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

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

B. Jessie Hill*

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* Assistant Professor, Case Western Reserve University School of Law. B.A. 1992, Brown; J.D. 1999, Harvard. A draft of this Article was presented in September 2006 at the Health Law Scholars Workshop sponsored by the Saint Louis University Center for Health Law Studies and the American Society of Law, Medicine & Ethics. I 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. I would also like to thank Jonathan Adler, Jessica Berg, Mel Durchslag, Jonathan Entin, David Garrow, Paul Giannelli, Sharona Hoffman, Max Mehlman, Gary Simson, and Mark Stein. Deborah Urban provided extensive and outstanding research assistance; Chelan Bliss, Jessica Mate, and Frank Nardulli also provided excellent research assistance. All errors are mine.

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, the Supreme Court reached radically different results based on radically different reasoning.

*More recent developments, including last Term’s decision in *Gonzales v. Carhart*, have only highlighted the doctrinal confusion and the need for a resolution. In light of this pressing need, 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. 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 dignity interests. These 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 them.*

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.

I. 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.

For example, in two cases decided just one year apart—one concerning the right to choose “partial-birth” abortion² and one concerning the right to use medical marijuana—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 the physician’s reasonable medical judgment, that the procedure is safer for the woman than any other available abortion procedures.³ Moreover, the Court refused to defer to the state’s finding that the outlawed procedure was never medically necessary, accepting instead the plaintiff’s expert testimony demonstrating medical need.⁴ 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 and deferred to Congress’s finding that marijuana had no medically acceptable use, despite defendants’ evidence to the contrary.⁵

Courts continue to waver between two very different approaches when dealing with claims of a right to protect one’s health by making medical treatment decisions without government interference. In *Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach*,⁶ the D.C. Circuit

1. *England v. La. State Bd. of Med. Exam’rs*, 259 F.2d 626, 627 (5th Cir. 1958) (emphasis omitted) (holding that plaintiffs could challenge Louisiana’s prohibition on the practice of chiropractic medicine as a due process violation).

2. 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, 1095 (2001) (explaining that the term is not medically recognized and was selected by abortion opponents in the hope that it would conjure up graphic images of the procedure, thus undermining public support for abortion rights); cf. Richard G. Kopf, *An Essay on Precedent*, Standing Bear, *Partial-Birth Abortion and Word Games—A Response to Steve Grasz and Other Conservatives*, 35 CREIGHTON L. REV. 11, 12 n.7 (2001) (noting, as the judge who authored the district court opinion in *Carhart v. Stenberg*, 11 F. Supp. 2d 1099 (D. Neb. 1998), that the imprecision of the term “partial-birth abortion” was “a big problem”).

3. *Stenberg v. Carhart* (*Carhart I*), 530 U.S. 914, 938 (2000).

4. *Id.* at 934–36.

5. *United States v. Oakland Cannabis Buyers’ Coop. (OCBC)*, 532 U.S. 483, 490–93 (2001).

6. 445 F.3d 470 (D.C. Cir. 2006), *rev’d en banc*, 495 F.3d 695 (D.C. Cir. 2007).

initially 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 life⁷—then reversed itself in an en banc decision.⁸ In March 2007, the Ninth Circuit rejected the argument that seriously ill individuals had a substantive-due-process right to access medical marijuana, holding that there was no “fundamental right to use medical marijuana prescribed by a licensed physician to alleviate excruciating pain and human suffering.”⁹ Moreover, the Supreme Court revisited the “partial-birth” abortion issue in the 2006 Term and appears to be fumbling toward a reconciliation of the radically opposing approaches it has previously applied, although many questions remain to be answered. In the federal “partial-birth” abortion case just decided,¹⁰ the Court combined the language of deference with a result that still suggests the possibility of a constitutional right to protect one’s health in the abortion context.

But the need for a resolution remains pressing. And that need is more than just a doctrinal one—in fact, the right of access to one’s chosen medical treatment is poised to become an extremely important practical issue in our society as America’s population increasingly becomes an aging one that is likely to begin vociferously seeking access to new and controversial therapies. The national debate sparked by the possibilities of stem-cell research, for example, may be a preview of the controversy to come—a controversy that is centered not so much on the right to die, which was ascendant in the 1980s and 1990s, but on the right to try to stay alive.

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 these cases obviously invoke clearly established constitutional rights, such as the right to privacy, which require courts to apply heightened scrutiny. Others involve important governmental interests, such as the “war on drugs,” which tend to

7. *Id.* at 477. Several months after *Abigail Alliance* was decided, the FDA proposed new rules to make experimental drugs more widely available to seriously ill patients. Expanded Access to Investigational Drugs for Treatment Use, 71 Fed. Reg. 75,147 (Dec. 14, 2006) (to be codified at 21 C.F.R. pt. 312); Charging for Investigational Drugs, 71 Fed. Reg. 75,168 (Dec. 14, 2006) (to be codified at 21 C.F.R. pt. 312).

8. *Abigail Alliance*, 495 F.3d 695. The Washington Legal Foundation recently filed a certiorari petition to challenge the en banc court’s holding. Petition for Writ of Certiorari, *Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach*, No. 07-444 (U.S. Sept. 28, 2007), 2007 WL 2846053.

9. *Raich v. Gonzales*, 500 F.3d 850, 866 (9th Cir. 2007).

10. *Gonzales v. Carhart*, 127 S. Ct. 1610 (2007).

provoke almost knee-jerk reactions from courts in a rush to defer to legislative judgments.¹¹ 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 relationship to dictate an individual’s medical treatment options.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.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,

11. See, e.g., Posting of Lyle Denniston to SCOTUSblog, http://www.scotusblog.com/movabletype/archives/2005/06/commentary_just.html (June 6, 2005, 20:30 EST) (discussing Justice Kennedy’s “zero-tolerance” attitude toward drugs, which may shape his view of the other legal issues in a given case). Denniston’s post was cited in Jonathan H. Adler, *Is Morrison Dead? Assessing a Supreme Drug (Law) Overdose*, 9 LEWIS & CLARK L. REV. 751, 770 (2005) (“Other commentators have been less charitable in their initial assessments, suggesting that Justice Kennedy may have views about drug use that eclipse his concerns about the traditional federal state balance.”).

12. Of course, formulating the problem in this way inevitably raises the question of what constitutes medical treatment. In this Article, 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 state to forbid the practice of medicine by nonphysicians. Rather, my argument relies in part on the constitutional importance of the physician–patient relationship. See *Doe v. Bolton*, 410 U.S. 179, 197 (1973) (finding the statute limiting access to abortion unconstitutional because, along with other problems, “[t]he woman’s right to receive medical care in accordance with her licensed physician’s best judgment and the physician’s right to administer it are substantially limited”); *Roe v. Wade*, 410 U.S. 113, 153 (1973) (emphasizing that the physical, psychological, and emotional aspects of terminating a pregnancy “are factors the woman and her responsible physician necessarily will consider in consultation”). But see *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 884 (1992) (“Whatever constitutional status the doctor-patient relation may have as a general matter . . . it is derivative of the woman’s position. The doctor-patient relation does not underlie or override the two more general rights under which the abortion right is justified . . .”); *Rust v. Sullivan*, 500 U.S. 173, 202–03 (1991) (holding that a regulation prohibiting federally funded family-planning services from discussing abortion did not impermissibly interfere with the doctor–patient relationship). 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 a right to make medical treatment choices. See *Doe*, 410 U.S. at 197 (arguing that review by a hospital committee of the decision to have an abortion is unnecessary because a woman would only choose an abortion “in accordance with her licensed physician’s best judgment”). Perhaps further limitations might be imposed on the definition of medical treatment, such as a requirement that the proposed treatment have a minimum threshold of acceptance in the medical community.

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, *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.

beginning with *Jacobson v. Massachusetts*,¹⁴ which dealt with the constitutionality of mandatory-vaccination laws. These cases emphasize the police power of the state over individual rights. The second is the newer “autonomy” line of cases, beginning with *Griswold v. Connecticut*,¹⁵ which emphasizes individual dignity and autonomy interests.

In addition, a careful look at the cases in each line 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 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. The question of deference in these cases usually boils down to the question of who decides whether a medical treatment has therapeutic merit.¹⁶ I argue that legislatures are particularly ill suited to this task and that judges, while not ideally suited to making medical decisions, are in a better position to weigh the scientific evidence before them. This does not mean, of course, 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.

14. 197 U.S. 11 (1905).

15. 381 U.S. 479 (1965).

16. 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 that in turn is prohibited by law.

Part II of this Article describes and analyzes *Stenberg v. Carhart*,¹⁷ the Supreme Court's first "partial-birth" abortion case, and *United States v. Oakland Cannabis Buyers' Cooperative*,¹⁸ its first "medical marijuana" case, in order to demonstrate the conflict at the heart of my argument. Part III then traces that conflict to two opposing lines of constitutional doctrine, each touching on the right to make medical treatment decisions. It culminates in an analysis of *Gonzales v. Carhart*,¹⁹ decided in the 2006 Term, in which the Supreme Court combined the language of public health and autonomy, while still failing to reconcile the competing approaches. Finally, Part IV concludes that although the Supreme Court has recognized a right to make medical treatment choices, legislative-fact deference has played a largely unacknowledged role in the inconsistent application of that right. Part IV ends with some suggestions for how the right to make medical treatment choices and the corresponding legislative determinations of medical fact could be handled by courts in the future.

II. Same Question, Different Answers: Medical Marijuana and "Partial-Birth" Abortion

This Part considers two recent Supreme Court cases decided in consecutive Terms—*United States v. Oakland Cannabis Buyers' Cooperative* (*OCBC*) and *Stenberg v. Carhart* (*Carhart I*)—that took conflicting views of the right to make autonomous medical treatment decisions. *OCBC* and *Carhart I* are examined at length not simply because of their importance to this issue but also because 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 III, *OCBC* represents the public-health approach, and *Carhart I* exemplifies the autonomy approach. These cases grew out of distinct doctrinal lines, resulting in a glaring doctrinal inconsistency. As demonstrated in subpart III(D), this tension was evident in *Gonzales v. Carhart*, in which the Supreme Court appeared to incorporate elements of both approaches, while issuing a procedurally modest opinion that left most of the inconsistencies to be resolved at a later date.

A. Medical Marijuana and Medical Necessity

In *OCBC*, 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.²⁰ In so doing, the Court assumed a highly deferential stance toward congressional fact-

17. 530 U.S. 914 (2000).

18. 532 U.S. 483 (2001).

19. 127 S. Ct. 1610 (2007).

20. See *id.* at 27 (deferring to the Controlled Substances Act as an authoritative "regime specifically designed to regulate which controlled substances can be utilized for medicinal purposes, and in what manner").

finding.²¹ Although the Supreme Court's opinion in *OCBC* did not turn on the question whether individuals have a substantive-due-process right to make medical treatment choices, 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.²² In addition, the Supreme Court's reasoning in reaching the conclusion that the Controlled Substances Act contained no medical-necessity defense has important implications for how the Court might rule on the conceptually similar claim of a right of seriously ill individuals to choose 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 1996.²³ 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.²⁴ 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.²⁵ The government, by contrast, submitted absolutely no evidence to refute the defendants' medical position.²⁶

21. *Id.*

22. *United States v. Cannabis Cultivators Club*, 5 F. Supp. 2d 1086, 1102–03 (N.D. Cal. 1998) (citing Defendants' Supplemental Opposition Memorandum at 9, *Cannabis Cultivators Club*, 5 F. Supp. 2d 1086 (No. 98-0085)), *rev'd sub nom.* *United States v. Oakland Cannabis Buyers' Coop.*, 190 F.3d 1109 (9th Cir. 1999) (*per curiam*), *rev'd*, 532 U.S. 483 (2001).

23. *United States v. Oakland Cannabis Buyers' Coop. (OCBC)*, 532 U.S. 483, 486–87 (2001). 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 in the district court. *Cannabis Cultivators Club*, 5 F. Supp. 2d 1086, 1092–93.

24. *Cannabis Cultivators Club*, 5 F. Supp. 2d at 1101–03.

25. *Oakland Cannabis Buyers' Coop.*, 190 F.3d at 1115; Appellants' Opening Brief at 13–14, *Oakland Cannabis Buyers' Coop.*, 190 F.3d 1109 (No. 98-16950). A number of studies document the safety and potential medical benefits of cannabis. *See, e.g.*, INST. OF MED., MARIJUANA & 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.”); Donald I. Abrams et al., *Short-Term Effects of Cannabinoids in Patients with HIV-1 Infection: A Randomized, Placebo-Controlled Clinical Trial*, 139 ANNALS INTERNAL MED. 258, 264 (2003)

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."²⁷ The district court categorically rejected the notion that individuals have a "fundamental right to obtain the medication of choice,"²⁸ even on a physician's recommendation, and even assuming that marijuana was the only effective treatment for the symptoms.²⁹ The court relied heavily on *Carnohan v. United States*³⁰ and *Rutherford v. United States*,³¹ 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.³² 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."³³

On appeal, the Ninth Circuit strongly encouraged the court to issue an injunction allowing the distributors to provide marijuana to those individuals who met the requirements of medical necessity.³⁴ Consequently, by the time

(documenting the safety of cannabis for HIV patients); David Baker et al., *The Therapeutic Potential of Cannabis*, 2 LANCET NEUROLOGY 291, 294–96 (2003) (documenting the benefits for sufferers of neurological and neurodegenerative disease).

26. *Oakland Cannabis Buyers' Coop.*, 190 F.3d at 1115; Appellants' Opening Brief, *supra* note 25, at 15.

27. *Cannabis Cultivators Club*, 5 F. Supp. 2d at 1103 (quoting Defendants' Supplemental Opposition Memorandum, *supra* note 22, at 9).

28. *United States v. Cannabis Cultivator's Club*, No. C 98-0085 CRB, 1999 WL 111893, at *2 (N.D. Cal. Feb. 25, 1999).

29. *Id.* at *2, *2–3 ("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 Controlled Substances Act, suggesting instead that the issue would be better presented by an individual patient. See *Cannabis Cultivators Club*, 5 F. Supp. 2d at 1103. When four individual patients intervened in the suit and requested a declaration that they had such a right, however, they fared no better. *Cannabis Cultivator's Club*, 1999 WL 111893, at *2–3.

30. 616 F.2d 1120 (9th Cir. 1980).

31. 616 F.2d 455 (10th Cir. 1980).

32. See, e.g., Alistair E. Newbern, Comment, *Good Cop, Bad Cop: Federal Prosecution of State-Legalized Medical Marijuana Use After United States v. Lopez*, 88 CAL. L. REV. 1575, 1591 (2000) (noting that Laetrile proponents claimed that the drug taken in high doses slowed the effects of cancer). See generally Charles G. Moertel et al., *A Clinical Trial of Amygdalin (Laetrile) in the Treatment of Human Cancer*, 306 NEW ENG. J. MED. 201, 201 (1982) (detailing the history of medical uses of Laetrile).

33. *Cannabis Cultivator's Club*, 1999 WL 111893, at *3, *2–3 (quoting *Rutherford*, 616 F.2d at 457 (emphasis added)); see also *United States v. Osburn*, No. C 02-939 AHM, 2003 U.S. Dist. LEXIS 8607, at *6, *5–6 (C.D. Cal. Apr. 15, 2003) (rejecting "any protected, fundamental right to the choice of a particular treatment or medicine").

34. *United States v. Oakland Cannabis Buyers' Coop.*, 190 F.3d 1109, 1114–15 (9th Cir. 1999) (per curiam), *rev'd*, 532 U.S. 483 (2001).

the case reached the Supreme Court, 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 neither expressly provides for nor excludes such a defense.³⁵ The defendants, citing *Washington v. Glucksberg*,³⁶ had argued in their brief that if the Controlled Substances Act 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."³⁷ The Supreme Court declined to reach that argument, however, noting that the court of appeals had not addressed those constitutional claims.³⁸ 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—"is a difficult issue that is not presented here."³⁹

Although the Court declined to reach the issue whether seriously ill patients' substantive-due-process rights were implicated by the Controlled Substances Act'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 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 Controlled Substances Act, it should have considered the defendants' claim that the substantive-due-process argument provided an alternative basis for affirming the Ninth Circuit's decision remanding to the district court for modification of the injunction against the distributors.⁴⁰

35. *United States v. Oakland Cannabis Buyers' Coop. (OCBC)*, 532 U.S. 483, 490–91 (2001).

36. 521 U.S. 702 (1997).

37. Brief for the Respondents at 42–43, *OCBC*, 532 U.S. 483 (No. 00-151) (citing *Glucksberg*, 521 U.S. 702, 737 (1997) (O'Connor, J., concurring) and *id.* at 745 (Stevens, J., concurring)).

38. *OCBC*, 532 U.S. at 494.

39. *Id.* at 501 (Stevens, J., concurring). Justice Stevens's 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 (Carhart I)*, 530 U.S. 914 (2000) (allowing Dr. Carhart to assert his patients' constitutional right to a health exception).

40. *United States v. Oakland Cannabis Buyers' Coop.*, 190 F.3d 1109, 1115 (9th Cir. 1999) (per curiam), *rev'd*, 532 U.S. 483 (2001). The Court suggested that the issue was raised by defendants only as an argument that the Court should avoid constitutional questions in construing

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 lies in the Court's treatment of the defendants' medical evidence, which conflicts sharply with the Court's treatment of such evidence in *Carhart I*.⁴¹ Despite the defendants' submission of expert medical testimony showing the medicinal qualities of cannabis, which went uncontradicted by the Government, the Court deferred to Congress's finding in the Controlled Substances Act that marijuana "has 'no currently accepted medical use.'"⁴² The finding that marijuana lacks medical benefit was key to the Supreme Court's decision.⁴³ Moreover, in response to the defendants' argument 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."⁴⁴ Thus, the Court would also be likely to defer to the

the statute, *see OCBC*, 532 U.S. at 494, but the issue was clearly not only raised in this posture, *see* Brief for the Respondents, *supra* note 37, at 42–49; *see also* Transcript of Oral Argument at 38–39, *OCBC*, 532 U.S. 483 (No. 00-151), 2001 WL 300618.

41. *See infra* subpart II(B).

42. *OCBC*, 532 U.S. at 491 (quoting 21 U.S.C. § 812 (2000)). 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, 335 (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); *see also* Lars Noah, *Challenges in the Federal Regulation of Pain Management Technologies*, 31 J.L. MED. & ETHICS 55, 58 (2003) (describing the scheduling system for controlled substances). 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 59. Attempts to reschedule the drug have been administratively pursued but have failed. *See id.* at 60–61 (explaining how interdepartmental conflicts have contributed to the challenge of convincing the DEA and FDA to down-schedule marijuana).

43. *See 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'[s] findings that marijuana has no currently accepted medical use."), *rev'd*, 352 F.3d 1222 (9th Cir. 2003), *vacated and remanded sub nom. Gonzales v. Raich*, 545 U.S. 1 (2005); Noah, *supra* note 42, at 59 (noting that in *OCBC*, "the U.S. Supreme Court showed tremendous deference to the legislature's judgment about the appropriate classification of marijuana" and that the "decision turned entirely" on Congress's conclusion that marijuana lacked any currently accepted medical use).

44. *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*. 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

legislature's finding in a challenge based on the substantive-due-process right to make medical treatment choices.⁴⁵

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*,⁴⁶ the Supreme Court decided that the Controlled Substances Act, 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 substantive-due-process right to access the drug.⁴⁷ As in *OCBC*, the district court in *Raich* had rejected the patients' substantive-due-process claims on the basis of the Laetrile cases, *Rutherford* and *Carnohan*.⁴⁸ On remand, the Ninth Circuit agreed, stating that there was no long-standing, well-defined right to access cannabis for medicinal purposes.⁴⁹

B. "Partial-Birth" Abortion and the Health Exception

Unlike *OCBC*, *Stenberg v. Carhart*, the first "partial-birth" abortion case, arguably recognized a very strong form of a substantive-due-process right to make medical treatment choices. In *Carhart I*, the Court appeared to recognize the nearly absolute right of a woman to choose the safest abortion procedure for her, even when other safe methods of abortion exist.

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 [sic] 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). Thus, even the Government's attorney acknowledged the possibility of a "harder question" where Congress has made a scientific finding unsupported by current scientific evidence. *Cf.* *Gonzales v. Carhart*, 127 S. Ct. 1610, 1637–38 (2007) (highlighting the discrepancy between congressional and judicial findings on the medical necessity of "partial-birth abortion" and the practice of teaching the prohibited procedure in medical schools, and accordingly declining to defer uncritically to the legislative findings). 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.

45. The en banc D.C. Circuit also read *OCBC* as relevant to the plaintiffs' claim of a constitutional right to access experimental cancer drugs in *Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach*, 495 F.3d 695, 707–08 (D.C. Cir. 2007).

46. 545 U.S. 1 (2005).

47. *Id.* at 33.

48. *Raich*, 248 F. Supp. 2d at 928.

49. *Raich v. Gonzales*, 500 F.3d 850, 864–66 (9th Cir. 2007).

Moreover, the Court showed little willingness in *Carhart I* 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 I* recognized a powerful right, the existence of which 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.⁵⁰ 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."⁵¹ 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.⁵²

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*⁵³ and *Planned Parenthood of Southeastern Pennsylvania v. Casey*,⁵⁴ for two separate and independent reasons.⁵⁵ 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."⁵⁶ The Court had made clear since *Roe v. Wade* that such a health exception was required when the state regulates postviability abortions; because the Nebraska ban admittedly applied both previability and postviability, it was *a fortiori* unconstitutional without a health exception.⁵⁷ Second, the Court held that 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

50. *Stenberg v. Carhart (Carhart I)*, 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 id.* at 983 (Thomas, J., dissenting).

51. NEB. REV. STAT. ANN. § 28-326(9) (LexisNexis 2007).

52. *Carhart I*, 530 U.S. at 921–22 (quoting NEB. REV. STAT. ANN. § 28-328(1) (LexisNexis Supp. 1999)).

53. 410 U.S. 113 (1973).

54. 505 U.S. 833 (1992).

55. *Carhart I*, 530 U.S. at 929–30.

56. *Id.* at 931, 929–31 (quoting *Casey*, 505 U.S. at 879).

57. The D&X procedure may be used as early as sixteen weeks' gestation. *Id.* at 927.

and evacuation procedure (D&E).⁵⁸ 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 of Southeastern Pennsylvania v. Casey*.⁵⁹

Thus, the Court seemingly 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.⁶⁰ In so holding, the Supreme Court in *Carhart I* stated that 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.”⁶¹ Thus, *Carhart I* apparently held that 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.⁶² In support of its view, the State pointed to the testimony of its own medical expert, some amici, and an American Medical Association policy statement suggesting that the health benefits of D&X were questionable or even that D&X might entail special risks not present in D&E.⁶³ There was also

58. *Id.* at 935–45.

59. *Id.* at 938.

60. *See 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 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”).

Some of the Justices argued in dissent that the requirement of a health exception was not itself a separate and independent requirement but rather should be analyzed under the rubric of the undue burden inquiry. *See id.* at 968, 965–68 (Kennedy, J., dissenting) (arguing that a health exception was not required because the “marginal” safety differences between D&X and D&E “do not amount to a substantial obstacle to the abortion right”); *id.* at 1011 n.20 (Thomas, J., dissenting) (criticizing the majority’s failure to analyze the health risks with respect to undue burden). This view was largely rejected by lower courts, which believed they had the support of the Supreme Court itself. *E.g.*, *Planned Parenthood Cincinnati Region v. Taft*, 444 F.3d 502, 508 (6th Cir. 2006) (citing *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 330–31 (2006)); *Planned Parenthood of Idaho, Inc. v. Wasden*, 376 F.3d 908, 923 (9th Cir. 2004) (citing *Carhart I*, 530 U.S. at 930). In *Gonzales v. Carhart*, 127 S. Ct. 1610 (2007), however, the Supreme Court analyzed the lack of a health exception in the federal Partial Birth Abortion Ban Act in terms of whether it constituted an undue burden. *See id.* at 1637 (“The medical uncertainty over whether the Act’s prohibition creates significant health risks provides a sufficient basis to conclude in this facial attack that the Act does not impose an undue burden.”).

61. *Carhart I*, 530 U.S. at 931.

62. *Id.* at 933–34.

63. *Id.* at 933–36.

testimony to the same effect contained in the legislative history.⁶⁴ Nonetheless, the majority rejected the state's legislative view, 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.⁶⁵ 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.⁶⁶

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 the plaintiff can show "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,"⁶⁷ the Court held, the law requires a health exception unless the state can show "that a health exception is 'never necessary to preserve the health of women.'"⁶⁸ 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.⁶⁹

In understanding the significance of *Carhart I*, it is important to recognize that *Carhart I* (like *Carhart II*, the second "partial-birth" abortion case) is not about the right to choose abortion in the usual sense. For women affected by the D&X ban, their alternative is usually not to forgo the desired (or required) abortion but to have an abortion by a method that is at least arguably riskier. *Carhart I* 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.⁷⁰ It is therefore unlike the *Roe*

64. *Id.* at 1015–16 (Thomas, J., dissenting); *Prohibit Partial-Birth Abortion: Hearing on L.B. 23 Before the Comm. on the Judiciary*, 95th Leg., 1st Sess. 50, 64 (Neb. 1997).

65. *Carhart I*, 530 U.S. at 932.

66. *Id.* at 932–33.

67. *Id.* at 937.

68. *Id.* at 937–38 (quoting Reply Brief for Petitioners at 4, *Carhart I*, 530 U.S. 914 (No. 99-830)).

69. *Id.*

70. See Akhil Reed Amar, *Foreword: The Document and the Doctrine*, 114 HARV. L. REV. 26, 111 (2000) (noting that the law in *Carhart I* 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," and that "the law, if narrowly construed, outlawed only a single procedure, leaving other methods of abortion unaffected"); *id.* at 109–14 (noting philosophical and rhetorical distinctions between the opinions in *Carhart I* and *Roe*). This Article does not address the question of what sorts of concerns may be taken into account when deciding whether one procedure is safer than another—for example, mental-health concerns. This is an area that has remained poorly defined in abortion law. See, e.g., Brian D. Wassom, Comment, *The Exception that Swallowed the Rule? Women's Medical Professional Corporation v. Voinovich and the Mental Health Exception to Post-Viability Abortion Bans*, 49 CASE W. RES. L. REV. 799, 799–800 (1999) (discussing the ambiguity of and debate over the meaning of "health" in abortion case law). In general, the claimed safety benefits of D&X over other procedures pertain to the woman's physical health.

health-exception requirement, which is 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.⁷¹

In the *Carhart I* situation, the state's interest in potential life is not implicated because the fetus will not survive regardless of the method chosen. Thus, *Carhart I* 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 unrelated to fetal preservation. *Carhart I* thus apparently guaranteed the right to choose the safest abortion procedure, even when other safe procedures were available.

Justice Kennedy, dissenting in *Carhart I*, 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,"⁷² Justice Kennedy argued that the *Carhart I* 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."⁷³ *Carhart I* is therefore as notable for

71. *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 769 (1986) (citing *Colautti v. Franklin*, 439 U.S. 379, 400 (1979)), *overruled in part* by *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992), *abrogated in part* by *Webster v. Reprod. Health Servs.*, 492 U.S. 490 (1989). 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 privacy rights as well. *Id.* at 400. The Tenth Circuit held a similar choice-of-method statute unconstitutional in *Jane L. v. Bangerter*, 61 F.3d 1493 (10th Cir. 1995), *rev'd on other grounds sub nom. Leavitt v. Jane L.*, 518 U.S. 137 (1996) (per curiam), where the court emphasized that "a woman's health must be the paramount concern." *Id.* at 1504; *see also, e.g.*, Caitlin E. Borgmann, *Winter Count: Taking Stock of Abortion Rights After Casey and Carhart*, 31 *FORDHAM URB. L.J.* 675, 698, 697-98 (2004) (emphasizing the "absolute primacy of women's health," which may not be traded off against fetal survival, in post-*Roe*, pre-*Casey* Supreme Court decisions); April L. Cherry, *Roe's Legacy: The Nonconsensual Medical Treatment of Pregnant Women and Implications for Female Citizenship*, 6 *U. PA. J. CONST. L.* 723, 727, 727-28 (2004) (discussing *Thornburgh* and stating that the law is unambiguous that "in the context of abortion, women have the constitutional right to put their own lives and health before that of their fetuses, even after viability"); Seth F. Kreimer, *The Second Time as Tragedy: The Assisted Suicide Cases and the Heritage of Roe v. Wade*, 24 *HASTINGS CONST. L.Q.* 863, 898 (1997) ("The state may not require a pregnant woman to sacrifice her health even for a viable fetus.").

72. *Carhart I*, 530 U.S. at 968 (Kennedy, J., dissenting).

73. *Id.* at 970 (citing *Kansas v. Hendricks*, 521 U.S. 346, 360 (1997); *Jones v. United States*, 463 U.S. 354, 370 (1983); *United States v. Rutherford*, 442 U.S. 544 (1979); *Marshall v. United States*, 414 U.S. 417, 427 (1974); *Lambert v. Yellowley*, 272 U.S. 581, 596-97 (1926); and *Collins v. Texas*, 223 U.S. 288, 297-98 (1912)); *see also id.* at 1017-18 (Thomas, J., dissenting) (noting that the Nebraska Legislature had before it evidence suggesting that the D&X procedure is unsafe and that it is never medically indicated, and therefore arguing that "legislatures have been afforded the widest latitude in drafting such statutes . . . [w]hen a legislature undertakes to act in areas fraught with medical and scientific uncertainties" (omission in original) (quoting *Hendricks*, 521 U.S. at 369 n.3)).

its nondeferential approach to issues of legislative fact as for its apparently sweeping health-exception holding.⁷⁴

C. Summary

While they differed in the specific legal questions presented, *Carhart I* and *OCBC* both raise the issue of whether individuals possess a constitutional right to noninterference with medical treatment choices made in consultation with a physician. In *Carhart I*, 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 *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 not just the right to access medical treatment to relieve pain but also 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 *Carhart I* in *OCBC*, nor did it appear to think that the approach taken in the former case had any applicability to the latter case. In *Carhart I*, 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

74. Indeed, not only did the Court definitively recognize such a right for women seeking an abortion in *Carhart I*, it appeared to recognize that right as an absolute one. The Court did not contemplate that any state interest would be sufficient to overcome the woman's right to protect her health in this context, nor did it mention levels of scrutiny or standards of review. For this reason, the *Carhart I*-*Roe* 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) (discussing the confusing state of substantive-due-process doctrine); 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." (footnote omitted)). 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. David D. Meyer, *Lochner Redeemed: Family Privacy after Troxel and Carhart*, 48 UCLA L. REV. 1125, 1160, 1159-62 (2001) (noting that the Court in *Carhart I* 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 H. Tribe, *Lawrence v. Texas: The "Fundamental Right" that Dare Not Speak Its Name*, 117 HARV. L. REV. 1893, 1916, 1916-17 (2004) (acknowledging the majority's lack of an "explicit statement" pinpointing the standard of review).

plaintiffs to challenge the State's view of the medical evidence, ultimately accepting the plaintiffs' "substantial evidence" of health benefits associated with the procedure as sufficient to overcome the legislature's evidence to the contrary. *OCBC* is something like a mirror image of this paradigm, as the Supreme Court and the lower court peremptorily dismissed the claims of seriously ill patients seeking 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."⁷⁵ 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.⁷⁶

III. A Tale of Two Doctrines

What accounts for the puzzling difference in the Supreme Court's analytic approaches in *OCBC* and *Carhart I*? 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 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

75. *United States v. Oakland Cannabis Buyers' Coop. (OCBC)*, 532 U.S. 483, 494 n.7 (2001). The injunction 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 n.2.

76. *See State v. Corrigan*, No. C0-00-2190, 2001 Minn. App. LEXIS 889, at *2, *2-4 (Minn. Ct. App. Aug. 7, 2001) (refusing to reconsider the 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 (quoting *State v. Hanson*, 468 N.W.2d 77, 78 (Minn. Ct. App. 1991))); *id.* at *3-4 ("Whether 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.").

view, seeing sick individuals not so much as autonomous decision makers 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.⁷⁷ The public-health cases, of which *OCBC* is one, find their origin in the 1905 case of *Jacobson v. Massachusetts*. The autonomy line of cases, by contrast, beginning with *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. *Carhart I* 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. And in fact, *Carhart II* demonstrates the beginnings of a convergence of the two approaches, although leaving much to be desired in terms of actually reconciling them.

In Part IV, 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 its 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, which often plays the decisive role in these cases, has been used in a similarly reflexive manner by the Court and should be reexamined.

A. *The Public-Health Cases*

The public-health cases originate with *Jacobson v. Massachusetts*. They emphasize both the power and the 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*,⁷⁸ involved state-mandated medical or surgical interventions that the individuals wished to avoid—such as involuntary vaccination and sterilization—those cases set the

77. Cf. LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 11–14 (2000) (explaining that unlike medicine, which prioritizes the well-being of individual patients, public health prioritizes the collective well-being of populations); ALAN HYDE, BODIES OF LAW 243 (1997) (“The interest of the *Jacobson* [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, *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).

78. 274 U.S. 200 (1927).

stage for subsequent cases in which courts rejected patients' claims of a right to access the treatment of their choice.⁷⁹ 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”⁸⁰ or “seminal”⁸¹ 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.⁸² 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.⁸³

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.⁸⁴ While there is some confusion as to the exact reasons for Jacobson's refusal,⁸⁵ the opinion suggests that Jacobson feared an adverse health reaction from the vaccine, 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.”⁸⁶ Before the Supreme

79. *See id.* at 205, 205–07 (holding that the state could properly sterilize those determined to be “feeble-minded” to prevent the birth of “feeble-minded” children who might lead lives of crime or indigency); *Jacobson v. Massachusetts*, 197 U.S. 11, 39 (1905) (upholding Massachusetts's compulsory smallpox-vaccination program, citing a real and substantial relation to the protection of the public health and safety).

80. GOSTIN, *supra* note 77, at 66.

81. Wendy E. Parmet et al., *Individual Rights Versus the Public's Health—100 Years After Jacobson v. Massachusetts*, 352 NEW ENG. J. MED. 652, 652 (2005).

82. 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.

83. *Cf.* Wendy E. Parmet, *Legal Rights and Communicable Disease: AIDS, the Police Power, and Individual Liberty*, 14 J. HEALTH POL. POL'Y & L. 741, 751 (1989) (discussing *Jacobson*'s simultaneous affirmation of the state's power to act to protect the public and recognition of an individual right that could limit that power).

84. *Jacobson*, 197 U.S. at 12–13.

85. *See, e.g.*, Sheldon Gelman, *The Biological Alteration Cases*, 36 WM. & MARY L. REV. 1203, 1207 n.22 (1995) (noting that *Jacobson* is sometimes miscited as a case of religious refusal of vaccination).

86. *Jacobson*, 197 U.S. at 36. Indeed, such reactions had apparently been documented in the medical literature existing at the time. *See, e.g.*, GOSTIN, *supra* note 77, at 347 n.43 (describing Edward Jenner's original publication on smallpox vaccination as disclosing one case of a severe adverse reaction to the vaccine); Michael Willrich, “*The Least Vaccinated of Any Civilized Country*”: *Personal Liberty and Public Health in the Progressive Era*, J. POL'Y HIST. (forthcoming).

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.”⁸⁷ 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.⁸⁸

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.”⁸⁹ Indeed, the Court said, “Upon the principle of 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.”⁹⁰ Moreover, the Court

Jan. 2008) (manuscript at 9, on file with author) (mentioning a 1902 medical journal report of deaths of nine schoolchildren following tetanus vaccinations). 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.* (manuscript at 8–9).

87. *Jacobson*, 197 U.S. at 26.

88. *Id.* at 24, 36.

89. *Id.* at 26, 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. Wendy E. Parmet, *From Slaughter-House to Lochner: The Rise and Fall of the Constitutionalization of Public Health*, 40 AM. J. LEGAL HIST. 476, 478 (1996) [hereinafter Parmet, *From Slaughter-House to Lochner*]; 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, 272 (1993) [hereinafter Parmet, *Health Care*]. 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 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. Parmet, *From Slaughter-House to Lochner*, *supra*, at 495–97.

90. *Jacobson*, 197 U.S. 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 77, 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* text accompanying notes 95–99. 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, 966, 937–38, 938 & n.11, 966–67 (1989) (suggesting that *Jacobson*’s “doctrinal basis has eroded” and questioning why courts continue to apply the requirements derived therefrom). 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) (Stevens, J., concurring) (citing *Jacobson* in connection with the argument that an individual’s autonomy interests may be overridden by more important state interests in preserving life); *Roe v. Wade*, 410 U.S. 113, 154 (1973) (citing *Jacobson* for the

emphasized that “the legislature is primarily the judge” of that common good.⁹¹ 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.⁹²

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.⁹³ 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 matter involving the public health and safety to the final decision of a court or jury.”⁹⁴ Indeed, quoting at length and with approval from the New York state court’s opinion in *Viemeister v. White*,⁹⁵ 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 diseases. . . . [F]or 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.⁹⁶

The legislature was thus entitled to deference, whether its conclusions turned out to be correct or incorrect.⁹⁷

proposition that there is no “unlimited right to do with one’s body as one pleases,” without regard to countervailing state interests).

91. *Jacobson*, 197 U.S. at 27.

92. HYDE, *supra* note 77, at 243.

93. *Jacobson*, 197 U.S. at 23–30.

94. *Id.* at 30.

95. 72 N.E. 97 (N.Y. 1904).

96. *Jacobson*, 197 U.S. at 35 (quoting *Viemeister*, 72 N.E. at 99); accord *Duffield v. Sch. Dist. of Williamsport*, 29 A. 742, 743 (Pa. 1894).

97. Accord *State v. Hay*, 35 S.E. 459, 461 (N.C. 1900). But see *Burris*, *supra* note 90, at 961 (arguing that *Jacobson*’s apparent deference must be read in light of the 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

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.⁹⁸ The Court stated, in dicta, that in an "[e]xtreme case[]," such as an individual for whom vaccination would cause serious harm, the vaccination requirement should be waived.⁹⁹ Either 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," but the Court was:

not inclined to hold that the statute establishes the absolute rule 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.¹⁰⁰

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.¹⁰¹ In this way, *Jacobson* resembles *Carhart I* more than it appears at first glance.¹⁰²

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. *Jacobson*, 197 U.S. at 36. It appears that the Court found Jacobson's proffered evidence on this point inapposite because 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, 38–39.

100. *Id.* at 39.

101. In the autonomy cases, by contrast, the burden appears to be on the government to show that no health exception is necessary—as in *Carhart I*, discussed above. Similarly, in *Cleveland Board of Education v. LaFleur*, 414 U.S. 632 (1974), the Supreme Court rejected a school board's attempt to justify a mandatory pregnancy-leave policy based on generalized statements about the health risks associated with working while pregnant. *Id.* at 648. The Court thus placed the burden on the government to avoid individualized assessment of pregnant women's health needs. *See id.* at 644.

102. *Cf. Hay*, 35 S.E. at 461 (noting that a health exception to a vaccination law was required, although not provided for in the statutory language, and remanding a criminal conviction for a determination of whether the defendant was entitled to the benefit of that exception). Professor Michael Willrich 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 86, at 3.

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.¹⁰³ Relying on "the general declarations of the legislature and the specific findings of the [lower c]ourt"¹⁰⁴—the former included the finding "that experience has shown that heredity plays an important part in the transmission of insanity, imbecility, [etc.]"¹⁰⁵—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."¹⁰⁶ The principle alluded to, of course, is that individuals' interests may be subordinated to the government's power to protect the public health.¹⁰⁷ While *Buck* may be regarded as an irregularity in the fabric of constitutional law,¹⁰⁸ it fits within the paradigm of the public-health line of cases, characterized by its 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 ex rel. Williamson*,¹⁰⁹ which struck down a sterilization law for criminals on equal protection grounds and recognized procreation as a fundamental right,¹¹⁰ highlighting the schism in the Supreme Court's jurisprudence between those cases viewed as public-health cases and those viewed as autonomy cases.¹¹¹

103. *Buck v. Bell*, 274 U.S. 200, 207 (1927).

104. *Id.* at 207.

105. *Id.* at 206.

106. *Id.* at 207.

107. Moreover, "the Court did not view *Jacobson* as having required any substantive standard of necessity or reasonableness that would prevent what today would be considered an indefensible assault." Wendy K. Mariner et al., *Jacobson v. Massachusetts: It's Not Your Great-Great-Grandfather's Public Health Law*, 95 AM. J. PUB. HEALTH 581, 584 (2005).

108. 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 et al., *supra* note 107, at 586 ("Today, a general interest in the public's health or welfare could not justify sterilizing Carrie Buck against her will.").

109. 316 U.S. 535 (1942).

110. *Id.* at 541.

111. *Skinner* did not overrule but instead distinguished *Buck*. See *id.* at 539–42. 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*. Compare *Skinner*, 316 U.S. 535, which struck down a sterilization law for criminals on equal protection grounds, with *Buck*, 274 U.S. 200, which rejected due process and equal protection challenges to a Virginia law permitting coerced sterilization of the mentally incompetent. See also Lombardo, *supra* note 108, at 19, 18–19 (noting how the Court distinguished *Buck* in its decision in *Skinner*, in part due to the "more precise use of eugenic criteria" in *Buck*).

Likewise, the Supreme Court decided two cases during Prohibition that rejected challenges to the Volstead Act's limited exemptions for medicinal use of alcohol: *James Everard's Breweries v. Day*,¹¹² a challenge to the exclusion of malt liquors from the Act's allowance of alcohol for medicinal purposes, and *Lambert v. Yellowley*,¹¹³ a challenge to the Act's limitation on the amount of alcohol that could be prescribed. In both cases, the Court again rejected substantive-due-process challenges to government intervention in medical treatment decisions. The Court noted that while there was not a complete consensus of opinion on the topic, Congress had made a determination that malt liquor had no medicinal use¹¹⁴ and also had implicitly determined that there was no legitimate need for prescriptions above the quantities permitted by law.¹¹⁵ Of course, the 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.¹¹⁶ The Court explained in *Lambert* that Congress's finding, "in the presence of the well-known diverging opinions of physicians, cannot be regarded as arbitrary or without reasonable basis."¹¹⁷ Moreover, although the Prohibition cases, unlike the abortion or medical-marijuana cases, were decided in a context in which Congress had reviewed extensive quantities of evidence, it had not specifically made findings about the key issue in *Lambert*—namely, the medically appropriate doses of alcohol.¹¹⁸ In

112. 265 U.S. 545 (1924).

113. 272 U.S. 581 (1926).

114. *Everard's Breweries*, 265 U.S. at 561–62.

115. *Lambert*, 272 U.S. at 594–95 (citing *Everard's Breweries*, 265 U.S. at 560).

116. In a masterful recent article, Robert Post has situated *Everard's Breweries* and *Lambert* in the context of the debate over the appropriate scope of federal power in the Progressive era. See Robert Post, *Federalism, Positive Law, and the Emergence of the American Administrative State: Prohibition in the Taft Court Era*, 48 WM. & MARY L. REV. 1, 57–67 (2006). Indeed, Post explains that the original draft of the *Lambert* opinion:

cited *Everard's Breweries*, documented extensive state regulation of the prescription of alcoholic beverages for medicinal purposes in order to enforce municipal prohibition laws, and then concluded with the peremptory announcement [still contained in the opinion] that "[t]here is no right to practice medicine which is not subordinate to the police power . . . or to the power of Congress to make laws necessary and proper for carrying into execution the command of the Eighteenth Amendment."

Id. at 60 n.212 (omission and second alteration in original) (quoting THE LOUIS DEMBITZ BRANDEIS PAPERS, at Reel 29 (1985)).

117. *Lambert*, 272 U.S. at 595. *But cf.* *United States v. Freund*, 290 F. 411 (D. Mont. 1923) (holding, before *Everard's Breweries* 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," *id.* at 413, 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 414.

118. See *Lambert*, 272 U.S. at 598–605 (Sutherland, J., dissenting) (arguing that the legislature had not reviewed evidence on the specific issue before the Court).

addition, one “distinguished physician”¹¹⁹ had determined that the statute’s prohibitions conflicted with his medical judgment, and the American Medical Association had filed an amicus brief arguing that the statute’s dosage limitations were contrary to science, arbitrary, and unreasonable.¹²⁰

The public-health approach embodied by *Buck*, the Prohibition cases, and, at least in part, *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 *United States v. Rutherford*,¹²¹ the Supreme Court unanimously held that terminally ill cancer patients had no right to access Laetrile.¹²² As in *OCBC*, the Supreme Court decided the case on statutory grounds, construing the Food, Drug, and Cosmetic Act (FDCA) to reach Laetrile and to imply no exemption for terminally ill cancer patients.¹²³ 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.¹²⁴ Nonetheless, the Court’s reasoning fit the public-health model, as it paraded the horrors 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.”¹²⁵ 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.¹²⁶

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 the 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 “[u]nproven or [i]neffective drugs” would fly in the face of the “centuries-old function of government”¹²⁷ to “protect the

119. Post, *supra* note 116, at 62 (quoting *Lambert*, 272 U.S. at 488).

120. *Id.* at 61–64, 64 & n.20.

121. 442 U.S. 544 (1979).

122. *Id.* at 552.

123. *Id.*

124. *Id.* at 559 n.18.

125. *Id.* at 557–58.

126. *Id.* at 558.

127. Brief for the United States at 56, *Rutherford*, 442 U.S. 544 (No. 78-605).

public health and welfare”¹²⁸ 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.¹²⁹ 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 in protecting public health.”¹³⁰ 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 [L]aetrile 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.”¹³¹

Rutherford was decided against the backdrop of another Supreme Court case touching briefly on, and cursorily dismissing, the right to make medical treatment choices. *Whalen v. Roe*,¹³² 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.¹³³ 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.”¹³⁴ 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.¹³⁵ 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

128. *Id.* at 57.

129. *Id.* at 70–71. The Commissioner initially made no such finding; the Government argued at the beginning of the *Rutherford* litigation that Laetrile was a “new drug” under the FDCA that was not 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), *rev’d*, 442 U.S. 544. 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 a new drug that had not been proven safe and effective. *Rutherford*, 442 U.S. at 549.

130. *Rutherford v. United States*, 616 F.2d 455, 457 (10th Cir. 1980).

131. *Carnohan v. United States*, 616 F.2d 1120, 1122 (9th Cir. 1980).

132. 429 U.S. 589 (1977).

133. *Id.* at 592–93, 595.

134. *Id.* at 600, 599–600.

135. *Id.* at 603.

could prohibit entirely the use of particular Schedule II drugs.”¹³⁶ 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 that 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 about outlawing certain drugs were pure dicta.¹³⁷

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.¹³⁸ Individuals seeking access to medical treatment (or seeking to avoid medical treatment, as 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 IV, 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. 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.¹³⁹ Although it is arguably protected by the Fourth

136. *Id.* at 603 & n.30.

137. Specifically, the Court stated, “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 to use needed medication.” *Id.* at 603. It is thus unclear whether the Court recognized such a right but found that it had not been burdened in the instant case, or whether the Court remained agnostic as to the existence of such a right.

138. *Cf. Minnesota ex rel. Whipple v. Martinson*, 256 U.S. 41, 45 (1921) (“There can be no question of the authority of the State in the exercise of its police power to regulate . . . 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 in question.”).

139. *See, e.g., Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach*, 445 F.3d 470, 480 (D.C. Cir. 2006) (citing 1 WILLIAM BLACKSTONE, COMMENTARIES *125, *130) (“A right of control over one’s body has deep roots in the common law.”), *rev’d en banc*, 495 F.3d

Amendment,¹⁴⁰ Eighth Amendment,¹⁴¹ and even the common law,¹⁴² the notion of bodily integrity is perhaps most commonly associated with the Fourteenth Amendment¹⁴³ 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*,¹⁴⁴ 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.”¹⁴⁵ 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 own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.”¹⁴⁶ 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.”¹⁴⁷ 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.”¹⁴⁸

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

695 (D.C. Cir. 2007); *In re Cincinnati Radiation Litig.*, 874 F. Supp. 796, 816–18 (S.D. Ohio 1995) (outlining U.S. Supreme Court decisions regarding the right to be free from unwanted bodily intrusions dating back to 1884).

140. U.S. CONST. amend. IV; *see* *Winston v. Lee*, 470 U.S. 753, 755 (1985) (holding that a compelled surgical intrusion into an individual’s body for evidence would violate that individual’s “right to be secure in his person” and be “unreasonable” under the Fourth Amendment).

141. U.S. CONST. amend. VIII; *see* *Whitley v. Albers*, 475 U.S. 312, 327 (1986) (characterizing the Eighth Amendment as “specifically concerned with the unnecessary and wanton infliction of pain in penal institutions” and as “the primary source of substantive protection to convicted prisoners” in cases involving excessive force).

142. *See* *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891) (stating that the common law carefully guards the right of every individual “to the possession and control of his own person”).

143. U.S. CONST. amend. XIV; *see* *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997) (noting that the Court has held “the ‘liberty’ protected by the Due Process Clause [of the Fourteenth Amendment] includes the right[] . . . to bodily integrity”).

144. 141 U.S. 250 (1891).

145. *Id.* at 251.

146. *Id.*

147. *Id.*

148. *Id.*

present incarnation, the autonomy cases have come to stand for constitutional protection of certain dignity and equality interests,¹⁴⁹ 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 medical treatment choices.¹⁵⁰ Although 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

149. Thus, the autonomy cases ultimately gave rise to *Lawrence v. Texas*, 539 U.S. 558 (2003), which intertwines dignity and equality concerns. *See id.* at 575 (“Equality of treatment and the due process right to demand respect for conduct protected by the substantive guarantee of liberty are linked in important respects, and a decision on the latter point advances both interests.”). *See generally* Tribe, *supra* note 74, at 1902–07 (discussing *Lawrence*’s synthesis of substantive-due-process and equal protection concerns).

150. One might view *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535 (1942) as the true progenitor of *Griswold* and the other privacy cases, but *Skinner*, like the line of prisoner bodily integrity cases, including *Washington v. Harper*, 494 U.S. 210 (1990) (upholding forced antipsychotic treatment of a prisoner who was dangerous to himself and others, where medically appropriate); *Riggins v. Nevada*, 504 U.S. 127 (1992) (rejecting mandatory antipsychotic treatment of the defendant during trial where necessary findings were not made); and *Sell v. United States*, 539 U.S. 166 (2003) (holding that forced administration of antipsychotic drugs to defendants awaiting trial was permissible if the defendant was dangerous and treatment was medically appropriate), is not discussed here because, while relevant, it involves government-imposed harm and bodily invasion, which is quite different from a governmental attempt to prohibit access to a medication or treatment sought by an individual. *Cf. Rochin v. California*, 342 U.S. 165 (1952) (holding that forced stomach pumping of an arrested person to obtain evidence of illegal drug possession violated the Due Process Clause); *In re Cincinnati Radiation Litig.*, 874 F. Supp. 796 (S.D. Ohio 1995) (holding that the ability to pursue a wrongful-death claim based on radiation experiments conducted on cancer patients without their consent is a property interest protected by the Due Process Clause of the Fourteenth Amendment). *See generally* Gelman, *supra* note 85 (discussing the “biological alteration” cases). In addition, *Harper*, *Riggins*, and *Sell* were decided under the less strict standard of *Turner v. Safley*, 482 U.S. 78 (1987), for evaluating infringements on the liberty of prisoners. *See Sell*, 539 U.S. at 179–82 (applying the standard previously applied in *Harper*, 494 U.S. at 223–25, and *Riggins*, 504 U.S. at 134–35); *Riggins*, 504 U.S. at 134–35 (applying the standard previously applied in *Washington v. Harper*, 494 U.S. at 223–25); *Harper*, 494 U.S. at 223–25 (applying the standard from *Turner v. Safley*, 482 U.S. at 89). Nonetheless, the lack of deference to the legislature’s findings of medical fact in *Skinner*, for example, is noteworthy. *See Skinner*, 316 U.S. at 542 (“We have not the slightest basis for inferring that [the line drawn by the statute allowing sterilization of criminals convicted of larceny but not embezzlement] has any significance in eugenics, nor that the inheritability of criminal traits follows the neat legal distinctions which the law has marked between those two offenses.”). This lack of deference may be contrasted with the Court’s deferential stance in *Buck v. Bell*. *See Buck v. Bell*, 274 U.S. 200, 205, 207 (1927) (showing deference to the legislature’s findings that a “feeble minded” woman should be sterilized). *See generally* Lombardo, *supra* note 108 (discussing *Skinner* and *Buck* and tracing the origins of the reproductive-rights cases to those cases, as well as *Loving v. Virginia*, 388 U.S. 1 (1967)). Finally, it is interesting to note that even in the prisoner line of cases, the forced medication must be “medically appropriate” in order to be constitutional, suggesting that a prisoner might have a right to refuse antipsychotic treatment that would harm his health. *See, e.g., Harper*, 494 U.S. at 222–23, 222 & n.8 (discussing the requirement of medical appropriateness).

contraceptive device or material for her use.”¹⁵¹ 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.*”¹⁵²

Perhaps more importantly, contraceptives were sometimes prescribed for health reasons, and although health concerns receive only passing mention in one of the concurrences in *Griswold*, the toll on some women’s health caused by pregnancy was one of the driving concerns behind the birth-control movement.¹⁵³ 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.¹⁵⁴ 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.¹⁵⁵ The lack of a medical exception was also the subject of extensive litigation over Connecticut’s birth-control statute before *Griswold*.¹⁵⁶ *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*,¹⁵⁷ 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 down Massachusetts’s 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.¹⁵⁸ Justice Brennan’s majority opinion famously emphasized “the right of the *individual*, married

151. *Griswold v. Connecticut*, 381 U.S. 479, 480 (1965) (emphasis omitted).

152. *Id.* at 482 (emphasis added).

153. See *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” (citation omitted)); 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) (describing the impact that health concerns had on the development of Connecticut state law governing the use of birth control).

154. Dudziak, *supra* note 153, at 918.

155. *Id.* at 932.

156. *Id.* at 932–35.

157. 405 U.S. 438 (1972).

158. *Id.* at 442. 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.*

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,"¹⁵⁹ setting the stage for subsequent vindication of the right to abortion as an aspect of the right to privacy.¹⁶⁰

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.¹⁶¹ Both Justice White, in his concurrence, and Chief Justice Burger, in dissent, focused on this aspect of the case.¹⁶² Chief 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."¹⁶³ The majority, however, briskly dismissed the view that the Massachusetts law was a health measure,¹⁶⁴ 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.¹⁶⁵

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 "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."¹⁶⁶ 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.¹⁶⁷ Chief Justice Burger found that

159. *Id.* at 453.

160. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 857 (1992) (discussing the role of similar reasoning in Brennan's *Griswold* opinion in conceptualizing the privacy and birth-control cases that followed it).

161. DAVID J. GARROW, *LIBERTY AND SEXUALITY: THE RIGHT TO PRIVACY AND THE MAKING OF ROE V. WADE* 518–19 (1994).

162. *Eisenstadt*, 405 U.S. at 460–65 (White, J., concurring); *id.* at 465–72 (Burger, C.J., dissenting).

163. *Id.* at 469 (Burger, C.J., dissenting).

164. *Id.* at 452 (majority opinion) ("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 161, at 517–18.

165. See *Eisenstadt*, 405 U.S. at 447, 446–56 (discussing how, under the Equal Protection Clause analysis, no ground of difference "rationally explains the different treatment accorded married and unmarried persons" by Massachusetts law).

166. *Id.* at 463–64 (White, J., concurring).

167. *Id.* at 464.

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.”¹⁶⁸ 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.”¹⁶⁹ The disagreement between Justice White and Chief Justice Burger in *Eisenstadt* thus foreshadows the later dispute in *Carhart I* 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.¹⁷⁰

Roe v. Wade and its companion case *Doe v. Bolton*,¹⁷¹ 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.¹⁷² This latter perspective emerges most clearly in Justice Douglas’s concurrence; he viewed the decision as being at least partly about the constitutional right “to care for one’s health and person,”¹⁷³ or the “right to seek advice on one’s

168. *Id.* at 469 (Burger, C.J., dissenting).

169. *Id.* at 470.

170. *See supra* notes 42, 59–63 and accompanying text. In addition, the end of Chief Justice Burger’s opinion prophetically raises the specter of the Laetrile cases of the 1970s and 1980s. *Eisenstadt*, 405 U.S. at 472. The Chief Justice noted:

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.

Id.

171. 410 U.S. 179 (1973).

172. *See, e.g.*, *Roe v. Wade*, 410 U.S. 113, 153 (1973) (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*, 410 U.S. at 197 (mentioning the “woman’s right to receive medical care in accordance with her licensed physician’s best judgment and the physician’s right to administer it”); *see also, e.g.*, LAURENCE H. TRIBE, *ABORTION: THE CLASH OF ABSOLUTES* 13 (1990) (noting that Justice Blackmun had served as counsel to the Mayo Clinic prior to his appointment to the Supreme Court and suggesting that he may have been influenced by his medical background to focus the opinion on physicians rather than women’s equality); *cf.* Ruth Bader Ginsburg, *Speaking in a Judicial Voice*, 67 N.Y.U. L. REV. 1185, 1199–1200 (1992) (contrasting *Roe*’s emphasis on the physician’s judgment with *Casey*’s emphasis on sex equality). A recent, thoughtful article calls the commonly held view that Justice Blackmun was influenced by his health-law background into question, however. Nan D. Hunter, *Justice Blackmun, Abortion, and the Myth of Medical Independence*, 72 BROOK. L. REV. 147, 170 (2006) (“Yet it is apparent from his papers that Justice Blackmun brought no conscious agenda to this issue; indeed, he seems to have given it very little thought prior to joining the Court.”).

173. *Doe*, 410 U.S. at 213 (Douglas, J., concurring) (emphasis omitted).

health and the right to place reliance on the physician of one's choice;"¹⁷⁴ he viewed the abortion issue as "a medical one."¹⁷⁵ 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.¹⁷⁶

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."¹⁷⁷ *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.¹⁷⁸ 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 including *Carhart I* and *II*.

In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the decisional autonomy rationale seemed paramount.¹⁷⁹ 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

174. *Id.* at 219.

175. *Id.* at 215.

176. See Brief for Appellants at *94, *94–98, *Roe*, 410 U.S. 113 (No. 70-18), 1971 WL 128054 (arguing that "The Right to Seek and Receive Medical Care for the Protection of Health and Well-Being Is a Fundamental Personal Liberty Recognised 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 172, at 171–72 ("The substantive argument in the appellants' brief began with an assertion of a right to seek and receive medical care . . .").

177. *Roe*, 410 U.S. at 164, 163–64.

178. See *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 769 (1986) (observing that the Court had previously "recognized the undesirability of any 'trade-off' between the woman's health and additional percentage points of fetal survival" and that the State did "not take any real issue with this proposition").

179. See David B. Cruz, "The Sexual Freedom Cases"? *Contraception, Abortion, Abstinence, and the Constitution*, 35 HARV. C.R.-C.L. L. REV. 299, 313–14 (2000) (noting that *Casey* properly explicated the constitutional foundation of the reproductive rights cases in terms of a right to autonomy in making certain important personal decisions).

define the attributes of personhood were they formed under compulsion of the State.¹⁸⁰

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.¹⁸¹

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 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.¹⁸² In *Glucksberg*, the Supreme Court refused to recognize a fundamental "right to commit suicide which itself includes a right to assistance in doing so."¹⁸³ 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,¹⁸⁴ declined to extend the scope of that right to choosing medical treatment in the form of obtaining a prescription from one's physician for a drug that will hasten death.¹⁸⁵ 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. Justice O'Connor's concurrence 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

180. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992).

181. *Id.* at 857.

182. *See Washington v. Glucksberg*, 521 U.S. 702, 722–26 (1997).

183. *Id.* at 723.

184. *See 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 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).

185. *Glucksberg*, 521 U.S. at 720–22 (citing *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990)); *id.* at 753 (Souter, J., concurring) (noting that plaintiffs sought to obtain "medications . . . to be self-administered for the purpose of hastening . . . death" (omissions in original) (quoting Complaint ¶ 2.3, *Compassion in Dying v. Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994) (No. C94-119R))).

State's interests were sufficiently strong in the instant case to overcome any such right.¹⁸⁶ 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.¹⁸⁷

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 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*¹⁸⁸ 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.¹⁸⁹

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 merged 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*

186. *Id.* at 736, 736–37 (O'Connor, J., concurring).

187. See, e.g., Yale Kamisar, *On the Meaning and Impact of the Physician-Assisted Suicide Cases*, 82 MINN. L. REV. 895, 908 (1998) (noting evidence that five members of the Court would likely recognize a right to obtain death-inducing medication in order to alleviate suffering). 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 that the Court therefore did not need to decide whether patients had a right to be relieved 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. See *id.* at 745 (Stevens, J., concurring); *id.* at 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) ("The 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))).

188. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990).

189. *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," *id.*, Chief Justice Rehnquist 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," *id.* at 725, 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 727.

suggested would be required for any law interfering with a seriously ill patient's access to palliative care. *Carhart I*, 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 because the cases all pose fundamentally the same question. There are, of course, additional interests that may weigh in favor of 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 subpart, 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, like some of the Supreme Court cases discussed above, 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, 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*,¹⁹⁰ the U.S. District Court for the Southern District of Texas struck down a state regulation forbidding the practice of acupuncture by nonphysicians.¹⁹¹ 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

190. 498 F. Supp. 1038 (S.D. Tex. 1980).

191. *Id.* at 1057.

scrutiny.¹⁹² 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 of the safety and efficacy of the treatments.¹⁹³ Because 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 *Carey v. Population Services International*.¹⁹⁴

More recently, the D.C. Circuit surprised many commentators when it initially decided (before reversing itself en banc) 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.¹⁹⁵ 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.¹⁹⁶ The majority opinion relied in part on the importance and long persistence of the right to bodily integrity to decide that the Due Process Clause protected a right of self-preservation by prohibiting interference by the government with individuals' access to potentially life-saving drugs.¹⁹⁷

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."¹⁹⁸ Thus, the

192. *Id.* at 1048.

193. *Id.* at 1041, 1044.

194. *Id.* at 1046–51 (citing *Carey v. Population Servs. Int'l*, 431 U.S. 678 (1977)). The *Andrews* 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. *Id.* at 1056. The court thus did not recognize an unqualified right of patients to receive the treatment of their choice. See also *Sammon v. N.J. Bd. of Med. Exam'rs*, 66 F.3d 639, 647 (3d Cir. 1995) (asserting that individuals have "no constitutional right to their choice of a health care provider [i.e., a midwife] who does not meet quality control standards that a legislator might reasonably conceive to be desirable"); *Mitchell v. Clayton*, 995 F.2d 772, 775 (7th Cir. 1993) (rejecting patients' claim of a constitutional right to receive acupuncture treatment from a nonphysician).

195. *Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach*, 445 F.3d 470, 472 (D.C. Cir. 2006), *rev'd en banc*, 495 F.3d 695 (D.C. Cir. 2007); see Jerome Groopman, *The Right to a Trial*, NEW YORKER, Dec. 18, 2006, at 40, 42 (noting that the opinion "shocked legal scholars and officials at the F.D.A.").

196. *Abigail Alliance*, 445 F.3d at 478.

197. *Id.* at 479–86. 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 Laetrile to be safe, as the cancer drugs here were initially determined to be, see *id.* at 486 (quoting *Rutherford v. United States*, 616 F.2d 455, 457 (10th Cir. 1980)).

198. *Id.* at 487, 486–87 (Griffith, J., dissenting).

dissent complained, “[n]either the Constitution nor Congress has authorized this Court to determine which of these two litigants has a more scientifically and medically sound view.”¹⁹⁹ The dissent suggested, moreover, that the majority opinion would open the door to access to medical marijuana, among other unapproved treatments.²⁰⁰

In a subsequent en banc ruling, the D.C. Circuit reversed course, deciding that the fundamental right recognized by the initial panel did not in fact exist.²⁰¹ The court emphasized that the drugs at issue had not yet been proven either safe or effective,²⁰² which might explain its enigmatic statement, “We do not address the broader question of whether access to medicine might ever implicate fundamental rights.”²⁰³ By focusing on the lack of safety and efficacy of the drugs, the court implicitly deferred to the FDA’s view without giving any detailed consideration to the question of whether that view is necessarily entitled to deference—or in other words, how much proof of medical safety and efficacy is required, and who has the burden of proving it.²⁰⁴ Indeed, the court cited *OCBC, Rutherford*, and the Supreme Court’s opinion in *Gonzales v. Raich* to show that there is no “affirmative right of access to particular medical treatments reasonably prohibited by the Government.”²⁰⁵ The two dissenters, who were the two judges constituting the majority in the initial panel decision, predictably complained that the court should have “weigh[ed]” the interests of the government and the plaintiffs, and required “proof of the proposed government concerns, rather than merely accepting, under the rubric of rational basis scrutiny, any assertions the FDA chooses to offer.”²⁰⁶

Indeed, perhaps the most substantial line of lower court precedent has rejected any intimation of a constitutional right to choose appropriate medical treatment. The District Court for the District of Columbia has held, relying on the Laetrile cases, 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.²⁰⁷ Similarly, in *Kuromiya v. United States*,²⁰⁸ decided shortly before *OCBC*, the

199. *Id.* at 491.

200. *Id.* at 499.

201. *Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach*, 495 F.3d 695 (D.C. Cir. 2007) (en banc).

202. *Id.* at 703.

203. *Id.* at 701.

204. *See, e.g., id.* at 709 (finding no “constitutional right to override the collective judgment of the scientific and medical communities expressed through the FDA’s clinical testing process”).

205. *Id.* at 710 & n.18.

206. *Id.* at 714–15 (Rogers, J., dissenting).

207. *Smith v. Shalala*, 954 F. Supp. 1, 2 (D.D.C. 1996); *see also Kulsar v. Ambach*, 598 F. Supp. 1124, 1125–26 (W.D.N.Y. 1984) (relying on *Rutherford* and *Carnohan* to reject plaintiffs’ claim of constitutional right to access a hypoglycemia drug that the FDA had pulled from the market).

208. 37 F. Supp. 2d 717 (E.D. Pa. 1999).

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.²⁰⁹ 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 apply to the plaintiffs' claims, stating that "there is no fundamental right of privacy to select one's medical treatment without regard to criminal laws."²¹⁰ 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 Controlled Substances Act must be upheld; the existence of conflicting evidence was sufficient to require the court to uphold the prohibition—whereas in *Carhart I* 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.²¹¹

In another case, a court rejected, over a strong dissent, the 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*²¹² embraced the public-health approach in holding that rational basis review 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."²¹³ 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."²¹⁴ The dissent, by contrast, viewed the case as one in the line of autonomy cases, such as *Roe* and *Casey*.²¹⁵ 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."²¹⁶ The dissent thus believed that the majority should focus on the sufferings and the bodily

209. *Id.* at 725–27.

210. *Id.* at 726, 726–27.

211. *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.

212. 940 P.2d 604 (Wash. 1997) (en banc).

213. *Id.* at 618.

214. *Id.* at 618–19.

215. *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)).

216. *Id.* at 627.

integrity of the individual, instead of the alleged consequences to society of legalizing marijuana in some circumstances.²¹⁷

A similar pattern is apparent in *People v. Privitera*,²¹⁸ in which the California Supreme Court, writing prior to the Supreme Court and subsequent Tenth Circuit decisions in *Rutherford*, rejected the notion of a constitutional right to access Laetrile.²¹⁹ Emphasizing the state's police powers and legislative findings that Laetrile was ineffective and harmful, the court held that it would not "take[] sides" in the medical debate, allowing that "Laetrile advocates may yet be vindicated in the court of scientific opinion,"²²⁰ 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.²²¹ The impassioned dissent by then-Chief Justice Bird, by contrast, considered 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."²²² The dissent drew upon *Griswold*, *Roe*, and *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.²²³ 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."²²⁴

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

217. See *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).

218. 591 P.2d 919 (Cal. 1979).

219. *Id.* at 926.

220. *Id.* at 925.

221. *Id.* at 926, 924–26.

222. *Id.* at 927 (Bird, C.J., dissenting).

223. *Id.* at 923–36.

224. *Id.* at 946.

refusing to defer to legislative findings of medical fact in the face of ailing individuals' evidence to the contrary.²²⁵

Perhaps one of the most eloquent articulations of this conflict is contained in Justice Stevens's dissent in *Cruzan v. Director, Missouri Department of Health*, the "right-to-die" case. Taking the autonomy approach, Justice Stevens bemoaned the fact that the Court "permit[ted] the State's abstract, undifferentiated interest in the preservation of life to overwhelm the best interests of Nancy Beth Cruzan."²²⁶ But, he insisted, "the idea of life is not conceived separately from the idea of a living person. Yet, it is by precisely such a separation that Missouri asserts an interest in Nancy Cruzan's life in opposition to Nancy Cruzan's own interests."²²⁷ 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.²²⁸ This is precisely the drama that is repeated throughout the cases that alternately take the autonomy and public-health approaches to the right to make medical treatment choices.

D. *An Awkward Convergence: Gonzales v. Carhart*

Last Term, in *Gonzales v. Carhart* (*Carhart II*), the Supreme Court had the opportunity to reconsider the necessity of a health exception in D&X bans, as well as to reconcile the conflicting approaches represented by *Stenberg v. Carhart* (*Carhart I*) and *OCBC*. While it did the former with gusto, it only gestured toward the latter. The case clearly exhibited the tension between the two existing approaches but did not resolve it, opting instead to take a modest, procedurally oriented tack and to avoid direct confrontation with the issue of how the right to make medical treatment choices should be analyzed.

Carhart II involved a constitutional challenge to the federal Partial-Birth Abortion Ban Act (PBABA) of 2003, which outlaws D&X abortions "in or affecting interstate or foreign commerce," using terminology that is more precisely descriptive of the D&X procedure than that considered in

225. On occasion, as in *Rutherford* and *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 truly be said that the individual's right to medical treatment has been vindicated?

226. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 331 (1990) (Stevens, J., dissenting).

227. *Id.* at 347.

228. Michael Allen refers to this distinction as the (state's) "comprehensive interest" in human life, Allen, *supra* note 184, at 990, as opposed to the individual's "focused interest," *id.* at 989. See also Parmet, *Health Care*, *supra* note 89, at 270 (noting that constitutional cases dealing with health care all "question the relationship between the body politic and individuals who are facing the reality of physical vulnerability and, ultimately, biological mortality").

Carhart I.²²⁹ Like Nebraska's ban in *Carhart I*, however, the federal ban lacks a health exception.²³⁰ In its place, Congress put a series of findings explaining why no health exception is necessary. Those findings include medical statements, such as the statements that "[t]here is no credible medical evidence that partial-birth abortions are safe or are safer than other abortion procedures," that "[n]o controlled studies of partial-birth abortions have been conducted nor have any comparative studies been conducted to demonstrate its safety and efficacy compared to other abortion methods," and that "there have been no articles published in peer-reviewed journals that establish that partial-birth abortions are superior in any way to established abortion procedures."²³¹ They also include judgments such as that "[a] moral, medical, and ethical consensus exists that the practice of performing a partial-birth abortion . . . is a gruesome and inhumane procedure that is never medically necessary and should be prohibited,"²³² as well as legal conclusions supporting the necessity of deference to Congress by the federal courts in reviewing the PBABA.²³³

Justice Kennedy, who strongly dissented in *Carhart I*, wrote the majority opinion for a newly reconstituted Court in *Carhart II*, this time upholding the ban. Although the case has been met with consternation by pro-choice advocates and has been viewed as a shocking reversal of the Supreme Court's longstanding doctrine with respect to abortion rights,²³⁴ what is perhaps most surprising—at least considering the author of the opinion and the result—is the judicial modesty with which the Supreme Court ultimately acted in turning away the constitutional challenge.

The Court, upholding the PBABA in *Carhart II*, held first that the ban was written more precisely than the ban in *Carhart I* and therefore, in clearly restricting only D&X, was neither unconstitutionally vague nor unduly burdensome by prohibiting other, more common abortion procedures.²³⁵ Second, in a clear reversal of its prior approach to abortion cases—including that taken in *Carhart I*—the Court held that the absence of a health exception did not require invalidation of the PBABA on its face.²³⁶ Nonetheless, the Court did not explicitly overrule *Carhart I*, nor did it distinguish the prior case. Instead, the Court shed doubt on *Carhart I*'s demanding evidentiary standard for government attempts to regulate abortion procedures in a way

229. 18 U.S.C. § 1531 (2000 & Supp. V 2006).

230. *See id.*

231. Partial-Birth Abortion Ban Act of 2003, Pub. L. No. 108-105, § 2(14)(B), 117 Stat. 1201, 1204.

232. *Id.* § 2(1).

233. *Id.* § 2(3)–(12).

234. *See, e.g.,* Joanna Grossman & Linda McClain, *New Justices, New Rules: The Supreme Court Upholds the Federal Partial-Birth Abortion Ban Act of 2003*, FINDLAW'S WRIT, May 1, 2007, http://writ.news.findlaw.com/commentary/20070501_mcclain.html.

235. *Gonzales v. Carhart (Carhart II)*, 127 S. Ct. 1610, 1627 (2007).

236. *Id.* at 1632; *id.* at 1651 (Ginsburg, J., dissenting).

that may impose health risks,²³⁷ while still assuming that a regulation of abortion would be unconstitutional if it imposes significant health risks on the woman²³⁸ and leaving the door open for future as-applied challenges to abortion regulations lacking a health exception.²³⁹

The Court's reasoning and language often resembled the analytic structure of the public-health line of cases. For example, in language aptly criticized as paternalistic or worse, the Court, admittedly relying on "no reliable data," spoke of some women suffering psychological harm when they "regret their choice to abort the infant life they once created and sustained."²⁴⁰ The Court apparently reasoned that women might not know what really happens in a D&X abortion; that if they did know, many of them would not choose it or would later come to severely regret having chosen it; and therefore that the government may outlaw the procedure altogether for women's own good.²⁴¹ Such language, which suggests that the individual may be restricted in her liberty not only for society's greater good but also for her own good, is the quintessential talk of public-health protection.²⁴²

In addition, the Court at times appeared to behave as though the relevant standard to be applied in reviewing abortion restrictions were the rational basis standard, as if no particular constitutional right were at stake, rather than the heightened "undue burden" standard introduced by *Planned Parenthood of Southeastern Pennsylvania v. Casey*. Thus, the Court held:

The government may use its voice and its regulatory authority to show its profound respect for the life within the woman. . . . Where it has a rational basis to act, and it does not impose an undue burden, the State

237. *Id.* at 1638 (majority opinion).

238. *Id.* at 1635.

239. *Id.* at 1638–39; *see also id.* at 1651–52 (Ginsburg, J., dissenting).

240. *Id.* at 1634 (majority opinion); *see, e.g.*, Reva B. Siegel, *Sex Equality Arguments for Reproductive Rights: Their Critical Basis and Evolving Constitutional Expression*, 56 EMORY L.J. 815, 837–38 (2007) (describing Justice Ginsburg's criticism of the majority's decision based on its disrespect for women's autonomy).

241. *See Carhart II*, 127 S. Ct. at 1648–49 (Ginsburg, J., dissenting) ("The solution the Court approves, then, is *not* to require doctors to inform women, accurately and adequately Instead, the Court deprives women of the right to make an autonomous choice, even at the expense of their safety.").

242. *See, e.g.*, GOSTIN, *supra* note 77, at 91, 90–91 (noting that paternalistic regulation is sometimes justified by the fact that "individuals have cognitive limits;" that is, they "frequently make choices without full information about the risks"); *cf.* Siegel, *supra* note 240, at 837–38 (discussing the "woman-protective" language in *Carhart II*); Reva B. Siegel, *The New Politics of Abortion: An Equality Analysis of Woman-Protective Abortion Restrictions*, 2007 U. ILL. L. REV. 991, 1030 (observing, prior to *Carhart II*, that some "woman-protective" abortion restrictions were justified in the "language of public health (i.e., abortion is a bad choice)"). *Carhart II*'s language may be contrasted with the antipaternalistic tone struck by the Court in *Thompson v. Western States Medical Center*, 535 U.S. 357, 374, 374–75 (2002) (rejecting as invalid the Government's concern "that people would make bad decisions if given truthful information about" certain prescription drugs). Although that case dealt with regulation of prescription drugs—a traditional area of public-health concern—the Court struck down Congress's restrictions on advertising of compound drugs under the First Amendment. *Id.*

may use its regulatory power to bar certain procedures and substitute others, all in furtherance of its legitimate interests in regulating the medical profession in order to promote respect for life, including life of the unborn.²⁴³

On closer examination, however, it becomes clear that the Court was not actually applying the rational basis standard to this particular abortion restriction. Rather, the rational basis language appears in the section of the opinion in which the Court considered whether the PBABA had the *purpose*, as opposed to the *effect*, of imposing an undue burden on women seeking abortions. As such, the rational basis language refers to the Court's view that the government had a rational purpose or reason for acting as it did—namely, “protecting the integrity and ethics of the medical profession” by showing “respect for the dignity of [fetal] human life”—and that it therefore was not acting with the purpose of imposing an undue burden.²⁴⁴ Moreover, the “rational basis” language is accompanied by the “undue burden” language in the very same sentence.

Perhaps most significantly, the Court appeared to take a substantially more deferential approach to Congress's findings than it had taken to Nebraska's view of medical facts in *Carhart I*. The Court insisted, as had Justice Kennedy in his *Carhart I* dissent,²⁴⁵ that “[m]edical uncertainty does not foreclose the exercise of legislative power in the abortion context any more than it does in other contexts.”²⁴⁶ It then equivocated, however, stating, “Although we review congressional factfinding under a deferential standard, we do not in the circumstances here place dispositive weight on Congress' findings.”²⁴⁷ Perhaps most surprisingly, in the very next sentence, the Court asserted that it “retains an independent constitutional duty to review factual findings where constitutional rights are at stake,”²⁴⁸ thus citing the “constitutional fact” doctrine, which has not been consistently applied outside the context of the First Amendment's free-speech protections.²⁴⁹ After noting that some of the congressional findings were simply incorrect, the Court then concluded that “[u]ncritical deference to Congress' factual findings in these cases [was] inappropriate.”²⁵⁰ Moreover, although it did not give the plaintiffs' evidence as much weight as it had in *Carhart I*, it is

243. *Carhart II*, 127 S. Ct. at 1633.

244. *Id.* Indeed, the Court began part IV of its opinion by explaining that the PBABA would be unconstitutional if it had either the purpose or the effect of imposing an undue burden on women seeking abortions. *Id.* at 1632. Part IV(A) proceeds to analyze the purpose prong, whereas part IV(B) analyzes the effects prong. *Id.* at 1632–35.

245. See *Stenberg v. Carhart (Carhart I)*, 530 U.S. 914, 968 (2000) (Kennedy, J., dissenting).

246. *Carhart II*, 127 S. Ct. at 1637.

247. *Id.*

248. *Id.*

249. See, e.g., Adam Hoffman, Note, *Corralling Constitutional Fact: De Novo Fact Review in the Federal Appellate Courts*, 50 DUKE L.J. 1427, 1453 (2001) (“The area of the law to which the doctrine of constitutional fact has been most consistently applied is the First Amendment.”).

250. *Carhart II*, 127 S. Ct. at 1638.

noteworthy that the Court at least considered conflicting testimony presented by the parties' experts, as it had declined to do in *OCBC*.²⁵¹ The Court can therefore be said to have taken a more deferential approach to legislative facts than in *Carhart I*, but not as deferential as in *OCBC*.

Indeed, the key to understanding the Court's approach to Congress's findings of fact is perhaps contained in this sentence: "The medical uncertainty over whether the Act's prohibition creates significant health risks provides a sufficient basis to conclude *in this facial attack* that the Act does not impose an undue burden."²⁵² In other words, the Court concluded that a facial challenge to the law was a particularly inappropriate setting for sorting out the medical facts, as compared to an as-applied challenge—including a preenforcement as-applied challenge—in which the plaintiffs could present evidence showing that "in discrete and well-defined instances a particular condition has or is likely to occur in which the procedure prohibited by the Act must be used."²⁵³ As such, the Court avoided deciding what degree of deference to Congress's findings of medical fact was appropriate; it simply decided that the factual issues would have to be sorted out in a different case, presented in a different procedural posture.

Finally, *Carhart II* modified the holding of *Carhart I* in a significant way: in addition to doing away with *Carhart I*'s evidentiary standard, in which the government largely bears the burden of demonstrating that its abortion regulation will not threaten women's health, the Court analyzed the need for a health exception under the "undue burden" rubric, rather than treating it as a separate and independent constitutional requirement.²⁵⁴ Although some language in *Casey* could be read to suggest that the health exception was subject to undue burden analysis, the consensus had previously been that the health exception was a freestanding constitutional requirement.²⁵⁵ By subjecting the health exception to undue burden analysis, in which the burden is on the challenger to show that the abortion regulation puts a substantial obstacle in the path of women seeking abortions, the Court allows less discretion to physicians and most likely denies D&X procedures to women who need it for reasons that the courts would not deem sufficiently weighty.²⁵⁶

251. *Id.* at 1635.

252. *Id.* at 1637 (emphasis added).

253. *Id.* at 1638. Justice Ginsburg's dissent takes issue with the notion that such evidence cannot be dealt with in a facial challenge, and she notes that the record in the instant case contained detailed discussions of such medical conditions and the risk that would result from using an alternate procedure. *Id.* at 1652 (Ginsburg, J., dissenting).

254. *See id.* at 1637 (majority opinion) ("The medical uncertainty over whether the Act's prohibition creates significant health risks provides a sufficient basis to conclude in this facial attack that the Act does not impose an undue burden.").

255. *See supra* note 60.

256. *Cf. Borgmann, supra* note 71, at 699–700 (discussing the potential negative effects of language in *Casey* that "seemed to subsume the medical emergency exception within the undue burden test").

Ultimately, while *Carhart II* clearly changed the abortion-rights landscape in important ways, it also left some important aspects of the law unchanged. *Carhart II* may be read to acknowledge that a health exception is still required for abortion regulations to the extent that they can be shown by one party's medical evidence to impose significant health risks for certain women. In addition, *Carhart II*'s preference for as-applied challenges should not be understood to foreclose all but the most unlikely challenges—those by individual women with pressing health reasons for needing the D&X procedure. Rather, the Court made it clear that the medical issues could still be considered in the context of *preeenforcement* as-applied challenges.²⁵⁷ Of course, one might, like Justice Ginsburg, question exactly what such a preenforcement as-applied challenge would look like or how it would meaningfully differ from the instant facial challenge. Presumably, such a challenge would be brought by physicians claiming that they needed to use the D&X procedure in particular circumstances, such as where the woman suffers from cancer and preeclampsia, or in cases of fetal hydrocephaly.²⁵⁸ The plaintiffs would then presumably be given the opportunity to present medical evidence, such as expert testimony and medical-journal articles, much like what was already contained in the record in *Carhart II*, demonstrating that the procedure is necessary in those circumstances to avoid significant risks to the health of the woman. The court could then issue an injunction against the law as applied to women with particular health conditions, for example, but the court could not strike down the law on its face.

Yet if this is what the Court hopes for, and if the heart of the issue is thus simply one of remedy—of the form that the injunction will take—it is unclear why such an injunction could not have been issued in the original *Carhart II* litigation.²⁵⁹ In any case, such a lawsuit would not result in courts

257. *Carhart II*, 127 S. Ct. at 1638 (“The Government has acknowledged that preenforcement, as-applied challenges to the Act can be maintained. This is the proper manner to protect the health of the woman if it can be shown that in discrete and well-defined instances a particular condition has or is likely to occur in which the procedure prohibited by the Act must be used.” (citation omitted)).

258. See Transcript of Oral Argument at 22–23, *Carhart II*, 127 S. Ct. 1610 (No. 05-380) (discussing a hypothetical as-applied challenge based on the necessity of the D&X procedure to treat preeclampsia); see also *Stenberg v. Carhart (Carhart I)*, 530 U.S. 914, 929 (2000) (“The materials presented at trial referred to the potential benefits of the D&X procedure in circumstances involving nonviable fetuses, such as fetuses with abnormal fluid accumulation in the brain (hydrocephaly).”).

259. Perhaps this reading of *Carhart II*, which takes the Court's language at face value, is overly optimistic. In *Casey*, the Court declined to strike down a law imposing a twenty-four-hour waiting period, and the plurality emphasized that the particular record before the district court had been insufficient. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 887 (1992). There was, however, extensive evidence in the record of the requirement's unduly burdensome nature. See Borgmann, *supra* note 71, at 683 & n.62. Moreover, although Justice Blackmun, in dissent, took comfort in the notion that the Court had left open the possibility of future challenges on a different or more complete record, see *Casey*, 505 U.S. at 926, 938 n.9 (Blackmun, J., concurring in part and dissenting in part), no waiting-period law has ever been permanently struck down by the federal

deferring more to legislative judgments about medical issues; rather, it would ironically involve courts further in deciding and weighing medical questions, rather than leaving it to physicians to decide when a procedure is medically necessary. Nonetheless, taking the *Carhart II* majority at its word indicates that abortion regulations must still be lifted when they impose significant health risks on the woman; the means of achieving that result must simply be more procedurally modest and incremental than in the past.²⁶⁰

IV. Healing the Body of Doctrine

A. *Some Nonexplanations*

What, then, explains the different approaches taken by the Supreme Court regarding the right to make autonomous medical treatment decisions? 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 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 into the abortion and contraception cases, it is possible to separate that general right from the right that motivated the Court in *Roe* to hold (and to continue to assume) that a health exception is required whenever the state regulates abortion, previability or postviability, in a way that may impose significant health risks. Indeed, Eugene Volokh has recently argued that the abortion right actually consists of two different rights—a “right to abortion as reproductive choice” and a right to “medical self-defense,” which he defines

courts after *Casey*. There is thus reason to believe that a subsequent as-applied challenge to a D&X ban would meet the same fate. Additionally, as Justice Ginsburg pointed out at oral argument, it may not always be possible to generalize about the situations in which a health exception is needed; sometimes it may depend on the particular woman’s overall health picture, or on the doctor’s skill and comfort level with certain procedures. Transcript of Oral Argument, *supra* note 258, at 23–24.

260. *Cf. Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 328–32 (2006) (seeking a narrowly crafted remedy on remand rather than invalidating a New Hampshire abortion regulation statute in its entirety).

as “a right to defend oneself using medical care, even when this requires destroying the source of the threat.”²⁶¹

Thus, the right at stake in *Carhart I* and *II* is different from the right to reproductive choice. As explicated in *Casey*, the right to choose an abortion is most commonly understood as a right to be free from government intrusion into certain “personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education.”²⁶² 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, potential emotional anguish, and long-term, if not lifelong, emotional, moral, and financial ties and responsibilities.²⁶³ *Carhart I* and *II*, however, are 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 have the right, in consultation with a physician, to protect their health and to make medical treatment choices without unwarranted government interference.

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, say 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 and risk of even a normal pregnancy solely for the sake of the fetus.²⁶⁴ 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.

261. Eugene Volokh, *Medical Self-Defense, Prohibited Experimental Therapies, and Payment for Organs*, 120 HARV. L. REV. 1813, 1824 (2007). Volokh also notes that a woman possesses this right even when her health—and not her life—is at stake. *Id.* at 1824 n.53.

262. *Casey*, 505 U.S. at 851; see Cruz, *supra* note 179, at 313–14 (describing *Casey* as offering “a better explication of [the abortion] right’s constitutional foundation”).

263. *Casey*, 505 U.S. at 852, 852–53.

264. Susan Frelich Appleton, *Unraveling the “Seamless Garment”: Loose Threads in Pro-Life Progressivism*, 2 U. ST. THOMAS L.J. 294, 299, 299–300 (2005). Others have made this argument, perhaps most famously Judith Jarvis Thomson. See Judith Jarvis Thomson, *A Defense of Abortion*, 1 PHIL. & PUB. AFF. 47 (1971). I am indebted to Professor Appleton for encouraging me to address this line of argument.

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 situations, 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. 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. Conversely, although many of the autonomy cases are abortion or contraception cases, challenging restrictions on medical practices that affect only women, not all of those cases are abortion or contraception cases. The implications of *Glucksberg* 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 others).²⁶⁵ 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 cases involve threats to the health of others, and therefore the public good, in a way that the autonomy cases generally do not. Put differently, the public-health cases involve negative externalities that go beyond the individual patient.²⁶⁶

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, may be considered quite powerful, as well as different in kind from the harm of a medical treatment like aggressive and

265. See GOSTIN, *supra* note 77, at 85 ("Public health regulation entails potential trade-offs between public goods and private interests."); cf. Burris, *supra* note 90, at 933 (defining "public health law" broadly as "cases concerning state action taken in the name of preventing ill health or promoting good health").

266. Cf. CHRISTOPHER G. TIEDEMAN, A TREATISE ON THE LIMITATIONS OF THE POLICE POWER IN THE UNITED STATES 205 (St. Louis, F.H. Thomas Law Book Co. 1886). Tiedeman articulated the limitations of the state's police powers in the public health context as follows:

[T]he police power of the State can never be exercised in favor of, or against any system of medicine. The police power can be brought to bear upon quacks, and disreputable practitioners, to whichever school they may belong, but when reputable and intelligent members of the profession differ in theories of practice, the State has no power to determine which of them, if either, is wrong.

Id.

life-shortening palliative care, which is limited to the individual.²⁶⁷ But the autonomy-oriented abortion cases hold that the state's interest in preserving viable fetuses is also a compelling one. Whether this last interest may be categorized as affecting the "public good," in the traditional public-health sense of the term, or as regulating an "externality" in economic terms is perhaps a philosophical question beyond the scope of this Article. Most likely, the concepts of externalities, public good, and harm to others are ultimately far too vague and malleable to be of much help in explaining the two separate lines of cases. In any case, it seems, at least from a constitutional perspective, that the state interests articulated in autonomy cases, such as *Roe*, are no less important than the public-health interests that lie behind the *Laetrile* and medical-marijuana cases.

Moreover, at least until *Carhart II*, the Supreme Court rarely indicated that its decisions hinged on the merits of the asserted governmental interests.²⁶⁸ The majority in *Carhart I*, following *Roe*, 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."²⁶⁹ 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.²⁷⁰

267. See, e.g., Asa Hutchinson, *An Effective Drug Policy to Protect America's Youth and Communities*, 30 *FORDHAM URB. L.J.* 441, 454–56 (2003) (detailing some of the harms resulting from illegal drugs). *But cf.* Conant v. McCaffrey, 172 *F.R.D.* 681, 694 n.5 (N.D. Cal. 1997) ("It is unreasonable to believe that use of medical marijuana by this discrete population for this limited purpose will create a significant drug problem."); Noah, *supra* note 42, at 57 (suggesting that the FDA may be overly concerned about patients' use of controlled substances, as when it has approved painkillers with serious and potentially fatal side effects because they will substitute for narcotics that would otherwise be prescribed). One might also argue that it is the prohibition of drugs, and not the drugs themselves, that leads to violence and crime.

268. *But see* Meyer, *supra* note 74, at 1171, 1171–72 (arguing that the Court's opinion in *Carhart I* "must rest upon a[n] . . . unstated judgment about the relative weight of the competing interests").

269. Stenberg v. Carhart (*Carhart I*), 530 U.S. 914, 937 (2000).

270. E.g., *United States v. Osburn*, No. C 02-939 AHM, 2003 U.S. Dist. LEXIS 8607, at *5–6 (C.D. Cal. Apr. 15, 2003) ("Defendants have not established that they have any protected, fundamental right to the choice of a particular treatment or medicine."); *Raich v. Ashcroft*, 248 F. Supp. 2d 918, 927–28 (N.D. Cal. 2003) ("While plaintiffs may vehemently disagree with the wisdom of the federal government's determination that marijuana has no medical efficacy . . . they do not have a fundamental, constitutional right to obtain and use it for treatment."); *United States v. Cannabis Cultivator's Club*, No. C 98-00085 CRB, 1999 WL 111893, at *2, *1–3 (N.D. Cal. Feb. 25, 1999) ("[T]here is no constitutional right to obtain medication free from the lawful exercise of the government's police powers.").

Perhaps *Glucksberg* and *Carhart II* can be read to call for such balancing;²⁷¹ 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 contradicting the efficacy and safety of vaccines or recommending the use of Laetrile, for example. On the other hand, the Court in *Carhart I* specifically required, and found, substantial evidence to support the medical necessity of D&X.²⁷²

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 Chief Justice Burger in *Eisenstadt* refused to accept the notion that the state should be required to support its public-health decisions at all.²⁷³ Thus, although the degree of

271. See also *Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach*, 469 F.3d 129, 138 (D.C. Cir. 2006), *rev'd en banc*, 495 F.3d 695 (D.C. Cir. 2007) (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"); *Abigail Alliance*, 495 F.3d at 716 (Rogers, J., dissenting) ("[T]he claimed fundamental right is to attempt to preserve one's life; whether the risks associated with doing so justify restraining that right is properly considered only after the right is deemed fundamental.").

272. See *Carhart I*, 530 U.S. at 937 ("[A] significant body of medical opinion believes [the] procedure may bring with it greater safety for some patients and explains the medical reasons supporting that view . . .").

273. *Eisenstadt v. Baird*, 405 U.S. 438, 468 (1972) (Burger, C.J., dissenting). The Chief Justice argued:

medical evidence supporting a particular intervention may explain some of the outcomes, it does not explain the reasoning of the relevant cases.²⁷⁴

B. The Right to Make Medical Treatment Choices: Existence of the Right

In the final subparts of this Article, 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. I also suggest that *Carhart II* may provide a template for how the Court could analyze claims of a right to make medical treatment choices in the future.

An important contention of this Article, and the inevitable conclusion to be drawn from my review of the case law, is thus that the Supreme Court has already recognized a substantive-due-process right to make medical treatment decisions without unwarranted government interference. 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 I*, *Griswold*, and *Botsford*, in which the Court never suggested that any governmental interest would be sufficient to override the plaintiff’s bodily integrity right—but has

It is possible, of course, that some members of the Massachusetts Legislature desired contraceptives to be dispensed only through medical channels in order to minimize their use, rather than to protect the health of their users, but I do not think it is the proper function of this Court to dismiss as dubious a state court’s explication of a state statute absent overwhelming and irrefutable reasons for doing so.

Id.

274. 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 into the doctor–patient relationship. As several commentators have noted, surgery is subject to far less legal regulation than drugs. *See, e.g.,* Amer S. Ahmed, Note, *The Last Twist of the Knife: Encouraging the Regulation of Innovative Surgical Procedures*, 105 COLUM. L. REV. 1529, 1530–32, 1532 n.17 (2005) (citing sources comparing surgery regulation with drug regulation). It is not apparent that there is any good reason behind this discrepancy, however. *See 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.

sometimes suggested that bodily integrity is a right that must be balanced against legitimate governmental interests, as in *Glucksberg* and *Carhart II*. Nevertheless, 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-defense²⁷⁵—a right to which even Justice Scalia might grant constitutional status.²⁷⁶ 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.²⁷⁷ Indeed, even *Jacobson v. Massachusetts*, the original public-health case, recognized the necessity of a health exception to actions otherwise within the state’s police power; even *Gonzales v. Carhart* assumed that abortion regulations imposing substantial health risks would be unconstitutional; and even the en banc opinion in *Abigail Alliance* left open the possibility that individuals might have a constitutional right to access safe and effective medical treatments that could save their lives.²⁷⁸

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.²⁷⁹ 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. Finally, *Whalen v.*

275. Volokh, *supra* note 261, at 1815–18.

276. *See id.* at 1818 & n.17 (noting that Justice Scalia authored a plurality opinion suggesting that there is a substantive-due-process right to self-defense (citing *Montana v. Egelhoff*, 518 U.S. 37, 56 (1996) (plurality opinion))).

277. John A. Robertson, *Embryo Culture and the “Culture of Life”: Constitutional Issues in the Embryonic Stem Cell Debate*, 2006 U. CHI. LEGAL F. 1, 7–15. This Article, too, argues only that there is a negative, not positive, right to make medical treatment choices—that is, it asserts that there is a right against government interference with medical decision making but does not mean to suggest that there is a right to have government-financed access to medical treatment. On the distinction between negative and positive rights, see Cass R. Sunstein, *A New Progressivism*, 17 STAN. L. & POL’Y REV. 197, 206, 206–07 (2006) (distinguishing between “barriers to government action” and “entitlements to government protection”).

278. *See also* *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 327 (2006) (noting that the state did not dispute the constitutional requirement that minors have access to abortion when necessary to preserve their life or health); Michael C. Dorf, *The Supreme Court’s Surprisingly Unanimous Abortion Decision: A Parting Gift for Justice O’Connor?*, FINDLAW’S WRIT, Jan. 30, 2006, <http://writ.findlaw.com/dorf/20060130.html> (arguing, in discussing *Ayotte v. Planned Parenthood*, that a minor woman “has a constitutional right to be free of state regulation that effectively subjects her to a serious 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 of whether an abortion prohibition without a health exception would be constitutional).

279. *See supra* notes 128–32 and accompanying text.

Roe alluded, albeit ambiguously, to the “right to decide independently, with the advice of [a] physician, to acquire and to use needed medication.”²⁸⁰ It is therefore not necessary to argue that the Supreme Court should recognize a new right—as it is in any case unlikely to do²⁸¹—to believe that neither the initial D.C. Circuit panel in *Abigail Alliance* nor the plaintiffs before the Ninth Circuit on remand in *Raich* were on completely shaky ground.²⁸²

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.²⁸³ First, those wishing to challenge government action would most likely have to show that the government action actually burdens the constitutional right to make medical treatment choices.²⁸⁴ Thus, a criminal prohibition on using marijuana, even for

280. *Whalen v. Roe*, 429 U.S. 589, 603 (1977).

281. See Mariner et al., *supra* note 107, at 587 (“During the past decade, the Court has been reluctant to recognize constitutional protection for new aspects of liberty.”); Brian Hawkins, Note, *The Glucksberg Renaissance: Substantive Due Process Since Lawrence v. Texas*, 105 MICH. L. REV. 409, 428–29, 430 (2006) (concluding, from a review of cases citing *Glucksberg* and *Lawrence*, that there is a strong judicial reluctance to recognize new constitutional rights). Other commentators have made the argument that the Court should recognize an individual substantive-due-process right to access specific medical treatments, such as medical marijuana or treatments resulting from embryonic-stem-cell research. See, e.g., Robertson, *supra* note 277, at 7–15 (arguing that there is a constitutional right to access embryonic-stem-cell-derived medical therapies); Matthew Segal, Note, *Overdue Process: Why Denial of Physician-Prescribed Marijuana to Terminally Ill Patients Violates the United States Constitution*, 22 SEATTLE U. L. REV. 235, 237 (1998) (arguing that laws denying medicinal marijuana “violate[] the Due Process Clauses of the Fifth and Fourteenth Amendments”); Note, *Last Resorts and Fundamental Rights: The Substantive Due Process Implications of Prohibitions on Medical Marijuana*, 118 HARV. L. REV. 1985, 1985 (2005) (“[A] law completely banning the use of marijuana will, as applied to some patients, infringe upon an array of fundamental rights . . .”).

282. Perhaps the fact that courts generally apply the overly formalistic analysis set out in *Glucksberg*, according to which they must both engage in a “careful description of the asserted fundamental liberty interest,” *Washington v. Glucksberg*, 521 U.S. 702, 721 (1997) (quoting *Reno v. Flores*, 507 U.S. 292, 302 (1993)), and determine whether that interest is “deeply rooted in this Nation’s history and tradition,” *id.* (quoting *Moore v. City of East Cleveland*, 431 U.S. 494, 502 (1977)), and “implicit in the concept of ordered liberty,” *id.* (quoting *Palko v. Connecticut*, 302 U.S. 319, 325 (1937)), generally resulting in a very narrow view of the rights that are protected by substantive due process, has caused courts to overlook the right to autonomy in medical treatment choices that clearly runs through Supreme Court jurisprudence. Interestingly, courts have continued to apply the *Glucksberg* analysis, although the Supreme Court apparently abandoned it in *Lawrence v. Texas*. See generally Hawkins, *supra* note 281, at 411 (chronicling the lower courts’ continued application of the *Glucksberg* test in 102 cases decided since *Lawrence*).

283. 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 (2007) (“If access to experimental drugs is considered a fundamental right, the FDA’s regulatory authority is inevitably diminished, as is its ability to conduct premarket review of new pharmaceuticals for safety and effectiveness.”).

284. The notion of “burden” as part of the substantive-due-process analysis is familiar from *Casey*, which instituted the “undue burden” standard for determining when a government regulation actually strikes at the heart of the abortion right. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S.

medicinal purposes and pursuant to a physician's prescription, probably burdens the right; a requirement that medical cannabis users place their names in a national registry probably does not.²⁸⁵ Second, the challengers would have to overcome any asserted government interest capable of outweighing their right. At least in this scenario, however, individuals could challenge even traditional public-health regulations and force the government to come forward with some evidence to support its medical judgments when there is reason to doubt their validity.

Given this framework, it seems 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.²⁸⁶ 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: either in determining whether the individual right is actually burdened or in determining whether any state interests outweigh the claimant's right.

C. *To Defer or Not to Defer*

Although legislative facts have probably always played a role in constitutional adjudication, the debate over the extent to which courts should defer to legislative findings of fact may be traced back at least to the early twentieth century.²⁸⁷ Disagreement was manifest in *Lochner*-era cases between Justice Oliver Wendell Holmes, for example, who dissented in

833, 874 (1992). In addition, the notion of burden, or “magnitude of the disadvantage,” has long played an important role, sometimes acknowledged and sometimes unacknowledged, in the “fundamental rights” strain of equal protection analysis. See Gary J. Simson, *A Method for Analyzing Discriminatory Effects Under the Equal Protection Clause*, 29 STAN. L. REV. 663, 673, 673–75 (1977) (discussing cases in which the Burger Court implicitly incorporated a “magnitude of the disadvantage” calculus into equal protection decisions).

285. *Cf. Whalen*, 429 U.S. at 598–604 (holding that a registration requirement does not pose a serious threat to a patient's right to make important medical decisions independently).

286. Again, it is possible that the *Glucksberg* framework encourages this short-circuiting, since it forces courts to focus on narrowly articulating the specific constitutional right that is being claimed and then determining whether that right is supported by tradition and history. In the context of claims to autonomy in medical treatment decisions, this process shifts focus away from the medical and scientific questions such as safety, efficacy, and medical necessity.

287. David L. Faigman, “Normative Constitutional Fact-Finding”: *Exploring the Empirical Component of Constitutional Interpretation*, 139 U. PA. L. REV. 541, 553–64 (1991). I am here referring to “legislative facts,” a term famously coined by Professor Kenneth Culp Davis in an article entitled *An Approach to Problems of Evidence in the Administrative Process*, 55 HARV. L. REV. 364 (1942). Legislative facts, according to Davis, are “the facts which inform . . . legislative judgment,” in contrast to “adjudicative facts,” which are “facts concerning immediate parties—what the parties did, what the circumstances were, what the background conditions were,” and so on. *Id.* at 402. Confusingly, some commentators use the term “legislative facts” interchangeably with “constitutional facts” when discussing constitutional cases, see, e.g., Faigman, *supra*, at 552–53, and others distinguish between the two, see, e.g., Hoffman, *supra* note 249, at 1434–35 (treating constitutional facts as a type of adjudicative fact).

Lochner,²⁸⁸ and Justices Peckham and Harlan over the necessity of deferring to legislatures on factual matters and on social policy more generally.²⁸⁹ Despite this long history, there has been little consistency in courts' treatment of legislative facts.²⁹⁰ For the most part, however, the Supreme Court has emphasized the superiority of legislatures over courts in finding facts,²⁹¹ and the conventional wisdom holds that courts should defer to legislative fact-finding for at least three reasons: first, that separation of powers allocates to legislatures the fact-dependent task of determining social policy; second, that democratic institutions possess more legitimacy than courts when finding facts; and third, that legislatures are more competent than courts at finding facts.²⁹²

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.²⁹³

288. *Lochner v. New York*, 198 U.S. 45 (1905), *overruled in part by* *Day-Brite Lighting, Inc. v. Missouri*, 342 U.S. 421 (1952) and *Ferguson v. Skrupa*, 372 U.S. 726 (1963).

289. *See, e.g.*, Faigman, *supra* note 287, at 559–64, 562 n.73, 564 n.86. It is interesting to note that this debate in *Lochner* took place in the context of what was considered a “public health” measure.

290. *See, e.g.*, DAVID L. FAIGMAN, *LABORATORY OF JUSTICE: THE SUPREME COURT’S 200-YEAR STRUGGLE TO INTEGRATE SCIENCE AND THE LAW* 364 (2004) (noting that despite the passage of time, the Court remains inconsistent in deciding “under what circumstances [it] should be deferential to legislatures”).

291. *Id.*

292. Note, *Deference to Legislative Fact Determinations in First Amendment Cases after Turner Broadcasting*, 111 HARV. L. REV. 2312, 2315–16 (1998). 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. 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 fact-finding; this nondeference must be justified independently. *Compare, e.g.*, *Turner Broad. Sys., Inc. v. FCC*, 520 U.S. 180, 195–208 (1997) (deferring to Congressional fact-finding in an intermediate-scrutiny context), with *Schad v. Borough of Mount Ephraim*, 452 U.S. 61, 72–74 (1981) (refusing to defer to a local government’s fact-finding where that government failed to provide evidence of harms of nude dancing). *See generally* Daniel J. Solove, *The Darkest Domain: Deference, Judicial Review, and the Bill of Rights*, 84 IOWA L. REV. 941, 961–62 (1999) (noting that courts often defer to other decision makers even when fundamental rights protected by heightened scrutiny are at stake); Harper Jean Tobin, *Confronting Questionable Abortion Information: Informed Consent, Deference, and Fetal Pain Laws*, 16 COLUM. J. GENDER & L. (forthcoming 2008) (manuscript at 25, on file with author) (asserting that deference to legislative fact-finding has a role in factually close issues). Although it may well be a good rule that courts should not defer to legislatures whenever constitutional rights are at stake, I do not take a position on that question here, as it is beyond the scope of this Article. *Cf.* Note, *supra*, at 2316–23 (arguing that deference is inconsonant with First Amendment norms such as judicial primacy and the need for accurate decision making when important individual rights, requiring protection from the majority, are at stake). I simply argue that such nondeference is not the current state of the law.

293. *See, e.g.*, Neal Devins, *Congressional Factfinding and the Scope of Judicial Review: A Preliminary Analysis*, 50 DUKE L.J. 1169, 1178 (2001) (noting the traditional argument that “Congress has numerous advantages over the courts in pursuing information. Legislatures, as compared to courts, ‘have substantial staff, funds, time and procedures to devote to effective

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.²⁹⁴ And whereas a court's judgment is ossified in legal precedent as constituting a quasi-legal determination, often without any mechanism for reopening an issue of legislative fact previously decided, legislatures can revisit and revise previous legislative decisions as necessary to adapt them to changing factual circumstances.²⁹⁵

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,²⁹⁶ or for a state legislature to determine whether a minimum-wage requirement is necessary to prevent exploitation of workers,²⁹⁷ 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 *pi*.²⁹⁸ 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-

information gathering and sorting.” (quoting Robin Charlow, *Judicial Review, Equal Protection and the Problem with Plebiscites*, 79 CORNELL L. REV. 527, 578 (1994)); 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, 1740 (2002) (“A wide variety of resources, unmatched by any other legislature of the world, are at the disposal of members [of Congress] and their committees.”).

294. Devins, *supra* note 293, at 1169–70, 1179.

295. *Id.* at 1180; cf. *A Woman's Choice-East Side Women's Clinic v. Newman*, 305 F.3d 684, 688, 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”).

296. See *Nev. Dep't of Human Res. v. Hibbs*, 538 U.S. 721, 728–32 (2003) (discussing the extensive statistical and testimonial record before Congress of widespread gender discrimination in family-leave policies as a basis for passage of the Family and Medical Leave Act).

297. See *W. Coast Hotel Co. v. Parrish*, 300 U.S. 379, 398–99 (1937) (upholding Washington's minimum-wage law for women in deference to state legislative findings that the law was necessary for protecting the health of female workers).

298. See Jonathan L. Entin, *Innumeracy and Jurisprudence: The Surprising Difficulty of Counting Petition Signatures*, 33 JURIMETRICS J. 223, 243 & n.55 (1993) (observing that there actually has been an attempt to legislate the value of *pi*).

policy determinations, would be driven by politics, value judgments, or the desires of the majority.²⁹⁹

Yet the Supreme Court has also considered scientific questions to be “matters not within specialized judicial competence” and therefore within the competency of Congress to gather data and reach conclusions.³⁰⁰ 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.”³⁰¹ In *Gonzales v. Carhart*, Justice Kennedy’s opinion for the Court stated that the Court “has given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty,”³⁰² echoing some of the sentiments in his dissent in *Carhart I*.³⁰³

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 fact-finding; that legislative fact-finding 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.³⁰⁴ 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.³⁰⁵ Daniel Solove has suggested that deference to other decision makers in constitutional cases seriously threatens the federal courts’ ability to vindicate individual rights³⁰⁶ and has likewise questioned the robustness of institutional-competence-based arguments,

299. *But cf.* Ann Woolhandler, *Rethinking the Judicial Reception of Legislative Facts*, 41 VAND. L. REV. 111, 119 (1988) (arguing that legislative fact-finding is value driven and that “this is true even for the hard sciences,” but acknowledging that it is “especially true for the soft sciences”).

300. *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 33, 33–34 (1976) (internal quotation marks omitted) (quoting *United States v. Gainey*, 380 U.S. 63, 67 (1965)).

301. *Marshall v. United States*, 414 U.S. 417, 427 (1974).

302. *Gonzales v. Carhart (Carhart II)*, 127 S. Ct. 1610, 1636 (2007).

303. *Stenberg v. Carhart (Carhart I)*, 530 U.S. 914, 970–72 (2000) (Kennedy, J., dissenting).

304. Devins, *supra* note 293, at 1183–84.

305. *See id.* at 1184–85 (explaining that lawmakers revisit prior legislation only when there is organized interest group pressure to do so and that even then inertia and other obstacles often prevent reform); *cf.* Rachael N. Pine, *Speculation and Reality: The Role of Facts in Judicial Protection of Fundamental Rights*, 136 U. PA. L. REV. 655, 726–27 (1988) (arguing that adherence to precedent should not bind courts to follow prior cases upholding a statute when legislative facts previously essential to its constitutionality have changed or their falsehood has become demonstrable).

306. *See* Solove, *supra* note 292, at 1015–19 (arguing that the modern bureaucratic state is by nature inimical to individual rights and that nondeferential judicial review is essential to correct its excesses).

particularly to the extent that they underestimate the problems of bias and capture by special interests.³⁰⁷

Douglas Laycock has made similar arguments, specifically addressing legislative fact-finding on matters affecting religious rights, but in terms that are generally applicable and worth quoting at length:

Legislators *can* do serious investigations, but they rarely do. The typical Congressional hearing consists of witnesses reading prepared five-minute statements in panels of three or four. Many committee members do not attend and those who do often wander in and out. Each member gets to make an opening statement and to ask five minutes of questions to each panel, that is, one to two minutes of questions and answers per witness. . . .

. . . .

The party in the minority often gets fewer than half the witnesses and only one week's notice of the hearing. No interest group is guaranteed the right to testify. But anyone with enough time or money can lobby. Most of the real discussions in which legislators "find" facts occur *ex parte* and off the record. . . .

. . . .

. . . [O]ften [legislators] are locked into positions by ideology or political pressure before the hearing ever begins. Then the hearing is a charade.³⁰⁸

In judicial fact-finding, by contrast:

Each side is guaranteed a fair and equal opportunity to present its evidence and arguments. Litigants may invoke the judicial process as of right; unlike legislators, judges cannot simply ignore questions presented to them. Because each side has an advocate to marshal its case, it is far more likely that a judge will hear the most important evidence than that a Congressional committee will. Witnesses can be effectively cross-examined, which is rare in legislative hearings. Judges are overworked just as legislators are, but in an important case presenting a serious constitutional question, judges can usually commit substantial blocks of time. Judges do not wander on and off the bench while hearings continue in their absence. All judicial proceedings are on the record, and *ex parte* contacts are forbidden. When a judge makes up her mind because a campaign contributor talks to her before the hearing begins, it is corruption; when a legislator does the same thing, it is business as usual.³⁰⁹

307. *See id.* at 1010–14 (critiquing the factual and theoretical assumptions of the notion of institutional competence and similar justifications for judicial deference).

308. Douglas Laycock, *A Syllabus of Errors*, 105 MICH. L. REV. 1169, 1174–75 (2007) (reviewing MARCI A. HAMILTON, *GOD VS. THE GAVEL: RELIGION AND THE RULE OF LAW* (2005)).

309. *Id.* at 1176.

All of those criticisms are applicable to legislative determinations of medical fact. Yet commentators have not primarily focused on the unique aspects of medical fact-finding that make it even more unsuitable a subject for judicial deference. To the extent that they have considered the problems of “scientific” legislative fact, they have primarily focused on courts’ and legislatures’ use of empirical social-science evidence.³¹⁰ I contend, however, that judicial deference to legislative fact-finding is particularly inappropriate with respect to medical fact because the traditional reasons supporting such deference apply even less.³¹¹

I argue 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; this view has extended beyond social facts regarding economic, social, or policy matters to encompass even medical and scientific 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 fact-finding as a general matter, it is not a desirable approach when considering individuals’ rights to access medical treatment.

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 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,³¹² those individuals and

310. See, e.g., Faigman, *supra* note 287, at 552–64 (discussing the role that assertions of social, political, and economic fact have played in the Court’s most famous cases); Timothy Zick, *Constitutional Empiricism: Quasi-Neutral Principles and Constitutional Truths*, 82 N.C. L. REV. 115, 147–53 (2003) (discussing a judicial movement toward reliance on empirical social-science and other data in reaction to earlier decisions relying on less measurable forms of social-science information).

311. The issue of deference to legislative fact-finding also raises the question whether states are entitled to lesser or greater deference than the federal government, but that question is beyond the scope of this Article.

312. 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 293, at 1738, 1738–39 (describing “support agencies” for Congress). But they do not conduct medical or scientific studies; as Professor Laycock has noted:

Despite [legislatures’] problems, broad policy questions are better left to legislatures than courts. . . . [W]ith respect to broad, multi-polar questions about how complex economic and social systems will respond to proposed changes in policy, no one finds facts very well because the facts are simply too complicated. But such questions are particularly ill-suited to the judicial process, which is designed for two-sided disputes that can be focused on one or a few specific questions.

Laycock, *supra* note 308, at 1175.

institutions generally do not possess any background in medical science or any unique expertise in analysis of medical evidence and literature.³¹³

As Professor Laycock pointed out, when judges are asked to evaluate competing medical claims, they are required, unlike legislators, to hear evidence from both sides, chosen by the adversaries, and to allow cross-examination.³¹⁴ 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.³¹⁵ Federal Rule of Evidence 706 allows courts to appoint independent experts,³¹⁶ and courts also make use of numerous other mechanisms, ranging from the Federal Judicial Center's *Reference Manual on Scientific Evidence*³¹⁷ 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."³¹⁸ 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 *Daubert v. Merrell Dow Pharmaceuticals Co.*³¹⁹ This is not to say that courts' treatment of scientific evidence has gone without criticism.³²⁰ Some may fear, for

313. 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's other fact-gathering arms. See The National Academies, About, <http://www.nationalacademies.org/about/faq1.html>. It carries out studies primarily at the behest of government sponsors, but it has no funding of its own. *Id.* But it is unclear how often Congress, not to mention state legislatures, relies on studies conducted by the National Academies.

314. See also Kenneth L. Karst, *Legislative Facts in Constitutional Litigation*, 1960 SUP. CT. REV. 75, 100–03 (describing the virtues of the trial process for evaluating legislative facts).

315. See Stephen Breyer, *Introduction to REFERENCE MANUAL ON SCIENTIFIC EVIDENCE* 1, 5 (Fed. Judicial Ctr. ed., 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 (AMA) 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 opposed to the liberalization of state abortion laws in the 1960s. *Roe v. Wade*, 410 U.S. 113, 142–43 (1973) (noting that the AMA Committee on Human Reproduction advocated a policy of opposition to induced abortion).

316. FED. R. EVID. 706.

317. REFERENCE MANUAL ON SCIENTIFIC EVIDENCE, *supra* note 315.

318. *Id.* at 6.

319. 509 U.S. 579 (1993); see also *Kumho Tire Co. v. Carmichael*, 526 U.S. 137, 147–49 (1999) (applying the general principles of *Daubert* to all expert testimony); *Gen. Elec. Co. v. Joiner*, 522 U.S. 136, 143–47 (1997) (applying *Daubert* principles to epidemiological expert testimony in the toxic-tort context).

320. See, e.g., *Daubert*, 509 U.S. at 601, 600–01 (Rehnquist, C.J., concurring in part and dissenting in part) (worrying that *Daubert* will encourage judges to act as "amateur scientists"); Samuel R. Gross, *Expert Evidence*, 1991 WIS. L. REV. 1113, 1114–17 (noting the longstanding criticisms of the use of expert evidence in common law courts). Some critics of the *Daubert*

instance, that judicial examination of scientific issues encourages “battle[s] of experts” that obscure scientific truth and make relatively undisputed scientific issues appear to be contested.³²¹ 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.³²² 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 fact-finding domain in which the interest in public participation and legislatures’ relative institutional competency are at their lowest.

Some of the recent laws passed or considered by Congress in the controversial realm of abortion evince such flawed fact-finding. As Justice Ginsburg’s dissent in *Gonzales v. Carhart* clearly demonstrates, the findings of fact supporting the federal PBABA are largely inaccurate and driven by a highly politicized process.³²³ It is one salient example of a situation in which the legislature proved itself less competent than the courts at managing medical fact-finding. Congress’s scientific findings explaining why no health exception to the PBABA was necessary were, first, unsupported by, and often in conflict with, the underlying congressional record itself.³²⁴ Second, they did not contain any evidence that had not essentially been before the Court when it decided *Carhart I*,³²⁵ Congress did not update its findings in

decision suggest, however, that the *Daubert* standard is overly conservative, favoring defendants over plaintiffs and excluding much relevant scientific evidence. See Carl F. Cranor, *The Dual Legacy of Daubert v. Merrell-Dow Pharmaceutical: Trading Junk Science for Insidious Science*, in *RESCUING SCIENCE FROM POLITICS* 120, 120 (Wendy Wagner & Rena Steinzor eds., 2006); Jennifer Wolsing, Note, *Daubert’s Erie Problem*, 82 *IND. L.J.* 183, 190 (2007) (noting that the gatekeeping function for the trial courts created by *Daubert* has resulted in more exclusion of plaintiffs’ proposed experts than before *Daubert*). See generally *id.* at 192 n.73 (citing criticisms of *Daubert* as conflicting with contemporary scientific standards). There is consequently reason to think that plaintiffs will not be as highly advantaged by a regime of nondeference as it may initially appear. Indeed, the Court remarked in *Weisgram v. Marley Co.*, 528 U.S. 440 (2000) that *Daubert* imposes “exacting standards of reliability” on litigants. *Id.* at 455.

321. *E.g.*, Gross, *supra* note 320, at 1175.

322. Of course, on the margin, it will sometimes be difficult to determine what is a “pure” issue of medical or scientific fact, particularly where the issue is one of public health, which inevitably involves policy judgments. But in cases where the question is whether a particular treatment is medically appropriate—that is, safer or more effective than the alternatives for some individuals—it seems that only pure medical questions are involved.

323. *Gonzales v. Carhart (Carhart II)*, 127 S. Ct. 1610, 1643–44 (2007) (Ginsburg, J., dissenting).

324. *Id.* at 1644 (citing *Carhart v. Ashcroft*, 331 F. Supp. 2d 805, 1008–09 (D. Neb. 2004) and *Nat’l Abortion Fed’n v. Ashcroft*, 330 F. Supp. 2d 436, 488 (S.D.N.Y. 2004)).

325. See *Nat’l Abortion Fed’n*, 330 F. Supp. 2d at 492 (asserting that the evidence before the Court in *Carhart I*, like the testimony on which Congress relied in passing the PBABA, revealed a division of medical opinion on whether women could potentially benefit from “partial-birth” abortions).

light of new medical evidence. Finally, the factual findings mischaracterized both the Supreme Court's holding in *Carhart I* and the current state of medicine.³²⁶ 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. 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.³²⁷

The proposed federal Unborn Child Pain Awareness Act (UCPA),³²⁸ introduced in 2005 and again in 2006, is another example of similarly defective legislative investigation of scientific fact. The bill essentially requires abortion providers to inform women seeking abortions after twenty weeks' gestation that "[t]here is substantial evidence that the process of being killed in an abortion will cause the unborn child pain" and to offer to administer anesthesia directly to the fetus.³²⁹ This requirement is justified by congressional findings that are highly misleading, if not blatantly inaccurate, ignoring the fact that some of the most current studies estimate that fetuses cannot feel pain before approximately twenty-nine weeks.³³⁰ The hearings on the bill, moreover, left something to be desired: Congress invited only two physicians, one attorney, and one medical ethicist to testify, and only the last

326. *Carhart II*, 127 S. Ct. at 1643–44 (Ginsburg, J., dissenting); *Nat'l Abortion Fed'n*, 330 F. Supp. 2d at 485 & n.30; *Planned Parenthood Fed'n of Am. v. Ashcroft*, 320 F. Supp. 2d 957, 1003–10 (N.D. Cal. 2004).

327. *Carhart II*, 127 S. Ct. at 1644–46 (Ginsburg, J., dissenting). 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 fact-finding 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, 160–61 (2001) (criticizing the Supreme Court's use of legislative record review); Ruth Colker & James J. Brudney, *Dissing Congress*, 100 MICH. L. REV. 80, 83–85 (2001) (attacking the Rehnquist Court's approach to legislative history for requiring excessively detailed evidence in support of congressional enactments). 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.

328. Unborn Child Pain Awareness Act of 2006, H.R. 6099, 109th Cong. (2006); Unborn Child Pain Awareness Act of 2005, H.R. 356, 109th Cong. (2005).

329. H.R. 6099 § 3. There are slight differences between the 2006 version (which failed to pass the House) and the 2005 version (which has not been voted on), but they require the same information to be conveyed to the woman and recite the same findings. For simplicity, the rest of this Article will refer only to the 2005 bill.

330. See, e.g., Linda P. McKenzie, *Federally Mandated Informed Consent: Has Government Gone Too Far?*, 20 J.L. & HEALTH 267, 295 (2006–2007) (discussing a study concluding that "a fetus cannot perceive pain until . . . around twenty-nine to thirty weeks gestational age"); Tobin, *supra* note 292 (manuscript at 29–30) (suggesting that scientific literature supports a conclusion that a fetus lacks the physical structures necessary to perceive pain until twenty-nine to thirty weeks' gestational age).

of those opposed the bill.³³¹ Congress also failed to invite any of the authors of a recent, important metastudy of fetal pain published in the *Journal of the American Medical Association*, and “[n]one of the leading fetal surgery centers were represented before the committee.”³³²

D. *Back to the Future: Carhart II and Jacobson v. Massachusetts*

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 nonapproved 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 to weigh the individuals’ rights 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 initial *Abigail Alliance* panel 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 because individuals would 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.³³³ Finally,

331. McKenzie, *supra* note 330, at 281–82.

332. *Id.* at 282–83.

333. Susan Okie, *Access Before Approval—A Right to Take Experimental Drugs?*, 355 NEW ENG. 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

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.³³⁴

Perhaps *Carhart II* can be seen as gesturing toward a reconciliation of the public-health and autonomy lines of cases and hinting at how the right might be operationalized in the future. One of the most important (and for some, troubling) aspects of the *Carhart II* opinion is that it clearly used the undue burden analysis to determine the necessity for a health exception to the PBABA. Although the undue burden standard is less protective of women's health than the apparent per se requirement of a health exception set forth in *Carhart I*, it may represent one way to unite the public-health and autonomy lines of cases by recognizing a right to protect one's health while allowing for important governmental interests to play a significant role. Although the undue burden standard itself is notoriously vague and difficult to apply, it seems to recognize the need for a balancing of individual constitutional rights against governmental interests or a weighing of the extent to which a governmental action actually burdens those rights, or both.³³⁵ Indeed, some have read *Jacobson v. Massachusetts* to require a similar inquiry regarding public-health regulations; that is, an inquiry as to whether the regulations are necessary and proportional to the evil sought to be addressed.³³⁶

Of course, the undue burden standard leaves much to be desired, and this Article's call for balancing individual rights against governmental interests leaves many questions unanswered. Perhaps one of the most important questions left unanswered, for example, is whether concerns for morality may outweigh the individual's right to protect her health. *Lawrence v. Texas* might suggest that state interests in enforcing moral standards are to be treated with great suspicion;³³⁷ *Carhart II*, on the other hand, shows great solicitude for Congress's moral interests in "protecting the integrity and ethics of the medical profession" and "promot[ing] respect for . . . life of the

129, 138 (2006), *rev'd en banc*, 495 F.3d 695 (D.C. Cir. 2007), and the interest in the viability of clinical trials may well be important enough to override individual patients' rights.

334. 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. See Robertson, *supra* note 277, at 17 (concluding that no asserted state interest "is sufficiently robust to justify the health loss to individuals denied safe and effective ESC [embryonic-stem-cell] therapies" but that the FDA or other agencies can regulate the right to receive medical treatment "in the interest of the health and safety of patients and the community").

335. In other words, the undue burden standard from *Casey* can be understood either to require that any regulation burdening the right to access an abortion in a sufficiently onerous way must be struck down (thus emphasizing the word "burden"), or it may be read to require that regulations of the right to access an abortion must be struck down whenever they are not sufficiently justified (thus emphasizing the word "undue"). It seems to me that both of these issues should be taken into account when considering whether a regulation affecting the right to make medical treatment choices should be upheld.

336. *E.g.*, GOSTIN, *supra* note 77, at 68–69.

337. See *Lawrence v. Texas*, 539 U.S. 558, 567 (2003).

unborn.”³³⁸ Nonetheless, an explicit balancing, combined with the proposed explicitly nondeferential treatment of medical legislative facts, would go a long way toward clarifying the analysis in cases dealing with the right to make medical treatment choices.

Another lesson that may be gleaned from *Carhart II* is that while the government should not be entitled to complete deference to its findings of scientific fact, the burden remains with the challenger to show, in the context of an as-applied challenge, the necessity of a health exception in her particular case. The desire to shift the evidentiary burden from the government to the plaintiffs, along with a concern for avoiding a remedy that is too sweeping,³³⁹ is arguably the driving force behind the Court’s opinion in *Carhart II*. And recognizing an individual right to present evidence showing that an exception to a general rule is necessary to protect one’s health would give due weight to *Jacobson*’s language appearing to require the same. Even the Ninth Circuit on remand in *Raich v. Gonzales*, after rejecting the plaintiffs’ request for an injunction preventing enforcement against them of the Controlled Substances Act, suggested—somewhat puzzlingly in light of the Supreme Court’s *OCBC* holding—that a medical necessity defense may still be available “in the context of a concrete case where a statute is allegedly violated, and a specific prosecution results from the violation.”³⁴⁰ Of course, it remains to be worked out exactly how much and what sort of evidence would be required in a given case. It might be unreasonable to require plaintiffs to conduct studies to show medical necessity or efficacy with respect to new and innovative medical treatments, especially in the absence of any claim or any specific findings by the government that the treatment is unsafe or ineffective. On the other hand, it may be necessary to introduce more evidence to overcome a scientific finding embodied in a statute.

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;³⁴¹ 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

338. *Gonzales v. Carhart (Carhart II)*, 127 S. Ct. 1610, 1633 (2007).

339. Cf. Daryl J. Levinson, *Rights Essentialism and Remedial Equilibration*, 99 COLUM. L. REV. 857, 885 (1999) (arguing that “the threat of undesirable remedial consequences” may “motivat[e] courts to construct the right in such a way as to avoid those consequences”).

340. *Raich v. Gonzales*, 500 F.3d 850, 861 (9th Cir. 2007).

341. Cf. *Andrews v. Ballard*, 498 F. Supp. 1038, 1056 (S.D. Tex. 1980) (holding that while Texas may not limit the practice of acupuncture to licensed physicians—effectively rendering the treatment unavailable—the state may require a diagnosis or referral from a physician).

contexts.³⁴² On the other hand, as in the abortion context, courts may generally be hostile to so-called procedure bans, in which one medically indicated procedure is completely prohibited.³⁴³ Of course, the determination of what sorts of regulations are acceptable—like the determination of whether governmental interests outweigh the individual right to access treatment—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.

Unifying the analysis in this manner would not only have the advantage of making the Court's jurisprudence more coherent; it would also provide a framework for thinking about future regulations that may arise. Regulations of stem-cell therapies and therapeutic cloning are already cropping up, for example. At least one state has attempted to restrict the way in which mifepristone (also known as the abortion drug RU-486) may be prescribed, and other states have proposed to take similar measures or to ban it altogether.³⁴⁴ And 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.³⁴⁵ 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.³⁴⁶ In other words, such regulations tend to be analyzed under the public-health model rather than the autonomy model. Clearly, some consistency of analysis would bring at least a degree of much-needed predictability to this area.

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, such as the

342. Cf. TIEDEMAN, *supra* note 266, at 205 (distinguishing between legitimate state regulation of “quacks and disreputable practitioners” and illegitimate regulation of medical decision making by medical professionals).

343. See e.g., *Stenberg v. Carhart (Carhart I)*, 530 U.S. 914, 931 (2000) (striking down Nebraska's “partial-birth” abortion ban in part because it prohibited certain abortion procedures); *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 79 (1976) (overturning a Missouri law that prohibited the use of the saline amniocentesis abortion procedure).

344. See H.B. 126, 125th Gen. Assem., Reg. Sess. (Ohio 2004) (regulating mifepristone); H.B. 1038, 48th Leg., 1st Sess. (Okla. 2001) (banning mifepristone); see also CTR. FOR REPRODUCTIVE RIGHTS, LAWS AND REGULATIONS AFFECTING MEDICAL ABORTION (2003), http://www.reproductiverights.org/pub_fac_medabor2.html (discussing proposed state legislation that would restrict medical abortion).

345. Gillian E. Metzger, *Abortion, Equality, and Administrative Regulation*, 56 EMORY L.J. 865, 868 (2007).

346. *Id.* at 868–69.

FDA, are subject to the sort of capture and biased fact-finding that has afflicted both legislatures and other agencies.³⁴⁷ 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.³⁴⁸ 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 the finding that Laetrile was a “new drug” lacking proof of safety and efficacy until well into the litigation.³⁴⁹ In *OCBC* and *Raich*, courts relied on Congress’s findings, not the FDA’s, regarding the absence of medical uses for marijuana. And in the *Abigail Alliance* case, clinical trials had preliminarily found the drugs at issue to be safe, although more trials remained to be conducted, and the FDA had not yet approved the drugs 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.

V. Conclusion

The Court’s jurisprudence touching on the right to make autonomous medical treatment decisions has been split between two opposing lines of cases. Those two lines of cases take conflicting views of the existence of the right itself and of the deference due to legislatures’ medical determinations. 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 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.

For further discussion of this Article, visit www.texasrev.com/seealso.

347. Henry A. Waxman, *Politics and Science: Reproductive Health*, 16 HEALTH MATRIX 5, 19–21 (2006); Michael E. Horwin, Comment, “War on Cancer”: *Why Does the FDA Deny Access to Alternative Cancer Treatments?*, 38 CAL. W. L. REV. 189, 217–20 (2001).

348. See Amicus Curiae Brief of The Marijuana Policy Project and Rick Doblin, Ph.D. and Ethan Russo, M.D. in Support of the Respondents at 2–3, *United States v. Oakland Cannabis Buyers’ Coop.*, 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).

349. See *supra* note 129.