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PROTECTING PATIENT-DOCTOR DISCOURSE: INFORMED CONSENT AND DELIBERATIVE AUTONOMY

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I

Government and Patient-Doctor Discourse

The spring and summer of 1999 once again saw the national political debate turn to issues about health care financing and administration. Political pundits noted that health care is a steady voter concern and that the mostly partisan debate had important political significance for next year's congressional campaigns. [FN1] Largely at issue were the rights and relations patients/consumers would have within managed care. [FN2]

Although many people view the issues in the current health care debate as essentially political dilemmas concerning consumer's rights and funding decisions, the debate includes matters ***942** that fundamentally affect the patient-doctor relationship. [FN3] One fact both the Republicans and Democrats could presumably agree upon is that government involvement in health care inevitably impacts the patient-doctor relationship. Legislation that encourages the use of health maintenance organizations (HMOs), implements cost saving measures for Medicare, [FN4] or formulates the particulars of a "patients' bill of rights," inevitably affects the context within which patients and doctors make decisions about health care. Such legislation fundamentally impacts patient-doctor discourse. [FN5]

This Article argues that health care regulations that restrain patient-doctor discourse invoke constitutional principles and protections. The Article proposes a constitutional framework for legislators, citizens, and the judiciary evaluating government measures that significantly interfere with patient-doctor discourse. [FN6] The proposed constitutional framework prohibits government ***943** from impermissibly obstructing the significant preconditions needed for patients to meaningfully participate in health care decisions because to do so would violate a patient's deliberative autonomy. Patient-doctor discourse is a significant precondition, one that has become an intricate part of patient deliberations when patients are faced with weighty and self-defining decisions involving health care. Patient-doctor discourse is a significant precondition for deliberative autonomy because of the social, legal and individual patient's reliance upon informed consent and the traditional casting of the patient-doctor relationship in terms of fiduciary responsibility. [FN7]

The constitutional protection of patient-doctor discourse understood within this framework both expands and limits the autonomy right. The approach fundamentally relies on an understanding and acknowledgement of the full context of the patient-doctor relationship and the process of a patient's medical decision-making. The proposed approach expands the constitutional aspect of a patient's autonomy right by acknowledging the importance that certain significant medical decisions have to an individual. Such decisions define an individual. For example, decisions about abortion or whether to undergo organ transplantation or intensive chemotherapy are fundamental life defining decisions intrinsically tied to one's autonomy. One does not make these decisions in a vacuum, but makes them by deliberating with family, friends, doctors, and nurses. Deliberations regarding such important decisions ought to remain unfettered by government regulations, because the government's prescription of patient-doctor discourse would threaten government takeover of "the totality of our lives." [FN8]

***944** The proposed approach keeps patients' autonomy right from becoming a flyaway right by emphasizing the deliberative attributes of autonomy and limiting constitutional protections to the preservation of the necessary and significant preconditions which citizens need to exercise deliberative autonomy. The framework I advance does not guarantee that the patient actually participates meaningfully in her health care. Nor does it mean that government ensure that a particular medical option is available for a patient. For example, the government may legitimately decide to limit the number of bone marrow transplantations for breast cancer, [FN9] but may not constitutionally

interfere with patient-doctor discourse by mandating that the doctor disseminate particular information to the patient intended to dissuade the patient from choosing bone marrow transplantation. Similarly, a statute that excludes informed consent requirements for medical genetics research might result in an impermissible circumvention of constitutionally protected patient- doctor discourse. [FN10]

This Article seeks to outline an approach that lends a constitutional dimension to the protection of patient-doctor discourse and offer insight into how a patient's autonomy right is intimately ***945** connected with patient- doctor discourse. Part II of this Article looks to the common law doctrine of informed consent as the traditional legal theory governing patient-doctor discourse. The discussion proceeds by examining informed consent's foundation in battery, and subsequently, negligence theory. This section extracts the doctrine's aspirational roots, which draw upon fiduciary principles and principles of patient autonomy. It will, in other words, examine what and how the doctrine of informed consent means to protect. The section concludes that the common law informed consent doctrine protects a patient's ability to meaningfully participate in medical decision-making and recognizes the necessity of the doctor's participation in that decision-making. Informed consent is not based on a fundamental right of every patient to achieve absolute and perfect autonomy. Rather, the patient's fundamental right exists within the context of the patient-doctor relationship and the community.

Part III of this Article discusses three cases, Rust v. Sullivan, [FN11] Planned Parenthood v. Casey, [FN12] and Cruzan v. Director, Missouri Department of Health. [FN13] The first two cases illustrate the United States Supreme Court's inability to fully understand patient-doctor discourse. The Supreme Court has consistently shown its acceptance of a patient's right to medical self-determination but has failed to understand third party effects on the patient-doctor relationship. The third case, Cruzan, shows eight of the Justices looking to varying degrees to the common law of informed consent to understand the character and extent of the patient's autonomy right. [FN14]

Parts II and III of this Article argue that common law tradition shows that the right to medical self-determination is a basic liberty. These two parts also emphasize the ability of patient-doctor discourse to define and limit the patient's autonomy right.

Part IV of this Article relies on Professor Fleming's constitutional theory to argue for protecting patient-doctor discourse as a necessary precondition to deliberative autonomy. [FN15] Although ***946** Fleming makes a strong effort to "tether" his substantive rights approach, I seek to further limit and "tether" the protection for patient-doctor discourse by relying on the common law doctrine of informed consent.

In conclusion, I propose a kind of hybrid approach, relying on the common law and Fleming's aspirational theory. The two approaches together succeed in outlining a theory that shows a constitutional aspect to the protection of patient-doctor discourse from government interference. Declining such protection allows the government to, in the words of Justice Stevens, "inject into a [person's] most personal deliberations its own views about what is best." [FN16]

II

Informed Consent Defines and Tempers Patient Autonomy

Beginning at the turn of the last century, courts began to give shape to the protections of patients' medical decision-making. Although the theoretical underpinnings remained somewhat inarticulate and contradictory, the early decisions reflected the deep roots of an individual's right to self- determination. Time and experience allowed courts and commentators to place the underlying principle of autonomy where it had been all along, firmly within the context of patient-doctor discourse. [FN17]

A. Historical Underpinnings of Informed Consent

1. The Early Cases

The early consent cases invariably involved surgery. The cases reflected a judicial awareness of the patient's decision-making process and the importance of information to that process. For example, the court in Mohr v. Williams, [FN18] a 1905 case, stated that a patient who had consented to surgery on his right ear had a cause of action in battery against a doctor who decided during the procedure to operate on the patient's other ear. The court reached this conclusion relying on precedent that a person's "right to himself" was a "free citizen's first and greatest

right." [FN19] ***947** This "right to himself" forbade a physician "to violate without permission the bodily integrity of his patient . . . without [the patient's] consent or knowledge." [FN20]

Two points make this 1905 case noteworthy. First, the court did not accept the patient's general consent to an ear operation as sufficient. The court might have viewed the patient's general consent as sufficient for defeating a cause of action in battery while allowing the plaintiff to proceed on a negligence-based medical malpractice theory. Second, the court understood the importance of the patient's decision-making process:

> If the physician advises his patient to submit to a particular operation, and the patient weighs the dangers and risks incident to its performance, and finally consents, [the patient] thereby, in effect, enters into a contract authorizing [the] physician to operate to the extent of the consent given, but no further. [FN21]

The court recognized that incomplete information about the risks and dangers of the contemplated procedure would alter the balance of the decision-making process and affect the patient's decision. The court implicitly understood that the patient's autonomy right was defined by and existed within the context of patient-doctor discourse.

In 1914, Justice Cardozo, in Schloendorff v. Society of New York Hospital, [FN22] articulated the theoretical basis for requiring a patient's consent to surgery within the right to self-determination. He wrote: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages." [FN23] The cause of action lay in common law battery and its protection of bodily integrity. Justice Cardozo's reliance upon bodily integrity meant that damages arose as soon as the battery occurred and the successful plaintiff did not need to show that lack of consent caused physical injury.

Notwithstanding the articulated right to determine what happens to one's body, Cardozo's opinion did not specify that the right was grounded in a fundamental right to autonomy. Rather, the right stood more on the protection of physical integrity based ***948** on common law battery than on the broader right of autonomy. [FN24]

The term "autonomy" has many meanings, including self-determination, self- government, independence, and sovereignty, yet the various definitions share an element of self will that extends beyond mere protections of one's physical body. [FN25] The word's etymology helps clarify its essence. Auto (self) and nomos (rule or law) suggest that the right to determine what happens to one's body is part of an autonomy right but represents its incomplete expression. [FN26] Autonomy's complete expression extends beyond the confines of the body to an individual's participation in meaningful decision- making about one's life and the society in which one lives.

In the early part of the nineteenth century, doctors regularly obtained patients' consent before surgical procedures. However, the reason for obtaining consent lay neither exclusively nor, perhaps, primarily in respect for autonomy. Indeed, scholars, commenting on courts' use of battery law's protection of bodily security or well-being, have noted that battery law's protections failed to coincide with a protection of autonomy. [FN27] Faden and Beauchamp, describing medical practices in the nineteenth and early twentieth centuries, stated that "[t]he connection between consent and autonomy had yet to be made." [FN28] Many factors ***949** other than respect for autonomy, factors such as beneficence, patients' demands, financial factors (a doctor may not collect for an unwanted surgery), etiquette, or general fairness might explain the practice of respecting a patient's refusal to surgery.

A 1911 example shows the difficulty of evaluating the degree to which autonomy is inherent, even in surgical consent cases, and the degree that beneficence or paternalism controlled both physician views and popular expectations in the early part of the twentieth century. A case report tells of a man with a leg injured "beyond repair" who was unwilling to grant consent for an amputation advised by his physicians. [FN29] The doctors, told by legal counsel that the patient's wishes must be followed as long as he remained competent, did not violate the patient's wishes and the injured man soon died. Apparently, the patient, lawyers, and doctors were aware of a consent requirement. However, the basis and strength of this requirement remain unclear. The authors of the case report explained:

> On the other hand, should an operation be performed in accordance with the dictates of common humanity, but contrary to the patient's consent and orders, the operator might be called upon to defend his action in court. The probabilities were that under the circumstances no jury would render a verdict for the plaintiff. [FN30]

The case report illustrates several points in addition to the reluctant respect for the patient's consent. First, the appeal to common humanity contrasts respect for the patient's consent. The case takes place before the formulation of the hybrid battery/negligence doctrine of informed consent, yet its language suggests that applying a reasonable

patient standard would better conform with "the dictates of common humanity" than would applying an autonomy based standard. The second point regards the societal norm implicit in the jury's probable verdict. A societal norm that approves of beneficent physician behavior explains the case report's speculative jury outcome: a social norm that holds that a reasonable surviving patient ought to neither complain nor benefit from the doctor overriding the patient's expressed desires if doing so essentially saves the patient's life.

The consent cases in the early part of the twentieth century did not strictly apply a concept of autonomy that exclusively focused ***950** upon the individual. [FN31] Rather, the early cases understood that the relationship between patient and doctor and the views of society helped to define the context in which a patient exercises self-determination.

2. The Shortcomings of Common Law Battery

The consent for surgery cases, based on common law battery, protected bodily integrity, rather than the more abstract notion of individual autonomy. The emphasis on bodily integrity makes common law battery a poor fit for most contemporary informed consent cases, which typically concern a doctor's failure to inform a patient of risks, alternatives, and explanations of a particular planned invasive procedure. The patient has already given some measure of consent, implied or explicit, to allow the doctor to examine and treat. In contrast, most battery cases involve a degree of anti-social motivation, often between relative strangers. [FN32] The public often treats assault and battery as a single concept capturing what happens in a bar fight. The anti- social flavor is mostly lacking in the relationship between doctors and patients. Today's prototypical informed consent case involves a failure by the physician to disclose relevant information that will enable a patient to make an informed medical decision. The patient sues the doctor because patient- doctor discourse has broken down.

Battery law has no reasonableness requirement. This exposes it to problems of over-inclusiveness and under-inclusiveness. Battery law is under- inclusive when it treats a patient's general acceptance as satisfactorily authorizing specific invasive treatment without mandating disclosure of risks, prognosis, and alternatives. Conversely, battery law is over-inclusive when it indicts a physician for failing to inform a patient of an uncommon risk ***951** and subjects the doctor to the harsh results of battery liability. [FN33] In contrast, negligence law requires the plaintiff to clear a higher causation hurdle, requiring the plaintiff to show that she would have decided differently had she known about the risk not disclosed by the physician. [FN34] Commentators have suggested that the presumption in battery cases that the defendant's conduct is anti-social explains the almost casual causation requirement. [FN35] Battery law's low causation threshold applied to all informed consent cases may lead to harsh results for physicians. [FN36] On the other hand, the low causation threshold allows recognition of damage to a patient's dignity and prevents the professional standard of care from easily defeating a patient's expectations. [FN37]

Another reason for battery law's poor fit is that its historical foundation on protecting bodily integrity means that it only protects patients' interests within the context of invasive procedures. For example, a doctor is not liable under battery law for failing to mention to a patient that a risky surgery offers only a statistically insignificant improvement for the chance of survival. The physician may be liable under a negligence theory, but under a battery analysis the patient has consented to the bodily invasion. [FN38] Similarly, battery law's focus on protection of the body leads to its uncertain view about the administration of drugs and general advice to patients about prognosis, course of treatment, lifestyle (including sexual behavior), and other information. [FN39]

***952** Although battery law's underpinnings as an autonomy-like right seem to justify its use in medical consent cases, experience and closer analysis reveal that battery law inadequately protects a more expansive view of informed consent. Common law battery inadequately protected patients' ability to meaningfully participate in their medical decision-making because common law battery failed to fully account for a patient's medical decision-making taking place within the context of patient-doctor discourse.

3. Negligence and Informed Consent

In the middle years of the twentieth century, courts began to utilize negligence theory when analyzing informed consent cases. This resulted in a battery/negligence hybrid theory of liability. [FN40] Court decisions emphasized informed consent in contrast to merely consent. Many judicial decisions expanded the duty of physicians to include more information about risks and alternatives, but limited the scope of the physician's duty to information that other physicians disclosed in their practices. The battery law notion of a right to bodily integrity remained, but was commonly administered through the more flexible standards of negligence ***953** law: standard of care, higher

causation threshold, and emphasis on reasonableness.

Applying the negligence doctrine to informed consent cases makes the potential plaintiff-patient's physical well-being paramount since the plaintiff can only prevail by showing physical injury caused by lack of full disclosure. Reminiscent of the 1911 case report of the man with the severely injured leg who refused treatment, negligence doctrine's emphasis on physical injury reflects a hesitation to hold physicians liable when they "have not really done anything wrong," where wrong is defined in technical, medical terms, rather than the more abstract terms of violating broad autonomy interests. [FN41] This emphasis upon the physical status of the patient changed the focus away from the workings of the patient's decision-making process. Commentators have noted that reliance upon the negligence doctrine results in a physician- centered application of informed consent, reliance on a professional standard of care, and a failure to completely protect patients' dignity and autonomy. [FN42]

Whether utilizing common law battery, negligence, or a hybrid theory, a patient's right to participate in their medical decision-making remains the essence of informed consent. Informed consent protects and promotes a deliberative kind of autonomy, one that exists within the context of patient- doctor discourse.

B. The Intimate and Inseparable Connection Between a Patient's Right to Self Determination and the Fiduciary Character of the Patient-Doctor Relationship

1. Canterbury v. Spence

Canterbury v. Spence [FN43] quickly became a landmark case, known for its patient-centered approach to informed consent and its articulation of the basis of informed consent in the patient-doctor relationship. [FN44] The court began its analysis by stating, "we ***954** are forced to begin at first principles" and proceeded to identify these "first principles" as both a patient's right to self-determination in making decisions and "the fiducial qualities of [the patient-doctor] relationship." [FN45] Canterbury revealed the intimate and inseparable connection between the patient's right to self- determination and the fiduciary character of the patient-doctor relationship:

> True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each. The average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision. From these almost axiomatic considerations springs the need, and in turn the requirement, of a reasonable divulgence by physician to patient to make such a decision possible. [FN46]

Reminiscent of the 1905 decision Mohr v. Williams, [FN47] the court in Canterbury focused on the decision-making process of the patient and the importance of patient-doctor dialogue in reaching an informed decision. Also reminiscent of earlier battery-based decisions, the Canterbury court rejected the use of a professional practice standard as the measure for adequate disclosure of information.

Moreover, the court in Canterbury protected more than just bodily integrity. Instead, the patient has a legally protected interest to participate in "chart[ing] his course:"

> To the physician, whose training enables a self-satisfying evaluation, the answer may seem clear, but it is the prerogative of the patient, not the physician, to determine for himself the direction ***955** in which his interests seem to lie. To enable the patient to chart his course understandably, some familiarity with the therapeutic alternatives and their hazards becomes essential. [FN48]

According to Canterbury, protection of a patient's ability to participate meaningfully in her medical care requires a physician's help because of the general disparities in the relationship, specifically the disparities in information. Importantly, the patient is under no duty to ask the physician for information. Instead, since "[c]aveat emptor is not the norm for the consumer of medical services," the physician is required to disclose relevant information without being asked. [FN49] Only within the context of patient- doctor discourse can a patient effectively chart a course through the maze of medical and lifestyle options.

Canterbury recognized the intimate and inseparable connection between a patient's right to self-determination and the fiduciary character of the patient-doctor relationship.

2. Fiduciary Principles

Fiduciary principles apply to informed consent decisions because patients need to obtain trustworthy information

when confronted with an illness. Most patients feel that they have inadequate information about an illness when they are first diagnosed. Patients often need to rely on members of the medical profession to help them make a valid decision. Fiduciary principles have for a long time helped describe and explain aspects of the patient-doctor relationship. [FN50] The Hippocratic Oath, while silent regarding the specifics of informed consent, instructs doctors to act on their patient's behalf and honor their trust. [FN51] The ***956** American Medical Association's (AMA) Principles of Medical Ethics describes itself as "developed primarily for the benefit of the patient." [FN52] The AMA's position on conflicts of interest states that all conflicts between a physician's interest or the interests of a third party to the patient-doctor relationship should be resolved to the patient's benefit. [FN53] A past editor of the New England Journal of Medicine uses the language of trust law to describe a physician's role; a physician is "an agent and trustee for the patient." [FN54]

Courts and commentators similarly view the physician's responsibilities towards her patients in terms of fiduciary principles. [FN55] Fiduciary principles apply particularly to aspects of the ***957** patient-doctor relationship concerning information because, as Canterbury recognized, patients typically lack adequate information needed in order to make meaningful decisions about medical care. The court in Cobbs v. Grant [FN56] stated: "[T]he patient, being unlearned in medical sciences, has an abject dependence upon and trust in his physician for the information on which he relies during the decisional process, thus raising an obligation in the physician that transcends arms-length transactions." [FN57]

One commentator notes that aspects of fiduciary law operate within the doctrine of informed consent to ensure effective disclosure to patients. [FN58] Many patients may not fully comprehend what their doctor has told them in complex medical jargon. Fiduciary principles operate to minimize this risk and emphasize that mere disclosure may not be effective or adequate disclosure.

3. Defining a Patient's Autonomy Right Within the Context of the Patient-Doctor Relationship

a. Arato v. Avedon: Patient-Doctor Discourse Defines Reasonableness

The Supreme Court of California in Arato v. Avedon [FN59] examined what kind of information a doctor is obligated to tell a patient under the doctrine of informed consent. The physician in Arato did not inform the patient, diagnosed with pancreatic cancer, of his statistically dismal life expectancy. The deceased patient's family claimed that Mr. Arato would not have consented ***958** to the painful and miserable therapy had he known of his poor prognosis. The California Supreme Court upheld the jury's verdict for the defendant, and ruled, while reaffirming a "reasonable patient" based standard of disclosure, that the law mandated general but not specific information regarding risks and alternatives. [FN60] Thus, the physician defendants properly used expert testimony to help the jury decide the appropriate content of the duty to disclose additional information. Moreover, the court emphasized the importance of the jury in evaluating the adequacy of the disclosure. Reminiscent of the 1911 case report quoted earlier, which commented that a jury would not find a physician liable for ignoring a dying man's refusal to give consent as long as the treatment was successful, the Arato court deferred to the jury's ability to determine the particulars of adequate disclosure within the patient-doctor relationship. The California Supreme Court concluded:

> Rather than mandate the disclosure of specific information as a matter of law, the better rule is to instruct the jury that a physician is under a legal duty to disclose to the patient all material information - that is, "information which . . . would be regarded as significant by a reasonable person in the patient's position when deciding to accept or reject a recommended medical procedure"--needed to make an informed decision regarding a proposed treatment. [FN61]

Such judicial deference to the jury recognized the importance of the community's values and ideas of reasonableness. Thus, Arato acknowledged the patient's general right to autonomy but defined the right in terms of the community and medical profession's notions of reasonableness. Again, the court defined the patient's autonomy right within the context of patient-doctor discourse.

***959** b. Truman v. Thomas: Patient-Doctor Discourse Helps Locate The Middle Course

The California Supreme Court, in Truman v. Thomas, [FN62] illustrated the practical necessity of looking to the medical profession's standard of practice for helping to define the specific requirements of informed consent. In a

4-3 decision the majority held that a family practitioner, Dr. Claude R. Thomas, had a duty to inform his patient of the seriousness of the risks of not consenting to a Pap smear that he had recommended several times. [FN63] Mrs. Truman refused her doctor's recommendations because she could not afford the cost of the test; she died of cervical cancer at age thirty. Dr. Thomas admitted that he did not tell Mrs. Truman of the specific risks of foregoing the Pap smear, adding that he thought patients had a responsibility to either know or ask if they did not know the repercussions. The supreme court disagreed with the doctor and reversed the jury's verdict for the doctor, focusing on evidence that suggested that Mrs. Truman did not "appreciate the fatal consequences of her conduct." [FN64]

The dissent criticized the majority for placing an unlimited burden on physicians. Describing the results of the majority's reasoning, the dissent showed that the content of information which patients need to give informed consent must be defined and limited:

In short, today's ruling mandates doctors to provide each such patient with a summary course covering most of his or her medical education. Most medical tests--like pap smears--are designed to detect illness which might prove fatal absent timely treatment. Explaining the purposes of each procedure to each such patient will obviously take hours if not days. [FN65]

Praised by some for appreciating the patient's perspective and criticized by others for unreasonable expansion of the physician's duty, [FN66] Truman illustrates that the doctrine of informed consent ***960** works best following a decisional analysis down the center of the two opinions in Truman. Mandating that doctors ensure that their patients' every unspoken question is answered is not a workable formulation. Recognizing, however, that a doctor faced with evidence of a patient's lack of understanding has a duty to further explain basic aspects of that patient's medical care is reasonable. The patient requires appropriate and sufficient information to participate meaningfully in making decisions. Both physicians and patients determine what constitutes appropriateness and sufficiency of information, and they do so through discourse.

C. Conclusion: Informed Consent Has Evolved to Temper and Define Patients' Autonomy Right with Patient-Doctor Discourse

One commentator noted that, although various opinions disagreed about the details and application of the informed consent doctrine, "universal support [[exists] for the principles and goals of informed consent." [FN67] The same commentator defined these goals as "patient autonomy and improved decision-making," yet he acknowledged that individual autonomy has its limitations. [FN68]

The early informed consent cases framed the patients' claims in common law battery and protection of bodily integrity. Battery's underlying principle is autonomy defined in physical terms. The uncertainty of the earlier surgical consent cases and judicial expansion of the battery-based right suggests that the early jurisprudence, which restricted the patient's protections to physical self-determination, might have been too restrictive. The legal doctrine of informed consent has expanded in recent decades to more completely embrace the principle of autonomy, yet it continues to define the autonomy right at stake within the context of the doctor-patient relationship. A doctor's fiduciary responsibilities to her patients and the community's ability to define the reasonable ***961** expectations of the patient-doctor relationship act to effectively define and temper the patient's right to autonomy. Informed consent is not based on a fundamental right of every patient to achieve absolute and perfect autonomy. Rather, the underlying principle of informed consent is that patients should be able to meaningfully participate in their medical decision- making as part of their deliberative autonomy, a decision that often relies substantially, unavoidably, and traditionally within patient-doctor discourse. [FN69]

III

Third Parties to the Patient-Doctor Relationship

Today, third parties, whether insurance companies, employers, or government agencies, increasingly make health care decisions. [FN70] Third parties formulate care pathways, determine which doctors patients may see, decide what therapies to fund, and may even mandate what a doctor says and what a patient hears when making decisions about, as described in 1905, a "free citizen's first and greatest right," the "right to himself." [FN71] Although lack of informed consent may appear as the best available legal theory to ensure that a patient receives information about all relevant ***962** alternative therapies, including experimental and expensive therapies, the doctrine is generally not available against third parties. [FN72] The informed consent doctrine arose at the level of the patient-doctor relationship. Case law developed from patients suing doctors rather than third party insurers/managers.

This Part of the Article will examine one type of third party involvement in patient-doctor discourse, government regulation. Although much health care is administered by private institutions, the influence of government regulations upon patient-doctor relations necessitates a public discussion about constitutional considerations. The current debate surrounding a "patient's bill of rights" exemplifies how government influences the patient-doctor relationship. Congress is currently considering to what extent insurance companies or physicians will define "medical necessity." [FN73] Congress may proscribe limitations on managed ***963** care organizations interfering with free and open communications between patients and doctors. [FN74]

This Article will not examine how the constitutional protections of patient-doctor discourse will be applied. Instead, I will argue for the continued importance of patient-doctor discourse in the face of the increasing influence of third parties to the patient-doctor relationship, and will suggest an approach to beginning a constitutional dialogue about patient-doctor discourse.

A. Supreme Court Decisions

In the early 1990s, the Supreme Court decided a series of cases affecting patient-doctor discourse. Two of these decisions, Rust v. Sullivan [FN75] and Planned Parenthood v. Casey, [FN76] were abortion cases, yet they raised important questions about how to balance the relationship between doctors, patients, and the state. [FN77] Commenting on Rust, George Annas wrote:

> It cannot be too strongly emphasized that this decision is not primarily about abortion but, rather, about the doctor-patient relationship and the care of the poor in the United States. Some of the constitutional questions it raises are these: How much control over conversations between doctors and patients can the federal government now claim for health care it funds through Medicare and Medicaid? [FN78]

In Rust and Casey, the Supreme Court, focusing on the funding aspects of the regulations, failed to understand how patients make decisions and dismissed the importance of patient-doctor discourse. The Supreme Court superficially focused on physicians' speech rights and only cursorily considered the effects of ***964** government regulations on patients' rights. [FN79] The Court fundamentally failed to comprehend that the danger of the regulations mandating content in the patient-doctor dialogue was that the regulations enabled the government to impose its orthodoxy on medical decisions, precisely the kind of "creeping totalitarianism" and "unarmed occupation of individual lives" that so concerns Rubenfeld and others. [FN80]

1. Rust v. Sullivan

Chief Justice Rehnquist's majority opinion in Rust reveals a lack of understanding by the Supreme Court of patient decision-making and the importance of patient-doctor discourse. The discordance between the Court's result in Rust and both the majority and dissent's acceptance of the still ill- defined "right to medical self-determination" and right "to make informed medical decisions free of government-imposed harm" illustrates the lack of understanding. [FN81]

The facts of Rust began in 1970 with Congressional enactment of Title X of the Public Health Services Act, [FN82] which provided federal funding for family planning. The legislation contained the limitation that, "[n]one of the funds appropriated under this subchapter shall be used in programs where abortion is a method of family planning." [FN83] In 1988, the Department of Health and Human Services (HHS) issued new regulations designed to preserve the distinction between Title X family planning programs and abortion. These regulations restricted conduct and speech of physicians and other participants in Title X family planning clinics. ***965** Specifically, the regulations prohibited doctors and other Title X workers from "counseling concerning the use of abortion as a method of family planning" or referring patients to another clinic that provided abortions. [FN84] Rust involved a facial challenge of these HHS regulations. [FN85]

a. The Rust Court's Aborted First Amendment Analysis

The Supreme Court upheld the HHS regulations in a decision by Chief Justice Rehnquist that utilized an unconstitutional conditions analysis [FN86] and addressed the problem by balancing the parties' interests. [FN87] The doctors, whose conduct and speech was restricted by the regulations, entered the balancing equation of unconstitutional analysis as government agents and employees obligated to perform official duties. On the other side of the balance, Chief Justice Rehnquist placed the government's need to make funding decisions. According to

the Court, the case was not about the First Amendment at all, but was "merely" a governmental funding decision: "[T] he Government has not discriminated on the basis of viewpoint; it has merely chosen to fund one activity to the exclusion of the other." [FN88] According to the Court, the limitations on the doctors' conduct and speech were legitimate governmental means for defining the scope of the federal ***966** funding. To help discount the First Amendment based argument that the regulations impermissibly restricted content based viewpoints (the physician's speech) the majority invoked the analogy of the Congressionally established National Endowment for Democracy. [FN89] Enacted to promote democracy throughout the world, the establishment of the National Endowment for Democracy did not constitutionally require that Congress also fund competing political philosophies like communism or fascism. The Court reasoned that the government may express preferences by choosing to fund one ideology and not another. Chief Justice Rehnquist's view of the Constitution, therefore, permitted content based family planning funding and content based medical care.

The Court's analogy ignored the First Amendment aspects. [FN90] A more applicable analogy would have been whether the Constitution allowed lawmakers to enact popularly supported legislation to promote democracy in our public universities and allowed regulations that prevented federally funded university professors from discussing fascism or communism with students on campus. [FN91] One might argue that the majoritarian will of the legislature supports both campus promotions of democracy and regulations limiting abortion. Like the regulations in Rust, the regulations limiting the topics of teacher-student discussions are "merely" funding decisions and not penalties for particular content. The students are free to attend private universities if they want to learn about communism or fascism, just like the patients in Rust were free to seek counseling and treatment from private, abortion performing physicians.

The analogy is instructive. Like the underlying right to freedom of speech that protects academic freedom, patient-doctor discourse invokes the "whole" Constitution, including the First and Fourteenth Amendments. [FN92] Like the political character of ***967** professors and students engaged in discussions about alternatives to democracy, discourse between patients and doctors also invokes politics. [FN93] As discussions about political philosophy help define a person, her society, and the complex interaction between the two, a patient's decisions about medical care define herself and her society. Perhaps more apparent today, as questions of costs and rationing, assisted suicide, cloning, and genetic information increasingly enter the political arena, the political and personal attributes of patient-doctor discourse nevertheless rest solidly within our tradition. [FN94] Indeed, Chief Justice Rehnquist acknowledges that the patient-doctor relationship is one grounded in tradition and were the Title X program "sufficiently all- encompassing" the "traditional relationship" of doctor and patient might enjoy First Amendment protections. [FN95]

Chief Justice Rehnquist provided further evidence of the political attributes of the regulations at issue in Rust. He argued that the Title X patient-doctor relationship at issue was exempt from the acknowledged Constitutional protections because it wasn't "sufficiently all encompassing so as to justify an expectation on the part of the patient of comprehensive medical advice." [FN96] His argument revealed the disproportionate effect of the regulations upon those unable to afford private health care. [FN97] Poor people obligated to rely on state-funded physicians will seldom have justified ***968** expectations for "comprehensive medical advice" and will seldom have the ability to learn of all available medical options. On the other hand, the expectations of monetarily wealthier people may reasonably include more comprehensive medical advice.

b. The Court Opens the Door to a Fifth Amendment Right to Medical Self-Determination

The Court in Rust evaluated two Fifth Amendment arguments. The first argument was that the regulations violated a woman's right to choose an abortion, and was easily discounted by the Court invoking the line of cases beginning with Maher v. Roe [FN98] and Harris v. McRae [FN99] and ending with Webster v. Reproductive Health Services. [FN100] Again concentrating on the funding aspects of the case, the Court acknowledged that a poor pregnant woman may encounter difficulties when a Title X project neither provides nor counsels for an abortion, but the Court concluded that "Congress' refusal to fund abortion counseling and advocacy leaves a pregnant woman with the same choices as if the Government had chosen not to fund family-planning services at all." [FN101]

The Court did not so summarily discard the argument that the regulations impermissibly restricted the right to medical self determination. The Court considered whether the regulations "impermissibly infring[ed] on the doctor-patient relationship and depriv[ed] a Title X client of information" and thus violated a "woman's Fifth Amendment right to medical self-determination and to make informed medical decisions free of government-imposed harm."

[FN102] The majority clearly acknowledged that its previous decisions in City of Akron v. Akron Center for Reproductive Health, Inc., [FN103] and Thornburgh v. American College of Obstetricians and Gynecologists [FN104] protected, what it ***969** termed, "patient-doctor dialogue" from government intrusion. [FN105] The protection of "patient-doctor dialogue," however, was an abstract and general right that did not apply to any particular patient or doctor, or specific patient-doctor discourse. Chief Justice Rehnquist emphasized that the HHS regulations in Rust did not apply to all doctors or all patients. This fact distinguished Rust from the government's impermissible intrusion on patient-doctor dialogue in Akron and Thornburgh. Rehnquist wrote: "Under the Secretary's regulations, however, a doctor's ability to provide, and a woman's right to receive, information concerning abortion and abortion-related services outside the context of the Title X project remains unfettered." [FN106]

The telltale use of the word "unfettered" without any modifier such as "significantly" or "substantially," reveals the Court's failure to understand the workings of patient-doctor discourse. The Chief Justice reasoned that patients' and doctors' rights were "unfettered" because the patient-doctor relationship at issue was not "sufficiently all encompassing so as to justify an expectation on the part of the patient of comprehensive medical advice." [FN107]

c. The Court's Flawed Analysis

The Court's reasoning in Rust failed in two ways. First, it inaccurately portrayed modern medical practice. Perhaps the court had in mind a family practitioner of fifty years ago when it required a "sufficiently all encompassing" patient-doctor relationship. The administration of health care today often involves specialists, emergency department physicians, and cross- covering physicians, all of whom deliver care that is likely not "sufficiently all encompassing." For Chief Justice Rehnquist, patient-doctor discourse was apparently deserving of protection but only if it was "sufficiently all encompassing" and "comprehensive." Neither Chief Justice Rehnquist nor the Court, however, contemplated any guidelines for establishing which patient- doctor relationships qualify. Perhaps a patient's first delivery after diligent prenatal care would qualify but the first abortion does not? Should courts or legislatures, or neither, decide which patient-***970** doctor relationships qualify? One might imagine a difference in opinion between a court and a woman who has seldom visited a doctor and who plans to undergo a significant medical procedure, such as an abortion, trusting that the doctor will give her comprehensive medical advice. In any event, the number of qualifying patient-doctor relationships is likely scarce.

Second, the Court's reasoning that a woman's rights remain wholly unrestrained because she can simply go elsewhere to exercise her rights ignores that a particular patient will not be able to participate meaningfully in her medical decision-making within a particular patient-doctor relationship. Ironically, the Court interprets the Constitution in a manner that fails to protect a patient's rights when the government is involved because a woman is free to go to a physician in the private sphere; however, once in the private realm, the patient is unable to invoke constitutional rights because of the absence of government involvement. The patient receives little protection from stilted medical information from either the government or private third parties. Unable to rely upon patient-doctor discourse, the patient is significantly "fettered" from meaningful participation in medical decision- making.

The Supreme Court's impression that the HHS regulations only make it a bit more difficult for a pregnant woman seeking information about abortion failed to recognize the dynamics of the patient-doctor relationship. The common law use of fiduciary principles to help describe the patient-doctor relationship indicates that patients often depend on doctors to help them make decisions. [FN108] Trust is an essential part of the relationship. [FN109] Professor Berg reviewed the literature on the patient-doctor relationship, much of it empirical, and concluded that:

> The insights of social science into doctor-patient interaction strongly indicate that the Supreme Court has overestimated the extent to which patients' critical rationality and inquisitiveness will neutralize the coercive effect of government messages that are delivered by physicians. [P] atients are likely ***971** to give great weight to physicians' expressions of state preferences, not because they are persuaded by the messages, but merely because the messages are delivered by physicians. [FN110]

Professor Berg emphasized that non-white, poor, or elderly patients are less likely to question state influenced physician speech and more likely to follow the decision-making path advocated by the HHS regulations in Rust. [FN111] This disproportionate effect on particular minority groups and women generally reveals the inherently political character of patient-doctor discourse. [FN112]

d. The Dissent's View of Patient-Doctor Discourse

Part III of Justice Blackmun's dissent in Rust, joined by Justices Marshall and Stevens, [FN113] indicated the traditional value of patient-doctor dialogue by describing it as dialogue the Court has "guarded so jealously." [FN114] Justice Blackmun echoed the inherent ***972** fiduciary character of the patient-doctor relationship when he described patient-doctor dialogue as one that "embodies a unique relationship of trust." [FN115] As Justice Blackmun was aware, the HHS regulations violated this sense of trust:

> The majority . . . [contends] that "the Title X program regulations do not significantly impinge upon the doctor-patient relationship." That the doctor-patient relationship is substantially burdened by a rule prohibiting the dissemination by the physician of pertinent medical information is beyond serious dispute. . . . A woman seeking the services of a Title X clinic has every reason to expect, as do we all, that her physician will not withhold relevant information regarding the very purpose of her visit. To suggest otherwise is to engage in uninformed fantasy. [FN116]

For Blackmun the "unique relationship of trust" between patient and doctor arises out of the "specialized nature of medical science and the emotional distress often attendant to health-related decisions." [FN117] These characteristics result in most people closely considering and often following the advice of their physicians. Secondly, Blackmun's view of the patient- doctor relationship for Title X clinic patients does not fundamentally differ from his view of the patient-doctor relationship a Supreme Court Justice may have with her physician; we all have every reason to expect that our doctor will not withhold essential medical information. From this perspective of patient-doctor dialogue, Blackmun concluded that the HHS restrictions on doctor's advice violated pregnant women's Fifth Amendment rights. [FN118] For Blackmun, "the Government will have obliterated the freedom to choose as surely as if it had banned abortions outright." [FN119]

e. Rust's Revelations

The Court in Rust acknowledged the existence of a patient's right to medical self-determination but failed to understand the essential role that patient-doctor dialogue plays in defining the patient's right. [FN120] The case revealed that simply granting patients ***973** a right to medical self- determination means little unless patients have the ability to exercise the right. For patients to have the ability to exercise their right does not mean that the government must fund all medical treatments, but it does mean that a patient needs to be able to make an informed choice. This ability depends on the unrestricted flow of information between doctor and patient. [FN121] As the discussion about informed consent concluded, and the Rust case illustrated, a patient's autonomy right lies within the context of a patient's deliberations with family, friends, and other members of the patient's community, and within each individual's patient-doctor relationship, whether the relationship is with the patient's primary care doctor, midwife, oncologist, or a one-time visited specialist. Protecting a patient's autonomy right mandates protecting the dialogue between patient and doctor, a right which the patient must exercise. Moreover, and as I will later discuss, understanding an autonomy right in terms of community and patient-doctor discourse helps define and narrow the character of the constitutional protection of a patient's autonomy right. [FN122]

2. Planned Parenthood v. Casey: Another Example of the Court Misunderstanding Patient-Doctor Discourse

In Planned Parenthood v. Casey [FN123] the Supreme Court reaffirmed the "essential holding" of Roe v. Wade [FN124] and the validity of a substantive as well as procedural component to the Due Process Clause of the Fourteenth Amendment. Moreover, Justice O'Connor's plurality opinion referred to the "promise of the Constitution" to point out "[the] realm of personal liberty which the government may not enter." [FN125] Having established the general legitimacy of a substantive component, Justice O'Connor resisted the temptation proffered by Justice Scalia, in Michael H. v. ***974** Gerald D., [FN126] to interpret the substantive components of the Due Process Clause at the "most specific level." [FN127] Such an approach, wrote Justice O'Connor, would betray the promise of the Constitution, a promise the Supreme Court had previously kept. [FN128] As I will discuss in Part IV, this "aspirational" constitutional approach forms part of the bedrock for protecting patient-doctor discourse.

Although reaffirming the "essential holding" of Roe v. Wade, the Supreme Court in Casey upheld a Pennsylvania statute that sought to utilize patient- doctor discourse to influence patients' medical decision-making toward a decision preferred by the government. [FN129] Unlike Rust, the regulations in Casey applied to all patient-doctor discourse, not just discourse in publicly funded clinics. The plurality opinion asked whether the regulations "unduly burdened" a woman's established privacy right to choose an abortion. Concluding that the regulations did not "unduly burden" women's privacy rights, [FN130] the plurality opinion then considered the physicians' First Amendment rights. While the Court acknowledged that such First Amendment rights "are implicated," it reasoned

that since advising patients is a part of the ***975** practice of medicine, patient-doctor discourse is subject to reasonable licensing and regulation by the State. The government may mold the flavor and content of patient-doctor dialogue as part of the state's police power. [FN131] The plurality opinion of Casey reminds the reader that "under the undue burden standard a State is permitted to enact persuasive measures which favor childbirth over abortion, even if those measures do not further a health interest," [FN132] and even if such "persuasive measures" limit a physician's discretion to exercise sound medical judgment. [FN133] Casey requires only that governmental regulation of patient-doctor discourse furthers a legitimate governmental interest and that the information that the regulation requires the doctor to pass on to the patient is neither false nor misleading. [FN134]

The Court in Casey, as in Rust, failed to understand the essential role that patient-doctor dialogue plays in defining the patient's right. This is evident in the method of the Court's analysis whereby it considered, and dismissed, physicians' First Amendment rights but never mentioned patients' First Amendment rights. [FN135] Listeners, as well as speakers, have First Amendment protections and neither the listener nor the speaker's right means much without the other. [FN136] In Virginia State Board of Pharmacy v. Virginia Citizens Consumer Council, [FN137] the Supreme Court recognized that the protection extends to "the communication, to its source and to its recipients both." [FN138] The proper First Amendment ***976** analysis, therefore, requires consideration of the interaction between listener and speaker, and the circumstances and effect of the speech. The Court in both Casey and Rust failed to appreciate that both patient and doctor speak and listen to one another. The dialogue and interaction between the patient and doctor fundamentally define the patient's decision-making. This dialogue is an integral and inseparable part of the patient's right to meaningfully participate in medical decision-making, and serves as an essential precondition to deliberative autonomy. [FN139]

Similarly, the Court focused on women's privacy rights without recognizing physicians' rights and protecting the traditional patient-doctor relationship. The regulations in Casey applied to all patient-doctor discourse and extended beyond regulating how, when, or even whether, a woman received an abortion. The Casey regulations forced all doctors to function as agents of a particular governmental viewpoint.

Casey's plurality opinion revealed a lack of understanding of the intimate influence patient-doctor discourse has upon a patient's medical decision- making. This lack of understanding resulted in inconsistency between the plurality's formulation and interpretation of the "undue burden" standard and its acknowledgement of the essential character of the liberty interest at stake: "At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State." [FN140] The Pennsylvania statute at issue in Casey aimed to influence how an individual defines himself regarding a constitutionally protected choice. The Court could only have concluded that the restraints on all patient-doctor discourse did not constitute an "undue burden" if it failed to understand the essential effects patient-doctor discourse has on an individual's protected liberty interest.

Justice Stevens recognized the extent of the government's intrusion upon "decisional autonomy." He explained: "Decisional autonomy must limit the State's power to inject into a woman's most personal deliberations its own views of what is best." [FN141] Stevens ***977** recognized that influencing patient-doctor discourse was a way to inject state ideology into a patient's "most personal deliberations." [FN142]

3. Cruzan v. Director, Missouri Department of Health: Formulating a Constitutional Right in the Terms of Common Law Informed Consent

Whereas Rust and Casey involved the political and emotional issue of abortion, Cruzan v. Director, Missouri Department of Health [FN143] concerned the question of whether the Constitution requires the withdrawal of life-sustaining medical treatment. [FN144] The constellation of opinions, five in all, reveal that the concept of informed consent sat heavily in the minds of at least eight of the Justices as they contemplated the character and extent of the fundamental liberties at stake. [FN145] With the exception of Justice Scalia, who viewed the case as one about the right to suicide, [FN146] all of the Justices agreed that the common law of informed consent was instructive in defining Nancy Cruzan's constitutionally protected liberty interest.

Chief Justice Rehnquist viewed Nancy Cruzan's right as invoking an individual liberty interest balanced against the state's interest in protecting and preserving human life. [FN147] Moreover, all of the Justices, except Justice Scalia, defined Nancy Cruzan's right in terms of the common law's formulation of informed consent, ***978** thus revealing that for eight of the Justices, the underlying principle of informed consent sat solidly within the

Constitution, well "'rooted in our tradition." ' [FN148]

Chief Justice Rehnquist, writing the Court's opinion, relied on the common law doctrine of informed consent to define the issue in Cruzan. [FN149] A lengthy, eight-page, discussion of the common law doctrine of informed consent and relevant state statutes [FN150] concluded that the common law doctrine established "the right of a competent individual to refuse medical treatment." [FN151] The opinion then briefly, in two pages, discussed how the "liberty interest" under the Fourteenth Amendment's Due Process Clause "may be inferred from our prior decisions." [FN152]

Chief Justice Rehnquist's reliance upon inference combined with his apparent reliance on the tradition of informed consent common law and statutes reveals a mixed approach to establishing the liberty interest. Unlike Justice Scalia, Chief Justice Rehnquist's conceived traditions are different from simple ***979** historical practices. Chief Justice Rehnquist's methodology of inference suggests that he used previous cases to distill the aspirational principles underlying common law informed consent [FN153] instead of only looking to historical practices as a historical deposit.

Chief Justice Rehnquist reveals in Cruzan his limited and staunchly individual view of autonomy. Confronted with placing the authority for making a medical decision to withdraw care with the state or with the person's family, Chief Justice Rehnquist chose the state. [FN154] If the Chief Justice had understood that a person's ability to define himself lies within his interactions with family and friends, Rehnquist would have also understood that a person's autonomy interest does not disappear merely because the person's wishes are not clearly or convincingly articulated prior to an event.

Justice O'Connor concurred to emphasize the strength of the protections for "patient's liberty, dignity, and freedom to determine the course of her own treatment" [FN155] and to discuss her broader view of the liberty interest at stake. Justice O'Connor grounded the liberty interest on the same principles that the earlier informed consent cases based their protections of patients' interests. Echoing the earlier informed consent cases, Justice O'Connor wrote: "Because our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination, ***980** the Court has often deemed state incursions into the body repugnant to the interests protected by the Due Process Clause." [FN156]

Unlike the Chief Justice, Justice O'Connor recognized that surrogate decision-making may protect autonomy. [FN157] Justice O'Connor's view invoked the discourse between patient and family, recognizing the tendency of patients to select family members as surrogates. Justice O'Connor traveled part of the way to recognizing a fuller, more deliberative definition of autonomy when she suggested that a patient's appointment of a family member as a surrogate may be protected by the "'freedom of personal choice in matters of . . . family life." ' [FN158]

Justice Brennan dissented because the clear and convincing standard required by the Missouri statute violated a person's constitutionally protected liberty interest grounded in the "common-law tradition of medical self-determination." [FN159] For Justice Brennan, the Due Process Clause protects the right to participate in medical decision-making, even according to the more limited view that protects only those liberties "deeply rooted in this Nation's [history and] traditions." [FN160] Moreover, Justice Brennan used common law informed consent derived principles to explain the characteristics of the liberty interest at stake. He stated: "The right to be free from unwanted medical attention is a right to evaluate the potential benefit of treatment and its possible consequences according to one's own values and to make a personal decision whether to subject oneself to the intrusion." [FN161] Justice Brennan's language is reminiscent of the earlier common law informed consent cases and shows a reliance on the language and principles of common law informed consent doctrine to define the constitutional right. [FN162]

***981** Justice Stevens, who also wrote a dissenting opinion, argued that "Nancy Cruzan's liberty to be free from medical treatment must be understood in light of the facts and circumstances particular to her." [FN163] Thus, Justice Stevens placed the liberty interest within the context of Nancy Cruzan's family and community, recognizing implicitly that one's right to participate meaningfully in one's medical decision-making exists within the context of the person's life, including, as in this case, family. Moreover, for Justice Stevens, any theory that results in the state defining "personhood" instead of the individual defining "personhood" for themselves is "radically inconsistent with the foundation of all legitimate government." [FN164] Justice Stevens understood the dangers of allowing the government's pursuit of a general policy to interfere with "the individual's vital interest in liberty." [FN165]

4. Informed Consent's Continued Presence in the Constitutional Analysis of

Patient-Doctor Discourse

The various opinions in Cruzan reveal how the common law doctrine of informed consent defines the basis and characteristics of an individual's liberty right within the patient-doctor relationship. [FN166] Other Supreme Court cases extended privacy protections to the patient-doctor relationship, [FN167] but a better understanding of the basis of patient's individual liberty interest ***982** at stake in Cruzan, Rust, Casey, and other cases lies in common law informed consent doctrine. Recall that informed consent is not based on a fundamental right of every patient to achieve absolute and perfect autonomy, nor has its evolution through hybridization with negligence law led to an exclusive focus on the individual. Instead, the patient has a fundamental right to meaningfully participate in her medical decision-making, but the right exists within the context of the patient-doctor relationship and the community generally. Thus, a person's autonomy right does not lie exclusively within the individual, but becomes perfected within the various discourses the individual has with her family, friends, and environment. Achieving autonomy is a constant process and patient-doctor discourse comprises an essential part of the autonomy right.

IV

Deliberative Autonomy and Patient-Doctor Discourse

I rely in this Part primarily on Professor Fleming's construction of the Constitution to provide the remainder of the foundation for protecting patient- doctor discourse. In particular, Fleming's emphasis on the importance of securing the preconditions for deliberative autonomy provides the bedrock for protecting patient-doctor discourse. With Fleming's construction of the Constitution as the background, I argue several closely related points. First, the Constitution protects patient-doctor discourse as a necessary precondition to deliberative autonomy. Second, protecting patient-doctor discourse both expands and narrows the individual's right to autonomy. Protection of discourse properly expands the individual's autonomy right in the sense that courts and legislatures have yet to recognize patient-doctor discourse as an essential precondition to defining an individual's autonomy. Patient-doctor discourse based on a patient's autonomy right simultaneously narrows the autonomy right because the approach recognizes that the right does not lie isolated within an individual, but exists fundamentally within people's interactions. The autonomy right is deliberative. [FN168] The last point is that the ***983** common law of informed consent has helped define and limit the patient's autonomy right, teaching that the right exists within the complex interactions between doctors, patients, their families, friends, and society generally.

A. Fleming's Deliberative Autonomy

Fleming begins by noting that even narrow originalists accept constitutional structure as one of the three legitimate sources for constitutional values: "text, history and structure." [FN169] With structure as his touchstone, Fleming seeks to finish the "unfinished business of Charles Black" and show "the coherence and structure of certain familiar basic liberties (commonly grouped under the names of privacy, autonomy, or substantive due process) on the basis of a fundamental theme of securing deliberative autonomy." [FN170] He describes his activity of construction as analogous to the archaeologist, or perhaps he meant paleontologist, fitting the "bones" of the unenumerated fundamental rights [FN171] recognized over the years into the "skeleton" of the constitutional ***984** structure. [FN172] In other words, the "bones" comprise the first and best evidence of the "skeleton."

Recalling Justice O'Connor's plurality opinion in Casey, Fleming's constitutional theory is aspirational. Similar to Justice O'Connor writing about the "promise" of the Constitution to continue to define and examine the realm of "personal liberty which the government may not enter," Professor Fleming's method of constitutional constructivism distills its "principles and substantive liberties from our constitutional democracy's ongoing practice, tradition, and culture." [FN173] Fleming continues:

> These principles are aspirational--the principles to which we as a people aspire, and for which we as a people stand--and may not be fully realized in our historical practices, statute books, and common law. Accordingly, constitutional constructivism recognizes that our principles may fit and justify most of our practices or precedents but criticizes some of them for failing to live up to our constitutional commitments to principles such as liberty and equality. [FN174]

The idea that a theory of the Constitution includes the ability to aspire, instead of the textualist's primary acceptance of judgments made by people who lived hundreds of years ago, [FN175] is central for Fleming. [FN176]

***985** For Fleming, the conception of citizens as free and equal persons and society as a fair system of social

cooperation are the aspirational principles. Such free and equal persons in such a society would exercise two moral powers: the "capacity for a sense of justice," associated with deliberative democracy, and the "capacity for a conception of the good," associated with deliberative autonomy. [FN177] The basic liberties, then, are the preconditions for the "development and exercise" of these two moral powers. [FN178] Deliberation is important for both, but it is deliberation for the good, whether about what policies and approaches are best for the common good or whether about how to best live one's life.

Professor Fleming's focus on the deliberative quality of the autonomy right stresses that although the individual person remains the "locus of moral agency, responsibility, and independence" the term deliberative autonomy "allows room for a social dimension." [FN179] For Fleming, the exercise of deliberative autonomy emphatically includes, "consulting with others, taking their views into account, and associating with them." [FN180] The "unenumerated" fundamental rights contribute to the structure of deliberative autonomy because they implicate citizen's deliberations, or their "capacity to deliberate" about a person's fundamental life decisions. [FN181] Moreover, protection of deliberative autonomy functions to safeguard citizens from government's "creeping totalitarianism, an unarmed occupation of individuals' lives." [FN182] Again evoking the intimate connection between autonomy and sovereignty, Fleming asserts that "[i]f persons do not have the freedom to deliberate about and make such decisions, they are ***986** not free." [FN183]

Instead of relying on the more commonly used values of privacy and liberty to provide the underpinnings to deliberative autonomy, Fleming relies upon liberty of conscience and freedom of association. He emphasizes freedom of association as one of the two "matrix values underwriting deliberative autonomy" [FN184] because he wants to "bring out that deliberative autonomy relates to persons' deliberations and decisions in pursuing their conceptions of the good, individually and in association with others." [FN185]

1. The Autonomy Right Tethered

Fleming responds to critics who complain that autonomy is either a flyaway right or that incorporating autonomy into the Constitution is to enact comprehensive liberalism. He describes deliberative autonomy as intimately intermixed with the process of deliberations and associations with others. This acts to limit or "tether" the autonomy right. Although Fleming relies upon Rawls, he insists that he utilizes Rawls' political liberalism rather than comprehensive liberalism. [FN186] Only those basic liberties that are significant merit constitutional protection. Fleming quotes Rawls' explanation for the criterion of significance: "'[A] liberty is more or less significant depending on whether it is more or less essentially involved in, or is a more or less necessary institutional means to protect, the full and informed and effective exercise of the moral powers in one (or both) of the two fundamental cases." ' [FN187] I argue that a person making important medical decisions exercises her moral power. Restriction of patient-doctor ***987** discourse significantly threatens a person's ability to make an informed and effective decision, because patient-doctor discourse is necessary for the individual citizen to fully exercise her moral powers. Patient-doctor discourse, therefore, qualifies as one of the "unenumerated" fundamental rights.

B. Deliberative Autonomy and Patient-Doctor Discourse

1. Deliberative Autonomy Protects Patient-Doctor Discourse

Medical decisions about fertility and decisions about how to die invoke a person's moral powers. Decisions about whether to undergo bone marrow transplantation or whether to agree to genetic testing as a condition of employment [FN188] similarly call upon a person to assess what is important and most valuable in their life. For example, a person faced with a diagnosis of cancer with a dismal five year survival might face the choice of undergoing a bone marrow transplant with its significant emotional, physical, and financial costs for themselves, family, and friends. Such a decision calls upon one's religious and philosophical beliefs and summons evaluations of personal courage and considerations of the effects upon family and friends. Such a decision allows a person to pursue her concept of the good, a pursuit ultimately made individually but in association with other people. It is fundamentally deliberative with one's self and with others. This kind of decision invokes Fleming's second moral power, the capacity for a conception of the good. [FN189]

A person can only invoke one's moral power if effectively informed. The Constitution's purpose is to ensure that preconditions exist for the development and exercise of the individual's moral powers. [FN190] A government that does not attempt to distort ***988** or influence the individual's exercise of moral power is a government that conceives of its citizens as free and equal persons. [FN191] For example, a government regulation may limit the

availability of government funding for bone marrow transplantation to particular circumstances without destroying the preconditions needed to deliberate the justice of such an approach or the remaining personal options. However, governmental restrictions prohibiting federally funded physicians from discussing bone marrow transplantation in certain cases in an effort to generally limit costs and minimize dissatisfaction with government funded programs would fail to ensure the existence of the preconditions for a patient's deliberations on both the common and individual good. [FN192]

Fleming describes the capacity for a sense of justice as "the capacity to understand, apply, and act from (and not merely in accordance with) the political conception of justice that characterizes the fair terms of social cooperation in a constitutional democracy." [FN193] Protecting patient- doctor discourse allows a patient to participate meaningfully in the political process, in decisions affecting health care. The patient can participate meaningfully in the political process only if adequately informed. Again, importance lies in protecting the preconditions to deliberation. [FN194] An example in terms of abortion is that a patient can only "understand, apply, and act from the political conception of justice" if she knows that in her case an abortion is not medically contra-indicated and that the government neither funds abortions nor ***989** permits certain physicians to counsel patients about abortions. [FN195] Government regulations that restrict patient- doctor discourse seek to deny citizens their ability to exercise their essential capacity by infiltrating patients' deliberations. Similarly, a patient's ability to seek particular medical treatment elsewhere is only possible if the patient knows other relevant medical options exist. Moreover, restricting a doctor from disclosing economic incentives to perform fewer tests, or not allowing physicians from recommending non-plan approved specialists would keep information from patients that they need to deliberate and understand the political facets of these measures. Such deliberations are about more than mere funding decisions. Deliberations are about who we are individually and as a society. Governmental restriction of patient-doctor discourse, therefore, fails to protect the preconditions necessary for the development of personal and political deliberations.

The counter argument that a patient need not rely on her doctor for all medical information to participate in the political process, that other sources such as the Internet are available, misses the point for at least four reasons. First, our tradition and law have established the fiduciary character of the patient-doctor relationship. Patients have come to rely upon the trust existing in the relationship [FN196] and some evidence supports the therapeutic effect of the trust between patient and doctor. Second, the common law doctrine of informed consent has evolved to recognize that the patient's autonomy right exists within the context of the patient-doctor relationship and the community generally. To ignore the importance of patient-doctor discourse in defining patient autonomy, while asserting that patients have an autonomy right, would result in the kind of flyaway and distorted autonomy right that so concerns some critics. In contrast, maintaining patients' ***990** autonomy right in the context of patient-doctor discourse and the community generally grounds autonomy within the community. Third, the counter argument suffers from the same shortcomings as other unconstitutional conditions approaches. [FN197] Fourth, the counter argument fails to understand the totalitarian character of the governmental restrictions on patient-doctor discourse. Not only do the restrictions aim to direct patient decision-making in a particular direction, but the restrictions method of implementation interferes with patients' ability to utilize their decision-making capacity. As Justice Stevens explained in Casey, we should be wary of state power injecting into a person's deliberations its own view of what is best.

These reasons contribute to the significance of patient-doctor discourse and reveal the institutional character of the individual right to unfettered patient-doctor discourse. They also reveal that the involved liberty is grounded in community and responsibility.

Understood in this manner, the protection of patient-doctor discourse based on deliberative autonomy remains strongly tethered to the structure of the Constitution. The right does not mandate that the doctor perform or the government fund a particular therapy, nor does the deliberative autonomy right prevent the government from deciding to cut back on funding for bone marrow transplantation or abortion. Instead, the right protects and encourages [FN198] the free flow of information that passes between doctor and patient because patient-doctor discourse defines the content and shape of how the patient approaches important medical decisions. The information a patient needs to make an important medical decision is a significant precondition to deliberative autonomy.

C. Shortcomings

Fleming's constitutional theory is more noteworthy for his use of deliberative autonomy than for his reliance on

deliberative democracy. ***991** As Professor Sunstein points out, advocating deliberative democracy as the focus of constitutional interpretation is nothing new. [FN199] However, Fleming believed that deliberative democracy failed to fully respect the liberal protections against government, an essential part of his dualist system. He, therefore, included deliberative autonomy, and relied upon it to support a right to abortion and consensual sexual activity.

No constitutional theory survives without criticism. [FN200] Fleming's theory faces not only the critics of substantive due process but also those who acknowledge a narrower version of substantive due process. One critic, Cass Sunstein, faults Fleming for making our federal constitution a kind of utopian document. Sunstein states that Fleming has glossed over the distinctions between a just society, just constitutions, and the proper role for reviewing courts. Concentrating on the judicial enforcement of the Constitution, Sunstein favors courts protecting democratic deliberation because it is "an ideal built deeply into American constitutionalism and unusually susceptible to both definition and development--the benefits are likely to be great, and the risks are far lower." [FN201]

I have two responses to these criticisms of Fleming's and, implicitly, my argument with its significant reliance on Fleming. First, as mentioned in the introduction, my purpose is to promote a constitutional discussion among citizens, their legislators, and courts. My purpose is not to tell the courts how to decide cases involving a claim for substantive rights, but to increase awareness of the existence of a constitutional dimension to patient-doctor discourse. [FN202] Secondly, the informed consent cases and the Supreme Court cases illustrate how our tradition and history establish the view that a patient's autonomy right is implemented in patient-doctor discourse. Judicial and public opinion see a largely unavoidable gap in medical knowledge between patients and doctors and they recognize the often vulnerable position patients ***992** face when making medical decisions. [FN203] Public opinion has voiced its objections to patient-doctor relationships becoming more and more like other commercial endeavors. To paraphrase the court in Canterbury, caveat emptor should not apply to patient-doctor discourse because patients are often sick and confused, confused because they are sick and because of the complexities of the medical system and technology. Patients do not want their patient-doctor relationship to be just another commercial relationship. Medicine is more than health care administration. Perhaps these pithy emotions are no more than nostalgia. Notwithstanding, the constitutional aspects of patient-doctor discourse with its long history, the continued public expressions for improvements in communication, and the continued cost of health care mean that the public and private deliberations about a constitutional aspect to patient-doctor discourse should not be coming to an end. Many people, including the Supreme Court Justices and legislators, note the continued importance of patient-doctor discourse. My purpose is to promote discussions of constitutional approaches that recognize the importance of patient-doctor discourse.

Another critic of my argument might attack my portrayal of patient- doctor discourse, noting that despite Justice Cardozo's rhetoric of self- determination as a person's most fundamental right, the practice of informed consent is mostly illusory. [FN204] My response is that I acknowledge what Professor Schuck calls the informed consent gap, the difference between the ideal of informed consent and its practice, [FN205] but maintain that the gap has lessened since Canterbury. Moreover, my reliance on the common law of informed consent relies more on the principle than the historical occurrences of actual patient-doctor interaction. The autonomy right I advocate does exist for the benefit of patients. I only argue that it is better understood within the context of patient-doctor discourse as a means of both limiting and fulfilling the autonomy right.

***993** Conclusion

My approach sets forth a constitutional framework that supports a narrow, limited, 'tightly tethered,' and concrete view of the protected autonomy right. One part establishes, relying on Fleming's constitutional theory, a patient's right to the necessary preconditions for making significant medical decisions. The basis of this right lies in Fleming's central tenet of deliberative autonomy. This leaves the question of what necessary preconditions the government should guarantee. This can be answered by looking at the common law doctrine of informed consent.

Common law notions of informed consent extend back to at least the early part of this century and probably earlier. [FN206] The common law has established the fiduciary character of the patient-doctor relationship. Informed consent also teaches the importance of patient-doctor discourse in determining how the patient makes a decision. Patient-doctor discourse is a significant and necessary precondition to deliberative autonomy, and government measures that significantly interfere with patient-doctor discourse invoke constitutional principles and protections.

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[FN1]. See Alison Mitchell, Senate Takes Up Patients' Rights Bill, N.Y. Times, July 13, 1999, at A1; Bob Herbert, In America; Money vs. Reform, N.Y. Times, July 15, 1999, at A25; Robert Pear, Most in H.M.O.'s Wouldn't Benefit From Senate Bill, N.Y. Times, July 17, 1999, at A1.

[FN2]. In contrast to fee for service, managed care involves greater involvement of third party insurers or managers in health care. Under fee for service, physicians and patients made most of the treatment decisions that determined health care spending. See David Mechanic, Rationing of Medical Care and the Preservation of Clinical Judgment, 11 J. Fam. Pract. 431 (1980); Mark Hall, Making Medical Spending Decisions 8 (Oxford University Press, 1997). ("Cost-sensitive treatment decisions can be made by patients, by physicians, or by third parties--primarily private and government insurers but also various regulatory or review organizations."). Today, third party insurers and managers (Medicaid, Medicare, and managed care organizations (MCO's)) increasingly make treatment decisions through the implementation of "care pathways" and reimbursement requirements.

[FN3]. Critics of the current "patient bill of rights" note that most versions focus on consumer rights rather than on patient rights. See Wendy K. Mariner, Standards of Care and Standard Form Contracts: Distinguishing Patient Rights and Consumer Rights in Managed Care, 15 J. Contemp. Health L. & Pol'y 1 (1998); George J. Annas, A National Bill of Patients' Rights, 338 New Eng. J. Med. 695 (1998); George J. Annas, Going Hollywood With Patient Rights in Managed Care, 281 J.A.M.A. 861 (1999).

[FN4]. Despite the Balanced Budget Act of 1997's infusion of market driven reforms into Medicare, the Congressional Budget Office still predicts Medicare will grow 7.5% per year. Rochelle Sharpe, Greenspan Addresses Medicare Overhaul, Wall St. J., Apr. 21, 1998, at A2; Jennifer E. Gladieux, Medicare+Choice Appeal Procedures: Reconciling Due Process Rights and Cost Containment, 25 Am. J.L. & Med. 61 (1999).

[FN5]. Previous lawmakers have defined the context within which patients and doctors discussed and made decisions about abortions. See Lynn D. Wardle, "Time Enough": Webster v. Reproductive Health Services and the Prudent Pace of Justice, 41 Fla. L. Rev. 881 (1989) (discussing state statutes that regulate doctor-patient discourse about abortion); Paula Berg, Toward a First Amendment Theory of Doctor-Patient Discourse and the Right to Receive Unbiased Medical Advice, 74 B.U. L. Rev. 201 (1994) (arguing that the First Amendment protects patients' interest in receiving complete, unbiased medical information and advice); George J. Annas, Restricting Doctor-Patient Conversations in Federally Funded Clinics, 325 New Eng. J. Med. 362 (1991). Another method of achieving cost savings by influencing physician decision-making at the level of individual patient-doctor relationships is through governmental implementation of capitation. See David A. Asch & Peter A. Ubel, Rationing By Any Other Name, 336 New Eng. J. Med. 1668 (1997) (discussing examples of cases where the doctor decides in favor of treatment that she believes is less effective but less expensive and justifiable in the present case. All the decisions are made by the physician without telling the patient of the more expensive but arguably better (perhaps only marginally, but nevertheless better) treatment or diagnostic procedure.).

[FN6]. I use the term "patient-doctor discourse" to include more than the information passing between the two parties. It includes preconceptions that have accumulated over time within our institutions and individual patients, doctors, and other health care professionals. Although some of these are more desirable than others, I do not intend to debate their merits.

[FN7]. Traditionally, the law has treated patients differently from consumers and the obligations of physicians have included fiduciary responsibilities beyond those of vendors. See Maxwell J. Mehlman, Fiduciary Contracting: Limitations on Bargaining Between Patients and Health Care Providers, 51 U. Pitt. L. Rev. 365 (1990).

[FN8]. Jed Rubenfeld, The Right of Privacy, 102 Harv. L. Rev. 737, 787 (1989). Rubenfeld describes the privacy right as one "to be invoked only where the government threatens to take over or occupy our lives-to exert its power in some way over the totality of our lives." Id. Rubenfeld's concern is government's "creeping totalitarianism, an unarmed occupation of individual's lives … a society standardized and normalized, in which lives are too substantially or too rigidly directed." (emphasis in original) Id. at 784.

[FN9]. Bone marrow transplantation for breast cancer allows administration of higher chemotherapy doses because high doses of chemotherapy kill the bone marrow cells responsible for making blood and helping the immune system. Following the end of chemotherapy, the patients receive their own bone marrow stem cells, which have been stored during the chemotherapy.

[FN10]. For example, a heated political debate is unfolding in Oregon as research and pharmaceutical interests seek to change Oregon's current Genetic Privacy Act, ORS 659.700-659.720 (1999), to dilute the requirement for individual informed consent for the use of genetic information. The research and pharmaceutical interests complain that the current law destroys research and outcomes analysis using genetic information and, thereby, halts scientific and medical progress. Interview with Dr. Brad Popovich, Director of Oregon Health Sciences University Molecular Diagnostics Laboratory (May 1999). Exemptions to informed consent requirements limited to "anonymous" genetic information also limits a patient's ability to meaningfully participate in their medical decision-making, since genetic information that may affect patients' decisions about whether to have children or how to lead their lives would exist but never reach the patients. Patients would likely be able to waive informed consent requirements on an individual basis within the context of individual patient-doctor relationships, but this Article suggests that a statute could not waive the right for all patients without invoking constitutional protections.

For a comparative and more patient-centered approach taken by the Council of Europe, see Council of Europe Committee of Ministers Recommendation N. R (97) 5 to Member States on the Protection of Medical Data (adopted February 13, 1997). We are "[c]onvinced that it is desirable to regulate the collection and processing of medical data, to safeguard the confidentiality and security of personal data regarding health, and to ensure that they are used subject to the rights and fundamental freedoms of the individual, and in particular the right to privacy." Id.

[FN11]. 500 U.S. 173 (1991).

[FN12]. 505 U.S. 833 (1992). Both cases involve government regulations proscribing aspects of patient-doctor discourse.

[FN13]. 497 U.S. 261 (1990).

[FN14]. Id.

[FN15]. I rely primarily on two of Fleming's articles: James E. Fleming, Securing Deliberative Autonomy, 48 Stan. L. Rev. 1 (1995); James E. Fleming, Constructing the Substantive Constitution, 72 Tex. L. Rev. 211 (1993).

[FN16]. 505 U.S. at 916 (Stevens, J., concurring in part, dissenting in part).

[FN17]. See generally, Ruth R. Faden & Tom L. Beauchamp, A History and Theory of Informed Consent (1986).

[FN18]. 104 N.W. 12 (Minn. 1905).

[FN19]. Id. at 14.

[FN20]. Id.

[FN21]. Id. at 15.

[FN22]. 211 N.Y. 125 (1914).

[FN23]. Id. at 129-30.

[FN24]. Of course, Justice Cardozo may have been utilizing sound judicial decision-making by narrowly limiting his analysis, and his opinion does not imply that "every human being of adult years and sound mind" does not possess a broader autonomy right. His reservation of the right to adults of "sound mind" suggests a certain "deliberative" quality to the right. Id.

[FN25]. Professor Fleming explains:

[Autonomy] is used sometimes as an equivalent of liberty (positive or negative in Berlin's terminology),

sometimes as equivalent to self-rule or sovereignty, sometimes as identical with freedom of the will. It is equated with dignity, integrity, individuality, independence, responsibility, and self-knowledge. It is identified with qualities of self-assertion, with critical reflection, with freedom from obligation, with absence of external causation, with knowledge of one's own interests. It is even equated by some economists with the impossibility of interpersonal comparisons. It is related to actions, to beliefs, to reasons for acting, to rules, to the will of other persons, to thoughts, and to principles.
Fleming, Securing Deliberative Autonomy, supra note 15, at 30 (quoting Gerald Dworkin, The Theory and Practice of Autonomy 6 (1988)). Fleming uses this quote to explain his use of his more definite term "deliberative autonomy."

[FN26]. Id.

[FN27]. See, e.g., Marjorie Maquire Schultz, From Informed Consent to Patient Choice: A New Protected Interest, 95 Yale L.J. 219 (1985); Faden & Beauchamp, supra note 17.

[FN28]. Faden & Beauchamp, supra note 17, at 76.

[FN29]. See Faden & Beauchamp, supra note 17, at 80.

[FN30]. Faden & Beauchamp, supra note 17, at 83.

[FN31]. See, e.g., In re Johnson's Estate, 16 N.W.2d 504 (Neb. 1944). In this case, the patient gave consent for operation to remove uterine tumor. Before the operation, however, the surgeon changed his diagnostic impression to most probably appendectomy and pregnancy without informing the patient. He performed an appendectomy without consent and told the patient and the patient's family that she was pregnant. As it turned out, the patient was not pregnant but did have a uterine tumor that was later removed by a different surgeon. The issue of informed consent did not even come up, since the patient had given general consent to surgery. Instead, the issue tried was whether the surgeon had been negligent in making his diagnosis.

[FN32]. Schultz, supra note 27, at 225.

[FN33]. A doctor who fails to warn of a rare complication from a procedure is nevertheless liable, even if the standard of care does not mandate disclosure.

[FN34]. Cf. Aaron D. Twerski & Neil B. Cohen, Informed Decision-making and the Law of Torts: The Myth of Justiciable Causation, U. Ill. L. Rev. 607 (1988); Marcus L. Plante, An Analysis of "Informed Consent," 36 Fordham L. Rev. 639, 666 (1968); Schultz, supra note 27, at 225.

[FN35]. Schultz, supra note 27, at 225 (citing W. Keeton, D. Dobbs, R. Keeton & D. Owen, Prosser & Keeton on the Law of Torts § 9, § 43, at 35 & 263 (5th ed. 1984)).

[FN36]. Schultz, supra note 27, at 223-29.

[FN37]. Id.

[FN38]. See generally Faden & Beauchamp, supra note 17; Peter H. Schuck, Rethinking Informed Consent, 103 Yale L.J. 899 (1994) (focusing on the fiduciary aspect of development of informed consent and present importance of cost effectiveness and proposing a new "contextualized informed consent" that tailors legal requirements to "the different settings in which risks arise and are discussed, assessed, and acted upon"); Schultz, supra note 27.

[FN39]. One remnant of informed consent's roots in common law battery is that many cases require a proposed invasive procedure to trigger informed consent's requirements. See, e.g., McGeshick v. Choucair, 9 F.3d 1229 (7th Cir. 1993). But see Gates v. Jensen, 595 P.2d 919 (Wash. 1979) (holding that ophthalmologist had an obligation to inform patient of test results showing possible glaucoma even though he made a medical judgement not to treat or test further; another court might have analyzed the same facts solely under a medical malpractice theory). Critics note this requirement as a serious shortcoming of informed consent doctrine's basis in negligence law because medical decisions often do not involve physical touching. See Schultz, supra note 27, at 229-48. Professor Schultz, an advocate of expanding informed consent requirements, describes the various "health care choices of vast

consequence [that] can be made and implemented without such bodily contact ...." Id. at 230. She cites an example of doctors commonly making judgments about what level of diagnostic clarity is needed for a firm diagnosis. Id. Physicians and administrators, constantly faced with questions concerning limiting the number and kind of medical tests needed to establish a diagnosis, seldom share their levels of confidence regarding diagnosis.

Echoing some of the concerns mentioned by critics, the Washington Supreme Court lowered the invasive procedure threshold in its formulation of informed consent. For example, in Gates v. Jensen, 595 P.2d 919 (Wash. 1979), the court invoked the disclosure requirements "whenever the doctor becomes aware of an abnormality which may indicate risk or danger." Id. at 923. Thus, the doctor's possession of information rather than an impending procedure triggered the protections. Gates revealed the complex interaction between doctor and patient that is an integral part of informed consent. The duty to disclose arises within the context of the patient-doctor relationship, and may arise without the looming presence of a scheduled invasive procedure.

[FN40]. See generally Faden & Beauchamp, supra note 17; Schuck, supra note 38; Schultz, supra note 27.

[FN41]. See Schultz, supra note 27, at 323.

[FN42]. See generally Schultz, supra note 27 (using this argument to advocate an expansion of patients' rights and interests in obtaining information within the patient-doctor relationship).

[FN43]. 464 F.2d 772 (D.C. Cir. 1972).

[FN44]. Canterbury involved typical facts and focused on the doctor-patient relationship. Canterbury involved a patient with back pain who was not told of the one percent risk of paralysis following laminectomy. The defendant neurosurgeon told the patient that "he would have to undergo a laminectomy," and the patient agreed, apparently without asking any questions. Id. at 777. As it turned out, the patient, Jerry Canterbury, recuperated normally for the first day after the operation, but then fell and, complaining that he was unable to move his legs, was taken back to the operating room. The patient never fully recovered use of his legs or full control of his bladder and bowel. Doctor Spence, the defendant, admitted that he did not generally discuss the one percent risk of paralysis because he was concerned that this might deter patients from undergoing the operation and that such information might psychologically interfere with the success of the operation.

[FN45]. Id. at 781 (quoting Emmett v. Eastern Dispensary of Cas. Hosp., 396 F.2d 931, 935 (C.A.D.C. 1967)). Importantly, the court began "at first principles" not because this was a new issue, it acknowledged that similar lawsuits about a physician's failure to disclose risks and alternatives dated back a "good half-century" , but because of the inconsistencies among courts and commentators regarding the issue. Id. at 779.

[FN46]. Id. at 780 (footnotes omitted).

[FN47]. 104 N.W. 12 (Minn. 1905).

[FN48]. 464 F.2d at 781.

[FN49]. Id. at 783 n.36. The court explained that "the patient may be ignorant, confused, overawed by the physician or frightened by the hospital, or even ashamed to inquire." Id.

[FN50]. See Mehlman, supra note 7.

[FN51]. Faden & Beauchamp, supra note 17, at 62. Faden and Beauchamp describe Hippocratic authoritarianism as, in many respects, the antithesis to the informed consent doctrine. They write:

Despite its failure to mention solicitation of patients' permissions or respecting patients' decisions, the Corpus does discuss various problems of truthtelling, bluntly advising physicians of the wisdom of "concealing most things from the patient, while you are attending to him ... turning his attention away from what is being done to him; ... revealing nothing of the patient's future or present condition." It is usually unclear how many contexts fall under such rules, but the physician is often portrayed as the one who commands and decides, while patients are conceived as persons who must place themselves fully in physicians' hands and obey commands.

Id. at 61 (footnotes omitted).

This description of inequality in positions fits the rubric of fiduciary principles. The Hippocratic Oath has meant different things to physicians practicing in different times. Therefore, if the dominant ethic is beneficence, then

physicians can use the Hippocratic Oath to justify withholding information for the patient's own good. In contrast, under a dominant ethic of autonomy, a physician may interpret the Hippocratic Oath as promoting the candid disclosure and discussion of information to patients.

[FN52]. Council on Ethical and Judicial Affairs, American Medical Association's Code of Medical Ethics xiv (1994).

[FN53]. Id. at 99 (Opinions on Practice Matters - Conflicts of Interest: Guidelines).

[FN54]. Arnold S. Relman, Dealing with Conflicts of Interest, 313 New Eng. J. Med. 749, 750 (1985).

[FN55]. See Petrillo v. Syntex Lab., Inc., 499 N.E.2d 952, 961 (Ill. App. Ct. 1986). The court in Petrillo noted the importance of fiduciary principles in the patient-doctor relationship:

> The existence of this fiduciary relationship indicates that there is more between a patient and his physician than a mere contract under which the physician promises to heal and the patient promises to pay. There is an implied promise, arising when the physician begins treating the patient, that the physician will refrain from engaging in conduct that is inconsistent with the "good faith" required of a fiduciary. The patient should, we believe, be able to trust that the physician will act in the best interest of the patient thereby protecting the sanctity of the physician-patient relationship.

Id.; see also Mehlman, supra note 7, at 374-88 (discussing patient's general lack of information and the general importance of patient information to patient welfare and the workings of a competitive market).

For more examples of other views supporting the fiduciary character of patient-doctor relations, see Bradford H. Grey, Trust and Trustworthy Care In The Managed Care Era, 16 Health Affairs 34 (1997) (arguing that trust in the physician's fiduciary ethic is essential to the patient-doctor relationship but has become less plausible within the context of managed care and concluding that despite measures available to MCO's to ensure trustworthiness, the strong fiduciary ethic held by physicians remains essential to trustworthy care); Steffie Woolhandler & David U. Himmelstein, Extreme Risk - The New Corporate Proposition for Physicians, 333 New Eng. J. Med. 1706 (1995) (articulating concern that "traditional" medical ethic's central principle of duty to the patient's best interest may be threatened by the new corporate structure increasingly prevalent in medicine).

[FN56]. 201 P.2d 1, 9 (Cal. 1972); see also Demers v. Gerety, 515 P.2d 645, 654 (N.M. Ct. App. 1973), rev'd on other grounds, 520 P.2d 869 (N.M. 1974) ("Modern medicine demands that the patient place unquestionable faith in the doctor because the average patient is ignorant of medical science."); see generally Mehlman, supra note 7, at 392 ("[D]isclosure of the risks and benefits of alternatives is a classic dimension of the provider's fiduciary obligations to obtain informed consent."). Mehlman notes that fiduciary law operates to impose fairness criteria even after physicians meet the disclosure requirements. This is because mere disclosure does not ensure effective disclosure and many patients do not fully comprehend what their doctor has told them using complex medical jargon. Thus, in many cases the law requires doctors to bear the burden of proving the adequacy and effectiveness of the disclosure. In informed consent cases, however, most courts keep the burden on the plaintiff and ask whether the information given by the doctor is comprehensible to the average patient. Id. at 397.

[FN57]. Id.

[FN58]. See Mehlman, supra note 7.

[FN59]. Arato v. Avedon, 858 P.2d 598 (Cal. 1993).

[FN60]. The Arato court explained:

> The [clinical contexts] in which physicians and patients interact and exchange information ... are so multifarious, the informational needs and degree of dependency of individual patients so various, and the professional relationship itself such an intimate and irreducibly judgement-laden one, that we believe it is unwise to require as a matter of law that a particular species of information be disclosed.

Id. at 606.

[FN61]. Id. at 607.

[FN62]. 611 P.2d 902 (Cal. 1980).

[FN63]. Id. at 906.

[FN64]. Id. at 907.

[FN65]. Id. at 910 (Clark, J., dissenting).

[FN66]. See generally, Schuck, supra note 38 (citing Arato, 858 P.2d 598 (Cal. 1993), with approval for its "sensitivity to context"). Schuck argues that courts should foster this "sensitivity to context" not only by securing the jury's fact-finding role but also by "crafting and refining the legal rules of informed consent so that the doctrine distinguishes among different kinds of physician-patient settings when it defines the nature and scope of the duty to disclose." Id. at 918. But see George J. Annas, Some Choice: Law, Medicine, and the Market Ch. 5 (1998) (arguing that the California Supreme Court should have required the doctor to tell the patient information about the probability of success of a proposed treatment and attributing the outcome in Arato in part to our culture's general denial of death and celebration of medical technology).

[FN67]. Schuck, supra note 38, at 903 (distinguishing three different versions of the informed consent doctrine: the law in the books as developed primarily by the courts, the law in the mind as "imagined, feared, and often caricatured by some physicians," and the law in action as actually practiced by clinicians).

[FN68]. Schuck, supra note 38, at 959.

[FN69]. Many commentators have noted the inequities of power in the patient- doctor relationship. See, e.g., Howard Brody, The Healer's Power (1992); Samuel Haber, The Quest for Authority and Honor in the American Professions, 1750-1900 (1991). But see, Schuck, supra note 38 (arguing that recent changes in health care have diminished the power inequities between patient and doctor).

[FN70]. Hall, supra note 2 (classifying as third parties any institution external to the patient and doctor); see John Holahan et al., Medicaid Managed Care in Thirteen States, 17 Health Affairs 43 (1998) (noting that forty-nine states rely on some form of Medicaid managed care).

[FN71]. Mohr v. Williams, 104 N.W. 12, 14 (Minn. 1905).
Commentators have remarked on the use of gag clauses by Managed Care Organizations (MCO's) to limit patient-doctor discourse concerning alternative treatments. Citing a directive from Kaiser Permanente in Ohio that instructed physicians to "'not discuss proposed treatments with Kaiser Permanente members prior to receiving authorization' from the plan," commentators noted the ability of MCO's to isolate themselves from patients' legal claims. Julia A. Martin & Lisa K. Bjerknes, The Legal and Ethical Implications of Gag Clauses in Physician Contracts, 22 Am. J.L. & Med. 433, 444 (1996). The judicial reluctance to hold MCO's liable under an informed consent claim, the inherent difficulties of prevailing against an MCO under a theory of negligence, and the use of employment clauses limiting the ability of doctors to discuss treatment alternatives prior to authorization has resulted in MCO's ability to control their liability for denial of care by effectively limiting patients knowledge about alternative treatments. Id. at 463.

[FN72]. Patients' redress against MCO's usually follows a theory of corporate negligence. See Darling v. Charleston Community Mem'l Hosp., 211 N.E.2d 253 (Ill. 1965) (recognizing a cause of action for a hospital's direct corporate negligence); Elam v. College Park Hosp., 132 Cal. App.3d 332 (1982) (holding hospital has a general duty to insure the competence of its medical staff and evaluate the quality of treatment); Kearney v. United States Healthcare, Inc., 859 F. Supp. 182 (E.D. Pa. 1994) (recognizing that an MCO might be liable for failing to use due care in selecting providers of health care, but such a claim would be preempted under the Employee Retirement Income Security Act (ERISA); James Bartimus & Christopher A. Wright, HMO Liability: From Corporate Negligence Claims for Negligent Credentialing and Utilization Review to Bad Faith, 66 UMKC L. Rev. 763 (1998) (reviewing various legal theories for holding an HMO liable for the negligent acts of its agents or employees). Included in the current debate about health care is the role of ERISA preemption. See Employee Retirement Income Securities Act, 29 U.S.C. §§ 1001-53 (1994). Congressional intent was for ERISA to enable employers to more easily fund health plans because of the gained flexibility to design cost effective plans. See Mary Ann Chirba-Martin & Troyer A. Brennan, The Critical Role of ERISA in State Health Reform, 13 Health Affairs 142 (1994). For most beneficiaries of ERISA governed plans, the only remaining remedy is an action for wrongfully denied benefits and, perhaps, legal fees. Beneficiaries of ERISA governed health plans do not enjoy the protections of informed consent law, and thus ERISA alters the characteristics of the patient-doctor, and arguably

the patient-MCO, relationship. One result of ERISA is that fewer courts have hadan opportunity to respond to patients' lawsuits against MCO's alleging any state law violation, including lack of informed consent, on the part of the MCO. But see Shea v. Esensten, 107 F.3d 625 (8th Cir. 1997). Although state law enforcement of informed consent is not available to plaintiffs in ERISA cases, the United States Court of Appeals for the Eighth Circuit used the fiduciary requirements of ERISA to hold that the patient had a right to know that his MCO offered financial incentives that may have affected the physician's medical judgment. Id. at 628. The court concluded that only by being aware of his physician's financial stakes could the patient have "made a fully informed decision about whether to trust his doctor's recommendation." Id. at 629.

[FN73]. The Democratic Party's website on the Patient's Bill of Rights recites that health care plans must not restrict physicians from giving patients information about treatment options and emphasizes that "[c] ommunication between doctors and patients must be free and open," since "the doctor-patient relationship must be based on confidence and trust." The Democratic Patients' Bill of Rights Protects the Doctor/Patient Relationship, Fact Sheet (Democratic Policy Comm'n), June 28, 1999, at 1-2 <http:// www.senate.gov./<tilde>dpc/patients_rights/fs024.pdf>. As of the Spring of 2000, the U.S. Senate's website, http://www.senate.gov., search results showed 16 Bills entiled Patients' Bill of Rights. Most of the bills seem to be in committee.

[FN74]. Id.

[FN75]. 500 U.S. 173 (1991).

[FN76]. 505 U.S. 833 (1992) (plurality opinion).

[FN77]. For a discussion of Justice Blackmun's views on this tri-partite structure, see generally Harold Hongju Koh, Rebalancing the Medical Triad: Justice Blackmun's Contributions to Law and Medicine, 13 Am. J.L. & Med. 315 (1987).

[FN78]. Annas, supra note 5, at 364.

[FN79]. See Berg, supra note 5, at 206.

[FN80]. See Fleming, Securing Deliberative Autonomy, supra note 15, at 33 (quoting Jed Rubenfield, The Right of Privacy, 102 Harv. L. Rev. 737, 784 (1984) (emphasis omitted)).

[FN81]. Rust v. Sullivan, 500 U.S. 173, 202 (1991). The Chief Justice's opinion does not mention a "privacy right." Instead, the right to medical self-determination is discussed only as a Fifth Amendment right. Id. at 201-02; see also, Berg, supra note 5. Professor Berg advocates that First Amendment protections extend to patient-doctor discourse and accurately points out that regulations restricting patient-doctor discourse were traditionally challenged by asserting privacy rights. Most of the Supreme Court's decisions defining a patient's privacy right in the face of government restrictions on the patient-doctor relationship arise in the context of abortion. Moreover, the basis of the right, whether grounded in a general privacy right or tied specifically to the Fifth Amendment, remains unclear. In this and other ways, the right to medical self-determination lacks definition.

[FN82]. 42 U.S.C. §§ 300-300a-b (1994 & Supp. 1997).

[FN83]. Id.

[FN84]. Rust, 500 U.S. at 179 (quoting 42 C.F.R. § 59.2 (1989)).

[FN85]. See id. at 183. The Court emphasized the difficulty faced by the challengers of the regulations. "A facial challenge to a legislative act is, of course, the most difficult challenge to mount successfully, since the challenger must establish that no set of circumstances exists under which the Act would be valid." Id. (quoting United States v. Salerno, 481 U.S. 739, 745 (1987)).

[FN86]. The doctrine was used and developed in previous abortion funding cases and reveals the Court's focus on funding. See Harris v. McRae, 448 U.S. 297 (1980) (focusing on federal funding decisions while allowing denial of funding for some medically indicated abortions); Maher v. Roe, 432 U.S. 464 (1977) (allowing a state to refuse

to fund elective Medicaid abortions).

For a discussion of the doctrine of unconstitutional conditions, see Richard A. Epstein, Unconstitutional Conditions, State Power, and the Limits of Consent, 102 Harv. L. Rev. 5 (1988); Michael Fitzpatrick, Rust Corrodes: The First Amendment Implications of Rust v. Sullivan, 45 Stan. L. Rev. 185 (1992) (noting the "diametrically opposed results" between cases that view funding restrictions as penalties and those that consider the restrictions as "non-subsidies"); Kathleen M. Sullivan, Unconstitutional Conditions, 102 Harv. L. Rev. 1415 (1989) (tracing the doctrine to the Lochner era).

[FN87]. See Albert J. Rosenthal, Conditional Federal Spending and the Constitution, 39 Stan. L. Rev. 1103, 1121 (1987) (noting the increased tendency to weigh competing interests "case by case rather than to try to resolve them by reference to some broad formulation relating to unconstitutional conditions").

[FN88]. Rust v. Sullivan, 500 U.S. 173, 193 (1991).

[FN89]. Id. at 194.

[FN90]. For an in-depth discussion of the First Amendment and Rust, see Fitzpatrick, supra note 86.

[FN91]. The majority in Rust explicitly stated that "the university is a traditional sphere of free expression so fundamental to the functioning of our society that the Government's ability to control speech within that sphere by means of conditions attached to the expenditure of Government funds is restricted by the vagueness and overbreadth doctrines of the First Amendment." 500 U.S. at 200. Indeed, the Court acknowledges that the doctor-patient relationship is one grounded in tradition and that an analogy to the university setting might be made.

[FN92]. See, e.g., Board of Trustees v. Fox, 492 U.S. 469 (1989). The case reveals the Supreme Court's deference to First Amendment concerns whenever brought within the context of academia. In Fox, the Court struck down as overbroad the state university's regulations banning commercial activities in student dormitories. See also Berg, supra note 5, at 240-41. Berg relies on Fox, among other cases, to guard against the argument that the "profit-making context" of patient-doctor discourse deprives its First Amendment protections.

[FN93]. The fact that HHS promulgated the regulation under the Bush administration and the Clinton administration quickly suspended the rule reflects the rule's political quality. The Title X "Gag Rule," 58 Fed. Reg. 7455 (1993). The Rust decision itself was political, as shown when Senator Paul Simon held hearings about the decision shortly after it was announced. Many commentators have noted medicine's inherently political nature. See, e.g., Penny Kane, Family Planning in China, in Health Care and Traditional Medicine in China 1800-1982, 426, 431 (S.M. Miller & J.A. Jewell eds., 1983); Berg, supra note 5, at 201-02; Reva Siegel, Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection, 44 Stan. L. Rev. 261 (1992) (noting the medical profession's creation of a "physiological paradigm" for abortion and its influence on the successful nineteenth century campaign to criminalize abortion).

[FN94]. See generally Siegel, supra note 93 (discussing the political character of the patient-doctor relationship in the middle nineteenth century and the changes in view towards abortion).

[FN95]. 500 U.S. at 200.

[FN96]. Id.

[FN97]. Id.

[FN98]. 432 U.S. 464 (1977) (upholding state's refusal to fund elective abortions under Medicaid).

[FN99]. 448 U.S. 297 (1980).

[FN100]. 492 U.S. 490 (1989) (upholding a statute that forbade public employees from counseling women to have abortions not necessary to save their lives).

For a critical view of the Supreme Court's formulation and application of unconstitutional conditions, which the Court developed in Maher and McRae, see Richard A. Epstein, Unconstitutional Conditions, State Power, and the Limits of Consent, 102 Harv. L. Rev. 5 (1988) and Sullivan, supra note 84, at 179.

[FN101]. 500 U.S. at 202.

[FN102]. Id.

[FN103]. 462 U.S. 416 (1983).

[FN104]. 476 U.S. 747 (1986).

[FN105]. 500 U.S. at 202. The Court showed that the protections of patient-doctor dialogue established in City of Akron and Thornburgh were short-lived when it overruled portions of City of Akron and Thornburgh in Casey.

[FN106]. Id. at 203.

[FN107]. Id. at 200.

[FN108]. See supra Part II.B.

[FN109]. Grey, supra note 55. Grey argues that trust in the physician's fiduciary ethic is essential to the patient-doctor relationship but has become less plausible within the context of managed care, and concludes that despite measures available to MCO's to ensure trustworthiness, the strong fiduciary ethic held by physicians remains essential to trustworthy care. See also 500 U.S. at 173 (Justice Blackmun's dissent notes that, "[i]n our society, the doctor-patient dialogue embodies a unique relationship of trust").

[FN110]. Berg, supra note 5, at 229. See, e.g., Brody, supra note 69, at ch. 13 (arguing that the power differences between doctor and patient are inevitable and important for healing and therefore, the effort should be to control, not abolish, these inherent differences in power); Douglas W. Maynard, Interaction and Asymmetry in Clinical Discourse, 97 Am. J. Soc. 448 (1991) (stating that the asymmetry of knowledge and authority allows doctors to impose their view of disease on patients and society); Howard Waitzkin, A Critical Theory of Medical Discourse: Ideology, Social Control, and the Processing of Social Context in Medical Encounters, 30 J. Health & Soc. Behav. 220 (1989); Jay Katz, The Silent World of Doctor and Patient (1984).

[FN111]. Berg, supra note 5, at 230. See also Dorothy E. Roberts, Rust v. Sullivan, and the Control of Knowledge, 61 Geo. Wash. L. Rev. 587 (1993) (discussing the harmful impact of Rust on poor black women).

[FN112]. I argue that constitutional protections of patient-doctor discourse extend to all patient-doctor relationships. Some readers may interpret this paragraph as an appeal to a United States v. Carolene Products Co. footnote four argument by focusing on ensuring the processes of representative democracy rather than imposing substantive values; but I mention the disproportionate effect to show its political character. Unlike Carolene Products jurisprudence, I advocate a "substantive constitution." See United States v. Carolene Products Co., 304 U.S. 144, 152-53 n.4 (1938). For discussions about Carolene Products jurisprudence, see John Hart Ely, Democracy and Distrust (1980) (describing his theory as an elaboration of Carolene Products); James E. Fleming, Constructing the Substantive Constitution, 72 Tex. L. Rev. 211, 214 (1993) (seeks to do for substance what Ely has done for process). Many commentators have written about "The Footnote." See, e.g., J.M. Balkin, The Footnote, 83 Nw. U. L. Rev. 275 (1989); Robert M. Cover, The Origins of Judicial Activism in the Protection of Minorities, 91 Yale L.J. 1287 (1982).

[FN113]. Justice O'Connor joined Part I of the dissent, which argues that the HHS might have easily interpreted the federal statute in a manner that avoided serious doubt as to its constitutionality. Instead, Justice Blackmun argues, "in its zeal to address the constitutional issues, the majority sidesteps this established canon of construction." Rust, 500 U.S. at 204 (Blackmun, J., dissenting).

[FN114]. Id. at 218. "The majority's approval of the Secretary's regulations flies in the face of our repeated warnings that regulations tending to 'confine the attending physician in an undesired and uncomfortable straightjacket in the practice of his profession,' cannot endure." Id. (citation omitted).

[FN115]. Id.

[FN116]. Id. at 211 n.3 (citation omitted).

[FN117]. Id. at 218.

[FN118]. Id.

[FN119]. Id. at 217.

[FN120]. In one sense, the Court did understand that patient-doctor discourse helps define and give substance to the patient's liberty right when it insisted that the particular patient-doctor relationship be "sufficiently all encompassing" for the Constitution to protect the patient's rights. Id. at 200. What the Court failed to understand was that patient-doctor discourse is always present, in everymeeting, between patient and doctor.

[FN121]. This Article does not address the question of whether the government may refuse to fund abortions. I do argue, however, that the government may not restrict patient-doctor discourse under the rubric of a "mere" funding decision.

[FN122]. See infra Part IV.

[FN123]. 505 U.S. 833 (1992).

[FN124]. 410 U.S. 113 (1973).

[FN125]. 505 U.S. at 847.

[FN126]. 491 U.S. 110 (1989).

[FN127]. 505 U.S. at 847.

[FN128]. Justice O'Connor relied heavily on Justice Harlan's approach to constitutional theory as outlined in his famous opinion in Poe v. Ullman, 367 U.S. 497 (1961) (Harlan, J., dissenting). The following passage by Justice Harlan was quoted by Justice O'Connor:

> [T]he full scope of the liberty guaranteed by the Due Process Clause cannot be found in or limited by the precise terms of the specific guarantees elsewhere provided in the Constitution. This "liberty" is not a series of isolated points pricked out in terms of the taking of property; the freedom of speech, press, and religion; the right to keep and bear arms; the freedom from unreasonable searches and seizures; and so on. It is a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints.

Casey, 505 U.S. at 848 (quoting 367 U.S. at 543).

[FN129]. 18 Pa. Cons. Stat. Ann. §§ 3201-3220 (1983 & Supp. 1993). The statute clearly stated its preference for childbirth over abortion. Id. at § 3202(c). The "informed consent" provisions required doctors to tell every abortion-seeking patient about the risks of abortion and childbirth, the probable gestational age of the fetus, and the availability of printed materials. Id. at § 3205.

[FN130]. As Justice Stevens pointed out in Casey, the "undue burden" standard effectively overruled Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747 (1986), and Akron v. Akron Ctr. for Reprod. Health, Inc., 462 U.S. 416 (1983), which disallowed state efforts to regulate information with the purpose of influencing a "woman's informed choice between abortion or childbirth." Casey, 505 U.S. at 917 (Stevens, J., concurring in part and dissenting in part) (quoting Thornburgh, 476 U.S. at 760).

[FN131]. Id. The Court did mention that regulations may not constitutionally require physicians to convey false or misleading medical information.

[FN132]. Id. at 886.

[FN133]. Id.

[FN134]. Of course, a determination of what is misleading depends largely upon perspective. Determinations of

what qualifies as false information are difficult where many different and conflicting studies lead to different conclusions. The standard articulated by the Casey plurality is one that may result in a physician being required to tell patients medical information that the physician believes false or misleading but that a non-medical factfinder concludes is a reasonable interpretation of present medical knowledge.

[FN135]. 505 U.S. at 884-85. The Supreme Court did not directly address the analysis provided by the U.S. Court of Appeals, which classified patient- doctor discourse as commercial speech. See Planned Parenthood v. Casey, 947 F.2d 682 (3d Cir. 1991).

[FN136]. See Berg, supra note 5, at 244-45. Berg, citing a long list of cases, argues for a "constitutional right to accumulate knowledge and thereby retain control over one's own thought processes." Id.; Griswold v. Connecticut, 381 U.S. 479, 482 (1965) ("[T]he State may not, consistently with the spirit of the First Amendment, contract the spectrum of available knowledge.").

[FN137]. 425 U.S. 748 (1976).

[FN138]. Id. at 756.

[FN139]. See infra Part IV.

[FN140]. 505 U.S. at 851.

[FN141]. Id. at 916 (Stevens, J., concurring in part and dissenting in part); see also Fleming, Deliberative Autonomy, supra note 15, at 10-11.

[FN142]. Id.

[FN143]. 497 U.S. 261 (1990). Nancy Cruzan, injured in an automobile crash, had been in a persistent vegetative state for years. Transferred to a Missouri state hospital, she was given water and nutrition through surgically placed tubes. The Supreme Court of Missouri required clear and convincing evidence of the patient's wishes to disconnect the feeding and hydration tubes. Id. at 264-68.

[FN144]. Id. at 269. ("We granted certiorari to consider the question whether Cruzan has a right under the United States Constitution which would require the hospital to withdraw life-sustaining treatment from her under these circumstances.").

[FN145]. Chief Justice Rehnquist wrote the opinion for the Court and was joined by Justices Kennedy, O'Connor, Scalia, and White. Justices O'Connor and Scalia wrote separate concurring opinions. Justice Brennan filed a dissenting opinion joined by Justices Marshall and Blackmun. Justice Stevens filed a separate dissenting opinion. Id. at 261.

[FN146]. Id. at 292-93. For an analysis of Justice Scalia's opinion, see Benjamin C. Zipursky, The Pedigrees of Rights and Powers in Scalia's Cruzan Concurrence, 56 U. Pitt. L. Rev. 283 (1994).

[FN147]. 497 U.S. at 279. ("But determining that a person has a 'liberty interest' under the Due Process Clause does not end the inquiry; 'whether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests." ' (citations omitted)).

[FN148]. Id. at 295. I suggest only that the "traditional" character of the doctor-patient relationship may help its acceptance as deserving of constitutional protection. The opinions do not clearly establish the precise extent to which the various Justices rely on the kind of Burkian, backward- looking, conservatism used to justify the protection of the patient's right in order to refuse medical interest. Justice Scalia, who concurred in the result favoring the government's requirement of clear and convincing evidence of the patient's intent, stated that he did not find involvement of an individual's fundamental right because the case was fundamentally about suicide, which has traditionally and historically been illegal. Id. at 292-301. He stated, "no 'substantive due process' claim can be maintained unless the claimant demonstrates that the State has deprived him of a right historically and traditionally protected against state interference." Id. at 294. For more on the debate between Justice Scalia and others over fundamental rights, see David B. Anders, Justices Harlan and Black Revisited: The Emerging Dispute Between

Justice O'Connor and Justice Scalia over Unenumerated Fundamental Rights, 61 Fordham L. Rev. 895 (1993).

[FN149]. Chief Justice Rehnquist tried to narrow his opinion as much as possible. He stated that "[b]ut for purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition." 497 U.S. at 279.

[FN150]. Id. at 269-77 (reviewing California and Illinois cases that looked to state probate statutes for guidance in evaluating the right to refuse treatment).

[FN151]. Id. at 277.

[FN152]. Id. at 278. Chief Justice Rehnquist quoted Washington v. Harper as an example of a case that one can use to infer an applicable liberty interest: "'The forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty." ' Id. (quoting 494 U.S. 210, 221-22 (1990)) (emphasis added). The focus on consent and the reliance on the individual's underlying right to autonomy reveal that the common law doctrine of informed consent inexorably defines any constitutional analysis, notwithstanding Chief Justice Rehnquist's words that the common law is not a source available to Supreme Court Justices. Id. at 277.

[FN153]. Id. at 278 ("The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions."). See also Fleming, Constructing the Substantive Constitution, supra note 15, at 269 (explaining traditions as aspirational principles as put forth by Justice Cardozo in Palko v. Connecticut, 302 U.S. 319 (1937); aspirational principles are the "fundamental principles of liberty and justice" that may or may not be realized in our history).

[FN154]. 497 U.S. at 286. By rejecting any claim that the right included a right of substituted judgement and allowing Missouri's clear and convincing standard to stand, Chief Justice Rehnquist isolated the right to autonomy firmly within the individual. I argue that recognizing and protecting the context and circumstances surrounding an individual's decision-making regarding her autonomy derives a better view of autonomy. Thus, autonomy lies within community and is deliberative.

[FN155]. Id. at 287-92.
Requiring a competent adult to endure such procedures against her will burdens the patient's liberty, dignity, and freedom to determine the course of her own treatment. Accordingly, the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water.
Id. at 289.

[FN156]. Id. at 287 (citations omitted).

[FN157]. Id. at 289-92.

[FN158]. Id. at 292 (quoting Cleveland Bd. of Educ. v. LaFleur, 414 U.S. 632, 639 (1974)).

[FN159]. Id. at 306.

[FN160]. Id. at 305. Justice Brennan, seeking common ground, wrote: "The right to be free from medical attention without consent, to determine what shall be done with one's own body, is deeply rooted in this Nation's traditions, as the majority acknowledges." Id. (emphasis in original).

[FN161]. Id. at 309. Justice Brennan acknowledged that this constitutionally protected interest is not absolute and may be outweighed by a legitimate state interest. For Justice Brennan, however, the state's general interest in preserving life falls far short of the individual right at stake in Cruzan. Id. at 311-13.

[FN162]. See infra Part IV. See also David A. Strauss, Common Law Constitutional Interpretation, 63 U. Chi. L. Rev. 877 (1996) (arguing both descriptive and normative aspects of the common law approach to constitutional interpretation).

[FN163]. 497 U.S. at 331 (Stevens, J., dissenting).

[FN164]. Id. at 356.

[FN165]. Id. at 355.

[FN166]. Eight of the Justices agreed that the patient, Nancy Cruzan, had an individual liberty interest, although they disagreed whether the clear and convincing standard adequately protected the individual right. Interestingly, both the dissenters and the supporters of the Court's opinion quoted the same passage from Union Pacific Ry. Co. v. Botsford, 141 U.S. 250 (1891). See 497 U.S. at 269 & 343 (Stevens, J., dissenting). "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." Id. at 251.

[FN167]. See Griswold v. Connecticut, 381 U.S. 479 (1965); Roe v. Wade, 410 U.S. 113 (1973); Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747 (1986); George Annas, Leonard Glantz, & Wendy Mariner, The Right of Privacy Protects the Doctor-Patient Relationship, 263 JAMA 858 (1990) (commenting on Roe v. Wade: "Roe not only properly took full account of changing medical science, but also concluded that inherently personal medical decisions should be made in the context of a doctor-patient relationship protected from governmental dictates, absent a state interest sufficiently compelling to justify intervention." Id. at 861).

[FN168]. In other words, protection of patient-doctor discourse shows the workings of an autonomy right that combines the republican notion of liberty with the liberal notion of liberty. Fleming makes this distinction between liberty of the ancients (republican) and liberty of the moderns (liberal) by drawing on Benjamin Constant's description of the difference between the liberties of the ancients, often associated with Jean Jacques Rousseau and the liberties of the moderns, often associated with John Locke. Rousseau's brand favors political liberties and the values of public life, whereas Locke favored liberty of the conscience and basic rights of person and property. Fleming describes constitutional constructivists as generally desiring to meld together these two, somewhat contrary, themes. See Fleming, Securing Deliberative Autonomy, supra note 15, at 25.
For further explanation of these two camps and their respective roles in interpreting the American Revolution, see William W. Fisher III, The Defects of Dualism, 59 U. Chi. L. Rev. 955, 961-65 (1992) (book review of Bruce Ackerman, We The People: Foundations (1991)).

[FN169]. Fleming, Securing Deliberative Autonomy, supra note 15, at 5 (mentioning Bork and Scalia).

[FN170]. Id. Approaches of constitutional interpretation that emphasize the "whole" constitution include those who rely on structure, such as Charles Black, see Charles L. Black, Jr., Structure and Relationship in Constitutional Law (1969), and those like Akhil Reed Amar, who urge consideration of the entire constitutional text and history. See Akhil Reed Amar, Intratextualism, 112 Harv. L. Rev. 747 (1999) (urging a more holistic reading of the entire constitutional text when analyzing a clause instead of the tendency to view a particular clause in isolation).

[FN171]. See Fleming, Securing Deliberative Autonomy, supra note 15, at 7. The list Fleming provides as examples of Supreme Court decisions establishing "unenumerated" fundamental rights is long and familiar. Some examples include Roberts v. United States Jaycees, 468 U.S. 609 (1984) (freedom of intimate and expressive association); Moore v. City of E. Cleveland, 431 U.S. 494 (1977) (right to define one's own family as including one's extended family); Loving v. Virginia, 388 U.S. 1 (1967) (right to marry); Meyer v. Nebraska, 262 U.S. 390 (1923) (right to direct the education of one's children); Pierce v. Society of Sisters, 268 U.S. 510 (1925) (right to direct education and upbringing of one's children); Skinner v. Oklahoma, 316 U.S. 535 (1942) (right to procreate); Shapiro v. Thompson, 394 U.S. 618 (1969) (right to travel or relocate); Griswold v. Connecticut, 381 U.S. 479 (1965) (right to use contraceptives within the marital relationship); Eisenstadt v. Baird, 405 U.S. 438 (1972) (extending right to use contraceptives to non-married persons).

[FN172]. Although Fleming relies primarily upon structure, he also pays homage to history and tradition. He explains that "constitutional constructivism, with its two themes of deliberative autonomy, synthesizes our traditions and practices of higher law and ordinary law, civic republicanism and liberalism, and democracy and constitutionalism, in a conception of dualist constitutional democracy." Fleming, Securing Deliberative Autonomy, supra note 15, at 27 (emphasis added).

[FN173]. Id. at 16.

[FN174]. Id.

[FN175]. See David A. Strauss, Common Law Constitutional Interpretation, 63 U. Chi. L. Rev. 877, 880 (1996). Professor Strauss notes that we have more in common with Canadians of 1990 than with Americans of the 1780's or even 1860's. Strauss cites Noah Webster's point made in 1787 that they at the time lacked authority over future generations.

[FN176]. Adopting Dworkin's distinction between a "constitution of principle" (abstract normative principles) and a "constitution of detail" (a list of rules), Fleming sees his constitutional constructivism as a "'constitution of principle,' which embodies (or aspires to embody) a coherent scheme of basic liberties." Fleming, Securing Deliberative Autonomy, supra note 15, at 20 (citing Ronald Dworkin, Life's Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom (1993)) (emphasis added). Moreover, Fleming laments the "flight from aspirational principles to historical practices" in the Supreme Court's understanding of tradition reflected in the progression of cases beginning with Palko v. Connecticut, 302 U.S. 319 (1937), and Griswold v. Connecticut, 381 U.S. 479 (1965), and ending with Bowers v. Hardwick, 478 U.S. 186 (1986). See Fleming, Securing Deliberative Autonomy, supra note 15, at 56-57.

[FN177]. Id. at 18.

[FN178]. Id. at 19.

[FN179]. Id. at 32.

[FN180]. Id.

[FN181]. Fleming, Securing Deliberative Autonomy, supra note 15, at 7-9, 17- 19 (Fleming explains his terms "deliberative autonomy" and "deliberative democracy" and tells how the unenumerated rights help build the structure of deliberative autonomy.).

[FN182]. Id. at 33 (quoting Rubenfeld, supra note 8, at 804-07). Rubenfeld argues that the right to privacy is essentially a political doctrine. Democracies are characterized by the limits and control that the state imposes over people's lives. Thus, restrictions on abortion that channel individuals into particular and predictable personal decisions violate Rubenfeld's view of the Constitution. Id.

[FN183]. Id.

[FN184]. Fleming, Securing Deliberative Autonomy, supra note 15, at 36. Fleming acknowledges Justice Cardozo for the term "matrix values," Palko v. Connecticut, 302 U.S. 319 (1937), as providing "indispensable conditions" for most other associated freedoms. Thus, Fleming views freedom of association and conscience as "'basic liberties ... rooted in fundamental principles of liberty and justice which lie at the base of all our civil and political institutions." ' Id. at 39 (citing Palko v. Connecticut, 302 U.S. 319, 328 (1937)).

[FN185]. Id. at 37 (emphasis added).

[FN186]. Id. at 17-18.

[FN187]. Id. at 40 (citing John Rawls, Political Liberalism 335 (1993)) (emphasis added). Fleming emphasizes that the significance criteria is "not one of significance simpliciter, or simply whether an asserted 'unenumerated' fundamental right is significant or important in the abstract (or in someone's subjective scheme of values)." Id. at 4, n.13. He also distinguishes between significance and the "importance" of an asserted right since the Supreme Court rejected "importance" as relevant when determining which rights belong to the list. Id. at 40, n.230 (citing San Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S. 1 (1973)).

[FN188]. See, i.e., Francis Collins, Shattuck Lecture--Medical and Societal Consequences of the Human Genome Project, 341 New Eng. J. Med. 28 (1999). Collins presents a hypothetical clinical encounter where the patient

gives his informed consent to a series of genetic tests. The tests would be performed on DNA from the patient's cells collected on a cheek swab.

The information obtained as a condition of employment might fundamentally change a person's life. For example, a prospective employee might learn at age 25 of a 100 fold increase in a type of cancer or dementia without ever having asked.

[FN189]. Fleming, Securing Deliberative Autonomy, supra note 15, at 18-19.

[FN190]. Id. "The basic idea is that by virtue of their two moral powers persons are free and that their having these powers makes them equal. Possession of the two moral powers constitutes the basis of free and equal citizenship. The basic liberties are understood as preconditions for the development and exercise of the two moral powers." (citations omitted). Id. at 19.

[FN191]. Id. Fleming emphasizes that constitutional constructivism shares with Rawls a view of citizens as free and equal living in a society of fair social cooperation.

[FN192]. Of course, this regulation would also interfere with the democratic process, a more conventional basis for constitutional theory and justification for substantive rights.

[FN193]. Fleming, Securing Deliberative Autonomy, supra note 15, at 18.

[FN194]. See Hall, supra note 2 at 91-101. Hall discusses the role of deliberation in formulating and justifying third party rules. He notes the problem of "lack of technical expertise among ordinary citizens" to relying on a "democratic consensus ideal." Id. at 93. This problem is addressed by protecting patient-doctor discourse because it functions as a kind of insurance for patient information. Hall also discusses the potential tyranny of majority rule recognized by the framers of our Constitution, warning that we must guard against the majority implementing rules that adversely effect particular minorities. Again, protecting patient-doctor discourse protects against the potential majoritarian tyranny by ensuring that the law protects the preconditions to people's abilities to exercise their first and second moral powers.

[FN195]. Fleming, Securing Deliberative Autonomy, supra note 15, at 18. A pregnant women who visits a federally funded clinic and is neither offered nor told of the availability of abortion will have a different view of her government than the same women who hears from her clinic physician that an abortion is a legitimate medical option but that the government refuses to fund that particular option. See Roberts, supra note 111, at 587.

[FN196]. One effect of the tradition of the fiduciary character operating within the patient-doctor relationship is that people would rather trust their physician's rationing decisions than a third party's rationing decisions. See Hall, supra note 2, at 64-65 (citing various studies finding, for example, that seventy percent of respondents chose either their family doctor or a panel of doctors to set limits on health care and only nine percent chose insurers or employers).

[FN197]. See supra Part IIIA.

[FN198]. The right would encourage the flow of information because it would question the constitutional validity of statutes aimed at bypassing informed consent requirements. For example, one aspect of the current debate surrounding proposed revisions of the Oregon Genetic Privacy Act concerns an exemption of informed consent for genetic material from patients which will be used for genetic research that has IRB (internal review board) approval. A patient's right to patient-doctor discourse could arguably invalidate this kind of informed consent bypass. (Interview with Dr. Brad Popovich, Director of OHSU Molecular Diagnostics Laboratory) (April 7, 2000).

[FN199]. Cass R. Sunstein, Liberal Constitutionalism and Liberal Justice, 72 Tex. L. Rev. 305 (1993).

[FN200]. See Richard H. Fallon, Jr., How to Choose a Constitutional Theory, 87 Cal. L. Rev. 535, 537 (1999) (noting the "large and proliferating number of constitutional theories" and setting out to find where the many theories agree).

[FN201]. Sunstein, supra note 199, at 311.

[FN202]. There was little debate over the constitutional dimensions during the debate about a "Patient's Bill of Rights" in the summer of 1999. See supra, Introduction.

[FN203]. See Carl E. Schneider, The Practice of Autonomy (1998) (arguing that patients are inevitably in a poor position to make medical decisions because they are sick and despondent, irritable, and exhausted).

[FN204]. See Jay Katz, The Silent World of Doctor and Patient (1984) (critiquing the traditional physician-dominated medical decision-making process); Schultz, supra note 27.

[FN205]. Schuck, supra note 38, at 903-05.

[FN206]. Schuck, supra note 38, at 907-09, 924 (noting the "ancient pedigree" of the values that underlie the doctrine of informed consent).