

Necessity, Not Autonomy

Mark S. Stein*

Professor Hill's article is a major contribution to the fields of health law and constitutional law. She convincingly demonstrates that the "autonomy" and "public health" cases are related in ways that courts and commentators have ignored. I agree with much of what Professor Hill says; in this Comment, I focus on our disagreements.

Professor Hill argues that courts should recognize a generally applicable substantive-due-process right to make autonomous medical treatment decisions. While I am sympathetic to Professor Hill's project, I think she takes it too far. First, I disagree that the broad right Professor Hill advocates has already been recognized by the Supreme Court. Second, I prefer to speak of a right of medical necessity rather than a right to make autonomous treatment decisions. Third, I believe that courts should not endorse a universally applicable right of medical necessity, but should instead evaluate separately constitutional claims of medical necessity in different contexts. Fourth, I believe that if a claim of medical necessity would have a negative effect on social welfare, it should not attain the status of a right.¹ The latter three issues all relate to the order of proof in the litigation of a substantive-due-process claim.

I. Current Status of the Right

Professor Hill claims that "the Supreme Court has already recognized a substantive-due-process right to make medical treatment decisions without unwarranted government interference."² I view the case law differently. The Supreme Court has arguably recognized a right to choose to *refuse* medical treatment.³ But the Court has not yet recognized a general right to choose to *receive* medical treatment free of government interference. The Court has so far recognized such a right only in the context of abortion and contraception.⁴

* Academic Fellow, Harvard Law School, Petrie-Flom Center for Health Law Policy, Biotechnology, and Bioethics. I acknowledge with thanks the financial support of the Petrie-Flom Center and the comments of I. Glenn Cohen, Abigail Moncrieff, and Ben Roin.

1. Or more precisely, violations of the claimed right should be subject only to rational basis review.

2. B. Jessie Hill, *The Constitutional Right to Make Medical Treatment Decisions: A Tale of Two Doctrines*, 86 TEXAS L. REV. 277, 329 (2007).

3. See *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997) ("We have . . . assumed, and strongly suggested, that the Due Process Clause protects the traditional right to refuse unwanted lifesaving medical treatment."); *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278–79 (1990).

4. Professor Hill very rightly underlines *Whalen v. Roe*, 429 U.S. 589 (1977), a case of which I was unaware before reading her article. In the course of upholding a state reporting system for drugs susceptible to abuse, the Court in *Whalen* stated:

The abortion and contraception cases involve reproductive choice. The main impediment to using those cases to establish a right to receive medical treatment in other areas is that other areas do not involve reproductive choice. The abortion and contraception cases *could* support a broader right to receive medical treatment, free of government interference, but that is not an inevitable reading of those cases.

In arguing for a more general substantive-due-process right, Professor Hill relies to a great extent on the “health exception” in abortion doctrine, and in particular on what I call the right to a safe method of abortion.⁵ The right to a safe method of abortion was at issue in *Stenberg v. Carhart* (*Carhart I*)⁶ and *Gonzales v. Carhart* (*Carhart II*).⁷ Professor Hill insightfully argues that the right to a safe method of abortion has broader applicability than other aspects of abortion doctrine because it does *not* involve reproductive choice: “*Carhart I* and *II* . . . are not about the right to choose an abortion but rather the method by which the abortion will be performed.”⁸

The right to a safe method of abortion is indeed different, in important respects, from other aspects of the right to abortion. Nevertheless, reproductive choice is still in the picture. If the government prevents a woman from using the safest method of abortion, it makes abortion more dangerous and harder to accomplish.

I agree with Professor Hill to this extent: the right to receive necessary medical treatment is uneasily contained within the abortion and contraception cases. For the remainder of this Comment, I assume that there is or should be some spillover beyond the abortion and contraception cases. Still, I would be less expansive than Professor Hill in framing the right that spills over.

II. Necessity as an Element of the Right

First, the right should be, and probably would be, a right of medical necessity, not a right of decisional autonomy. It should be a right to receive

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. Although the State no doubt could prohibit entirely the use of particular Schedule II drugs, it has not done so.

Id. at 603. The Court’s reference to a “right to decide” on treatment could be used, in some later case, to support the recognition of a broad right to make medical treatment decisions, but I do not think that the Court’s statement itself constitutes such a recognition.

5. See Mark S. Stein, *Medical Necessity: The Abortion Analogy* (manuscript on file with author). For his part, Professor Eugene Volokh relies on another aspect of the health exception: the right to have a therapeutic abortion, an abortion that is itself necessary to preserve the woman’s life or health. See Eugene Volokh, *Medical Self-defense, Prohibited Experimental Therapies, and Payment for Organs*, 120 HARV. L. REV. 1813 (2007). Professors Hill and Volokh both make powerful arguments, but neither makes an irresistible argument.

6. 530 U.S. 914 (2000).

7. 127 S. Ct. 1610 (2007).

8. Hill, *supra* note 2, at 325.

necessary medical treatment free of government interference, not a right to make medical choices free of government interference. Necessity, after all, is an element of the health exception on which Professor Hill relies: the health exception only applies when abortion, or some method of abortion, is “necessary, in appropriate medical judgment,” to preserve the woman’s life or health.⁹

Professor Hill is not a thoroughgoing libertarian. She does not believe that people have, or should have, the right to choose medical procedures regardless of how beneficial those procedures are. But she would make lack of medical necessity an issue to be raised by the government in defense of the challenged regulation (even if the medical necessity claimant, as she suggests, might bear the burden of proof on this issue).¹⁰ It is possible that in Professor Hill’s opinion, the government’s interest in upholding a health regulation is always sufficiently substantial if the claimant cannot show medical necessity. In that event, there may be little difference between Professor Hill’s position and mine on this issue. Still, if medical necessity is effectively a prerequisite in every case, it should be characterized as an element of the claimant’s right, not an element of the government’s defense.¹¹

III. Piecemeal Consideration

A second and related way in which I would follow a less expansive approach is to abjure a generally applicable right of medical necessity, and instead evaluate separately constitutional claims of medical necessity in different contexts. So, for example, there might be a right to use medical marijuana, but not a right to use experimental drugs. If, after piecemeal consideration, courts decide that there is a right in every context, the separate rights can be unified into one broader right.

A piecemeal approach is more consistent with Supreme Court precedent, especially *Washington v. Glucksberg*.¹² In that case, the Court expressed a particular aversion to recognizing broad substantive-due-process rights. But even leaving *Glucksberg* aside, the “right to make autonomous medical treatment decisions”¹³ would be broader than any substantive-due-process right ever recognized by the Court; it would completely subsume the abortion and contraception cases.

9. See *Carhart II*, 127 S. Ct. at 1635; *Carhart I*, 530 U.S. at 931.

10. Hill, *supra* note 2, at 343.

11. I do not argue that courts should defer to legislative determinations of medical necessity. I agree with Professor Hill that courts show too much deference in the public health cases, but I am not completely persuaded that there should be no deference. Like Professor Hill, I would be most troubled by a policy of giving no deference where the medical determination underlying the challenged regulation was made by an expert agency rather than a legislature.

12. 521 U.S. 702 (1997).

13. Hill, *supra* note 2, at 345.

Once again, my difference with Professor Hill here is related to the order of proof. Professor Hill allows that the right to make autonomous medical treatment decisions can be overridden by a sufficiently weighty government interest. I would go further and say that if the likely consequences of recognizing a right of medical necessity are bad, in a particular setting, the right should not be recognized at all.

IV. Social Welfare

What kind of bad consequences should prevent a claim of medical necessity from attaining the status of a right? Consequences that are bad for the welfare of people in general. This brings me to the third way I would limit the substantive-due-process right: I would consider social welfare, and not just the welfare of the medical necessity claimant, in determining whether there is a right of medical necessity.

*Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach*¹⁴ is an instructive example. There was great consternation in some quarters at the initial panel decision of the D.C. Circuit in *Abigail Alliance*,¹⁵ later reversed by the court en banc.¹⁶ The initial panel decision recognized a right of access to experimental drugs that had not yet been approved by the FDA.¹⁷ Opponents of the new right of access to unapproved drugs argued that it would disrupt clinical trials of drugs, leading to a greater burden of death and disease overall.¹⁸ This argument was not entirely speculative; in the 1980s and 1990s, the wide availability of bone-marrow transplants as part of a treatment for metastatic breast cancer made it difficult to enroll subjects in randomized trials of the treatment, and consequently delayed the trials. When the trials were finally completed, it was discovered that chemotherapy with bone-marrow transplant was inferior to chemotherapy alone.¹⁹

In the view of the plaintiffs in *Abigail Alliance*, as well as their academic champion Professor Eugene Volokh, such effects on social welfare are not relevant to the recognition of a constitutional right; they are only relevant to a determination of whether the government has a sufficiently

14. 495 F.3d 695 (D.C. Cir. 2007) (en banc), *cert. denied*, 76 U.S.L.W. 3189 (U.S. Jan. 14, 2008) (No. 07-444).

15. *Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach*, 445 F.3d 470 (D.C. Cir. 2006).

16. *See Abigail Alliance*, 495 F.3d 695.

17. More precisely, the initial panel decision recognized a right of access to experimental drugs that had passed "Phase I" testing by the FDA but had not yet been approved. *Abigail Alliance*, 445 F.3d at 486.

18. *See, e.g.,* Ezekiel J. Emanuel, *Drug Addiction*, NEW REPUBLIC, July 3, 2006, at 9.

19. *Id.* at 11–12.

compelling interest to override that right.²⁰ But that is not the only way of approaching the matter. In *Michael H. v. Gerald D.*,²¹ the plurality stated:

We cannot imagine what compels [the] strange procedure of looking at the act which is assertedly the subject of a liberty interest in isolation from its effect upon other people—rather like inquiring whether there is a liberty interest in firing a gun where the case at hand happens to involve its discharge into another person's body.²²

Of course, if a right of medical necessity has already been recognized in some context, then the government's arguments about ill effects on social welfare would be heard as part of the government's effort to defeat the right in a particular case. But if no right has yet been recognized, and the government can demonstrate that the effect of such a right would overall be negative, there should be no right at all. Or more precisely: a violation of the claimed right should be subject only to rational basis review, which it should easily pass, given the negative effect that the claimed right would have on social welfare.

There is more than one conception of social welfare. I would advocate a utilitarian conception: social welfare is the sum (or average) of individual welfare.²³ A constitutional right of medical necessity would be a partial constitutionalization of the common law doctrine of necessity, a doctrine that is closely associated with utilitarianism.²⁴ Thus, it is not ridiculous to think that a utilitarian standard would be applied. In any event, some evaluations of social welfare do not require a specific commitment to utilitarianism. If the claimant seeks to avoid premature death and allowing the claim would lead to a greater loss of life overall, that could be bad for social welfare under some theories that are not specifically utilitarian.

To repeat, I have three reservations about Professor Hill's framing of the substantive-due-process right. I would hold that necessity is an element of the right, that there may be a right of medical necessity in some contexts and not others, and that a claim of necessity should not attain the status of a right if the consequences for social welfare would be bad. As to the first two

20. See Volokh, *supra* note 5, at 1830 (“[E]ven if the need-to-test argument justifies some limits on the use of experimental drugs by the terminally ill, it does not mean that people lack medical self-defense rights—it merely means that a strong enough justification may trump these rights.”).

21. 491 U.S. 110 (1989).

22. *Id.* at 124 n.4.

23. See MARK S. STEIN, *DISTRIBUTIVE JUSTICE AND DISABILITY: UTILITARIANISM AGAINST EGALITARIANISM* (2006) (defending utilitarianism against egalitarian views); Mark S. Stein, *Utilitarianism and Conflation*, 35 *POLITY* 479 (2003) (defending utilitarianism against the charge that it fails to respect the separateness of persons).

24. See, e.g., *United States v. Schoon*, 939 F.2d 826, 828 (9th Cir. 1991) (“Necessity is, essentially, a utilitarian defense.”), cited in Shaun P. Martin, *The Radical Necessity Defense*, 73 *U. CIN. L. REV.* 1527, 1554 n.120 (2005).

issues—necessity as an element of the right and piecemeal consideration—I believe my approach is more consistent with existing case law. As to the third issue—making the effect on social welfare an element of the right instead of deferring this issue to the government’s case—I am not as confident. Nevertheless, I would still advocate, on normative utilitarian grounds, that the effect on social welfare be addressed as part of the claimant’s case.

The problem with deferring considerations of social welfare to the government-interest part of the case is that the reasons the government offers for infringing on a substantive-due-process right are usually subjected to heightened scrutiny.²⁵ If welfare-based interests are subjected to heightened scrutiny, they will too easily be slighted.²⁶ For example, in the area of access to experimental drugs, it may be that allowing unlimited access to drugs not yet approved by the FDA will *probably* disrupt clinical trials, leading to a greater loss of life overall. But if the government’s arguments about social welfare are subjected to heightened scrutiny, the effect of unlimited access on clinical trials may be considered an inadequate justification for limiting access. The court may view the government’s argument as too speculative. Or the court may determine that the government has a less restrictive alternative, which in the end turns out not to be feasible. The court could, for example, determine that a less restrictive alternative is to entice patients into clinical trials by paying them substantial amounts of money, but this course could later be blocked by ethical concerns or budgetary problems.²⁷

V. A Positive Right of Medical Necessity?

The right of decisional autonomy that Professor Hill advocates is a negative right: it is a right to be free of government interference with choice, not a right to government subsidies for those who cannot afford their favored choices.²⁸ The right of medical necessity that I advocate is also a negative right.²⁹ Neither of us devote much attention to the prospect that a related positive right might be recognized.

Nevertheless, perhaps some consideration of the prospect of a positive right is warranted, however remote that prospect may seem at present. Would a necessity-based approach have different implications than an autonomy-based approach for the recognition of a positive right? I speculate that it would. Under perhaps the dominant conception of autonomy in

25. Professor Hill does not say what the level of scrutiny should be, but she clearly believes it should be stricter than rational basis review; she disapproves of cases that did apply the rational basis standard.

26. It is true, as Professor Hill observes, that a court can in theory subject government interests to heightened scrutiny while simultaneously deferring to the government’s determination of issues of fact. Hill, *supra* note 2, at 333 n.292.

27. I owe this example to Ben Roin.

28. Hill, *supra* note 2, at 330 n.277.

29. Stein, *supra* note 5.

American law, a person who wants a particular medical treatment suffers a violation of autonomy if the government prevents her from buying the treatment, but not if lack of means prevents her from buying the treatment. The concept of medical necessity, by contrast, does not easily admit such a distinction: medical necessity is offended when someone does not receive necessary medical treatment, for whatever reason. Thus, a necessity-based approach, while producing a less expansive negative right than an autonomy-based approach, may be more conducive to a positive right. If one would welcome a positive constitutional right to basic medical care, as I would, this may be an additional consideration in favor of a necessity-based approach.