [a] medical condition, or need cannabis to alleviate the medical condition or symptoms associated with the medical condition, and (4) have no reasonable legal alternative to cannabis for the effective treatment or alleviation of the . . . medical condition or symptoms . . . because the alternatives have been ineffective . . . or the alternatives result in side effects which the [patient] cannot reasonably tolerate.” *Id.* at 489.

78 *Accord* State v. Corrigan, Nos. C0-00-2190, C2-00-2191 & C9-00-2205, 2001 Minn. App. LEXIS 889, at *2-3 (Aug. 21, 2001) (refusing to reconsider state legislature’s determination that marijuana had “no currently accepted medical use in the United States,” despite the claim that the medical literature has come to recognize the therapeutic benefits of marijuana since that determination was made, and asserting that “[w]hether changed circumstances have occurred that would now warrant recognition of a medical necessity defense to a charge of possession of marijuana is for the legislature to determine, not for this court”).
their health, against the contrary claims of the state to regulate the individual’s chosen medical treatment. Yet they take sharply differing views of this right and of the individual asserting it. The “public health” cases take the population view, seeing sick individuals not so much as autonomous decisionmakers exercising control over their own bodies but rather as public health problems and thus as threats to others that can and indeed must be controlled.\footnote{Cf. ALAN HYDE, BODIES OF LAW 243 (1997) (“The interest of the Jacobson \emph{v. Massachusetts} case lies in the discursive process through which the unvaccinated body of Henning Jacobson is constituted a threat to society.”); Wendy E. Parmet, \textit{Terri and Katrina: A Population-Based Perspective on the Constitutional Right to Reject Treatment}, 15 TEMP. POL. & CIV. RTS. L. REV. 395 (2006) (contrasting the perspective of constitutional law, based primarily in liberal individualism, with the perspective of public health, which is population-based); LAWRENCE O. GOSTIN, \textit{PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT} 11-14 (2000).} In those cases, the body is not so much the site of individuality but a unit of regulation and the symbol of the state’s most fundamental power. The public health cases, of which \textit{OCBC} is one, find their origin in the 1905 case of \textit{Jacobson v. Massachusetts}. The “autonomy” line of cases, by contrast, beginning with \textit{Griswold v. Connecticut}, treats the right to choose appropriate medical treatment as an aspect of the rights to bodily integrity and decisional autonomy. These cases take the “individual” view of citizens and their bodies, emphasizing the personal nature of the decisions involved. \textit{Carhart} grows directly out of the autonomy line of cases. Yet, different though the two approaches are, the autonomy cases nonetheless retain traces of public-health concerns, and the public health cases occasionally voice autonomy-based concerns; this overlap serves to demonstrate the interrelation of the two cases – that they are indeed just two sides of the same coin.

In Part III, I draw on the taxonomy just set forth to suggest that the Court has basically decided whether individuals have a constitutional right to make autonomous medical treatment choices based on their largely superficial categorization of a given case as an autonomy case or a public health case, and that there are no satisfying doctrinal ways to explain the conflict between those two types of cases. In addition, I argue that deference to legislatures, often plays the decisive role in these cases, has been used in a similarly reflexive manner by the Court and should be re-examined.
A. The Public Health Cases

The public health cases originate with *Jacobson v. Massachusetts*. They emphasize both the power and duty of the state to protect citizens from threats to their health, taking primarily a “population” view rather than an “individual” view of sick persons and summarily dismissing individuals’ claims of a right to make autonomous medical treatment choices. While some of the early cases, such as *Jacobson* and *Buck v. Bell*, involved state-mandated medical or surgical interventions that the individuals wished to avoid, such as involuntary vaccination and sterilization, those cases set the stage for subsequent cases in which courts rejected patients’ claims of a right to access the drug of their choice. The medical marijuana cases, *OCBC* and *Raich*, can be said to grow out of this line of cases.

*Jacobson v. Massachusetts*, often considered a “foundational” or “seminal” opinion in the field of public health law, dealt with the state’s power to enforce a mandatory vaccination law. Since it was decided prior to the rise of modern substantive due process doctrine, it does not contain the modern rhetoric of constitutionally protected privacy rights. Nonetheless, *Jacobson* involved one of the most famous early confrontations between the assertion of an individual right to resist a state-mandated medical intervention and a state claim of justification in the name of public health and police power. In upholding the mandatory vaccination law, *Jacobson* is striking and important for its deference to legislative judgments in the name of respecting the states’ traditional police power to protect the public. At the same time, however, the extent to which *Jacobson* considers and validates personal autonomy interests regarding medical treatment is surprising.

---

80 274 U.S. 200 (1927).
81 GOSTIN, supra note ___, at 63.
83 In fact, *Jacobson* was a *Lochner*-era case. The doctrine of substantive due process was of course liberally applied in the *Lochner* era, but largely to strike down laws on the grounds that they interfered with economic rights, not fundamental personal rights.
Jacobson involved the criminal conviction of Reverend Henning Jacobson for refusing to be vaccinated against smallpox in compliance with a Massachusetts state law and a regulation of the Cambridge board of health.\(^{85}\) While there is some confusion as to the exact reasons for Jacobson’s refusal,\(^{86}\) the opinion suggests that Jacobson feared an adverse health reaction from the vaccine, and that he had been ill as a result of vaccination when he was a child “and that he had witnessed a similar result of vaccination, not only in the case of his son, but in the cases of others.”\(^{87}\) Before the Supreme Court, Jacobson argued that the mandatory vaccination law was unconstitutional because, among other reasons, it was “hostile to the inherent right of every freeman to care for his own body and health in such way as to him seems best.”\(^{88}\) And indeed, Jacobson had attempted to introduce evidence in the trial court demonstrating that vaccines are often impure and therefore dangerous; that vaccination can have harmful health effects on those vaccinated, sometimes resulting in death; and that it is difficult to predict the cases in which such adverse consequences are likely, but the evidence was excluded as irrelevant.\(^{89}\)

In upholding the vaccination requirement, the Supreme Court relied heavily on the notion that the states have broad police power to act in the interest of public health and safety, noting that individual liberty can always be subject to “manifold restraints” in the name of the “common good.”\(^{90}\) Indeed, the Court said, “Upon the principle of

\(^{85}\) Jacobson v. Massachusetts, 197 U.S. 11, 12-13 (1905).

\(^{86}\) See, e.g., Wendy E. Parmet, Richard A. Goodman, and Amy Farber, supra note __, at 653; Sheldon Gelman, The Biological Alteration Cases, 36 WM. & MARY REV. 1203, 1207 n.22 (1995).

\(^{87}\) Jacobson, 197 U.S. at 36. Indeed, such reactions had apparently been documented in the medical literature existing at the time. See, e.g., LAWRENCE GOSTIN, supra note __, at 347 n.43 (2000); Michael Willrich, ‘The Least Vaccinated of Any Civilized Country’: Personal Liberty and Public Health in the Progressive Era, J. POL’Y HIST. (forthcoming January 2008). Moreover, until mid-1902, approximately the time when Henning Jacobson resisted vaccination, vaccines were almost completely unregulated, and some vaccines that were ineffective or impure made their way to market. Id.

\(^{88}\) Jacobson, 197 U.S. at 26.

\(^{89}\) Id. at 36.

\(^{90}\) Id. at 25-26. As Wendy Parmet has persuasively demonstrated, the term “police power” was historically understood to have a specific meaning, closely tied to the power and duty of state and local governments to protect health, and it was understood as an affirmative source of power that could limit individual rights. According to Parmet, this understanding began to change in the Lochner era, in which not only traditional public health measures, such as the mandatory vaccination
self-defense, of paramount necessity, a community has the right to protect itself against an epidemic of disease which threatens the safety of its members.” Moreover, the Court emphasized that “the legislature is primarily the judge” of that common good. Most strikingly, as discussed below, in its haste to protect the public health, the Court simply brushed over Jacobson’s individual claim that he had specific health reasons for wanting to avoid vaccination; thus, one commentator has remarked that Henning Jacobson himself “disappear[s]” from the case.

The emphasis on the “common good” in Jacobson contrasts sharply with the individual-focused slant of the autonomy cases, as does its deference to the legislature’s scientific findings regarding the safety and efficacy of vaccination. The Court agreed with the lower court’s decision to exclude Jacobson’s evidence, much of which was aimed at challenging the legislature’s findings regarding vaccination. The Court primarily relied on the well-established efficacy and salutary effects of vaccination to reject Jacobson’s attempt to shed doubt on the requirement, but it also noted that when there is doubt about a scientific issue, legislatures have the power to decide it: “We must assume that … the legislature of Massachusetts was not unaware of these opposing theories, and was compelled, of necessity, to choose between them. It was not compelled to commit a

law in Jacobson, but more social and less obviously health-related laws, such as laws pertaining to working conditions, began to be justified in the name of police powers. Wendy Parmet, From Slaughter-House to Lochner: The Rise and Fall of the Constitutionalization of Public Health, 40 AM. J. LEGAL HIST. 476 (1996); Wendy E. Parmet, Health Care and the Constitution: Public Health and the Role of the State in the Framing Era, 20 HASTINGS CONST. L.Q. 267 (1992).

91 Id. at 27. Lawrence Gostin has influentially suggested that Jacobson may be read not only as an affirmation of the police power but also as imposing limitations on that power, including requirements of necessity, reasonable means, proportionality and harm avoidance. See, e.g., GOSTIN, supra note __, at 67-69. The last requirement, harm avoidance, may be read into the notion that a health exception should be implied in the vaccination statute, see infra __. The remaining requirements are arguably on less firm doctrinal ground, but courts have nonetheless frequently applied them. See, e.g., Scott Burris, Rationality Review and the Politics of Public Health, 34 VILL. L. REV. 933, 937-38 & n.11, 966-67 (1989). At the same time, Jacobson has often been cited to demonstrate that the public interest may limit the scope of individual rights, rather than to demonstrate the limits on public health actions by governments. See, e.g., Washington v. Glucksberg, 521 U.S. 702, 742 (1997); Roe v. Wade, 410 U.S. 113, 154 (1973).

92 Jacobson, 197 U.S. at 27.

93 HYDE at 243.

94 Jacobson, 197 U.S. at 23-30.
A Tale of Two Doctrines

matter involving the public health and safety to the final decision of a court or jury.” Indeed, quoting at length and with approval from the New York state court’s opinion in Viemester v. White, the Court went so far as to say:

The fact that the belief [in the efficacy of vaccination] is not universal is not controlling, for there is scarcely any belief that is accepted by everyone. The possibility that the belief may be wrong, and that science may yet show it to be wrong, is not conclusive; for the legislature has the right to pass laws which, according to the common belief of the people, are adapted to prevent the spread of contagious disease. . . . for what the people believe is for the common welfare must be accepted as tending to promote the common welfare, whether it does in fact or not.

The legislature was thus entitled to deference, whether its conclusions turned out to be correct or incorrect.

Jacobson would provide a perfect template for the deference exhibited by the opinions in OCBC nearly one hundred years later, except for a surprising turn that Jacobson takes near the end of the majority opinion. After rejecting Jacobson’s claim for a health-based exemption to the vaccination requirement on the ground that, confusingly, he “did not offer to prove that, by reason of his then condition, he was in fact not a fit subject of vaccination,” the Court went on to assert that some individuals would be entitled to a sort of health exception. The Court stated, in dicta, that in an “extreme case[,]” such as an individual for whom vaccination would cause serious harm, the vaccination requirement should be waived.

---

95 Id. at 30.
96 Id. at 35 (quoting Viemester v. White, 72 N.E. 97); accord Duffield v. School Dist., 29A. 742, 743 (Pa. 1894).
97 Accord State v. Hay, 35 S.E. 459, 461 (N.C. 1900). But see Burris, supra note ___, at 961 (arguing that Jacobson’s apparent deference must be read in light of Court’s Lochner-era willingness to scrutinize laws carefully while claiming to apply rationality review and arguing that “the Court’s reliance on the People’s right to choose vaccination as a health measure actually had more to do with the overwhelming social consensus that vaccination was medically valuable than a view that the medical bona fides of a health action were irrelevant”).
98 Id. at 36. It appears the Court found Jacobson’s proffered evidence on this point inapposite, since it was possible that he had had an adverse reaction to vaccination as a child but was now an adult who was sufficiently healthy to be vaccinated. Id. at 37.
99 Id. at 38-39.
that the vaccination law would have to be construed as not intended to reach such cases, “or, if it was so intended,” the Court could act to “protect the health and life of the individual concerned . . . . [W]e are not inclined to hold that an adult must be vaccinated if it be apparent or can be shown with reasonable certainty that he is not at the time a fit subject of vaccination, or that vaccination, by reason of his then condition, would seriously impair his health, or probably cause his death.”

The Court thus added an important qualification to its apparent paean to the police power: it essentially implied, on both statutory and constitutional grounds, a limited health exception to the vaccination law. While the Court did not explain in detail the precise burden on a plaintiff seeking such an exception, it clearly opened the door to plaintiffs challenging the applicability of a vaccination law based on their own medical evidence. In this way, *Jacobson* resembles *Carhart* more than it appears at first glance.

The Supreme Court applied *Jacobson*’s hallmark deference to legislatures and emphasis on the police power to protect the public health in the decades after *Jacobson*, while ignoring *Jacobson*’s suggestion of an individual right to protect one’s own health. In *Buck v. Bell*, for example, the Supreme Court infamously rejected due process and equal protection challenges to a Virginia law permitting coerced sterilization of the mentally incompetent. Relying on “the general declarations of the Legislature and the specific findings of the [lower c]ourt” – the former included the finding “that experience has shown that heredity plays an important part in the transmission of insanity, imbecility, etc.” – the Supreme Court cited *Jacobson* for the proposition that “[t]he principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes.” The principle alluded to, of course, is that individuals’ interests may be subordinated to the government’s power to protect the public

---

100 Id. at 39.
101 Accord State v. Hay, 35 S.E. 459, 461 (N.C. 1900) (noting that a health exception to a vaccination law was required, although not provided for in the statutory language, and remanding criminal conviction for a determination whether the defendant was entitled to the benefit of that exception). Professor Michael Willrich, relatedly, points to the lawsuits challenging mandatory vaccination as some of the first and most important moments in which judges began to recognize claims of individual rights against police power in the context of the Progressive Era. Willrich, supra note __.
102 274 U.S. 200, 205-08 (1927).
103 Id. at 206-07.
health. While *Buck* may well be regarded as an irregularity in the fabric of constitutional law, it fits within the paradigm of the “public health” line of cases, characterized by deference to legislative findings of medical fact and its blindness to claims of individual autonomy in favor of the population view, which sees sick individuals primarily as threats to the public health. Of course, *Buck* was decided only fifteen years before *Skinner v. Oklahoma*, which struck down on equal protection grounds a sterilization law for criminals and which recognized procreation as a fundamental right, highlighting the schism in the Supreme Court’s jurisprudence between those cases viewed as “public health” cases and those viewed as “autonomy” cases.

Likewise, the Supreme Court decided two cases during Prohibition, *Everard’s Breweries v. Day* and *Lambert v. Yellowley*, that rejected challenges to the Volstead Act’s limited exemptions for medicinal use of alcohol. In *Everard’s*, a challenge to the exclusion of malt liquors from the Act’s allowance of alcohol for medicinal purposes, and *Lambert*, a challenge to the Act’s limitation on the amount of alcohol that could be prescribed, the Court again rejected substantive due process challenges to government intervention in medical treatment decisions, noting that while there was not a complete consensus of opinion on the topic, Congress had made a determination that malt liquor had no medicinal use and that it had implicitly determined that there was no legitimate need for prescriptions above the quantities permitted by law. Of course, the

---

105 See, e.g., Paul A. Lombardo, *Medicine, Eugenics, and the Supreme Court: From Coercive Sterilization to Reproductive Freedom*, 13 J. CONTEMP. HEALTH L. & POL’Y 1, 8 (1996) (describing *Buck* as “an anomaly” and noting that “[e]xcept in the context of vaccination for contagious disease, coercive court ordered medical procedures had not been endorsed by the Supreme Court prior to *Buck*”); Mariner, supra note __, at 586.
107 *Skinner* did not overrule but instead distinguished *Buck*. *Skinner*, 316 U.S. 539-41. But the Court was much less deferential toward the legislature’s factual findings regarding the medical appropriateness of sterilization for certain classes of individuals in *Skinner* than in *Buck*. Id.; see also Lombardo, supra note __, at 18-19.
108 265 U.S. 545 (1924).
Court could not rely on the power to protect public health in the Prohibition cases, because the Volstead Act was federal, and Congress possessed no general police power. That did not stop the Court from deferring to Congress’s determinations regarding the public health, however. The Court explained in \textit{Lambert} that Congress’s finding, “in the presence of the wellknown diverging opinions of physicians, cannot be regarded as arbitrary or without reasonable basis.”\footnote{Lambert, 272 U.S. at 595.} It is true that the Prohibition cases, unlike the abortion or medical marijuana cases, were decided in a context in which the legislature had reviewed extensive quantities of evidence on the relevant issue\footnote{But see \textit{id.} at 598-603 (Sutherland, J., dissenting) (arguing that the legislature had not reviewed evidence on the specific issue before the Court).} and in which the overwhelming majority of scientific evidence favored the legislature; it is therefore difficult to speculate what the Court might have decided in the absence of such evidence. Nonetheless, the Court’s rhetoric in those cases was decidedly deferential.\footnote{Cf. Minnesota ex rel. Whipple v. Martinson, 256 U.S. 41, 45 (1921) (“[T]here can be no question of the authority of the State in the exercise of its police power to regulate the administration, sale, prescription, and use of dangerous and habit-forming drugs. The right to exercise this power is so manifest in the interest of the public health and welfare, that it is unnecessary to enter upon a discussion of it beyond saying that it is too firmly established to be successfully called into question.”).}

The public health approach embodied by \textit{Buck}, the Prohibition cases, and, at least in part, \textit{Jacobson} is manifested in more modern cases concerning patients’ access to Laetrile, an unapproved drug claimed by some to be an effective treatment for cancer. In \textit{United States v. Rutherford}, the Supreme Court unanimously held that terminally ill cancer patients had no right to access Laetrile.\footnote{United States v. Rutherford, 442 U.S. 544, 552 (1979).} As in \textit{OCBC}, the Supreme Court decided the case on statutory grounds, construing the Food, Drug, and Cosmetic Act to reach Laetrile and to imply no exemption for terminally ill cancer patients; although the plaintiffs had raised constitutional issues as well, and although those issues were extensively briefed, the Court did not reach them because the court of appeals had not ruled on them.\footnote{Rutherford, 442 U.S. 559 n.18.} Nonetheless, the Court’s reasoning fit the public health model, as it paraded the horribles that might occur if Congress’s and the FDA’s police power were not upheld. The Court suggested that creating an exemption for
terminal patients would ultimately “deny the [FDA] Commissioner’s authority over all drugs, however toxic or ineffectual, for such individuals.”

The Court continued:

If history is any guide, this new market would not be long overlooked. Since the turn of the century, resourceful entrepreneurs have advertised a wide variety of purportedly simple and painless cures for cancer, including liniments of turpentine, mustard, oil, eggs, and ammonia; peat moss; arrangements of colored floodlamps; pastes made from glycerin and limburger cheese; mineral tablets; and “Fountain of Youth mixtures of spices, oil, and suet."

Such fears echo the Court’s historical solicitude for the legislature’s ability to freely exercise its police powers to protect the public health.

In both the Government’s Supreme Court brief and the subsequent Tenth Circuit decision on remand rejecting plaintiffs’ constitutional claims of a right to access Laetrile, the public health rationale was predominant. In its brief, the Government argued that to recognize a constitutional right to access “unproven or ineffective drugs” would fly in the face of the “centuries-old function of government” to “protect the public health and welfare,” and cited Jacobson for the proposition that the Court should defer to Congress’s determination that the FDA was empowered to find that Laetrile was not safe and effective. Similarly, when the Tenth Circuit considered the constitutional issues on remand, it drew a distinction between “the decision by the patient whether to have a treatment or not,” which according to the court was “a protected right,” and the patient’s “selection of a particular treatment, or at least a medication,” which was “within the area of governmental interest

---

115 Rutherford, 442 U.S. at 557-58.
116 Id. at 558.
117 Brief for the United States at 56-57.
118 Id. at 70-71. The Commissioner had initially made no such finding; the Government had argued at the beginning of the Rutherford litigation that Laetrile was a “new drug” under the FDCA that had not been found to be safe and effective, although the FDA initially had produced no record to support that finding. Rutherford v. United States, 542 F.2d 1137, 1143 (10th Cir. 1976). After the Tenth Circuit upheld the district court’s injunction in favor of the plaintiffs, the FDA held hearings and ultimately determined, again, that Laetrile was an unsafe and ineffective “new drug.” Rutherford, 442 U.S. at 549; Rutherford v. United States, 438 F. Supp. 1287, 1289-90 (W.D. Okla. 1977).
in protecting the public health.”

Bringing the point home further, the Ninth Circuit held in a similar case raising basically identical constitutional issues that “[c]onstitutional rights of privacy and personal liberty do not give individuals the right to obtain laetrile free of the lawful exercise of government police power”; thus the court applied only rational basis review and found that the prohibition on access to Laetrile bore a “reasonable relation to the legitimate state purpose of protecting public health.”

*Rutherford* was decided against the backdrop of another Supreme Court case touching briefly on, and cursorily dismissing, the plaintiffs’ right to make medical treatment choices. *Whalen v. Roe*, decided only a few years after *Roe v. Wade*, somewhat equivocally embodies the public health approach. In *Whalen*, physicians and patients challenged a New York statute requiring that physicians notify the state health department whenever they prescribed certain drugs having a high potential for abuse. The plaintiffs argued that the statute invaded their right to privacy, meaning both their right to informational privacy and their right to make certain important decisions independently – namely, “decisions about matters vital to the care of their health.”

While *Whalen* notably appeared to recognize, albeit in passing, the individual “right to decide independently, with the advice of [a] physician, to acquire and use needed medication,” it rejected the plaintiffs’ medical privacy claim on a police power-public health rationale. Relying on the state’s “broad police powers in regulating the administration of drugs by the health professions,” the Court stated in dicta that “the State no doubt could prohibit entirely the use of particular Schedule II drugs.”

Yet, *Whalen* remains a somewhat ambiguous precedent on this point: while affirming the state’s public health powers to regulate access to drugs, the Court also noted the state had not, in fact, limited the decision to prescribe or use those drugs; the case was therefore not a particularly strong one for the asserted constitutional right, and the Court’s statements regarding outlawing certain drugs were pure

---

119 *Rutherford v. United States*, 616 F.2d 455, 457 (10th Cir. 1980).
120 *Carnohan v. United States*, 616 F.2d 1120, 1122 (9th Cir. 1980).
122 *Whalen*, 429 U.S. at 592-93, 595.
123 *Whalen*, 429 U.S. at 600.
124 *Id.* at 603.
125 *Id.* at 603 & n.30.
What characterizes the public health line of cases, as distinct from the autonomy cases, is not so much that every individual asserting a right to access or avoid a certain medical treatment has lost, but rather that the courts have consistently declined to apply any form of heightened scrutiny to individual claims of a right to make medical treatment decisions without governmental interference. The public health line of cases emphasizes the police power of the legislature, treating its power and duty to protect the public health as fundamental. Individuals seeking access to medical treatment (or seeking to avoid medical treatment, in Jacobson and Buck) are seen not as autonomous beings seeking to protect their own bodies and to make important decisions without government interference, but as potential threats to the health of the body politic. The language of protecting the public health, moreover, is dominant even in those cases, such as the Prohibition cases and the Laetrile cases, in which an act of Congress is involved, and therefore no general police power, in a strict sense, may be invoked. Of course, as discussed further in Part III, there is no doubt that the concerns emphasized in the public health cases, such as the necessity of protecting the public from quacks, snake oil salesmen, and unsafe and untested drugs, are legitimate ones. But courts applying the public health approach have simply privileged such concerns over individual autonomy rights, rather than balancing them.

B. The Autonomy Cases

The right to bodily integrity is one of the oldest fundamental rights recognized by the law. Although it is arguably protected by the Fourth Amendment, Eighth Amendment, and even the

---

126 Id. at 603. Specifically, the Court stated, somewhat ambiguously, “Nor can it be said that any individual has been deprived of the right to decide independently, with the advice of his physician, to acquire and use needed medicine.” Id. It is thus unclear whether the Court recognized such a right but found that right had not been violated in the instant case, or whether the Court remained agnostic as to the existence of such a right.


129 U.S. CONST. amend. VIII.
common law, the notion of bodily integrity is perhaps most commonly associated with the Fourteenth Amendment and substantive due process, under which it is closely tied to the concept of personal autonomy. The origins of the right to bodily integrity may be traced to Union Pacific Railway Co. v. Botsford, in which the Court held that a plaintiff in a personal injury suit could not be ordered “to submit to a surgical examination as to the extent of the injury sued for.” Holding the judge to be without authority under the common law to require such an invasion, the Court famously stated, “No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.” Indeed, the Court even suggested this right “to be let alone” was not just a liberty interest to be balanced against governmental interests but a “complete immunity.” Moreover, the Court’s language from that early case indicates that the right not to suffer physical invasion or harm at the hands of the state is tied to the right of autonomy over one’s person – the “right to possession and control” of one’s person and the right “to be let alone.”

It is largely the bodily integrity right, combined with the right to make certain intimate and important decisions autonomously, that is front and center in the autonomy line of cases. Yet the autonomy cases, epitomized by the Supreme Court’s reproductive rights jurisprudence, originally viewed the right at stake as having as much to do with protecting one’s health and making medical treatment choices in consultation with a physician as with more abstract autonomy rights such as deciding whether to bear a child. In their present incarnation, the autonomy cases have come to stand for constitutional protection of certain dignitary and equality interests, but they retain traces of their commitment to individual medical autonomy as well.

Griswold is the first autonomy case dealing with a right to make

---

131 141 U.S. 250 (1891).
132 Id. at 251.
133 Id.
134 Id.
135 Id.
136 Thus, the autonomy cases ultimately gave rise to Lawrence v. Texas, 539 U.S. 558 (2003), which intertwines dignitary and equality concerns. See generally Tribe, supra note ___, at 1902-07.
medical treatment choices. Nevertheless, the case is known for its holding regarding the right to privacy, especially within the marital relationship, the case also involved what was clearly recognized to be a medical intervention, in which the executive director of the Planned Parenthood League of Connecticut and its medical director, a physician, “gave information, instruction, and medical advice to married persons as to the means of preventing conception. They examined the wife and prescribed the best contraceptive device or
material for her use.” Moreover, the Court noted early in the *Griswold* opinion that the Connecticut contraceptives law “operate[d] directly on an intimate relation of husband and wife and their physician’s role in one aspect of that relation.”

Perhaps more importantly, contraceptives were sometimes prescribed for health reasons, and although health concerns receive only passing mention in one of the concurrences to *Griswold*, the toll on some women’s health caused by pregnancy was one of the driving concerns behind the birth control movement. As Mary Dudziak recounts in her essay on birth control in Connecticut before *Griswold*, in the presence of a strict prohibition like Connecticut’s, some women were forced to choose between forgoing marital sex and suffering potentially life-threatening conditions during pregnancy.

The lack of a “medical exception” outraged Dr. Lee Buxton, one of the challengers of the statute in *Griswold*, who had witnessed the serious harms and even deaths that women suffered as a result of the law. The lack a medical exception was also the subject of extensive litigation over Connecticut’s birth control statute before *Griswold*. *Griswold* thus concerned the right to protect one’s health through medical treatment choices made autonomously and without government interference -- not only in the sense that it centered on the right of married persons to use some drugs or devices available primarily by prescription, but also in the sense that the right of some women to protect their health by avoiding pregnancy was at stake in a very real way.

In *Eisenstadt v. Baird*, the themes of individual bodily privacy and autonomy appeared more prominent, although the briefs and concurring opinions in that case evidence the continuing importance of more medical concerns. In *Eisenstadt*, the Supreme Court struck

---

139 Id. at 482 (emphasis added).
140 Id. at 503 (White, J., concurring) (noting that the statute “forbids all married persons the right to use birth-control devices, regardless of whether their use is dictated by considerations of family planning, health, or indeed even of life itself” (citations omitted)). See Mary L. Dudziak, *Just Say No: Birth Control in the Connecticut Supreme Court Before Griswold v. Connecticut*, 75 IOWA L. REV. 915, 921-27 (1990).
141 Dudziak, supra note __, at 918.
142 Id. at 921-27.
143 Id. at 932-35.
down Massachusetts’ statutory scheme regulating contraceptives, which provided that only married persons could obtain contraceptives for the purpose of preventing pregnancy, and only from registered physicians or pharmacists. Justice Brennan’s majority opinion famously emphasized “the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child,” setting the stage for subsequent vindication of the right to abortion as an aspect of the right to privacy.

Yet, significantly, Eisenstadt was argued by the state of Massachusetts as if it concerned only the public health power of the state to limit the distribution of contraceptives to physicians. Both Justice White, in his concurrence, and Chief Justice Burger, in dissent, focused on this aspect of the case. Justice Burger, in fact, felt that the entire case should be decided based on the state’s police power to regulate the distribution of medical drugs and devices for the protection of public health: “So far as I am aware,” he urged, “this Court has never before challenged the police power of a State to protect the public from the risks of possibly spurious and deleterious substances sold within its borders.” The majority, however, briskly dismissed the view that the Massachusetts law was a health measure, sidestepping altogether the question whether distribution of contraceptives could be limited to physicians and instead focusing on the unequal treatment of married and unmarried persons.

Justice White also viewed the law as a public health measure; he merely disagreed with Chief Justice Burger as to the scrutiny to which the health measure should be subjected and the amount of evidence the government was required to present in order to show the reasonableness of its restriction. Justice White argued that the Court’s

---

145 Eisenstadt v. Baird, 405 U.S. 438, 442 (1972). Under the Massachusetts law, anyone—married or single—could obtain contraceptives from anyone—not just from doctors or pharmacists—for the purpose of preventing the spread of disease. Id.


149 Baird, 405 U.S. at 469 (Burger, C.J., dissenting).

150 Id. at 452 (“We conclude, accordingly, that, despite the statute’s superficial earmarks as a health measure, health, on the face of the statute, may no more reasonably be regarded as its purpose than the deterrence of premarital sexual relations.”). David Garrow notes that the strategy of the ACLU, which filed an amicus brief on behalf of Baird, was to keep the focus on the privacy issue. GARROW, supra note __, at 517-18.
“general reluctance to question a State’s judgment on matters of public health must give way where, as here, the restriction at issue burdens the constitutional rights of married persons to use contraceptives.”\[151\] Therefore, he argued that the state should have to present “proof of the probable hazards of using” those items widely available elsewhere without a prescription.\[152\] Chief Justice Burger found that suggestion outrageous, complaining that it put the state “to an unprecedented test: either the record must contain evidence supporting the classification or the health hazards of the particular contraceptive must be judicially noticeable.”\[153\] In his view, whether medical authorities agreed or disagreed about the safety of a particular contraceptive, it was “inappropriate for th[e] Court to overrule a legislative classification.”\[154\] The disagreement between Justice White and Chief Justice Burger in Eisenstadt thus foreshadows the later dispute in Carhart between the majority, which required the state to produce some medical evidence to support its findings, and the dissents, which insisted on the state’s power to make factual judgments, like the majority in OCBC, which relied unquestioningly on the legislative classification of cannabis.\[155\]

Roe v. Wade and its companion case Doe v. Bolton, as they evolved from the Griswold and Eisenstadt precedents, were ultimately decided primarily on a privacy rationale, although traces remained of concerns about the woman’s entitlement to protect her health and to make medical treatment choices independent of state interference and with a doctor’s advice.\[156\] This latter perspective emerges most clearly

\[151\] Id. at 463-64 (White, J., concurring).
\[152\] Id. at 464.
\[153\] Id. at 469 (Burger, C.J., dissenting).
\[154\] Id. at 470.
\[155\] In addition, the end of Chief Justice Burger’s opinion prophetically raises the specter of the laetrile cases of the 1970s and 1980s. See id. at 472 (“I am constrained to suggest that if the Constitution can be strained to invalidate the Massachusetts statute underlying appellee’s conviction, we could quite as well employ it for the protection of a ‘curbstone quack,’ reminiscent of the ‘medicine man’ of times past, who attracted a crowd of the curious with a soapbox lecture and then plied them with ‘free samples’ of some unproved remedy. Massachusetts presumably outlawed such activities long ago, but today’s holding seems to invite their return.”).
\[156\] See, e.g., Roe, 410 U.S. at 153 (cataloguing the physical and psychological harms that may result from carrying a pregnancy to term); id. at 164 (holding that in the first trimester, “the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman’s attending physician”); Doe v. Bolton, 410 U.S. 179, 198 (1973) (mentioning the “woman’s right to receive medical care in accordance with her licensed physician’s best judgment and the physician’s right to
in Justice Douglas’s concurrence; he viewed the decision as being at least partly about the constitutional right “to care for one’s body and health,” or the “right to seek advice on one’s health and the right to place reliance on the physician of one’s choice;” he viewed the abortion issue as “a medical one.” And indeed, that was precisely the theory with which the plaintiffs began the substantive portion of their briefs – citing, and distinguishing, Jacobson v. Massachusetts first and foremost.  

The fact that the right to make medical treatment choices, while not dominant in the majority opinion, nonetheless still lurked in Roe and Doe may explain as well why the court instituted, without much commentary, the health exception requirement. In Roe v. Wade, the Court held that after viability, the State may regulate or proscribe abortion altogether, except when it is necessary to preserve the life or health of the mother. Roe did not explain that holding, beyond saying that the state’s interest in the fetus becomes compelling at the point of viability; Thornburgh later elaborated that the state may not constitutionally force a woman to sacrifice her health for that of the fetus, whether viable or not. Neither Roe nor Thornburgh – nor, for that matter, Casey, which reaffirmed this aspect of Roe’s holding wholesale, while modifying many other aspects of abortion jurisprudence – explicitly stated that the right to protect one’s health is a constitutionally protected right. But the existence of such a constitutional right – and one that is in fact sufficiently robust to withstand the state’s otherwise compelling interest in the viable fetus – is the inescapable implication of Roe and its progeny, up to and

158 Brief for Appellants, Roe v. Wade, 1971 WL 128054, at *94-98 (arguing that “the right to seek medical care for the protection of health and well-being is a fundamental personal liberty recognized by decisions of this Court” and that Jacobson permitted interference with that right only in the face of a compelling state interest); see also Hunter, supra note __, at 171-72.
159 Roe, 410 U.S. at 163-64.
including *Stenberg v. Carhart*.

In *Planned Parenthood v. Casey*, the decisional autonomy rationale seemed paramount.\(^{160}\) As the joint opinion explained in that case,

> Our law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education. . . . At the heart of liberty is the right to define one’s own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.\(^{161}\)

The joint opinion further noted that the abortion right draws upon both the right to personal autonomy and the right of bodily integrity embodied in the Fourteenth Amendment: “*Roe* stands at an intersection of two lines of decisions . . . . *Roe* ... may be seen not only as an exemplar of *Griswold* liberty but as a rule … of personal autonomy and bodily integrity, with doctrinal affinity to cases recognizing limits on governmental power to mandate medical treatment or to bar its rejection.”\(^{162}\) By the time the Court decided *Casey*, the right at issue had thus taken on the distinct cast of an autonomy right. It invoked the right of autonomy over one’s own body as well as of autonomy in making certain important decisions.

This autonomy rationale remained dominant in *Washington v. Glucksberg*, in which the Court appeared to recognize at least a limited right to make medical treatment decisions.\(^{163}\) In *Glucksberg*, the Supreme Court refused to recognize a fundamental “right to commit suicide which itself includes a right to assistance in doing so.”\(^{164}\) In other words, the Supreme Court, which had previously suggested the existence of a right of competent persons to refuse even life-saving medical treatment,\(^{165}\) declined to extend the scope of that right to

---


\(^{161}\) Planned Parenthood v. Casey, 505 U.S. 833, 851 (1992) (plurality op.).

\(^{162}\) Id. at 857 (plurality op.) (citations omitted); Shepherd, supra note __, at 280.

\(^{163}\) 521 U.S. 702 (1997).


\(^{165}\) Id. at 725; Michael P. Allen, The Constitution at the Threshold of Life and Death: A Suggested Approach to Accommodate an Interest in Life and a Right to Die, 53 Am. U. L. Rev. 971, 986 (2004) (noting that the Supreme Court “has been less than
choosing medical treatment in the form of obtaining a prescription from one’s physician of a drug that will hasten death. Yet, Chief Justice Rehnquist’s majority opinion on that point was tempered somewhat by the other opinions in the case – especially Justice O’Connor’s concurrence, which provided the necessary fifth vote for Chief Justice Rehnquist’s majority opinion, and which equivocally stated that, while she agreed that the Constitution did not protect a right to suicide and therefore to assistance in committing suicide, she did not need to reach the “narrower question whether a mentally competent person who is experiencing great suffering has a constitutionally cognizable interest in controlling the circumstances of his or her imminent death,” because the state’s interests were sufficiently strong in the instant case to overcome any such right. In addition, several commentators have pointed out that five Justices in Glucksberg suggested that they would recognize a right to obtain medication from one’s physician in a quantity sufficient to alleviate physical suffering, even if it would hasten the patient’s death.

Glucksberg therefore constitutes somewhat uncertain precedent, but at a minimum it may be said that it appears to recognize both a fundamental right to choose to refuse certain medical treatment and a right to receive certain medical treatment in consultation with crystal clear” in its pronouncements on the right to refuse life-saving medical treatment, but that the Court most likely would accept the existence of such a fundamental right).

166 Glucksberg, 521 U.S. at 720-22 (citing Cruzan v. Director, Mo. Dept. of Health, 497 U.S. 261 (1990)); 753 (Souter, J., concurring) (noting that plaintiffs sought to obtain “medications . . . to be self-administered for the purpose of hastening death” (citing Complaint ¶ 2.3) (omissions in original)).

167 Id. at 736-37 (O’Connor, J., concurring).

168 See, e.g., Yale Kamisar, On the Meaning and Impact of the Physician-Assisted Suicide Cases, 82 MINN. L. REV. 895, 908 (1998). This view is based on the fact that Justice O’Connor’s concurrence, which was joined by Justices Ginsburg and Breyer, noted that the plaintiffs in the Glucksberg case had access under state law to obtain sufficient palliative care, and therefore that the Court did not need to decide whether patients had a right to the relief from suffering by receiving sufficient palliative care, even if that palliation might hasten death. Glucksberg, 521 U.S. at 736-38 (O’Connor, J., concurring). Justices Stevens, Breyer, and Souter, concurring separately, offered similar or even more expansive views of that purported constitutional right. Id. at 745 (Stevens, J., concurring); 779-82 (Souter, J., concurring); id. at 791-92 (Breyer, J., concurring). But see Norman L. Cantor, On Kamisar, Killing, and the Future of Physician-Assisted Death, 102 MICH. L. REV. 1793, 1835 (2004) (arguing that “[t]he legal status of terminal sedation is still unclear” (citing Norman L. Cantor & George C. Thomas III, The Legal Bounds of Physician Conduct Hastening Death, 48 BUFF. L. REV. 83, 142-50 (2000))).
one’s physician – namely, aggressive palliative care. Those rights are clearly viewed by the Justices in Glucksberg as autonomy rights deriving from the line of cases reaching back at least to Griswold, as is evident from Chief Justice Rehnquist’s framing of the issue in Cruzan and Glucksberg. In Glucksberg, Chief Justice Rehnquist noted that the issue was whether the right to physician-assisted suicide was within the “liberty” protected by the Due Process Clause of the Fourteenth Amendment.¹⁶⁹

The autonomy line of cases thus begins with the right to protect one’s health by making autonomous medical treatment decisions. By the time of Casey and Glucksberg, the interest in making medical treatment choices merges with other autonomy interests into a vaguer and broader autonomy right of bodily integrity and decisional independence. All of the autonomy cases grant some form of heightened scrutiny to claims of infringement on the right to choose appropriate medical treatment, whether it be in the form of a virtual per se rule that government may not interfere with a woman’s right to protect her health by choosing abortion, as in Roe, or in the form of some sort of careful balancing of interests, which the Court in Glucksberg suggested would be required for any law interfering with a seriously ill patient’s access to palliative care. Carhart, with its broad recognition of a woman’s right to choose the safest method of abortion, grows directly out of this line of cases.

C. A Right to Make Medical Treatment Choices?

Although the cases just discussed may be divided into two relatively neat categories, one of my principal contentions is that they all deal with essentially the same problem – the constitutional right of individuals to make medical treatment choices – and that the categories are not helpful to understanding or operationalizing this right. In other words, the different approaches are not doctrinally justified, since the cases all pose fundamentally the same question. There are, of course, additional interests that may weigh in favor of

¹⁶⁹ Glucksberg, 521 U.S. at 723. Acknowledging that Cruzan had viewed the right to refuse unwanted life-saving treatment as just such a “liberty interest,” he then noted that while the right to end one’s life may be “just as personal and profound as the decision to refuse unwanted medical treatment,” it is not similarly protected; although “many of the rights and liberties protected by the Due Process Clause sound in personal autonomy,” that did not mean “that any and all important, intimate, and personal decisions are so protected.” Id. at 725-27.
one party or another in various cases – for instance, some cases also
invoke the right to reproductive autonomy, whereas other cases
involve a governmental interest in protecting against an untested and
potentially harmful medical treatment – but this does not make the
cases so different that they cannot all be analyzed in similar terms.

In this section, I demonstrate the fundamental similarity of the
two kinds of cases by exploring how lower courts have dealt with
analogous cases. Lower courts have evinced tremendous confusion in
analyzing cases touching on the right to make medical treatment
choices, sometimes embracing an autonomy approach, sometimes
following a public health approach, and sometimes embodying both
approaches among the majority and dissenting opinions within a single
case. This fluidity, combined with the occasional overlap of public
health and autonomy concerns within the Supreme Court cases
themselves,\(^\text{170}\) demonstrates that either analytic approach is plausible,
given the existing precedent, and that there is no clear line demarcating
public health cases from autonomy cases. In the next Part, I consider
and reject some possible doctrinal explanations for the differing
approaches and results in the two lines of cases.

Some lower courts, faced squarely with the issue, have inferred
a right to make medical treatment choices in the face of government
attempts to forbid certain alternatives. In *Andrews v. Ballard*,\(^\text{171}\) the
U.S. District Court for the Southern District of Texas struck down a
state regulation forbidding the practice of acupuncture by non-
physicians.\(^\text{172}\) Relying on the right to privacy established by *Griswold, Roe,*
and their progeny, the court in *Andrews* held that the “decision to
obtain or reject medical treatment, presented in the instant case as the
decision to obtain acupuncture treatment,” was a fundamental right
and that infringements of that right were subject to strict scrutiny.\(^\text{173}\)
Moreover, the court rejected the legislature’s finding that acupuncture
was “experimental” and that its safety and effectiveness had not been
established, looking instead to the plaintiffs’ evidence on the safety
and efficacy of the procedure. Since the case was decided before
*Casey* and *Carhart* and while the laetrile cases were still being
litigated, it did not rely on those cases. Instead, the court found that the
right to choose a particular medical treatment was both sufficiently
personal and important to warrant constitutional protection under

\(^{170}\) *See supra* TAN ___.


\(^{172}\) *Id.* at 1057.

\(^{173}\) *Id.* at 1048.
More recently, the D.C. Circuit surprised many commentators when it decided that terminally ill patients had a substantive due process right to access experimental cancer drugs that had passed an initial phase of FDA review but were not yet approved by the agency. In Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach, the court held that Cruzan and Glucksberg led to the inference that terminally ill patients had a fundamental constitutional right, when “acting on a doctor’s advice, to obtain potentially life-saving medication when no alternative treatment approved by the government” was available. The majority opinion relied on the relatively recent role of the FDA in regulating access to medical treatment, the substantial and continuing tradition of “off-label” use of drugs, and the importance and long persistence of the right to bodily integrity to decide that the Due Process Clause protected a right of self-preservation through prohibiting interference by the government with individuals’ access to potentially life-saving drugs.

---

174 Id. at 1046-51 (citing Carey v. Population Services International, 431 U.S. 678 (1977)). The court also recognized, however, that it would be permissible for the state to regulate the practice of acupuncture, including by requiring diagnosis or referral by a licensed physician. The court thus did not recognize an unqualified right of patients to receive the treatment of their choice. Cf. Mitchell v. Clayton, 995 F.2d 772 (7th Cir. 1993) (rejecting patients’ claim of a constitutional right to receive acupuncture treatment from a non-physician); Sammon v. New Jersey Bd. of Med. Examiners, 66 F.3d 639, 647 (3d Cir. 1995) (asserting individuals have “no constitutional right to their choice of a health care provider [a midwife] who does not meet quality control standards that a legislator might reasonably conceive to be desirable”).

175 See, e.g., Groopman, supra note __, at 42 (noting that the opinion “shocked legal scholars and officials at the F.D.A.”).


177 Id. at 478.


179 Abigail Alliance, 445 F.3d at 480-86. The court distinguished the medical marijuana cases on the ground that the Supreme Court had never decided the substantive due process issues raised in OCBC and Raich, id. at 478 n.9, and it distinguished the laetrile cases on the ground that those cases involved “the governmental interest in protecting public health” and that no evidence showed marijuana to be safe, as the cancer drugs here were initially determined to be, id. at 486.
The dissent took the majority to task not only for recognizing an apparently new constitutional right but also for invading the “historical province of the democratic branches” by “[b]alancing the risks and benefits found at the forefront of uncertain science and medicine.”

Thus, the dissent complained, “[n]either the Constitution nor Congress has authorized this Court to determine which of these two litigants has a more scientifically sound and medically sound view.” The dissent suggested, moreover, that the majority opinion would open the door to access to medical marijuana, among other unapproved treatments.

These two cases apparently find a constitutional right to make medical treatment choices growing out of the Supreme Court’s autonomy line of cases. Another, quite substantial, line of lower court precedent has rejected any intimation of a constitutional right to choose appropriate medical treatment, however. In direct contrast to the D.C. Circuit in Abigail Alliance, for example, the District Court for the District of Columbia had earlier held, relying on the laetrile cases, Rutherford and Carnohan, that an individual suffering from Hodgkin’s lymphoma had no right to treatment with Antineoplastons, an experimental drug treatment available only through FDA-approved clinical trials.

Similarly, United States v. Kuromiya, decided shortly before OCB, the District Court for the Eastern District of Pennsylvania rejected the substantive due process claims of individuals seeking to use marijuana for medicinal purposes for a variety of illnesses. Citing a number of public health cases holding that no constitutional right was implicated by state health regulations, the court in Kuromiya determined that rational basis review would

---

180 Id. at 486-87 (Griffith, J., dissenting).
181 Id. at 491.
182 Id. at 499.
183 Cf. United States v. Freund, 290 F. 411 (1923) (holding, before Everard’s and Lambert were decided, that it was unconstitutional for Congress to override a physician’s judgment regarding the maximum amount of alcohol to be prescribed per day). The Freund court argued that such restrictions violate the “lawful property and personal right of physicians to prescribe alcohol for remedial purposes, and of ailing people to receive it,” and that “[i]t is an extravagant and unreasonable attempt to subordinate the judgment of the attending physician to that of Congress, in respect to matters with which the former alone is competent to deal.” Id. at 413-14.
apply to the plaintiffs’ claims, stating, “there is no fundamental right of privacy to select one’s medical treatment without regard to criminal laws.” The court further found that the “ongoing dispute regarding the safety and usefulness of marijuana” meant, in the context of rationality review, that the prohibitions of the federal CSA must be upheld; the existence of conflicting evidence was sufficient to require the court to uphold the prohibition – whereas in Carhart it was sufficient to require the Court to strike it down – and to do so without even permitting the plaintiffs to introduce expert evidence of their own.

In other cases, courts have rejected, over a strong dissent, plaintiffs’ claim of a right to access a particular medical treatment, and the majority and dissenting opinions can be read as embodying, respectively, the public health and autonomy approaches to the issue. Thus, the majority in Seeley v. State embraced the public health approach in holding that rational basis would apply to a terminally ill cancer patient’s claim of a fundamental right to use marijuana, noting that complex medical issues were involved and that, in light of the apparent disagreement over the effectiveness of marijuana, it would decline, despite copious expert evidence presented by both sides, to “interfere with the broad judicially recognized prerogative of the legislature.” In addition, the court asserted, “the determination of whether new evidence regarding marijuana’s potential medical use should result in the reclassification of marijuana is a matter for legislative or administrative, not judicial, judgment.”

The dissent, by contrast, viewed the case as one in the line of autonomy cases such as Roe and Casey. The dissent focused on the body of the individual, not the body politic, noting for example that “[t]here is little relation between the ingestion of marijuana by Mr. Seeley and the specter of drug abuse by others.” The dissent thus believed that the majority

186 Id. at 726.
187 Id. at 727. The court also stated that it did “not wish to minimize the suffering that the plaintiffs have experienced or the degree to which the threat of criminal sanctions may have exacerbated their conditions,” but that “[w]here reasonable people may differ, the court is bound to defer to the will of the legislature.” Id. at 731.
189 Id. at 618.
190 Id. at 618-19.
191 Id. at 626 (Sanders, J., dissenting) (“I find the analysis in Casey as well as its antecedent, Roe v. Wade, wholly dispositive in Mr. Seeley’s favor.” (citation omitted)).
192 Id. at 823.
should focus on the sufferings and the bodily integrity of the individual, instead of the alleged consequences to society of legalizing marijuana in some circumstances.\textsuperscript{193}

A similar pattern is apparent in \textit{People v. Privitera}, in which the California Supreme Court, writing prior to the Supreme Court and subsequent Tenth Circuit decisions in \textit{Rutherford}, rejected the notion of a constitutional right to access laetrile.\textsuperscript{194} Emphasizing the state’s police powers and the legislative findings that laetrile was ineffective and harmful, the court held that it would not “take sides” in the medical debate, allowing that “[l]aetrile advocates may yet be vindicated in the court of scientific opinion,” but that its only task was to determine whether there was a rational basis for the legislation aimed at protecting the “health and safety” of California citizens.\textsuperscript{195} The impassioned dissent by then-Chief Justice Bird, by contrast, viewed the existence of conflicting scientific evidence to weigh in the opposite direction: “So long as there is no clear evidence that [L]aetrile is unsafe to the user,” she stated, “I believe each individual patient has a right to obtain the substance from a licensed physician who feels it appropriate to prescribe it to him.”\textsuperscript{196} The dissent drew upon \textit{Griswold}, \textit{Roe}, and \textit{Doe}, among others, to argue that the Supreme Court has recognized an individual right to receive medical treatment, along with the physician’s central role in the exercise of that right.\textsuperscript{197} Chief Justice Bird also emphasized the suffering of the individual patients over the needs of the broader polity: “To these nineteen cancer victims, the enforcement of [the California law], the denial to them of medical treatment … must surely take on a Kafkaesque, a nightmare quality. No demonstrated public danger, no compelling interest of the state, warrants an Orwellian intrusion into the most private of zones of privacy.”\textsuperscript{198}

The same conflict between the public health and autonomy approaches is thus played out again and again, sometimes between

---

\textsuperscript{193} See also id. at 624 (criticizing the State’s taking a “larger focus” on the citizenry at large, which must be protected from drug abuse and the unknown effects of marijuana).

\textsuperscript{194} 23 Cal. 3d 697 (1979).

\textsuperscript{195} Id. at 708-09.

\textsuperscript{196} Id. at 711 (Bird, C.J., dissenting).

\textsuperscript{197} Id. at 719-24. This Article, too, argues that the physician’s role is central to the exercise of the plaintiff’s right. As such, the cases holding that there is no right of access to a drug or treatment per se (with or without a physician’s involvement), which are often cited by courts taking the public health approach, are inapposite.

\textsuperscript{198} Id. at 740.
cases that reach conflicting results on the same issue, and sometimes between the majority and dissent in a single case. In the public health approach, judges focus on the citizenry at large, the legislature’s role in protecting the health and safety of the public as a whole, and the deference due to the legislature in carrying out that task. In the autonomy approach, judges focus on the suffering individual and the state-mandated harm to the individual’s body, often refusing to defer blindly to legislative findings of medical fact in the face of ailing individuals’ evidence to the contrary.\footnote{\textsuperscript{199}}

Perhaps one of the most eloquent articulations of this conflict is contained in Justice Stevens’s dissent in \textit{Cruzan v. Director, Missouri Department of Health}, the “right-to-die” case. Taking the autonomy approach, Justice Stevens bemoans the fact that the Court “permits the State’s abstract, undifferentiated interest in the preservation of life to overwhelm the best interests of Nancy Cruzan.”\footnote{\textsuperscript{200}} But, he insists, “the idea of life is not conceived separately from the idea of a living person. Yet it is precisely by such a separation that Missouri asserts an interest in Nancy Cruzan’s life in opposition to Nancy Cruzan’s interests.”\footnote{\textsuperscript{201}} In other words, Justice Stevens criticized the Court’s and the state’s emphasis on the “big picture,” the government’s power and duty to protect public health and life in a broad, general, and abstract sense, which comes at a profound cost to the individual’s interests in her own health or life.\footnote{\textsuperscript{202}} This is precisely the drama that is repeated throughout the cases that alternatingly take the autonomy and public health

\textsuperscript{199} On occasion, as in \textit{Rutherford} and \textit{Carnohan}, courts distinguish between an established constitutional right to receive treatment and a nonexistent constitutional right to a particular treatment. Yet it is difficult to perceive such a distinction in the case law – the abortion cases, for example, draw no such distinction – and it is difficult to see how such a distinction can be clearly made in reality. If the only treatment legally available is ineffective for the particular individual, for instance, can it really be said that the individual’s right to medical treatment has been vindicated?

\textsuperscript{200} \textit{Cruzan v. Director, Missouri Dep’t of Health}, 497 U.S. 261, 331 (1990) (Stevens, J., dissenting)

\textsuperscript{201} \textit{Id.} at 347.

\textsuperscript{202} Michael Allen refers to this distinction as the (state’s) “comprehensive interest” in human life, as opposed to the individual’s “focused interest.” Allen, \textit{supra} note \textsuperscript{200}, at 989-90; \textit{see also} Wendy Parmet, \textit{Health Care}, at 270 (noting that constitutional cases dealing with health care all “question the relationship between the body politic and the individuals who are facing the reality of physical vulnerability and, ultimately, biological mortality”).
approaches to the right to make medical treatment choices. 203

III. HEALING THE BODY OF DOCTRINE

A. Some Non-Explanations

What, then, explains the different approaches taken by the Supreme Court regarding the right to make autonomous medical treatment decisions? Can it really be the case, for example, that a pregnant woman has a greater right to protect her health than a cancer patient? Before attempting to describe what accounts for this difference, it will prove helpful first to set out several doctrinal explanations that have some surface appeal but that ultimately fail to meaningfully differentiate the autonomy cases from the public health cases. I ultimately conclude that the Supreme Court has largely decided whether to apply deference or heightened scrutiny in a given case without any logical consistency, perhaps based largely on superficial determinations about what “category” the case falls into.

The first and most obvious possibility is that in the autonomy cases, a fundamental or quasi-fundamental constitutional right is involved, whereas no such right is involved in the public health cases; indeed, some of the latter cases even arise in the context of criminal activity, such as the use of marijuana. On closer examination, however, this argument proves incorrect, if not question-begging. The very issue in each of these cases is whether the individual has a right to access a particular medical treatment without government intervention. Although the constitutional right to individual autonomy in the form of avoiding unwanted motherhood certainly figures in the abortion and contraception cases, it is possible to separate that general right from the right that motivated the Court in Roe and, most recently, in Carhart, to hold that a health exception is required whenever the state regulates abortion, pre-viability or post-viability, and that a woman has the near-absolute right to choose the safest method of abortion for her. As Eugene Volokh has recently explained, the abortion right “actually

203 Professor Gillian Metzger has recently pointed out that abortion regulation is increasingly taking the form of administrative health regulations, often specifically targeting abortion providers and excluding providers of medically similar health care services. She asserts that framing abortion regulations as health regulations makes them look more like the sort of economic or social legislation that receives only rational basis review. Gillian Metzger, Abortion, Equality, and Administrative Regulation, 56 EMORY L.J. (forthcoming 2007). In other words, such regulations tend to be analyzed under the public health model rather than the autonomy model.
A Tale of Two Doctrines

consists of two different rights” – a “right to abortion as reproductive choice” and “a right to medical self-defense,” which he defines as “the right to protect your life using medical care, even when this requires destroying that which is threatening your life.”

Thus, as discussed above, the right at stake in Carhart is very different from the right to reproductive choice. As explicated in Planned Parenthood v. Casey, the right to choose an abortion is most commonly understood a right to be free from government intrusion into certain personal “decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education.”

When the state consigns a woman to carry an unwanted pregnancy to term, it subjects her not only “to anxieties, to physical constraints, to pain that only she must bear,” but also to limitations on her ability to participate fully in society and potentially to emotional anguish as well as a long-term, if not lifelong, emotional, moral, and financial ties and responsibilities.

Carhart, however, is not about the right to choose an abortion, but rather the method by which the abortion will be performed. Thus, it is no answer to say that in one case a constitutional right is involved and in another no such right is involved. The abortion cases present the same issue as the public health cases: whether individuals has the right, in consultation with a physician, to protect their health and to make medical treatment choices without unwarranted government interferences.

A second and related possibility is that the autonomy cases, particularly the contraception and abortion cases that comprise the bulk of them, are not concerned with the right to protect one’s health per se, but with the unconstitutionality of requiring only women to risk their health, in circumstances where people are generally not required to do so. Susan Frelich Appleton has observed that “the law never asks the parent of a child to provide, for example, a kidney or bone marrow for transplantation even if the child would die without the donation, because even recognized duties to rescue steer clear of such physical invasions and risks”; it is thus a devaluation of women and a denial of their equality to require them to bear the considerable physical strain

---

204 Eugene Volokh, Medical Self-Defense, Prohibited Experimental Therapies, and Payment for Organs, 120 HARV. L. REV. (forthcoming 2007). Volokh also notes that a woman possesses this right even when her health and not her life is at stake.

205 Planned Parenthood v. Casey, 505 U.S. 833, 851 (1992); see Cruz, supra note __, at 313-14 (describing Casey as offering “a better explication of [the abortion] right’s constitutional foundation”).

206 Casey, 505 U.S. at 852-53.
and risk of even a normal pregnancy solely for the sake of the fetus.\textsuperscript{207} Nor, by extension, would it be constitutional to require women to undergo a riskier method of abortion when, in general, individuals are not so constrained in their medical choices.

Undoubtedly much of the Supreme Court’s privacy jurisprudence can be illuminated by this perspective. But I maintain that the wide-angle view I take in this Article demonstrates precisely why it is not a sufficient explanation. Placing the abortion and contraception cases in a broader context demonstrates that the government can and does limit individuals’ medical treatment choices in a variety of contexts, even when the individual, her physician, and some considerable portion of the medical community believe that the prohibited treatment is the safest and most effective for the patient.\textsuperscript{208} In other words, the courts have upheld regulations on medical treatment, applying equally to both sexes, that are arguably at least as restrictive and harmful as bans on particular abortion methods. Thus, when courts strike down restrictions on abortion methods, one might even argue that women have, in the abortion context, a greater right to protect their health than the population at large: reproductive rights jurisprudence, rather than alleviating a state-imposed burden on women, instead provides women with a benefit that others are generally lacking when it comes to protecting their health. Conversely, although many of the autonomy cases are abortion or contraception cases, challenging restrictions on medical practice that affect only women, not all of those cases are abortion or contraception cases. The implication of the Justices in \textit{Glucksberg} and the holding of the D.C. Circuit in \textit{Abigail Alliance} apply to state regulations on medical treatment that burden both sexes equally. Again, the courts are not necessarily concerned exclusively, or primarily, with regulations that burden only one sex.

A third attempt to distinguish the two kinds of cases might be to focus on the government interests involved. Indeed, the term “public health law” traditionally implies a limitation on individual freedom in order to promote the public good (usually the health and welfare of

\textsuperscript{207} Susan Frelich Appleton, \textit{Unraveling the “Seamless Garment”: Loose Threads in Pro-Life Progressivism}, 2 UNIV. OF ST. THOMAS L.J. 294, 299-300 (2005). I am indebted to Professor Appleton for bringing this line of argument to my attention.

\textsuperscript{208} Moreover, the notion of enforced female-only Good Samaritanism has less apparent application when the issue is the choice of abortion techniques, not whether or not an abortion can be obtained at all.
The public health cases fit that definition nicely, emphasizing the government’s need to act in the interest of the public health and safety over the individual’s interests. Thus, one might argue that the public health line of cases involves threat to the health of others, and therefore the public good, in a way that the autonomy cases generally do not.

Admittedly, the government’s interest in combating the scourge of illegal drug use, for example, along with the violence, crime, and public health problems it entails, is powerful. The state interest in protecting the public from quacks and from dangerous or ineffective medical treatments seems no less compelling. Yet the interests cited by the state of Nebraska in attempting to ban D&X were also considerable by any measure: these included “preventing cruelty to partially-born children and ‘unacceptable disrespect for potential human life,’” “preserving the integrity of the medical profession” and “‘erecting a barrier to infanticide.’” Whether this last set of interests may be categorized as affecting the “public good,” in the traditional public-health sense of the term, is perhaps a philosophical question beyond the scope of this Article; but it seems, at least from a constitutional perspective, that the state interests articulated in autonomy cases such as Carhart are no less important than the public health interests that lie behind the laetrile and medical marijuana cases.
But a further, and perhaps more complete, response is to point out that there is nothing in any of the Supreme Court’s language to suggest that its decisions hinged on the merits of the asserted governmental interests.\textsuperscript{213} The majority in \textit{Carhart} did not even mention the asserted state interests in its analysis of the health exception requirement. It never suggested it was engaging in any sort of balancing of government interests; rather, it categorically held that in the face of a judicial finding that the procedure may avoid certain health risks, or at least a division of opinion over whether this is so, “the law requires a health exception.”\textsuperscript{214} Likewise, those courts that considered whether individuals have a right to access marijuana for medicinal purposes categorically rejected the existence of such a right and did not engage in balancing of the government’s interest in controlling illegal drug use against the individual’s autonomy interest.\textsuperscript{215} Only \textit{Glucksberg} and \textit{Abigail Alliance} can be read to call for such balancing;\textsuperscript{216} and in fact, a genuine balancing of interests, rather than a short-circuiting of the analysis through deference, is precisely what I argue is needed in these cases.

Perhaps, then, a fourth distinction might be drawn: one might point to the differing degrees of scientific support for one medical intervention over another. Courts may be more inclined to find a right to access a medical treatment when there is substantial evidence supporting that treatment and to reject the claims of constitutional right when the medical support for the treatment is weak. After all, many of the public health cases involved challenges to very well-supported medical judgments by the government: there was little evidence

\textsuperscript{213} \textit{But see Meyer, supra} note \underline{___}, at 1171-72 (arguing that the Court’s opinion in \textit{Carhart} “must rest upon a[n] . . . unstated judgment about the relative weight of the competing interests”).

\textsuperscript{214} \textit{Carhart}, 530 U.S. at 937.


\textsuperscript{216} \textit{See especially} \textit{Abigail Alliance for Better Access to Developmental Drugs v. Von Eschenbach}, ---F.3d----, 2006 WL 3359334 (D.C. Cir. Nov. 21, 2006) (emphasizing that the court, in recognizing terminally ill plaintiffs’ right to choose certain medications, has not “prejudge[d] whether the FDA policy challenged here outweighs the Alliance members’ interests in self-determination; we require further inquiry by the district court on remand as to the FDA’s countervailing interests”).
contradicting the efficacy and safety of vaccines, recommending the use of laetrile, or suggesting the medical need for large quantities of alcohol. On the other hand, the Court in Carhart specifically required, and found, substantial evidence to support the medical necessity of D&X.

As I argue below, it is perfectly sensible for courts to take into account the degree of scientific consensus supporting a given intervention before granting individuals access to it; and indeed, this may be what courts have by and large tried to do. But they have gone about it in a very strange way. Rather than recognizing that a constitutional right is implicated whenever the government takes certain medical treatment choices off the table, and then considering whether there are nonetheless sufficiently important government interests to override that right, courts in the public health cases have deferred to legislatures without considering the strengths of the claimants’ evidence and have used that deference to hold that no constitutional right exists at all, rather than deciding whether the constitutional right is outweighed by countervailing government interests. In the medical marijuana cases, for example, courts refused even to consider the defendants’ considerable evidence concerning the medical benefits of cannabis, instead deferring in almost automatic fashion to Congress’s finding to the contrary and holding that no constitutional right was implicated. And Justice Burger in Eisenstadt refused to accept the notion that the state should be required to support its public health decisions at all. Thus, although the degree of medical evidence supporting a particular intervention may explain some of the outcomes, it does not explain the reasoning of the relevant cases.217

217 Another possibility is that the Court has treated drugs differently from surgical interventions, perhaps because of the FDA’s authority to regulate drugs, or because of the view that regulating surgical interventions intrudes too much in the doctor-patient relationship. As several commentators have noted, surgery is subject to far less legal regulation than drugs. See Amer S. Ahmed, Note, The Last Twist of the Knife: Encouraging the Regulation of Innovative Surgical Procedures, 105 COLUM. L. REV. 1529, 1530-32 & n.17 (2005) (citing sources). It is not apparent that there is any good reason behind this discrepancy, however. Id. at 1531 (describing the difference in treatment as “a legal oddity”). In addition, at least some kinds of drugs, such as contraceptives and perhaps drugs needed for aggressive palliative care, have been treated by the Supreme Court under the autonomy line of cases and thus as subject to more limited government regulation.
B. The Right to Make Medical Treatment Choices: Preliminary Recommendations

In this final section, I build on the insights developed so far to draw two conclusions: first, that the Supreme Court has already recognized a substantive due process right to make medical treatment choices, which is related to but independent of other kinds of autonomy rights; and second, that courts have avoided recognizing and properly analyzing this right by automatically applying deference to legislative judgments in cases that they view as public health cases. The extent to which courts should defer to such legislative determinations of medical fact is a question that has therefore largely gone unaddressed, but which I argue should be confronted head-on. I conclude by arguing that deference may be inappropriate when pure questions of medical or scientific fact are involved, but that in any case, courts must be more systematic in both recognizing the right to make medical treatment choices and in balancing that right against countervailing government interests in light of the available scientific evidence.

1. The Existence of the Right. An important contention of this Article, and the inevitable conclusion to be drawn from my review of the case law, is that the Supreme Court has already recognized a substantive due process right to make medical treatment decisions without unwarranted government interference. While the contours of this right vary from case to case – for example, the Supreme Court has sometimes articulated a near-absolute immunity from government intervention in medical treatment choices, as in Carhart and Botsford, and has sometimes suggested that it is a right that must be balanced against legitimate governmental interests, as in Glucksberg – the assumption that some such right exists has been somewhat more consistent. Eugene Volokh has recently pointed to the existence of a right of “medical self-defense,” which, he argues, has its roots in the traditional common-law right of self-defense – a right to which even Justice Scalia appears willing to grant constitutional status.218 Likewise, John Robertson has recently made the argument that one can discern a negative constitutional right to medical treatment in substantive due process case law.219 Indeed, even Jacobson v.

218 Volokh, supra note __, at 7-11.
219 John A. Robertson, Embryo Culture and the “Culture of Life”: Constitutional Issues in the Embryonic Stem Cell Debate, 2006 U. CHI. LEGAL FORUM 1, 7-15. This Article, too, argues only that there is a negative, not positive right, to make medical
Massachusetts, the quintessential public health case, recognized the necessity of a health exception to actions otherwise within the state’s police power.

Even in the medical marijuana and laetrile cases, the Supreme Court did not so much squarely reject the existence of such a right as dodge the question entirely. Indeed, although the lower courts in the laetrile cases declined to recognize a constitutional right to access a particular drug, they did suggest in dicta that there was a right to access some medical treatment. But if courts, even in the public health cases, are willing to recognize a right to access medical treatment in general, it is hard to see how they can avoid recognizing a right to access a particular medical treatment, especially when the treatment sought is the safest or only effective one. 220 Finally, Whalen v. Roe alluded, albeit ambiguously, to the “right to decide independently, with the advice of [a] physician, to acquire and use needed medication.” 221 It is therefore not necessary to argue that the Supreme Court should recognize a new right – as it is in any case unlikely to do 222 – to believe that neither the D.C. Circuit panel in Abigail Alliance nor the plaintiffs before the Ninth Circuit on remand in Raich are on completely shaky ground.

2. The Problem of Defercence. If the existence of the right itself

---

220 See also Michael C. Dorf, The Supreme Court’s Surprisingly Unanimous Abortion Decision: A Parting Gift for Justice O’Connor? (Jan. 30, 2006), http://writ.findlaw.com/dorf/20060130.html (arguing, in discussing Planned Parenthood v. Ayotte, that a minor woman “has a constitutional right to be free of state regulation that effectively subjects her to a risk of losing a limb,” suggesting that even Justices Scalia and Thomas might agree, and further observing that, even if Roe v. Wade were overruled, there would still be a genuine constitutional question whether an abortion prohibition without a health exception would be constitutional).


is uncontroversial, it seems then that much of the problem addressed in this Article comes down to one of deference. Courts apply deference in the public health cases as a way of short-circuiting the constitutional analysis of whether and when individuals possess a right to access certain medical treatments. If such a right does exist, however, the question of deference does not disappear – it simply becomes important at a different stage of the analysis: in determining whether any state interests outweigh the claimant’s right.

To recognize that individuals possess a constitutional right to protect their health by making autonomous medical treatment decisions is not, by any means, to decide that the right is a trump card and that states are powerless to withhold drugs from the market, regulate the practice of medicine, or prosecute quacks. Rather, it is to allow individuals to challenge even traditional public health regulations and to force the government to come forward with some evidence of the validity of its medical judgments if and when those individuals present substantial evidence to the contrary. Thus, the question of whether and how much deference legislatures should receive on questions of medical science remains important to the analysis.

This Article argues that courts should not defer to legislative findings of medical fact. The Supreme Court has repeatedly invoked the maxim that legislatures’ greater fact-finding ability requires that courts defer to them on disputed issues of legislative fact, extending this view beyond “social facts” regarding economic, social, or policy matters to encompass even medical and scientific

---

223 Nor, as I discuss below, does it mean that the FDA’s authority must be decimated or that drug manufacturers will be free to stimulate demand without regulation. But see Peter D. Jacobson & Wendy E. Parmet, A New Era of Unapproved Drugs: The Case of Abigail Alliance v. Von Eschenbach, 297 JAMA 205, 207 (1997).

224 While lack of deference is often associated with heightened scrutiny in constitutional doctrine and a high degree of deference with rational basis review, this association has not been consistent. Compare, e.g., Turner Broadcasting System, Inc. v. FCC, 520 U.S. 180 (1997) (deferring to Congressional fact finding in intermediate scrutiny context) with City of Los Angeles v. Alameda Books, 535 U.S. 425 (2002) (granting very little deference in intermediate scrutiny context); see also Daniel J. Solove, The Darkest Domain: Defeference, Judicial Review, and the Bill of Rights, 84 IOWA L. REV. 941, 961-62 (1999) (noting that courts often defer to other decisionmakers even when fundamental rights protected by heightened scrutiny are at stake). Thus, my argument that the right to make autonomous medical treatment choices is a constitutionally protected right does not necessarily imply a lack of deference to legislative factfinding; this non-deference must be justified independently.
facts. There is, however, little reason to believe that legislatures possess, or exercise, superior institutional competency in the context of medical and scientific fact. Thus, whatever the merits of deference to legislative factfinding as a general matter, it is not a desirable approach when considering individuals’ rights to access medical treatment.

It has long been commonplace to assert that legislatures, not courts, are best suited to find social facts that pertain to the policy judgments behind legislation, largely because legislatures possess greater institutional competence in this regard. Thus, courts and commentators note that legislatures, unlike courts, have vast resources for fact-gathering, including large staffs and considerable funds designated for precisely that purpose; subpoena power; and the ability to take as much time as necessary to compile all the relevant information. In addition, legislatures, unlike courts, are highly diverse, representative bodies; as such, as a matter of separation of powers and democratic theory, legislatures, rather than courts, should be charged with compiling and, perhaps more importantly, evaluating the sorts of factual evidence that underlie the often delicate and nuanced policy choices involved. Finally, whereas a court’s judgment is ossified in legal precedent as constituting a quasi-legal determination, often without any mechanism for re-opening an issue of legislative fact previously decided, legislatures can revisit and revise previous legislative decisions as necessary to adapt them to changing factual circumstances.

This model appears to emphasize the legislatures’ superiority for deciding so-called issues of “social fact,” such as economic or social science matters. But it is one thing for Congress to determine whether the states have engaged in widespread gender-based discrimination and stereotyping with respect to family leave policies, or for a state legislature to determine whether a minimum

---

225 See, e.g., Neal Devins, Congressional Factfinding and the Scope of Judicial Review: A Preliminary Analysis, 50 DUKE L.J. 1169, 1178 (2001); see also Philip P. Frickey & Steven S. Smith, Judicial Review, the Congressional Process, and the Federalism Cases: An Interdisciplinary Critique, 111 YALE L.J. 1707 (2002) (noting that “[a] wide variety of resources, unmatched by any other legislature of the world, are at the disposal of members [of Congress] and their committees”).

226 Devins, supra note __, at 1169-70, 1179.

227 Id. at 1180; cf. A Woman’s Choice-East Side Women’s Clinic v. Newman, 305 F.3d 684, 688-89 (7th Cir. 2002) (describing issues of legislative fact as being decided “at the level of logic” and for “the nation as a whole”).

wage requirement is necessary to prevent exploitation of workers,\textsuperscript{229} and another thing entirely for a legislature to decide when and whether a particular abortion procedure is medically indicated or whether cannabis has any legitimate medical use – or for that matter, to determine the value of \textit{pi}.\textsuperscript{230} The former determination seems to be precisely the sort that legislatures are qualified to make and expected to make; it inherently involves not only the sorts of facts that legislatures regularly gather and contemplate but also the sorts of value judgments that legislatures, unlike judges, are expected to make. But there is no reason to think that legislatures are particularly competent to make the latter determination, and it causes some discomfort to imagine that such scientific determinations, unlike social policy determinations, would be driven by politics, value judgments, or the desires of the majority.\textsuperscript{231}

Yet, the Supreme Court has considered scientific questions to be “matters not within specialized judicial competence” and therefore within the competency of Congress to gather data and reach conclusions.\textsuperscript{232} As a result, “[w]hen Congress undertakes to act in areas fraught with medical and scientific uncertainties, legislative options must be especially broad and courts should be cautious not to rewrite legislation, even assuming, arguendo, that judges with more direct exposure to the problem might make wiser choices.”\textsuperscript{233} Justice Kennedy echoed that sentiment in his dissent in \textit{Stenberg v. Carhart}, explicitly connecting the deference principle to notions of institutional competence: he first stated that “[c]ourts are ill-equipped to evaluate the relative worth of particular surgical procedures,” and that “[t]he legislatures of the several States have superior factfinding capabilities in this regard.”\textsuperscript{234} He then pointed to precedent “allowing the State to take sides in a medical debate, even when fundamental liberty interests are at stake and even when leading members of the

\begin{footnotesize}
\begin{enumerate}
\item See West Coast Hotel Co. v. Parrish, 300 U.S. 379 (1937).
\item Cf. Ann Woolhandler, \textit{Rethinking the Judicial Reception of Legislative Facts}, 41 \textit{Vand. L. Rev.} 111, 119 (1988) (arguing that all legislative factfinding is value-driven and that “this is true even for the hard sciences,” but acknowledging that it is “especially true for the soft sciences”).
\item Usery v. Turner Elkhorn Mining Co., 428 U.S. 1, 33-34 (1976) (quoting United States v. Gainey, 380 U.S. at 67 (internal quotation marks omitted)).
\end{enumerate}
\end{footnotesize}
profession disagree with the conclusions drawn by the legislature.”

A number of commentators have critiqued the general notion of deference to legislatures. For example, Neal Devins has suggested, drawing in part on public choice theory, that legislative bodies do not always have incentives to engage in careful factfinding; that legislative factfinding is often driven by the political agendas of committee chairs; and that lobbyists know well enough to “pad” the legislative history to their advantage when possible. In addition, Devins has pointed out that while legislatures theoretically have the ability to modify prior policy choices based on changed factual circumstances, they rarely do so, due to inertia and competing claims on their time and resources. Daniel Solove has suggested that deference to other decisionmakers in constitutional cases seriously threatens the federal courts’ ability to vindicate individual rights and has likewise questioned the robustness of institutional competence-based arguments, particularly to the extent that they underestimate the problems of bias and capture by special interests.

All of those criticisms are applicable to legislative determinations of medical fact. Yet, commentators have not primarily focused on the unique aspects of medical factfinding that make it even more unsuitable a subject for judicial deference. To the extent that they have considered the problems “scientific” legislative fact, they have primarily focused on courts’ and legislatures’ use of empirical social science evidence. I contend, however, that judicial deference to legislative factfinding is particularly inappropriate with respect to medical fact. The traditional reasons supporting such deference simply do not apply.

There is, first, reason to doubt legislatures’ superior ability to discover medical truth. There is no reason to think that legislators or their staff members possess any particular expertise in evaluating

236 Devins, supra note __, at 1183-84.
237 Id. at 1184-85; cf. Rachael N. Pine, Speculation and Reality: The Role of Facts in Judicial Protection of Constitutional Rights, 135 U. PA. L. REV. 655, 726-27 (1988) (arguing that courts need not follow precedent when the legislative facts supporting the precedent are different or have changed in light of new information).
238 Solove, supra note __, at 1011-1019.
medical evidence that judges and their clerks lack. While it is presumed that legislators and their staffers often possess backgrounds in policy, and that where this background is lacking, it may be supplemented by agencies within the legislature that specialize in gathering and analyzing data, those individuals and institutions generally do not possess any background in medical science or any unique expertise in analysis of medical evidence and literature. Indeed, a similar argument for non-deference to an executive officer was recently made by the Supreme Court with respect to the Attorney General’s authority to determine what constitutes a “legitimate medical purpose” under the CSA: in Gonzales v. Oregon, the Court presumed that Congress did not intend to grant the power to make medical judgments to the Attorney General, “an Executive official who lacks medical expertise.”

When judges are asked to evaluate competing medical claims, moreover, they are required, unlike legislators, to hear evidence from both sides, chosen by the adversaries, and to allow cross examination. They may consider amicus briefs as well, and it is significant that amicus briefs from respected organizations such as the American Medical Association and the American College of Obstetricians and Gynecologists have played important roles in the Court’s abortion decisions, for example. Federal Rule of Evidence

240 The Congressional Research Service and General Accounting Office, for example, conduct studies, gather data, and analyze statistics in order to report them to Congress. See Frickey & Smith, supra note ___, at 1738-39. But they do not conduct medical or scientific studies.

241 The National Academies (formerly the National Academy of Sciences), an independent entity created by congressional charter to provide technical and scientific advice, is arguably the equivalent of some of Congress’ other fact-gathering arms. It carries out studies primarily at the behest of government sponsors, but it has no funding of its own. It is unclear how often Congress, not to mention state legislatures, rely on studies conducted by the National Academies.


243 See Stephen Breyer, Introduction, in FEDERAL JUDICIAL CENTER, REFERENCE MANUAL ON SCIENTIFIC EVIDENCE 1, 5 (2d ed. 2000) (speaking favorably of the role of amicus briefs in the Supreme Court when scientific issues are involved). Amicus briefs filed by medical organizations do not always support individuals’ claimed right to make autonomous medical treatment decisions, moreover. For example, the American Medical Association filed a brief opposing the legalization of physician-assisted suicide in Vacco v. Quill, 521 U.S. 793, 800 n.6 (1997), and was initially
706 allows courts to appoint independent experts,\textsuperscript{245} and numerous other mechanisms, ranging from the Federal Judicial Center’s \textit{Reference Manual on Scientific Evidence}\textsuperscript{246} to “case-management techniques like pretrial conferences to narrow the scientific issues in dispute, pretrial hearings where potential experts are subject to examination by the court, and appointment of specially trained law clerks or scientific special masters.”\textsuperscript{247} Of course, federal judges already deal with scientific evidence in a number of contexts, including medical malpractice, toxic tort, and products liability cases, and they have a framework for deciding the admissibility of such evidence under \textit{Daubert v. Merrell Dow Pharmaceuticals Co.}\textsuperscript{248} This is not to say that courts’ treatment of scientific evidence has been without its critics;\textsuperscript{249} but when considered in relative rather than absolute terms, there is no reason to think that judges are less experienced or less capable than legislatures in dealing with scientific evidence.

In addition, one of the chief reasons for allowing legislatures to make findings of fact in disputed areas – that they are democratic, representative bodies – seems to have no applicability where issues of pure medical fact are concerned.\textsuperscript{250} Unlike those cases in which so-
called “social facts” are involved, there is (or perhaps should be) no significant political element to the determination of medical fact. This is a factfinding domain in which the interest in public participation and legislatures’ relative institutional competency are at their lowest.

The federal Partial Birth Abortion Ban Act is one salient example of a situation in which the legislature proved itself less competent than the courts at managing medical factfinding. In enacting a new and improved federal version of the state “partial-birth” abortion ban that had been struck down in Carhart, Congress chose again to omit a health exception and instead to append a series of “findings” explaining why no health exception was necessary. Yet those factual findings were defective in numerous ways. First, they were unsupported by, and often in conflict with, the underlying congressional record itself. Second, they did not contain any evidence that had not essentially been before the Court when it decided Carhart; Congress did not update its findings in light of new medical evidence. Finally, the factual findings mischaracterized the Supreme Court’s holding in Carhart. When faced with determining the validity of the legislative findings and the necessity of a health exception, the lower courts, by contrast, almost uniformly reached very similar scientific conclusions, regardless of the political orientation of the individual judges. The district court opinions were all quite lengthy and contained thorough reviews of expert scientific evidence that were far more complete than the evidence before Congress when it passed the Act.

252 Id. at 492.
253 Id. at 485 & n.30; Planned Parenthood Fed’n v. Gonzales, 320 F. Supp. 2d 957, 1003-1010 (N.D. Cal. 2004).
254 See, e.g., PPFA, 320 F. Supp. 2d at 1014. As a point of clarification, I do not argue that legislatures should be required to build a legislative record, or demonstrate that they have engaged in a particular level of deliberation, before their factfinding may be accepted by courts. Such “due process lawmaking” or “on-the-record lawmaking” requirements have been amply and competently criticized. See, e.g., William W. Buzbee & Robert A. Schapiro, Legislative Record Review, 54 STAN. L. REV. 87 (2001); Ruth Colker & James J. Brudney, Dissing Congress, 100 MICH. L. REV. 80 (2001). Rather, I contend that individuals challenging the constitutionality of a law restricting access to medical treatment ought to have the opportunity to present expert medical testimony regarding the merits of the treatment and that legislative findings to the contrary should receive no special deference. Rather than blindly accepting unsupported legislative findings, courts should require governments to present proof refuting the challengers’ evidence.
3. Applications. If courts begin to recognize the existence of a right to make autonomous medical treatment decisions and cease deferring to legislatures on matters of scientific fact, what would the consequences be? I am arguing in this Article for a jurisprudence that would balance government interests against the individual claim of a right of access to a given medical treatment. Accordingly, the consequence would not be to grant individuals access to particular experimental or non-approved drugs in all cases. Instead, the outcome would differ depending on the factual context. This might mean that there would not be a radical shift in the results of many cases, but those results would at least be supported by better and more consistent reasoning.

Of course, the cases that appear to conflict most with my proposal are the public health cases. What would become of the results in those cases if courts were to take seriously the notion of an individual right to make autonomous medical treatment choices? In some cases, it seems that the result might, in fact, change. Although a comprehensive examination of the scientific evidence regarding the safety and efficacy of various medical interventions is beyond the scope of this Article, it seems that if courts were to recognize individuals’ rights to choose marijuana for medicinal purposes, considering the evidence supporting such medicinal uses on its own merits, and weigh it against the government interests in both preventing diversion to the illegal drug trade and in protecting patients’ health, prohibitions on medicinal use of cannabis may well turn out to be untenable. Similarly, at least for certain classes of patients and certain types of drugs, the right to access experimental cancer drugs vindicated by the Abigail Alliance case may well hold up in the face of asserted governmental interests. On the other hand, those individual interests might be outweighed by concerns about the consequences of permitting widespread access to unapproved drugs, such as the possibility that it would essentially end clinical trials as we know them, since individuals will not have an incentive to participate in trials where they may or may not be given the drug, nor would pharmaceutical companies have an incentive to conduct those trials, if individuals have a right to access the drug anyway.255

255 Susan Okie, Access Before Approval – A Right to Take Experimental Drugs?, 355 NEW ENGLAND J. MED. 437, 437 (2006). As the court emphasized in Abigail Alliance, a right to make autonomous medical treatment choices will not in all cases outweigh the countervailing government interests, Abigail Alliance for Better Access to Developmental Drugs v. Von Eschenbach, 469 F.3d 129, 138 (2006), and the
Finally, my model would provide a framework for determining whether patients have a right to access future forms of therapy, such as those that may one day be derived from embryonic stem cells. In addition, while this argument strongly suggests that the government would be more limited than it currently is in its ability to ban certain medical therapies, particularly where evidence can be marshalled to convince courts of the therapies’ medical validity, it does not mean that the government would be powerless to impose justifiable regulations on medical practice. Thus, states would be free to require that a physician recommend the treatment for a particular patient; indeed, the suggestion at the beginning of this Article that the right to make medical treatment choices is dependent on physician agreement is perhaps better understood in this way – that physician agreement is likely to be a per se reasonable requirement in most contexts. Thus, an analogy may be drawn to the abortion context, in which the Supreme Court has generally been hostile to so-called “procedure bans,” in which one medically indicated abortion option is completely removed from all women or some subset of women, but it has allowed regulations of abortion procedures that do not constitute an “undue burden” on the abortion right. Of course, the determination of what sorts of regulations are acceptable – like the determination whether governmental interests outweigh the individual right to access treatment in the first place – will not always be clear-cut or easy. But in this respect it is no different from the myriad balancing tests the federal courts are asked to apply on a regular basis, particularly in the substantive due process context.

A final caveat: I recognize that issues of both government interests and deference may be more complicated where administrative agencies, such as the FDA, are involved. Administrative agencies receive deference in part because of their unique technical and scientific expertise and capabilities; they are thus situated differently from legislatures in important ways. At the same time, however, there is reason to believe that even agencies

interest in the viability of clinical trials may well be important enough to override individual patients’ rights.

256 This Article therefore supports John Robertson’s view that embryonic stem-cell derived therapies most likely could not constitutionally be banned by states, although they could of course be regulated. Robertson, supra note ___, at 15-23.
such as the FDA are subject to the sort of capture and biased factfinding that has inflicted both legislatures and other agencies.\textsuperscript{260} There is reason to believe, for example, that this sort of bias has played a role in the failure of medical marijuana advocates to complete the studies required in order to obtain FDA approval of marijuana for medical use.\textsuperscript{261} But the number of cases in which specialized agencies have actually studied a scientific issue and reached relevant conclusions has been relatively small in this area. In the laetrile cases, for example, the FDA did not make findings about the safety and efficacy of the drug until well into the litigation.\textsuperscript{262} In \textit{OCBC} and \textit{Raich}, courts relied on Congress’s findings, not the FDA’s, regarding the absence of medical uses for marijuana. And in the \textit{Abigail Alliance} case, clinical trials had preliminarily found the drugs at issue to be safe, although the FDA had not yet approved them for marketing. Thus, while a more complete examination of this issue is beyond the scope of this Article, I wish to suggest that it will continue to arise in only a small category of cases, which may indeed warrant special treatment.

\section*{Conclusion}

The question whether individuals enjoy a substantive due process right to make medical treatment choices is presented in a number of cases working their way up to the Supreme Court. The Court’s jurisprudence to date has been split between two opposing lines of cases, taking conflicting views of this right, of the deference due to legislatures’ medical determinations, and of the individual body and its relationship to society. The Supreme Court will eventually have to resolve the conflict, and in doing so, it is imperative that it avoid using superficial doctrinal categories and automatic deference to short-circuit its analysis. The issue of when governmental interests outweigh


\textsuperscript{261} Amicus Curiae of the Marijuana Policy Project and Rick Doblin, Ph.D., and Ethan Russo, Ph.D., in Support of the Respondents, \textit{United States v. Oakland Cannabis Buyers’ Cooperative}, 532 U.S. 483 (2001) (No. 00-151) (arguing that government agencies have interfered with attempts to obtain FDA approval for cannabis as a prescription drug by maintaining a monopoly on the legal supply of cannabis for research purposes and systematically denying access to that supply).

\textsuperscript{262} See supra TAN \textsuperscript{__}.
the individual right to protect one’s health through making autonomous medical treatment choices is one that is not easily resolved, but it is worthy of the sort of serious consideration it has not yet received.