A PRISONER'S CONSTITUTIONAL RIGHT TO MEDICAL INFORMATION: DOCTRINALLY FLAWED AND A THREAT TO STATE INFORMED CONSENT LAW

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INTRODUCTION

In 1990, the Third Circuit ruled in *White v. Napoleon* that a prisoner stated a 42 U.S.C. § 1983 claim against a prison physician when the prisoner alleged that the physician refused to answer the prisoner's request for information about a prescription drug that the prison doctor recommended.[1] In so ruling, the court held that prisoners have a substantive due process right under the Federal Constitution's Fourteenth Amendment to receive sufficient information to make an intelligent choice about whether to consent to or refuse proposed medical treatments, and that the alleged breach of this right was sufficient to sustain the prisoner's § 1983 claim.[2]

Since *White*, a series of cases has stated that the Fourteenth Amendment's Due Process Clause protects, as a fundamental liberty interest, the right to receive material information about medical treatment as part of the informed consent process.[3] The right to

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1. White v. Napoleon, 897 F.2d 103, 113–14 (3d Cir. 1990).
2. *Id.* at 111–12.
3. *See* Rainwater v. Alarcon, 268 F. App'x 531, 534 (9th Cir. 2008) (holding that summary judgment is inappropriate when a question of fact remains as to whether the plaintiff received sufficient medical information pursuant to the Fourteenth Amendment); Pabon v. Wright, 459 F.3d 241, 246 (2d Cir. 2006) (finding that the Fourteenth Amendment right to refuse medical treatment carries with it a concomitant right to such information as a reasonable person would need to make an informed decision about medical treatment); Benson v. Terhune, 304 F.3d 874, 884 (9th Cir. 2002) (holding that the Fourteenth Amendment's Due Process Clause substantively protects the right to bodily

receive medical information was held to derive from a foundational right to refuse unwanted medical treatment, which is also protected under the Fourteenth Amendment's Due Process Clause.[4] These courts reasoned that a right to refuse treatment is meaningless unless it can be exercised intelligently, which requires that information be provided to a patient, and so the right to refuse treatment must give rise to a right to receive medical information.[5]

Moreover, this line of cases equates the scope of the constitutional right to receive medical information with the typical scope of a state-law right to receive all material treatment information, including information about one's diagnosis, prognosis, the nature of the proposed treatment, the risks and benefits of the proposed treatments, any alternatives to the proposed treatments, and the risks and benefits of any such alternatives.[6] In other words, *White* and its progeny transform disclosure duties under state liability law into a constitutional duty, at least whenever state action exists.

This Article argues that *White* and cases that have relied on its holding were wrongly decided both as a matter of constitutional

integrity, the right to refuse medical treatment, and the right to receive information sufficient to exercise those rights intelligently); Alston v. Bendheim, 672 F. Supp. 2d 378, 384 (S.D.N.Y. 2009) (dismissing claim that prison doctor violated a prisoner's substantive due process right to the disclosure of material information related to prescribed medication, but only for failure to sufficiently allege the intent element of the claim); Lara v. Bloomberg, No. 04-CV-8690, 2008 WL 123840, at *4–5 (S.D.N.Y. Jan. 8, 2008) (raising a separate Fourteenth Amendment claim when a prisoner alleged that prison physicians failed to provide him with information about the side effects of a medical treatment and dismissing the claim for failure to allege that the prison physicians acted with deliberate indifference to the prisoner's rights); O'Neil v. United States, No. 5:07-CV-00358, 2008 WL 906470, at *6 (S.D. W. Va. Mar. 31, 2008) (overruling a magistrate's dismissal of a prisoner's claim that prison doctors violated his due process rights under the Fifth Amendment by failing to provide the prisoner with medical information sufficient to permit an informed decision regarding medical treatment); Clarkson v. Coughlin, 898 F. Supp. 1019, 1048–49, 1052 (S.D.N.Y. 1995) (holding that a prison's failure to provide a sign-language interpreter to help provide treatment information to deaf inmates is sufficient to allege a violation of the Fourteenth Amendment due process right to receive treatment information in order to consent to or refuse proposed medication). *But see* Wright v. Fred Hutchinson Cancer Research Ctr., 269 F. Supp. 2d 1286, 1294–95 (W.D. Wash. 2002) (finding no violation of research subjects' substantive due process rights when researchers failed to disclose alleged financial conflicts of interest, so long as subjects were informed that they were participating in a medical experiment).

4. *See, e.g.*, *Pabon*, 459 F.3d at 249–50 ("[I]n order to permit prisoners to exercise their right to refuse unwanted treatment, there exists a liberty interest in receiving such information as a reasonable patient would require in order to make an informed decision as to whether to accept or reject proposed medical treatment.").

5. *See id.*

6. *See, e.g.*, *Benson*, 304 F.3d at 884 & n.10 (describing the elements of disclosure and equating them with typical state disclosure requirements).

doctrine and as a matter of policy. First, they rest on an unreasonable extrapolation from the U.S. Supreme Court's opinion in *Cruzan v. Director, Missouri Department of Health*,[7] which concerns the right to refuse life-sustaining medical treatment.[8] *Cruzan* should be read in the context of later cases confirming the power of states to outlaw physician-assisted suicide and the authority of government to inject itself into the informed consent process for abortion procedures.[9] Doing so reveals that individuals likely have a substantive due process right to avoid unwanted bodily invasions, but not a right to well-informed treatment decisions. This seems all the more likely given the Supreme Court's instruction that substantive due process claims must be resolved on the narrowest possible terms and that federal courts must guard against an expansive reading of the Due Process Clause.[10]

In short, the right of prisoners to be provided with material information about proposed medical care as part of the informed consent process as articulated in *White* is not secure because it is based on a weak doctrinal foundation. Furthermore, it is not necessary to protect the interest of prisoners in receiving sufficient treatment information because other alternatives exist—including the State's constitutional obligation to provide for the medical needs of those it holds in custody, and state and federal tort claims.[11]

Even beyond doctrine, however, protecting the medical interests of prisoners by recognizing a constitutional right for *all* to receive treatment information is a bad idea because it will confound state informed consent law. The state-action doctrine is not sufficient to prevent individuals outside of prison from challenging the validity of state informed consent law, because state action exists in many such cases. In those cases, the federal constitutional right to the disclosure of material treatment information would trump any state-law right. This would result in each state either enforcing two different disclosure standards (a federal standard for physicians when they are state actors and a state-law standard for when they are not), or adopting the constitutional standard as the state-law standard. Either way, the state's authority to regulate the medical profession is significantly diminished. Moreover, when *White*'s constitutional right to the disclosure of material treatment information is used to challenge state informed consent law, it will subject state law to the politics of federal substantive due process jurisprudence.

7. 497 U.S. 261 (1990).

8. *See infra* Part II.A.

9. *See* Washington v. Glucksberg, 521 U.S. 702, 725 (1997); Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 882–83 (1992).

10. *See, e.g.*, *Glucksberg*, 521 U.S. at 720–21 (warning that substantive due process rights should be expanded only reluctantly, and then based only on careful description).

11. *See infra* Part II.C.

In short, a right to the disclosure of material treatment information based, as it is under *White*, on a substantive due process right to refuse unwanted medical treatment threatens to destabilize state informed consent law. We are better served by relying on means for enforcing a prisoner's right to the disclosure of treatment information that are unlikely to affect state disclosure standards. Of course, this would mean that individuals could not use *White* to challenge woefully inadequate disclosure standards that exist in several states. Other strategies exist, however, to ensure that patients in those states receive an adequate minimum of information as part of the informed consent process, including the enforcement of disclosure standards in mandatory institutional policies, professional licensure actions, and—when state action exists—equal protection claims.

Part I describes *White* and its progeny as well as the reasoning that led to finding a right to receive treatment information. Part II critiques that line of cases as resting on an overly broad interpretation of *Cruzan*, and concludes that a prisoner's interest in informed medical decision making would be better protected if the right to the disclosure of treatment information was enforced through the Eighth Amendment or state and federal tort claims available to prisoners. Part III argues that a substantive due process right to the disclosure of material treatment information, as articulated in *White,* threatens to invade and alter disclosure standards under state law, which would undermine state regulation of medical practice and distort the normative framework of state informed consent law by subjecting it to federal substantive due process jurisprudence. Part III also argues that a broadly applicable substantive due process right to the disclosure of material treatment information is not necessary to address even the most inadequate state disclosure standards.

I. *WHITE V. NAPOLEON* AND THE CASES THAT FOLLOWED

Like most of the cases that have addressed whether the Fourteenth Amendment's Due Process Clause creates a right to receive treatment information, the dispute in *White v. Napoleon* arose out of medical care provided to an inmate.[12] Norwood White was one of three prisoners in the New Jersey prison system who jointly filed a civil-rights suit against a prison physician, Dr. John Napoleon.[13] White first came under the care of Dr. Napoleon when White was transferred to the prison where Dr. Napoleon worked.[14] White suffered from persistent ear infections, which had been brought under control by a different physician who had treated

12. White v. Napoleon, 897 F.2d 103, 105 (3d Cir. 1990).
13. *Id.*
14. *Id.* at 106.

White prior to his transfer.[15] White requested that Dr. Napoleon continue that course of treatment, and the doctor refused.[16] Instead, Dr. Napoleon insisted on pursuing treatments that, when attempted by White's prior physician, had proven ineffective and painful.[17] This was the common starting place for each of White's many complaints about the quality of care he received from Dr. Napoleon, including White's consent-related complaint.[18] He alleged that, at one point, Dr. Napoleon recommended that White use a substance called "Debrox."[19] White, who was allergic to penicillin, asked about the ingredients of Debrox in an effort to assure himself that it did not contain penicillin.[20] White alleged that Dr. Napoleon would not tell White anything about the substance except that it was a cleansing solution.[21] As a result, White refused the Debrox, and Dr. Napoleon filed disciplinary charges against White for failing to cooperate with the prescribed treatment plan.[22]

White's suit claimed that he had a constitutional right to be informed about the recommended treatment, as well as a right to be free from retaliation by Dr. Napoleon for seeking to exercise his right to be informed.[23] Further, he claimed that Dr. Napoleon filed disciplinary charges with the malicious intent to discourage White and other prisoners from exercising their right to refuse treatments he recommended.[24] Dr. Napoleon moved to dismiss White's claim, and the federal district court granted the motion.[25] White appealed, and a panel of the Third Circuit Court of Appeals reversed and remanded the case.[26] The appellate court held that the district court erred in interpreting White's claim as only a procedural due process claim, rather than also considering it as a substantive due process claim.[27] The court of appeals then went on to find that White adequately alleged a claim under a substantive due process analysis.[28]

Central to the Third Circuit's analysis was its holding that a right to receive treatment information is implicit in the substantive due process right to refuse unwanted medical treatment.[29] The court wrote that a "right to refuse treatment is useless without

15. *Id.*
16. *Id.*
17. *Id.* at 106–07.
18. *See id.* at 105–12.
19. *Id.* at 106.
20. *Id.*
21. *Id.*
22. *Id.*
23. *Id.* at 111.
24. *Id.*
25. *Id.* at 105.
26. *Id.* at 114–15.
27. *Id.* at 111.
28. *Id.* at 111–14.
29. *Id.* at 111.

knowledge of the proposed treatment,"[30] and thus recognized a right to be informed of treatment information.[31] Moreover, the court noted that the right to refuse treatment—from which the right to receive treatment information springs—is itself "derived from each person's fundamental right to be free from unjustified intrusions on personal security," a right that the court also described as a liberty interest in being free from "unjustified intrusions into the body."[32] Thus, while the constitutional right to receive the information described in *White* might arise out of a right to refuse treatment, both of these rights are based fundamentally on a liberty interest in being personally secure and free of unwanted bodily invasions.

Having recognized a right to the disclosure of treatment information, the *White* court went on to describe the extent of the right. It held that individuals "have a right to such information as is reasonably necessary to make an informed decision to accept or reject proposed treatment, as well as a reasonable explanation of the viable alternative treatments."[33] This standard is likely indistinguishable from the typical disclosure standard enforced by state courts in most professional liability claims by patients against their doctors for failure to disclose treatment information.[34] The typical standard requires doctors to disclose all information "material" to the patient's treatment decision,[35] which generally includes the patient's diagnosis and prognosis, the nature and risks of the proposed treatment, and the nature and risks of any viable alternative treatments.[36] Yet the Third Circuit also recognized that the application of this standard must account for the prison setting in which the physician in this case was determining what, if any, information to provide. Thus, the *White* court held that a "prison doctor's decision to refuse to answer an inmate's questions about treatment will be presumed valid unless it is such a substantial departure from professional judgment, practice or standards as to demonstrate that the doctor did not base the decision on such a judgment."[37] The court went on to note that "[i]n exercising judgment . . . the doctor must consider a prisoner's reasonable need to make an informed decision to accept or reject treatment, as well

30. *Id.* at 113.
31. *See id.* at 111.
32. *Id.* at 111–12 (citing Rennie v. Klein, 653 F.2d 836, 844 (3d Cir. 1981)).
33. *Id.* at 113.
34. *See* Benson v. Terhune, 304 F.3d 874, 884 n.10 (9th Cir. 2002) (describing the informational requirement established in *White* as "akin to the main components of the general doctrine of informed consent as statutorily mandated for medical practitioners in most states: diagnosis of condition, nature and purpose of the treatment, description of anticipated benefits and risks and alternative treatments (including no treatment) and their related risks").
35. *See, e.g.*, Canterbury v. Spence, 464 F.2d 772, 786–87 (D.C. Cir. 1972).
36. *See Benson*, 304 F.3d at 884 n.10.
37. *White*, 897 F.2d at 113.

as his need to know any viable alternatives that can be made available in prison."[38] Accordingly, *White* holds that the constitutional right to the disclosure of treatment information is a right to the disclosure of the same treatment information that most states *require* physicians to provide to patients under common-law liability standards, but a breach of that right in the prison setting is actionable as a civil rights claim only when the physician's disclosure decision was not based on a professional judgment that accounted for the prisoner's need to make an informed treatment decision.

With one exception discussed below, the case law since *White* has largely followed *White*'s lead. Several opinions employ the constitutional right to treatment information with little or no analysis.[39] The few that provide some analysis adopt *White*'s reasoning that a constitutional right to refuse treatment necessarily gives rise to a right to the disclosure of treatment information that will enable an informed treatment decision.[40]

There are, however, a few noteworthy developments. First, it might be assumed that *White* applies only to prisoners because it involves medical care provided to a prisoner by a prison physician and because the law imposes a special obligation on state and federal governments to adequately care for those they take into custody.[41] But language in *White*, and developments in case law since *White*, clarify that the right to treatment information is intended to be a right for all and not just for those in confinement.

Rather than argue that the right to receive treatment information sprung from the state's duty to care for those it confines, the *White* court held that the right is "retained" by individuals despite imprisonment, even though the right may be circumscribed by the state's legitimate interests in operating a prison.[42] The choice of the word "retained" in that context signals the court's belief that *everyone* enjoys the right to receive treatment information, not just prisoners.

38. *Id.*

39. *See, e.g.*, Rainwater v. Alarcon, 268 F. App'x 531, 534 n.2 (9th Cir. 2008); O'Neil v. United States, No. 5:07-CV-00358, 2008 WL 906470, at *7 (S.D. W. Va. Mar. 31, 2008); Lara v. Bloomberg, No. 04-CV-8690, 2008 WL 123840, at *4 (S.D.N.Y. Jan. 8, 2008).

40. *See, e.g.*, Pabon v. Wright, 459 F.3d 241, 249 (2d Cir. 2006) ("Absent knowledge of the risks or consequences that a particular treatment entails, a reasoned decision about whether to accept or reject that treatment is not possible."); *Benson*, 304 F.3d at 884 (acknowledging the right to receive treatment information as a corollary to the right to refuse treatment).

41. *See* Youngberg v. Romeo, 457 U.S. 307, 317 (1982) ("As a general matter, a State is under no constitutional duty to provide substantive services for those within its border. [But w]hen a person is institutionalized—and wholly dependent on the State— . . . a duty to provide certain services and care does exist . . . ." (citation omitted)).

42. *White*, 897 F.2d at 112–13.

Furthermore, the right to receive treatment information was derived from a right to refuse medical treatment, and, shortly after *White* was decided, the U.S. Supreme Court acknowledged in *Cruzan* that the right to refuse treatment could be inferred from the Court's prior opinions.[43] *Cruzan* concerned a patient in a persistent vegetative state whose parents sought to enforce what they believed to be the patient's preference to have life-sustaining medical treatment discontinued.[44] Because it did not involve a prisoner or one who was involuntarily committed to state custody, *Cruzan*'s acknowledgement of a right to refuse treatment does not rest on a special state duty to provide care. Thus, *Cruzan* lends support to the claim that the right to refuse treatment, and other rights that derive from it, belong to all individuals.[45] Indeed, cases addressing the right to treatment information after *White* cite to *Cruzan* as providing a foundation from which to derive a constitutional right to treatment information.[46]

Also noteworthy is that the cases after *White* have interpreted

43. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 278 (1990). The majority opinion in *Cruzan* did not actually hold that a competent person has a substantive due process right to refuse unwanted treatment. Rather, the Court's statements on the issue were more limited. In order to bypass the question of whether such a right is constitutionally protected and move instead to an analysis of countervailing state interests, the Court merely "assumed" that a right to refuse treatment is a fundamental liberty interest under the Fourteenth Amendment. *Id.* at 279. Additionally, as noted above, the Court stated only that such a right "may be inferred" from the Court's prior rulings. *Id.* at 278. The Court's acknowledgement of this inference, despite being dicta, has sent a strong signal that the Court would rule in favor of constitutional protection for such a right if faced squarely with the issue—so strong, in fact, that *Cruzan* is repeatedly cited as proof that a constitutional right to refuse treatment already exists. *See, e.g.*, *Rainwater*, 268 F. App'x at 534 n.2. Indeed, the Supreme Court itself has been caught under the weight of its assumption and dicta from *Cruzan*. In the process of rejecting a claimed substantive due process right to physician-assisted suicide, which was based in part on the *Cruzan* assumption and dicta, the Court did not simply rest on the fact that its statements were not holdings. Instead, it went to the trouble of clarifying the would-be right in *Cruzan* so as to distinguish it from the claimed right to physician-assisted suicide. *See* Washington v. Glucksberg, 521 U.S. 702, 722–25 (1997).

44. *Cruzan*, 497 U.S. at 265.

45. Further support might be found in *Wright v. Fred Hutchinson Cancer Research Center*, 269 F. Supp. 2d 1286 (W.D. Wash. 2002), in which a substantive due process right to the disclosure of information related to medical research was raised by individuals who were not being held in government custody. In that case, the plaintiffs were individuals who had volunteered to participate in medical research and who claimed that they had a substantive due process right to the disclosure of information relating to the researchers' potential financial conflicts of interest. *Id.* at 1297. While the claim was dismissed, the reason was *not* because the plaintiffs were not prisoners or otherwise held involuntarily. *Id.*

46. *See, e.g.*, *Rainwater*, 268 F. App'x at 534 n.2; Pabon v. Wright, 459 F.3d 241, 249 (2d Cir. 2006).

the right to treatment information to include a right to receive the disclosure of treatment information by one's physician whether or not one asked for it, and not merely a right to pursue such information oneself. *White* involved a patient who asked for treatment information and whose physician refused the request. Thus, the right to treatment information applied in *White* could have been interpreted as only a right to receive answers to questions asked about proposed treatments. The Ninth Circuit seemed to employ this limitation on the right to treatment information in its 2002 opinion, *Benson v. Terhune*.[47] Upholding a denial of habeas corpus relief, the Ninth Circuit held that a prisoner waived her right to receive information about psychotropic drugs when she did not ask for the information prior to ingesting the drugs,[48] and concluded that "the jail staff had no affirmative duty to volunteer information about the drugs."[49] But the apparent limitation employed in *Benson* seems to have been an aberration because courts—including the Ninth Circuit in an opinion after *Benson*[50]—have ruled that the right to treatment information *requires* the disclosure of information, even when a patient has not asked for it. For example, in *Pabon v. Wright*, the Second Circuit held that a prisoner who received treatment in prison for Hepatitis C, including a liver biopsy and doses of interferon, had a right under the Fourteenth Amendment's Due Process Clause to be provided with risk information by his physicians prior to consenting to treatment, and the court did so without addressing whether or not the prisoner had asked for such information.[51]

While most cases that have addressed the right to treatment information have recognized a right to receive all information that is reasonably necessary to make an informed decision, there is one exception. In *Wright v. Fred Hutchinson Cancer Research Center*, a federal district court dismissed a 42 U.S.C. § 1983 claim that alleged that the research center and several of its staff physician-researchers had violated the substantive due process rights of several human subjects participating in a cancer study when the researchers failed to disclose their financial interests in the outcome

47. 304 F.3d 874, 883–85 (9th Cir. 2002).

48. *Id.* (employing the standard for a knowing waiver of *Miranda* rights in the court's analysis of whether the prisoner waived the right to treatment information acknowledged in *White*).

49. *Id.* at 885.

50. *See Rainwater*, 268 F. App'x at 534 n.2.

51. *Pabon*, 459 F.3d at 249–50. This holding was part of an analysis of whether the defendants were entitled to qualified immunity. Despite finding that the prisoner had a constitutional right to receive treatment information from his physicians, which was violated by his physicians, the Second Circuit held that the defendants were entitled to qualified immunity because the right to treatment information was not clearly established under the law at the time of the alleged breach. *Id.* at 254–55.

of the study.[52] In so ruling, the court acknowledged that a human subject has a protected liberty interest in being told that she is participating in an experiment rather than in therapeutic treatment,[53] but the court declined to extend that right any further. The plaintiffs' claim failed under this standard because the plaintiffs knew that they were participating in an experiment that might or might not provide therapeutic benefit.[54] It also explained away the holding in *White* on the grounds that the *White* court had not intended for *every* tortious breach of the duty to obtain informed consent to be a constitutional violation.[55] Accordingly, *Wright* should be understood to recognize a right to treatment information, but one that is substantially more limited than the right applied in *White* and its progeny. Rather than acknowledging a right to receive all information necessary for an individual to make an informed decision about whether to refuse or consent to treatment, the *Wright* court recognized only a right to be informed of whether proposed treatment is being provided as part of a medical experiment and, if so, the likelihood that the experimental treatment will provide therapeutic benefit.[56]

In the end, a substantive due process right to treatment information has taken root. It has been recognized and applied by the Second, Third, and Ninth Circuits, and by several district courts in those circuits. It is not a liberty interest unto itself; rather, it is derived from the liberty interest to refuse unwanted treatment. Additionally, it is generally interpreted as a right to be provided with treatment information from a health care provider even in the absence of a request for such information by the patient. Moreover, most courts interpret the disclosure duty to be fulfilled only when the patient has been provided with all information necessary to make an informed treatment decision, which is virtually identical to the standard for disclosure employed by most states for the purpose of determining liability in informed consent cases.

II. THE RIGHT TO REFUSE TREATMENT AS A RIGHT TO AVOID A BATTERY RATHER THAN A RIGHT TO AUTONOMOUS DECISION MAKING

A fundamental flaw in *White* and its progeny is their misinterpretation of the constitutional right to refuse treatment

52. Wright v. Fred Hutchinson Cancer Research Ctr., 269 F. Supp. 2d 1286, 1294–97 (W.D. Wash. 2002).

53. *Id.* at 1294.

54. *Id.* at 1295.

55. *Id.* Given that the research center in this case is a private institution, the state action on which the claim must be based is unclear, and the court's opinion does not address—or even mention—this issue. See *infra* Part III.A for a discussion of the state action doctrine as an incomplete barrier to the use of a prisoner's right to the disclosure of treatment information outside of the prison setting.

56. *Wright*, 269 F. Supp. 2d at 1294–95.

from which those cases claimed to derive a right to treatment information. As argued herein, a constitutional right to refuse treatment is primarily a right to have one's refusal of treatment respected by others so as to be free of an unwanted bodily invasion, and such a right is significantly narrower than a right to autonomous medical decision making. Because a right to refuse treatment is concerned with the actions of others in the face of an individual's refusal of invasive treatment, it is only incidentally concerned with the decision-making process that resulted in the treatment refusal. This is evident in Supreme Court opinions that clarify that the liberty interest at issue is the prevention of a battery rather than the protection of a broad notion of personal autonomy,[57] that allow states to promote or restrict treatment refusals by third parties on behalf of incompetent individuals,[58] and that uphold state regulations that substantially influence the communication of material treatment information from physician to patient but do not unduly burden the patient's right to consent to or refuse treatment.[59] Such case law—especially when read together with Supreme Court instructions to construe the boundaries of substantive liberty interests narrowly—suggests that a constitutional right to have others respect a treatment refusal requires a refusal made without undue influence and with knowledge of only the invasive nature of the treatment. If so, then the right of prisoners to receive disclosure of material treatment information, as articulated in *White* and its progeny, is unstable because it lacks a sound constitutional foundation.

A. Separating Consent to a Bodily Invasion from the Assumption of Treatment Risks and the Waiver of Alternative Treatments

Central to the claim that the constitutional right to refuse treatment necessarily gives rise to a right to receive the disclosure of material treatment information is the argument that a right to refuse treatment is meaningless without all such information.[60] The argument reflects a belief that the right to refuse treatment cannot be "meaningfully" separated from the right to do so with the benefit of material treatment information. The logic underlying this belief goes something like this: (1) there is a right to refuse treatment, which (2) implies a right to make an autonomous treatment decision, which (3) cannot be realized unless the decision maker has all material information necessary to make an informed decision, and so (4) the right to refuse treatment implies a right to receive

57. *See* Washington v. Glucksberg, 521 U.S. 702, 724–25 (1997).

58. *See* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 280–81 (1990).

59. *See* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 882–83 (1992); Rust v. Sullivan, 500 U.S. 173, 201–02 (1991).

60. *See supra* notes 4–5 and accompanying text; *see also, e.g.*, White v. Napoleon, 897 F.2d 103, 113 (3d Cir. 1990).

information necessary for an informed choice.[61] As explained below, however, this logic is undercut by the very structure of informed consent law.

In most states, the right to consent to receive or refuse treatment is closely related to the right to material treatment information, and certainly a fully informed treatment decision is better than one based on incomplete or no information. Yet it is not true that the right to consent to or refuse treatment is "meaningless" in the absence of all material treatment information. An individual who voluntarily consents to an invasive treatment with an understanding of the invasive nature of the treatment can be said to have autonomously authorized the bodily invasion (the "touching," to put it in battery terms) that takes place in the course of treatment. This is true even if she is uninformed of the material risks of, and alternatives to, the treatment. In such a case, the patient has consented to the touching involved in the treatment even though she has not assumed the undisclosed risks of the treatment nor waived her right to receive an alternative treatment. In other words, the bodily invasion that the treatment imposes, the assumption of each material risk of that treatment, and the waiver of each viable alternative to the treatment are distinct aspects of informed consent that can receive protection under the law separately.

The independence of these aspects of informed consent is clearly reflected in nearly every state's informed consent law.[62] Indeed, the doctrine acknowledges two separate duties that are imposed on physicians: a duty to refrain from providing medical care to a patient without the patient's consent, and a duty to disclose material information about a proposed treatment to a patient *prior to seeking* the patient's consent.[63] A battery theory is used when a physician is alleged to have violated the first duty of the informed consent doctrine—the duty to refrain from treating without the prior consent of the patient.[64] The complete lack of consent in such a case

61. For a theoretical account of autonomous decision making in the context of informed consent, see generally RUTH R. FADEN ET AL., A HISTORY AND THEORY OF INFORMED CONSENT (1986).

62. *See* Joan H. Krause, *Reconceptualizing Informed Consent in an Era of Health Care Cost Containment*, 85 IOWA L. REV. 261, 309 (1999) (stating that most jurisdictions recognize a negligence action for failure to adequately disclose treatment information and a battery action for the failure to obtain consent to treatment at all).

63. Robert Gatter, *Informed Consent and the Forgotten Duty of Physician Inquiry*, 31 LOY. U. CHI. L.J. 557, 561–62 (2000); *see also* Franklin v. United States, 992 F.2d 1492, 1496 (10th Cir. 1993); Ketchup v. Howard, 543 S.E.2d 371, 374 (Ga. Ct. App. 2000), *overruled on other grounds by* Blotner v. Doreika, 678 S.E.2d 80 (Ga. 2009); Scott v. Bradford, 606 P.2d 554, 557 (Okla. 1979); Lounsbury v. Capel, 836 P.2d 188, 192 (Utah Ct. App. 1992).

64. *See, e.g.*, McNeil v. Brewer, 710 N.E.2d 1285, 1288–89 (Ill. App. Ct. 1999).

results in treating the procedure as an offensive touching and a compensable harm.[65]

Meanwhile, a patient who consented to treatment but claims that she was insufficiently informed about a treatment risk because her physician breached the second duty—the duty to disclose material treatment information—may only pursue her claim under a negligence theory.[66] Here the violation is not the "touching" because the patient consented to the treatment. Instead, it is the failure of the physician to warn of a potential harm associated with the treatment, which means that responsibility for any harm that arises from that particular risk was not assumed by the patient and remains with the physician. Consequently, the only compensable harm in such a case is harm to the patient caused by the materialization of the undisclosed—and therefore unassumed—risk.[67] In short, the laws of nearly all states recognize that insufficient understanding of the material risks of, and alternatives to, a treatment does not negate one's consent to treatment.[68]

Such an overwhelming consensus among states' laws is evidence of a common normative view that consent to a bodily invasion is different from a decision to assume the risks of a treatment and to forgo alternative treatments. Consequently, consent to the bodily invasion that results from treatment is independently meaningful under the law even if it is given without an understanding of the risks of and alternatives to that treatment. To be clear, a liability regime that recognizes only a duty to obtain consent to a medical touching certainly fails to protect patients adequately. Nevertheless, the law's recognition that consent to a medical touching, as distinct from consent to the risks of and alternatives to the touching, is rational and meaningful.

If a right to consent to or refuse the bodily invasion associated with a treatment can exist separately from a right to consent to material risks and to the waiver of each alternative treatment, then this substantially narrows any derived right to information. To autonomously consent to the physical invasion of treatment, a patient would need to understand only that the treatment is invasive and that she has the right to refuse the invasion. This, of course, is substantially less than information about all material

65. *See, e.g.*, Harvey v. Strickland, 566 S.E.2d 529, 536 n.4 (S.C. 2002) (holding that pain and suffering from a completely unauthorized treatment is a cognizable injury (citing Tisdale v. Pruitt, 394 S.E.2d 857 (S.C. Ct. App. 1990))).

66. *See* JESSICA W. BERG ET AL., INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE 132–36 (2d ed. 2001).

67. *See* Canterbury v. Spence, 464 F.2d 772, 790 (D.C. Cir. 1972) (holding that a compensable injury occurs only when an unrevealed risk actually materializes and causes harm); Prissel v. Physicians Ins. Co. of Wis., No. 02-1729, 2003 WL 2998133, at *10–11 (Wis. Ct. App. Dec. 23, 2003).

68. *See* BERG ET AL., *supra* note 66, at 140–41 (listing the elements necessary to establish liability for a failure to obtain informed consent).

risks and alternatives.

B. The Rights to Treatment and Information Under Supreme Court Precedent

The failure of *White* and its progeny to distinguish an individual's interest in avoiding nonconsensual medical invasions of her body from her interest in making well-informed treatment decisions is critical to understanding why the claimed right to treatment information lacks doctrinal support. This is because the United States Supreme Court recognized such a distinction in its substantive due process analyses in *Cruzan*[69] and *Washington v. Glucksberg*.[70] As explained below, these cases indicate that the Fourteenth Amendment's Due Process Clause protects an individual's interest in avoiding unwanted bodily invasions associated with treatment, but not an individual's interest in autonomous medical decision making.

In *Cruzan*, the Court held that a substantive due process right to refuse treatment was not violated by a Missouri law prohibiting family members of an incompetent patient from refusing life-sustaining medical treatment on the patient's behalf, absent clear and convincing evidence that the patient, if competent, would refuse such treatment.[71] Contrary to popular conception, the Court did not hold that an individual has a right to refuse unwanted treatment. Rather, the Court assumed, without holding, that such a right is protected as a liberty interest under the Fourteenth Amendment in order that the Court could reach the issue it preferred to rule on: namely, whether countervailing state interests justified a deprivation of the assumed right to refuse treatment.[72] Yet *Cruzan*, through its dicta, provides substantial support for a substantive due process right to refuse treatment by stating that a constitutional right to refuse unwanted treatment can be inferred from the Court's prior rulings.[73] Indeed, the Court's analysis of its prior rulings indicates how difficult it would be for the Court, if faced squarely with the issue, to reach any conclusion other than that a constitutional right exists to refuse the bodily invasion associated with an invasive treatment.[74] At the same time, the Court's review of prior rulings that gave rise to the Court's dicta reveals that a substantive due process right to refuse treatment is a right to avoid the bodily invasion associated with an invasive treatment, which, absent a patient's consent, would constitute a battery.[75] The

69. Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 277–78 (1990).
70. 521 U.S. 702, 724–25 (1997).
71. *Cruzan*, 497 U.S. at 280.
72. *Id.* at 278–79.
73. *Id.* at 278.
74. *Id.* at 278–79.
75. *Id.*

holdings to which the Court cites each address the right to be free from unnecessary bodily invasion or physical confinement.[76] Justice O'Connor's concurrence also makes this clear, acknowledging that "the liberty interest in refusing medical treatment flows from decisions involving the State's invasions into the body."[77] Her concurrence goes on to explain the many ways that medical treatment of an unwilling patient, including the forcible provision of artificial nutrition and hydration, involves bodily "restraint and intrusion" that implicates a protected liberty interest and justifies a constitutional obligation of the state to respect an individual's decision to refuse treatment.[78] Thus, *Cruzan* establishes that a constitutional right to refuse treatment is not a right to autonomous medical decision making, but rather a right to be free of unwanted incursions into one's body, which is protected by requiring the state to honor an individual's refusal of such physical invasions.

Cruzan discusses state informed consent law, but *Cruzan* did not find that a right to informed consent is a corollary to the assumed right to refuse treatment. Rather, the Court recognized that states have widely adopted the informed consent doctrine, which protects individuals from bodily invasions absent their consent, and that a "logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment."[79] Thus, while it recognized that a right to refuse treatment could be derived from a right to consent to treatment, the Court said nothing about deriving a constitutional right to the disclosures commonly afforded by state informed consent law from a right to refuse treatment.

In the end, the Court in *Cruzan* outlined a right to refuse treatment on rather narrow terms as a right to avoid a medical invasion of the body rather than a broader notion of a right to autonomous medical decision making. It did so not only because the narrower understanding of the right was most consistent with the Court's prior rulings, but also because it was in keeping with precedent that counseled federal courts to avoid an expansive interpretation of substantive due process rights.[80] Thus, in justifying the Court's decision to assume, rather than hold, that a right to refuse treatment is constitutionally protected, Chief Justice

76. *Id.* For example, the Court cites to *Washington v. Harper*, 494 U.S. 210 (1990), and quotes the following statement from the case: "The forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty." *Id.* at 229. The Court also cites to *Parham v. J.R.*, 442 U.S. 584 (1979), and quotes the following line: "[A] child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment." *Id.* at 600.

77. *Cruzan*, 497 U.S. at 287 (O'Connor, J., concurring).

78. *Id.* at 287–90.

79. *Id.* at 270 (majority opinion).

80. *Id.* at 277–79.

Rehnquist wrote:

> This is the first case in which we have been squarely presented with the issue whether the United States Constitution grants what is in common parlance referred to as a "right to die." We [note that] in deciding "a question of such magnitude and importance . . . it is the [better] part of wisdom not to attempt, by any general statement, to cover every possible phase of the subject."[81]

If any confusion remained after *Cruzan* about whether the Fourteenth Amendment's Due Process Clause protects a right to be free of unwanted medical intrusions into the body or a broader right to autonomous medical decision making, it was resolved by the Court's holding in *Glucksberg* several years later.[82] In *Glucksberg*, the Court upheld a ban imposed by the State of Washington on assisted suicide against a claim by several terminally ill patients and their physicians that the ban violated their liberty interests in choosing to participate in physician-assisted suicide.[83] Although the petitioning patients were not receiving unwanted life-sustaining medical treatment, the patients relied on *Cruzan* to make their case.[84] They argued that, by acknowledging a right to refuse life-sustaining treatment, *Cruzan* recognized that individuals have a substantive due process right to choose to hasten death by any means and to have the state respect such a personal choice.[85] The Court rejected this assessment of *Cruzan*, clarifying again that a right to refuse treatment is not a right to autonomous decision making, but rather a right to avoid a medical battery arising out of a tradition evident in state medical consent laws.[86] The Court wrote:

> The right assumed in *Cruzan* . . . was not simply deduced from abstract concepts of personal autonomy. Given the common-law rule that forced medication was a battery, and the long legal tradition protecting the decision to refuse unwanted medical treatment, our assumption was entirely consistent with this Nation's history and constitutional traditions.[87]

The Court similarly rejected the claim that the Due Process Clause protects a liberty interest in making "intimate and personal

81. *Id.* at 277–78 (quoting Twin City Bank v. Nebeker, 167 U.S. 196, 202 (1897)).

82. Washington v. Glucksberg, 521 U.S. 702, 725 (1997); *see also* Giordano v. Conn. Valley Hosp., 588 F. Supp. 2d 306, 318–20 (D. Conn. 2008) (analyzing the right to refuse treatment referenced in *Cruzan* in light of the later *Glucksberg* decision).

83. *Glucksberg*, 521 U.S. at 725–32.

84. *Id.* at 722–25.

85. *Id.*

86. *Id.*

87. *Id.*

choices" without undue state influence, which would encompass a right to choose to participate in physician-assisted suicide.[88] In doing so, the Court wrote: "That many of the rights and liberties protected by the Due Process Clause sound in personal autonomy does not warrant the sweeping conclusion that any and all important, intimate, and personal decisions are so protected."[89] This was a justification for why the Constitution has been read to protect the personal choice of a woman to have an abortion, but not the personal choice of a terminally ill individual to participate in physician-assisted suicide.[90] Yet the case reveals that autonomy for the sake of protecting against invasions of one's body is constitutionally different from other applications of autonomy, and this helps to explain further how the Due Process Clause can require states to respect an individual's refusal of a bodily intrusion associated with a proposed medical treatment without necessarily requiring states to facilitate autonomous medical decision making.

Glucksberg also reaffirms that substantive due process rights must be interpreted very narrowly. It notes that, for fear of placing important matters "outside the arena of public debate and legislative action," the Court has "always been reluctant to expand the concept of substantive due process because guideposts for responsible decision making in this uncharted area are scarce and open-ended."[91] Accordingly, such constitutional protection is afforded only to fundamental rights and liberties that are "deeply rooted in this Nation's history and tradition."[92] Moreover, such history and tradition are used as parameters to craft a "careful description"[93] of any substantive due process rights recognized by the Court.[94] The Court used these principles to distinguish between the assumed right to avoid a medical battery and the claimed right to choose to participate in physician-assisted suicide, finding that the former has a long history in state laws requiring consent to

88. *Id.* at 726–27.

89. *Id.* at 727.

90. *Id.* at 727–28.

91. *Id.* at 720 (quoting Collins v. City of Harker Heights, 503 U.S. 115, 125 (1992)) (internal quotation marks omitted).

92. *Id.* at 721 (quoting Moore v. City of E. Cleveland, 431 U.S. 494, 503 (1977)) (internal quotation marks omitted).

93. *Id.* at 721 (quoting Reno v. Flores, 507 U.S. 292, 302 (1993)) (internal quotation marks omitted).

94. In *Lawrence v. Texas*, 539 U.S. 558 (2003), which was decided after *Glucksberg*, the Supreme Court appeared to reestablish a more expansive test for identifying substantive liberty interests than the history-and-traditions test from *Glucksberg*. *Id.* at 571–73; *see also* Steven G. Calabresi, *Substantive Due Process After* Gonzales v. Carhart, 106 MICH. L. REV. 1517, 1525 (2008) (noting *Lawrence*'s "sweeping but almost incomprehensible language" that expands substantive liberty interests). Since *Lawrence*, however, the Court revived the *Glucksberg* test in what has been described as "a pro-judicial restraint, anti-substantive due process decision." *Id.* at 1520.

medical treatment while the latter is contradicted by the historical bans states have placed on suicide and assisted suicide.[95]

These rules of construction in substantive due process jurisprudence indicate that the Court would not hold that a right to the disclosure of all material treatment information necessarily arises from a right to refuse treatment. Instead, the Court would more likely construe narrowly the assumed right in *Cruzan* as a right to have the state respect a decision to refuse treatment, rejecting a broader interpretation of that right as a right of autonomy in medical decision making. Further, the Court would likely find that such an interpretation of the right to refuse treatment is supported in the nation's legal history, which reveals that states required consent to treatment well before requiring the disclosure of treatment information in support of any request for consent,[96] and that a consent to the bodily invasion associated with a treatment is not negated by a lack of material treatment information under almost any state's law.[97]

The Supreme Court's abortion jurisprudence is also instructive because it indicates the degree to which the Court interprets the Due Process Clause to protect a right to informed medical decision making. In *Rust v. Sullivan*[98] and *Planned Parenthood of Southeastern Pennsylvania v. Casey*,[99] the Court addressed the constitutionality of governmental manipulation of abortion information disclosed by physicians to pregnant women. Read together, these cases suggest that substantive due process protects individuals from fraud and coercion in medical decision making, but does not obligate states to ensure that medical decisions are well informed.

In *Rust*, the Court reviewed federal regulations that, among other things, prohibited physicians who care for indigent, nonpregnant, or recently pregnant women through a federally funded family planning program from either counseling their patients about abortion or referring them for abortion.[100] One issue was whether those regulatory prohibitions on the disclosure of abortion as a treatment option deprived women served by the program of a substantive due process right to make informed medical decisions free of governmental intrusions.[101] If a woman served by the program asked her physician about abortion or sought an abortion referral, the regulations permitted her physician to

95. *Glucksberg*, 521 U.S. at 710–19, 724–26.
96. *See* FADEN ET AL., *supra* note 61, at 76.
97. *See supra* notes 600–68 and accompanying text.
98. 500 U.S. 173 (1991).
99. 505 U.S. 833 (1992).
100. *Rust*, 500 U.S. at 179.
101. *Id.* at 202. Because the challenge was aimed at federal regulations, the substantive due process claim in this case was based on the Due Process Clause of the Federal Constitution's Fifth Amendment.

respond that "the project does not consider abortion an appropriate method of family planning and therefore does not counsel or refer for abortions."[102] The Court upheld the federal regulations on the grounds that they were part of a program subsidizing medical care which the government was under no constitutional obligation to enact, and which did not deprive women served by the program of their freedom to seek care outside of the program.[103] In so holding, the Court reasoned that while the U.S. Constitution prohibits the federal government from depriving individuals of protected substantive due process rights, it does not obligate them to subsidize the exercise of those rights.[104] Accordingly, the government was found to have no constitutional obligation to ensure that women served by the federally funded program were provided with all information necessary for informed medical decision making.[105]

Unlike *Rust*, which addressed the constitutionality of a prohibition on disclosing certain material treatment information, *Casey* concerned the constitutionality of a statute requiring the disclosure of information from doctor to patient. In *Casey*, several abortion clinics and one physician challenged the constitutionality of provisions of Pennsylvania's Abortion Control Act, one of which concerned the disclosure of medical information during the informed consent process.[106] In the case of a patient considering an abortion, the law required that, in addition to disclosing material treatment information related to risks and alternatives, a physician must disclose to her patient the probable gestational age of the patient's fetus and the risks associated with carrying her fetus to term.[107] It also required that the physician offer to provide the patient with additional printed materials published by the state; inform the patient that monetary assistance might be available to pay for prenatal care, childbirth, and neonatal care; and inform the patient that the biological father is liable for child support.[108] The petitioners claimed that these requirements violated a woman's substantive due process right to choose to receive an abortion.[109]

102. *Id.* at 180 (quoting 42 C.F.R. § 59.8(b)(5) (1989)) (internal quotation marks omitted).

103. *Id.* at 202.

104. *Id.* at 201.

105. *Rust* is a widely criticized opinion. *See* Robert C. Post, *Subsidized Speech*, 106 YALE L.J. 151, 168 (1996) (documenting the degree of political and academic criticism of the opinion).

106. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 844–45 (1992).

107. *Id.* at 881.

108. *Id.* at 966–67 (Rehnquist, C.J., concurring in part and dissenting in part).

109. *Id.* at 881–87 (majority opinion). The petitioners also argued that the disclosure provisions deprived a woman of her right to privacy in her relationship with her treating physician. *Id.* at 883. The Court rejected this argument, reasoning that the doctor-patient relationship in this context does not have a constitutional status independent of the woman's right to choose to

The Court upheld the disclosure provisions, and, in the process, employed a new standard: a law violates a woman's right to choose to have an abortion when it imposes an "undue burden" on that right.[110] The Court clarified that an undue burden exists if the law's "purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability."[111] Applying this standard, the Court found that the required disclosures did not unduly burden a woman's right to choose to have an abortion because the information was relevant, truthful, and not misleading.[112]

While it is difficult to draw hard conclusions from *Rust* and *Casey* about whether or not the Supreme Court would find a substantive due process right to the disclosure of material treatment information, the cases offer some interesting insights. First, they suggest that the Constitution does not prohibit governments from regulating the disclosure of information in the informed consent process, whether in the form of prohibiting the disclosure of material information or requiring the disclosure of particular information.[113] Second, they indicate that the Constitution probably does not require states to ensure that patients are provided with treatment information—so long as individuals have a means to access that information—even if it is a more burdensome means of access as compared to being provided the information.[114] Finally, they imply that the constitutionality of a state's disclosure law is determined based on whether the law places a substantial obstacle in the path of a patient's exercising her right to consent to or refuse offered treatment, and, in the context of disclosure practices, that the analysis would likely turn on whether those practices would result in treatment decisions based on fraud or coercion.[115]

The foregoing analysis of *Cruzan*, *Glucksberg*, *Rust*, and *Casey* suggests that *White*'s claimed right to treatment information reasonably necessary for informed decision making suffers from several doctrinal flaws. First, and most fundamentally, it fails to recognize that the right to refuse treatment information is more modest than a right to autonomous medical decision making and protects only against a battery. Second, while a right to avoid an

have an abortion. Instead, whatever constitutional protection the doctor-patient relationship is entitled to is merely "derivative" of the woman's right. Accordingly, the Court found that that relationship "does not underlie or override the two more general rights under which the abortion right is justified: the right to make family decisions and the right to physical autonomy." *Id.* at 884.

110. *Id.* at 874.
111. *Id.* at 878.
112. *Id.* at 881–87.
113. *See supra* notes 105, 112 and accompanying text.
114. *See supra* notes 102–05, 110–12 and accompanying text.
115. *See supra* notes 105, 112 and accompanying text.

unwanted medical intrusion of the body likely implies a right to be apprised of the invasive nature of the treatment, it does not necessarily give rise to a right to know all material information about the treatment. Information about a patient's medical condition, her prognosis with and without treatment, the risks of a proposed treatment, and the risks of alternatives to the proposed treatment are all valuable to autonomous medical decision making. The traditions and practices of state informed consent law, however, do not establish that the absence of such information invalidates an individual's consent to the invasion accompanied by treatment. In fact, quite the opposite is true.[116] Accordingly, it is very difficult to justify constitutional protection for a right to know all material treatment information based on a fundamental right to refuse a medical invasion of the body, and it is equally difficult to argue that the lack of such information places an undue burden on the right to refuse such a bodily invasion. Third, even a constitutional right to know the invasive nature of a proposed treatment does not translate into a right to have a health care provider volunteer that information. Instead, it is more likely a right to receive truthful and nonmisleading answers to questions about the invasive nature of the treatment. Certainly, it might be easier and more befitting of a patient's lack of medical expertise for a state's laws to require that physicians provide such information without being asked. Placing the burden on a patient to inquire about the invasiveness of a proposed treatment, however, is not likely to be deemed "undue" because it provides a reasonable means of access to the information and therefore does not place a substantial obstacle in the path of a patient seeking to exercise her right to the information or her right to refuse the bodily intrusion of a proposed treatment.

C. Alternatives for Recognizing a Prisoner's Right To Receive the Disclosure of Material Treatment Information

It is important to protect prisoners' interests in receiving the disclosure of material treatment information as part of the informed consent process for any medical care they receive while incarcerated. Indeed, the importance of this interest may have been what motivated the Third Circuit's effort in *White* to derive a right to such disclosure from the right to be free of unwanted bodily invasions under the Fourteenth Amendment.[117] Yet, as described above, *White* is doctrinally flawed and therefore constitutionally suspect.[118] Accordingly, the interest of prisoners in receiving sufficient information to make informed treatment decisions is in jeopardy unless one or more alternatives exist for prisoners to enforce a right to the disclosure of material treatment information. This Subpart

116. *See supra* notes 60–68 and accompanying text.
117. *See supra* notes 28–31 and accompanying text.
118. *See supra* notes 57–59 and accompanying text.

identifies some possible alternatives. While it is beyond the scope of this Article to analyze each alternative in detail, this Subpart describes a sufficient number of alternatives to establish that the right described in *White* is not necessary in the effort to protect a prisoner's informed consent rights.

One such alternative might be a 42 U.S.C. § 1983 claim enforcing the state's obligation to provide for the medical care of those it holds in custody. This duty was articulated by the United States Supreme Court in *Estelle v. Gamble*, which held that "deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain' . . . proscribed by the Eighth Amendment."[119] The same duty has been found to arise out of the Fourteenth Amendment for individuals held in state custody but not incarcerated.[120]

The logic underlying the constitutional obligation of states to provide for the medical needs of those they hold in custody is based on the reality that those held in custody are unable to provide for their own needs, including their own medical needs. As one commentator put it:

> At the most simple level, an inmate cannot self-treat by calling in sick, changing a diet, or purchasing and using simple remedies such as aspirin, cold pills, laxatives, or bandages. More significantly, the inmate cannot choose a doctor or form of treatment. Because inmates cannot go to the emergency room of a local hospital, inmates will have medical needs that must be met on an emergency basis and around the clock. Prohibitions on the individual possession of drugs or medical devices, in addition to other security restrictions regulating medical care, result in the need for constant medical care.[121]

Case law has not adequately addressed whether a failure to disclose material treatment information is actionable as a violation of the Eighth Amendment duty requiring the state to provide for the medical needs of those it holds in custody.[122] Yet the condition of

119. Estelle v. Gamble, 429 U.S. 97, 104 (1976) (quoting Gregg v. Georgia, 428 U.S. 153, 173 (1976)).

120. *See* Bell v. Wolfish, 441 U.S. 520, 535–37 (1979) (holding that the government may not hold a pretrial detainee in conditions that violate the Fourteenth Amendment's Due Process Clause).

121. MICHAEL B. MUSHLIN, RIGHTS OF PRISONERS § 3:1, at 355–56 (3d ed. 2002) (footnotes omitted).

122. While no cases directly address this question, a few touch on it indirectly, sending mixed signals as to the viability of an Eighth Amendment claim. For example, in *Riddick v. Modeny*, 250 F. App'x 482 (3d Cir. 2007), a prisoner complained that prison doctors failed to provide him with medication he requested and instead prescribed a different medication that burned the prisoner's skin. *Id.* at 482–84. The prisoner claimed a violation of the Eighth Amendment duty to address the prisoner's medical needs, alleging that the doctors violated the duty by (1) failing to provide the requested medication, (2)

dependence that justifies the obligation of the state to provide treatment appears broad enough to encompass such a disclosure duty owed by a state to prisoners. In addition to lacking the expertise to know the risks of, and alternatives to, a treatment, prisoners also lack the ability to obtain such information easily on their own through research or by asking for information from other patients or other health care professionals. Just as the state is the prisoner's only source for medical care, it is also the prisoner's source for information about proposed medical care.

To avoid the primary weakness of the right as conceived under *White*, the right should be re-articulated as the right to receive the disclosure of material treatment information as founded on the Eighth and Fourteenth Amendment obligation of the state to provide medical care to those held in custody. It need not be derived from a right to be free of unwanted bodily invasions. Instead, it allows for a court to reason from a preexisting duty to provide medical care. Another advantage of basing the right on the state's obligation to provide for the medical needs of those it holds in custody is that the right is more clearly limited to cases involving prisoners and others held in state custody.

While a prisoner's right to the disclosure of material treatment information seems to find support in the Eighth Amendment duty of the state to attend to the medical needs of those it holds in custody, the claim remains untested. Nonetheless, options remain for prisoners seeking to enforce such a disclosure right. For example,

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delaying the time of treatment by a couple of days, and (3) failing to warn him of the risk of burns associated with the medication the doctor prescribed. *Id.* at 483. The Third Circuit upheld a lower court's dismissal of the prisoner's complaint for failure to state a cognizable claim. *Id.* The court reasoned that the doctors could not be found deliberately indifferent to the prisoner's medical needs even though they may have been negligent in their choice of medication, noting that the Eighth Amendment duty should not be used to address acts of medical malpractice. *Id.* at 483–84. Although *Riddick* does not specifically address the failure-to-warn claim, it could be interpreted to implicitly reject such a claim if one were to interpret a failure to warn as an act of professional negligence. On the other hand, the Second Circuit, in *Hathaway v. Coughlin*, 37 F.3d 63 (2d Cir. 1994), held that a viable Eighth Amendment claim was stated by a prisoner claiming that adequate treatment of his hip pain was delayed for such a long period of time after the defendant doctor knew, but did not disclose, that the pain could have been caused by broken pins inserted in an earlier surgery as to amount to deliberate indifference to the prisoner's medical needs. *Id.* at 67–69. In holding that a reasonable juror could find that the physician was deliberately indifferent, the court specifically relied on the physician's failure to disclose to the prisoner the potential cause of his hip pain. *Id.* at 69. Additionally, two other cases dismissed Eighth Amendment claims by prisoners that were based on a failure to disclose material treatment information, but the dismissals were based on a failure to establish any injury rather than a noncognizable duty to disclose such information under the Eighth Amendment. *See* Ieng v. Fleck, No. 98-36228, 2000 WL 1593397, at *3 (9th Cir. Oct. 25, 2000); Abdush-Shahid v. Coughlin, 933 F. Supp. 168, 182 (N.D.N.Y. 1996).

prisoners may have a cause of action based on state law claims for medical malpractice and negligence.[123] Additionally, a prisoner may claim a violation of a state statute, regulation, or policy that requires prisons to provide adequate medical care to prisoners.[124] Prisoners may also bring claims under the Federal Torts Claims Act.[125]

Given these possible alternatives, the right announced in *White* is unnecessary. As explained in the next Part, an added benefit of relying on those alternatives and overturning the substantive due process right announced in *White* is that it avoids the threat that *White* and its progeny pose to state informed consent law.

III. IMPLICATIONS OF A CONSTITUTIONAL RIGHT TO TREATMENT INFORMATION FOR STATE LAW

The substantive due process right to receive treatment information recognized in *White* overlaps significantly with the typical right to receive treatment information enforced through

123. *See, e.g.*, Johnson v. Richland Corr. Inst., No. 2002-09081, 2003 WL 21739049, at *1 (Ohio Ct. Cl. July 10, 2003) (prisoner brought suit against correctional facility for personal injuries arising from medical malpractice); Moore v. State, No. W2008-02699-COA-R3-CV, 2009 WL 4932203, at *1 (Tenn. Ct. App. Dec. 23, 2009) (prisoner brought medical malpractice and negligence actions against a physician's assistant employed by the State who refused to recommend surgery for the degenerative arthritis in the prisoner's hip); Pontbriand v. Bascomb, No. 2009-042, 2009 WL 2477608, at *7 (Vt. July 2009) (prisoner brought medical malpractice claim against health care contractor retained by Department of Corrections claiming that contractor's response to prisoner's heart attack was negligent).

124. *See, e.g.*, ME. REV. STAT. ANN. tit. 30-A, § 1561 (1996) ("Any person incarcerated in a county jail has a right to adequate professional medical care."); Watson v. State, 26 Cal. Rptr. 2d 262, 263 (Ct. App. 1993) (prisoner brought an action against the State and the county based on their alleged failure to summon and provide medical care after he injured himself at a county jail and was transferred to state prison as required by California Government Code § 845.6); Rasmussen v. Skagit County, 448 F. Supp. 2d 1203, 1206 (W.D. Wash. 2006).

125. *See, e.g.*, Chapman v. United States, No. 08-11212, 2009 WL 4039658, at *1 (5th Cir. Nov. 23, 2009) (federal prisoner filed claim under Federal Tort Claims Act alleging that the Federal Bureau of Prisons negligently failed to obtain written consent for his leg amputation); Camp v. United States, No. CV207-149, 2009 WL 1154112, at *1 (S.D. Ga. Apr. 28, 2009) (finding that a prisoner sufficiently stated a medical malpractice claim against the government under the Federal Tort Claims Act).

Despite these different causes of action, prisoners often do not bring these claims for a number of reasons, including sovereign immunity, civil disability statutes, and budgetary limitations. *See* MUSHLIN, *supra* note 121, § 3:1, at 360. Moreover, prisoners must exhaust remedies available through a prison's internal grievance system before they can sustain court claims. *See* 42 U.S.C. § 1997e(a) (2006) ("No action shall be brought with respect to prison conditions under section 1983 of this title, or any other Federal law, by a prisoner confined in any jail, prison, or other correctional facility until such administrative remedies as are available are exhausted.").

states' informed consent liability standards. Consequently, the right will substantially affect state informed consent law, at least whenever state action is present. This is because the right sets a constitutional floor for disclosure that is in close proximity to prevailing state liability standards, and it does so on the basis of a right to refuse treatment, which is shared by all individuals. Thus, unless the right's applicability is limited to circumstances in which the patient is held in government custody, it threatens to alter state liability standards, inject the politics of substantive due process into the interpretation of state informed consent law, and undermine the prerogative of each state to regulate the medical profession as it sees fit.

This Part begins with a brief explanation of why the state action doctrine will not prevent the application of the constitutional right recognized in *White* and later cases in informed consent claims outside of the prison context where disclosure standards under state law normally control.

A. State Action as an Incomplete Barrier to the Application of White *in State Informed Consent Cases*

To appreciate how the constitutional right recognized in *White* and its progeny might threaten state informed consent law, it is necessary to understand that the state action doctrine cannot provide a reliable barrier between that constitutional right and states' informed consent disclosure standards. First, state actors are defendants in many informed consent cases. While medical care and informed consent most often take place in the context of a private treatment relationship, care is often provided by a physician acting on behalf of the government. Examples include care provided by a health care professional employed by the Veterans Administration, the Public Health Service, an Indian Health Service Hospital, or a state or local public hospital.[126] A nonscientific review of all informed consent opinions published in 2008 and 2009 suggests that about twelve percent of cases decided in those years involved a state actor as a defendant.[127]

126. *See, e.g.*, Frantz v. United States, 29 F.3d 222, 223 (5th Cir. 1994) (claim for treatment at Veterans Administration hospital); Borosavage v. United States, 667 F. Supp. 2d 208, 210 (D. Mass. 2009) (claims against Veterans Administration hospital physician); Santistevan v. United States, 610 F. Supp. 2d 1036, 1038–39 (D.S.D. 2009) (claim against physician employed by a Federal Indian Health Services Hospital); Leab v. Chambersburg Hosp., 230 F.R.D 395, 396 (M.D. Pa. 2005) (claim against employee of the Federal Public Health Service); Velazquez *ex rel.* Segarra v. City of N.Y. Health and Hosps. Corp., 894 N.Y.S.2d 15 (App. Div. 2010) (action brought against public hospital in New York City).

127. I entered this search-string into Westlaw's "allcases" database: HE ("informed consent" /p (physician doctor medic!)) and DA (2009 2008). One hundred and nineteen opinions were returned, and, of those, fifteen involved a

Second, state action might be satisfied even in the case of private providers when care takes place in a jurisdiction with a significant statutory or regulatory structure concerning informed consent. Texas and Louisiana provide extreme examples; no state governments are more entangled in the informed consent process between doctors and patients.

A Texas statute creates a state-sponsored "medical disclosure panel" ("Panel") whose job it is to review all medical procedures and sort them into one of two official lists: those for which risks must be disclosed (known as "List A" procedures) and those for which no risk disclosure is required (known as "List B" procedures).[128] For List A procedures, the Panel also identifies and publishes the risks that must be disclosed.[129] A physician proposing that a patient consent to a List A procedure is obligated to disclose the risks identified by the Panel and only those risks, and the physician can disclose those risks by merely handing to the patient the risk disclosures created by the Panel.[130] By providing those disclosures and obtaining the patient's consent in writing, a physician triggers a presumption that she has fulfilled her disclosure duty,[131] which can only be rebutted by a showing of fraud or incapacity of the patient.[132] Likewise, a physician who does not disclose treatment risks of a List B procedure is entitled to a rebuttable presumption that she has fulfilled her disclosure duty.[133]

A very similar system exists in Louisiana except that the Secretary of the Louisiana Department of Health and Hospitals is responsible for creating the lists of disclosures, rather than a specially created disclosure panel.[134] As in Texas, the lists of

state actor as a defendant.

128. *See* TEX. CIV. PRAC. & REM. CODE ANN. § 74.103(a)–(b) (West 2005).

129. *See id.* § 74.103(b)–(c).

130. *See* Earle v. Ratliff, 998 S.W.2d 882, 891–92 (Tex. 1999) (holding that a physician who discloses all of the risks identified by the Medical Disclosure Panel for a List A procedure cannot be found negligent for failing to disclose other risks of the procedure).

131. *See* § 74.106(a)(1).

132. *See, e.g.*, *Earle*, 998 S.W.2d at 891–92.

133. *See* § 74.106(a)(1). Because the issue has not been addressed by a Texas court, it is unclear how such a presumption could be rebutted. Given that the risks listed for a List A procedure are the only risks that a physician is obligated to disclose, which leaves a plaintiff with only the strategy of attacking the validity of the consent, it seems likely that a court would not permit a plaintiff to rebut the presumption that the physician was not obligated to disclose any treatment risks for a List B procedure with evidence of the treatment risks associated with that procedure—again leaving the plaintiff with only the strategy of rebutting the consent. In short, the presumption appears to be conclusive with respect to fulfillment of the duty to disclose.

134. *See* LA. REV. STAT. ANN. § 40:1299.40 (2008). Although the Louisiana Secretary of Health and Hospitals has responsibility for the system today, Louisiana originally relied on a medical disclosure panel when it began to codify informed consent risk disclosure. A 2008 state law reassigned the

disclosures are published in the state administrative code.[135] Unlike the Texas statute, Louisiana's informed consent statute does not require that physicians disclose at least those risks identified by this administrative process. Rather, it permits physicians to identify and provide the appropriate disclosures on their own or to use the disclosures identified and published by the Secretary.[136] Yet, the statute provides a powerful incentive to rely on the state-created disclosure lists. A physician who provides a patient with the disclosures identified by the Louisiana Secretary of Health and Hospitals for the treatment at issue is entitled to a rebuttable presumption that she has satisfied her legal duty to provide material treatment information to the patient prior to seeking consent to treatment.[137]

Based on these regulatory structures, a compelling argument can be made that state action exists in most informed consent cases in Texas and Louisiana. According to United States Supreme Court precedent, state action exists when "there is such a 'close nexus between the State and the challenged action' that seemingly private behavior 'may be fairly treated as that of the State itself.'"[138] This includes circumstances in which private actors pursue state-sanctioned private remedies using "state procedures with the overt, significant assistance of state officials."[139] So, for example, the Supreme Court has held that state action exists when a state court named a private executor over a private estate according to state probate procedures.[140] Likewise, the Supreme Court has also found state action when a state court clerk, pursuant to a state statute, issued a writ of attachment in a private debt collection action, and the writ was executed by a sheriff.[141]

Using these standards, a plaintiff in an informed consent case could credibly argue that state action exists when her private physician relied on the work of the disclosure panel (in Texas) or the Secretary of Health and Hospitals (in Louisiana) to satisfy her disclosure obligations to the plaintiff. Imagine, for example, that private physicians, relying on the presumptions of nonliability promised under both states' laws, disclosed the risks of proposed treatments to patients by handing over the lists of risks created by an administrative agency. In each case, the physician uses a state-created procedure to gain a presumption of nonliability, and they do

responsibilities of the panel to the Secretary of Health and Hospitals. *See* Historical and Statutory Notes to § 40:1299.40.

135. *See* LA. ADMIN. CODE tit. 48, §§ 2301–2463 (2010).

136. *See* § 40:1299.40.E(2)(b).

137. *See* § 40:1299.40.E(7)(a)(i).

138. Brentwood Acad. v. Tenn. Secondary Sch. Athletic Ass'n, 531 U.S. 288, 295 (2001) (quoting Jackson v. Metro. Edison Co., 419 U.S. 345, 351 (1974)).

139. Tulsa Prof'l Collection Servs. v. Pope, 485 U.S. 478, 486 (1988).

140. *Id.* at 487.

141. *See* Lugar v. Edmondson Oil Co., 457 U.S. 922, 924–25, 942 (1982).

so with the assistance of the work product of a state agency. Moreover, the assistance to those physicians by Texas or Louisiana is significant because the State has determined for each physician what, if any, treatment information to disclose. Outside of Texas or Louisiana, those determinations are made by private physicians without aid from the State.

While Texas and Louisiana are unique in their administrative determinations of informed consent disclosures, states often employ the more common procedure of requiring public review panels to certify the authenticity of private malpractice claims (including informed consent claims) before they may be filed in court.[142] Still other states make a review by such a public panel available at the discretion of a state court judge or upon the request of either party to a malpractice claim, and some of those states make the panel's findings admissible in court as presumptive evidence of negligence or non-negligence.[143] Again, these procedures give rise to a credible claim of state action. In each instance, a private party is making use of state procedures for the resolution of a private dispute with the overt and significant assistance of a state-created panel.

Because informed consent cases regularly arise involving a state actor outside of the prison context, and because agencies in many states are directly involved in the regulation or resolution of informed consent claims, we should expect that the substantive due process right to the disclosure of material treatment information as articulated in *White* will come into play.[144] It will be available in some cases to trump state disclosure standards, which, as described more fully below, could alter state law significantly. That would result in two different disclosure standards operating at once in a jurisdiction: one for cases involving state action and one for all other cases. Given the complexities of the state action doctrine, this would undoubtedly add significant confusion to a state's informed consent law and muddy any behavioral signal the law might otherwise send to health care professionals.

B. How White *and Its Progeny Might Invade State Informed Consent Law*

While informed consent law varies from state to state, there are several common attributes.[145] The doctrine imposes two duties on

142. *See, e.g.*, IND. CODE § 34-18-8-4(1) (1999); LA. REV. STAT. ANN. § 40:1299.47.B(1)(a)(i) (2008); NEB. REV. STAT. § 44-2840 (2004).

143. *See, e.g.*, DEL. CODE ANN. tit. 18, § 6812 (1999); FLA. STAT. § 766.106 (2009); KAN. STAT. ANN. § 65-4901 (2002); N.H. REV. STAT. ANN. § 519-B:8 (2005).

144. An interesting question is whether a constitutional standard for disclosure would influence state law even in the absence of state action. For example, a court might rely on the constitutional standard as persuasive authority for how to interpret state informed consent law in a dispute among private actors.

145. For in-depth analysis of the history, ethics, and law of informed

physicians: a duty to refrain from providing medical care to a patient without the patient's consent, and a duty to disclose material information about a proposed treatment to a patient prior to seeking the patient's consent.[146] An injurious breach of either duty gives rise to a cause of action, but the nature of the claim (and the remedy) depends on which duty is breached. Harm caused by a breach of the duty to refrain from treating a patient without her consent is remedied through a battery action, which recognizes the treatment itself as a compensable harm.[147] The duty does not apply in the case of an emergency in which consent to stabilizing treatment is presumed. Battery claims for medical treatment are rare; when filed, they typically allege that a physician exceeded the scope of the consent provided by the patient.[148]

Far more common are claims for the breach of the duty to disclose material information. Such a claim arises when a patient has consented to a treatment but alleges that her consent was insufficiently informed because of the physician's failure to disclose relevant information. Except in Pennsylvania, such claims are brought under a professional negligence theory.[149] While all states require the disclosure of material information, they employ different standards of materiality. Nearly half of all states use the reasonable person standard,[150] which defines material information as that which a reasonable person would consider relevant to the treatment decision at issue.[151] The other states use the prudent physician standard, which defines material information as that which a reasonably prudent physician in the same or similar clinical circumstances would disclose.[152] There are several exceptions to the duty to disclose.[153] A physician is obligated to disclose neither

consent, see generally BERG ET AL., *supra* note 66; FADEN ET AL., *supra* note 61; and JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (1984).

146. BERG ET AL., *supra* note 66, at 12.

147. *Id.* at 132.

148. *Id.*

149. *See, e.g.*, Canterbury v. Spence, 464 F.2d 772, 778 (D.C. Cir. 1972). Fraud in obtaining a patient's consent to treatment is an exception. When proven, the fraud negates the patient's consent and gives rise to a battery claim. *See* BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 282–83 (6th ed. 2008). Pennsylvania law is unique. Rather than remedying negligent disclosure through a professional negligence claim and fraud in obtaining consent through a battery claim, it relies on a battery action for all claims related to informed consent, including negligent failure to disclose material information. *See* Isaac v. Jameson Mem'l Hosp., 932 A.2d 924, 929 (Pa. Super. Ct. 2007).

150. *See* Gatter, *supra* note 63, at 563.

151. *See, e.g.*, *Canterbury*, 464 F.2d at 786–87.

152. *See* FURROW ET AL., *supra* note 149, at 240 (citing examples and reporting that a "slight majority" of jurisdictions have adopted the professional disclosure standard).

153. *See* MARK A. HALL ET AL., HEALTH CARE LAW AND ETHICS 220 (7th ed. 2007).

treatment risks that are too remote when considered in light of the severity of harm, nor risks that are already known to the particular patient or to laypersons generally.[154] Nor must a physician disclose treatment information to a patient suffering from an emergency, or when the patient waives her right to such disclosures, or when the physician determines, based on "sound medical judgment that communication of the risk information would present a threat to the patient's well-being."[155]

Regardless of the standard for disclosure, all states require the plaintiff to establish "decision-causation," meaning that the failure to disclose information *caused* the treatment decision.[156] A few states permit a subjective standard for decision-causation, asking whether the plaintiff herself would have refused the treatment had the undisclosed information been revealed.[157] The vast majority of jurisdictions, however, reject the subjective standard out of concern that it would saddle fact finders with prejudicial testimony from sympathetic plaintiffs having the benefit of hindsight.[158] Instead, these jurisdictions employ an objective standard for decision-causation: whether a reasonable person, in the patient's position and armed with the undisclosed information, would have refused the treatment.[159] In addition to requiring proof of decision-causation, all states require that plaintiffs establish that the treatment resulted in a bad outcome attributable to the undisclosed information.[160] So, for example, a plaintiff claiming that her physician failed to disclose a material risk of infection associated with a procedure to which she consented must prove not only that a reasonable person in her position would not have consented to the procedure had the risk of infection been disclosed, but *also* that the risk actually materialized in her case causing her harm. Unlike battery claims for failure to refrain from treatment absent consent, negligence claims for failure to disclose material information do not recognize the treatment itself as a compensable harm. Instead, damages are limited to harm caused by the undisclosed risk that materialized in the patient's treatment.[161]

154. BERG ET AL., *supra* note 66, at 57.

155. *Canterbury*, 464 F.2d at 789.

156. *See id.* at 791; Margaret A. Berger & Aaron D. Twerski, *Uncertainty and Informed Choice: Unmasking* Daubert, 104 MICH. L. REV. 257, 270 & n.79, 271 (2005).

157. *See, e.g.*, 40 PA. CONS. STAT. ANN. § 1303.504(d)(1) (West 2010); Scott v. Bradford, 606 P.2d 554, 558–59 (Okla. 1979).

158. *See, e.g.*, *Scott*, 606 P.2d at 559.

159. *See, e.g.*, *Canterbury*, 464 F.2d at 791.

160. *See id.* at 790; Berger & Twerski, *supra* note 156, at 270–71.

161. *See* BERG ET AL., *supra* note 66, at 134, 141. The underlying logic is that a negligent failure to disclose material treatment information does not negate the consent provided by the patient, but it works as an estoppel against a physician's claim that the patient, through her consent to treatment, assumed responsibility for the undisclosed risk and the harm that resulted when that

While informed consent law is generally well settled in each state, controversies remain about how to interpret and apply the law. Additionally, there are important differences among the states, both as to the standards employed and how those standards are applied in a particular case. A constitutional "right to such information as is reasonably necessary to make an informed decision to accept or reject proposed treatment [including] a reasonable explanation of the viable alternative treatments"[162] has substantial implications for these controversies and differences.

Consider, for example, a garden-variety claim that a physician failed to disclose a treatment risk prior to the patient's consenting to and receiving the treatment. The process of determining whether the defendant-physician breached a duty to disclose material information by failing to disclose this risk information calls for several legal and factual judgments, which, if made in such a way as to deny recovery to the plaintiff-patient, could be challenged as violating the patient's substantive due process right to information "reasonably necessary" to an informed treatment decision, at least in cases in which state action exists. The first of these judgments requires (in jurisdictions applying the prudent physician standard of materiality) determining the "clinical circumstances" to assess what a reasonably prudent physician would disclose, or (in a jurisdiction applying the reasonable person standard of materiality) determining the "patient's position" to assess what a reasonable patient would consider significant to the treatment decision at hand.[163] Whether and to what extent "clinical circumstance" or "patient's position" include idiosyncratic attributes of the patient (e.g., her goals for treatment, her level of risk aversion, her religious beliefs, etc.) beyond her diagnosis and the treatment her physician has recommended significantly affects whether the undisclosed risk will be deemed "material" under state law and thus subject to disclosure.[164] The fewer idiosyncrasies accounted for in a state court decision, the more likely that the decision can be challenged as an unconstitutional deprivation of the right to information reasonably necessary to enable the patient to make an informed treatment decision. Then there is the determination of materiality itself. A state court verdict based on a determination that certain risk information was not material could be challenged as violative of the constitutional right to information reasonably necessary for an informed decision. State court decisions finding that risk

risk materialized in her case.

162. White v. Napoleon, 897 F.2d 103, 113 (3d Cir. 1990).

163. *See* Gatter, *supra* note 63, at 566 (arguing that the starting place in the application of either objective standard of materiality is to determine which subjective attributes of the patient must be accounted for in the objective test and which subjective attributes may be disregarded).

164. *See id.*

information need not be disclosed because the risk is "remote" or "common knowledge" among laypersons would be subject to similar challenge.[165]

If *White* is correct that a substantive due process right exists for individuals to receive information reasonably necessary to make informed treatment decisions, additional constitutional challenges could result concerning matters over which states are split. For example, states are split as to whether information concerning the treating physician (e.g., her level of experience with a particular procedure, her history of alcohol or drug abuse, or her financial conflicts of interest) constitutes material information that must be disclosed.[166] When state action exists, a ruling that such information is not material potentially violates a right to information reasonably necessary to informed treatment decisions. More fundamentally, states are split over whether to measure the sufficiency of disclosures from the perspective of a prudent physician (treating disclosures as a matter of medical expertise) or whether to do so from the perspective of a reasonable person (treating disclosures as a matter of personal values).[167] The use of the prudent physician standard could be challenged as violating a constitutional right to information reasonably necessary to informed decision making to the extent that it results in permitting fewer disclosures than would a standard that requires the fact finder to

165. The challenge would likely occur as part of an appeal of any case in which the plaintiff lost at trial. Whether targeting the state trial court's determination as a matter of law that a particular undisclosed risk was immaterial or too remote under the state's prevailing disclosure standard, or the state court's jury instructions concerning the standards for disclosure and remoteness, or the state court's reliance on a jury verdict to dispose of the case, the losing plaintiff would likely challenge the trial court's judgments as a deprivation of a substantive liberty interest without due process of law pursuant to the Fourteenth Amendment. Additionally, a losing plaintiff might challenge a state court decision on procedural due process grounds, arguing that state law is procedurally defective to the extent that it does not assess whether risk information found to be immaterial under state law is nonetheless "reasonably necessary" to an informed treatment decision pursuant to *White*. *See, e.g.*, Zinermon v. Burch, 494 U.S. 113, 132–35 (1990) (discussing the plaintiff's application of a state policy and procedure for involuntary commitment by staff members at a state mental hospital and determining that those procedures were inadequate to satisfy procedural due process rights under the Fourteenth Amendment).

166. *See, e.g.*, Albany Urology Clinic, P.C. v. Cleveland, 528 S.E.2d 777, 780 (Ga. 2000) (finding no obligation to disclose drug use under state informed consent law); Hidding v. Williams, 578 So. 2d 1192, 1196 (La. Ct. App. 1991) (holding that physician's failure to disclose chronic alcoholism violated state informed consent law); Duttry v. Patterson, 771 A.2d 1255, 1259 (Pa. 2001) (holding that state-mandated disclosure of physician's personal characteristics and experience is irrelevant to an informed consent claim); Johnson v. Kokemoor, 545 N.W.2d 495, 505 (Wis. 1996) (recognizing a duty to disclose lack of experience with a particular procedure).

167. *See supra* notes 151–53 and accompanying text.

assess the necessity of information from the perspective of laypersons who must ultimately make the treatment decisions.[168]

The foregoing describes how readily common state-law questions about the proper scope of disclosure requirements can become constitutional questions, at least when there is state action. The more this occurs, the larger questions of federalism will loom.

The more influential a federal constitutional standard becomes, the more we risk losing the heterogeneity of approaches to disclosure laws that we enjoy today.[169] To be clear, the diversity of approaches reflects more than just different ways to enforce the same norms; it also reflects normative differences.

Informed consent law is perceived to be at the heart of the doctor-patient relationship.[170] Accordingly, it reveals a normative view of that relationship, and its ongoing application to cases offers the opportunity to publicly reaffirm or amend that viewpoint. Thus, some states may take the view that the doctor-patient relationship is a fiduciary one and that this justifies a standard of disclosure obligating physicians to reveal not only material information about a treatment, but also material information about themselves to their patients.[171] Meanwhile, another state might conceive of the doctor-patient relationship as something akin to an arms-length relationship in a specialized market and that disclosure rules provide an incentive for physicians to at least warn patients of

168. Although the Court in *Canterbury* was not addressing a constitutional claim, it outlined the logic that might lead a court to conclude that a constitutional right to information reasonably necessary to informed decision making would require a disclosure standard that considers the value of information from the perspective of the layperson who has the right to make that decision:

> [T]he patient's right of self-decision shapes the boundaries of the duty to reveal. That right can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is the information material to the decision.

Canterbury v. Spence, 464 F.2d 772, 786 (D.C. Cir. 1972) (footnote omitted).

169. *See generally* Elaine W. Shoben, *Uncommon Law and the Bill of Rights: The Woes of Constitutionalizing State Common-Law Torts*, 1992 U. ILL. L. REV. 173.

170. *See* Robert Gatter, *The Mysterious Survival of the Policy Against Informed Consent Liability for Hospitals*, 81 NOTRE DAME L. REV. 1203, 1264–66 (2006) (arguing that the reason courts resist imposing informed consent liability on hospitals is because of an unarticulated sense that to do so would disrupt a delicate and intimate moment that sustains trust in the doctor-patient relationship).

171. *See* Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 487–90 (2002) (arguing that informed consent law is a quintessential example of a syllogistic stance with respect to health law and trust, and that because the doctor-patient relationship is, or should be, a relationship of trust, physicians have a fiduciary obligation to disclose information and seek consent prior to treatment).

potential hazards in proposed treatments and options for avoiding those hazards. As a result, the disclosure rules in that state might not be interpreted to require the disclosure of information about the physician. A substantive due process right to the disclosure of material treatment information could significantly diminish the opportunity to articulate and reassess the normative viewpoints that underlie informed consent law. Yet the normative differences revealed in state law today would not disappear as a result. Rather, the differences would exist, but informed consent law would be less likely to reflect those differences, which could have a destabilizing effect on informed consent law.

This is consistent with current conceptions of health law generally. A persistent theme among those who seek cohesive principles for health law is that such principles may be out of reach unless normative clashes are better articulated and resolved, at least within the particular topical spheres where health law operates.[172] If accurate, this description of the state of health law as a coherent field counsels in favor of allowing states to conduct the interpretive work on disclosure rules as much as possible.

The issue goes beyond concerns about federalizing disclosure law and includes concerns implicated by "constitutionalizing" disclosure law through substantive due process. Recognizing an individual's interest in receiving all information reasonably necessary to informed medical decision making as a fundamental liberty interest would not only push debate about the normative underpinnings of disclosure laws out of public arenas (other than federal courts), but would also redefine those debates in terms of liberty and self-determination. Other normative issues that combine with the value of respect for individual liberty in developing a disclosure rule for liability purposes would be largely stripped away. These include the assignment of responsibility for risks of treatment between doctor and patient; fair compensation to those injured as a result of professional negligence; protection of physicians from liability based on a bad outcome rather than professional negligence; and, as described above, promotion of a shared normative view of the doctor-patient relationship.[173] Rulemaking that fails to account adequately for all of these issues may result in rules that are impractical or that lack public support

172. *See, e.g.*, M. Gregg Bloche, *The Invention of Health Law*, 91 CAL. L. REV. 247 (2003); William M. Sage, *Relational Duties, Regulatory Duties, and the Widening Gap Between Individual Health Law and Collective Health Policy*, 96 GEO. L.J. 497 (2008).

173. *See* Alexander Morgan Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 365–76 (1974) (describing the several functions of informed consent law as including protecting patient autonomy, encouraging reflection by physicians and rationality by patients in medical decision making, and involving the public generally in medicine).

because they express a norm of self-determination at the expense of other concerns with which rules of liability must contend.

Additionally, the more state informed consent law becomes subject to the information disclosure rule under *White*, the more it becomes subject to the unique politics of substantive due process jurisprudence. Whether the guarantee of due process in the Federal Constitution gives rise to any substantive rights and, if so, *what* rights, is deeply controversial and closely linked to the politics of judicial activism, separation of powers, and federalism.[174] Moreover, substantive due process is tied inexorably to the hot-button topics of privacy, abortion, physician-assisted suicide, refusing life-sustaining medical care, and homosexuality.[175] This, in turn, has implications for how disputes are resolved through substantive due process. Thus, when the Supreme Court holds that the Federal Constitution does not protect a liberty interest in physician-assisted suicide, it must carefully distinguish an interest in assisted suicide from an interest in avoiding a medical battery.[176] Similarly, the Court must distinguish between concepts of autonomy, which were referenced in opinions protecting against unduly burdensome abortion restrictions (and yet given no weight in an opinion on physician-assisted suicide), and concepts of tradition and liberty that justify a right to refuse unwanted life-sustaining treatments.[177] Moreover, this explains why activists for reproductive rights find it necessary to support a constitutional challenge to state prohibitions on physician-assisted suicide.[178] Accordingly, one risk of the substantive due

174. *See* ROBERT H. BORK, THE TEMPTING OF AMERICA: THE POLITICAL SEDUCTION OF THE LAW 31 (1990) (describing substantive due process as a "sham"); Randy E. Barnett, *Scrutiny Land*, 106 MICH. L. REV. 1479, 1480 (2008) (addressing the problems of judicial activism associated with various standards for identifying substantive rights protected under the Due Process Clause); James W. Ely, Jr., *The Oxymoron Reconsidered: Myth and Reality in the Origins of Substantive Due Process*, 16 CONST. COMMENT. 315, 315 (1999) (stating that substantive due process is a politically contentious doctrine); Patrick M. Garry, *A Different Model for the Right to Privacy: The Political Question Doctrine as a Substitute for Substantive Due Process*, 61 U. MIAMI L. REV. 169, 201 (2006); Rosalie Berger Levinson, *Reining in Abuses of Executive Power Through Substantive Due Process*, 60 FLA. L. REV. 519, 521 (2008) (describing substantive due process as "one of the most . . . controversial areas of constitutional law" because of its protection of "contentious non-textual rights" and the issues it raises "regarding the proper role of the judiciary in reviewing the actions of the other branches of government").

175. *See* Susan Frelich Appleton, *Assisted Suicide and Reproductive Freedom: Exploring Some Connections*, 76 WASH. U. L.Q. 15, 16–17 (1998) (recognizing the political and potential legal links between rights to physician-assisted suicide and abortion); Yale Kamisar, *Can* Glucksberg *Survive* Lawrence*? Another Look at the End of Life and Personal Autonomy*, 106 MICH. L. REV. 1453, 1456–57 (2008) (recognizing the link between substantive due process, privacy, and sexuality); Levinson, *supra* note 174, at 523.

176. *See supra* notes 82–89 and accompanying text.

177. *See supra* notes 87, 89 and accompanying text.

178. *See* Appleton, *supra* note 175, at 15.

process right articulated in *White* is that the shadow issues of judicial activism, privacy, and abortion will predominate its application to state informed consent law, confusing other important political considerations or even crowding them out completely.

Thus, there is cause for concern that a substantive due process right to material treatment information as articulated in *White* will invade, distort, and destabilize disclosure rules in state informed consent law. This, in turn, leads to the conclusion that a narrow interpretation of the right to refuse treatment and any derivative right to information is the better interpretation, and not just the more doctrinally sound interpretation. It also provides an additional reason to protect the interest of prisoners to receive material treatment information through some mechanism other than the right articulated in *White*.[179]

C. White *Is Not Necessary To Correct the Most Inadequate State Disclosure Standards*

Of course, some states have grossly inadequate disclosure standards, including Georgia, Pennsylvania, and Texas.[180] Remedying those inadequacies is the best argument for a broadly applicable constitutional right to the disclosure of material treatment information as articulated in *White*. Yet, as discussed below, it is not a sufficient argument because there are other ways to address those inadequacies.

In Georgia, a statute grants individuals the right to be provided with material treatment information, including risk information and alternatives, if they are considering a surgical procedure that would be provided under general, spinal, or regional anesthesia or if they are considering whether to consent to amniocentesis or any diagnostic procedure involving the injection of intravenous or intraductal contrast material.[181] The statute does not address whether the disclosures required for the listed procedures are also required for other nonlisted procedures.[182] The Georgia Court of Appeals ruled that the statute does not preclude a common law duty for physicians to disclose material treatment information to patients that applies beyond the limited clinical circumstances described in the statute.[183] In 2009, however, the Georgia Supreme Court overruled this opinion, holding that the statute imposes a duty to disclose material treatment information only in those limited circumstances and that it prohibits courts from recognizing a

179. *See supra* Part II.C.

180. *See* GA. CODE ANN. § 31-9-6.1 (2009); 40 PA. CONS. STAT. ANN. § 1303.504 (West 2010); TEX. CIV. PRAC. & REM. CODE ANN. § 74.103(a)–(b) (West 2005).

181. *See* § 31-9-6.1(a).

182. *See generally* § 31-9-6.1.

183. Ketchup v. Howard, 543 S.E.2d 371, 377–78 (Ga. Ct. App. 2000), *overruled by* Blotner v. Doreika, 678 S.E.2d 80 (Ga. 2009).

common law duty to disclosure beyond the limited duty recognized in the statute.[184] What results is an absurdly unfair disclosure regime in which patients have a right to the disclosure of the risks of surgery, but not the risks of prescription medications or of a chiropractic manipulation.[185] Certainly, a substantive due process right to the disclosure of material treatment information, which applies to all treatments, could be used to invalidate the Georgia statute and to enforce disclosure across all treatments.[186]

Pennsylvania enforces a duty to disclose material information, but, as in Georgia, it does so only in the case of certain procedures listed in a state statute.[187] These include surgery, the use of anesthesia for surgery, radiation, chemotherapy, blood transfusions, insertion of a surgical device or appliance, the administration of an experimental drug or of an approved drug in an experimental manner, and the administration of an experimental device or an approved device in an experimental manner.[188] As a result, Pennsylvania courts have dismissed claims brought by patients alleging that their physicians failed to disclose material treatment information when the treatments at issue did not appear on the statutory list.[189] Thus, Pennsylvania law is as absurd as the law in Georgia, enforcing a right to receive treatment information for only *some* kinds of medical care.

Texas informed consent law, described earlier, also imposes a duty of disclosure on physicians with respect to some procedures, but not others. Every procedure is categorized by an administrative panel as either a procedure for which risk disclosures are required ("List A" procedures) or a procedure for which no risk disclosure is required ("List B" procedures).[190] Even a cursory review of List B procedures reveals several highly invasive procedures that almost

184. *See Blotner*, 678 S.E.2d at 82.

185. *See* Robert Gatter, *Blowing* Blotner*: A Missed Opportunity To Rationalize Georgia's Informed Consent Law*, 11 HOUSTON J. HEALTH L. & POL'Y (forthcoming 2010).

186. The Georgia Court of Appeals made exactly this argument—without citing to *White*—in its rulings in both *Ketchup* and *Blotner*, even though neither case appeared to involve state action. The Supreme Court of Georgia, however, did not address the constitutional argument when it heard those cases.

187. *See* 40 PA. CONS. STAT. ANN. § 1303.504 (West 2010). Prior to the statute, Pennsylvania common law restricted the duty to disclose material information to cases in which the patient underwent surgery. *See* Morgan v. MacPhail, 704 A.2d 617, 619 (Pa. 1997) (holding that neither an injection of nerve blocking medication nor an injection of steroids is a surgical procedure and therefore neither triggers the common law duty of a physician to disclose risk information).

188. *See* § 1303.504.

189. *See* Kremp v. Yavorek, 57 Pa. D. & C.4th 225, 231 (Ct. C.P. 2002) (affirming the dismissal of a patient's claim that her physician had failed to provide sufficient treatment information prior to a nonsurgical or natural childbirth).

190. *See supra* notes 128–33 and accompanying text.

certainly have significant risks associated with them: appendectomy, colonoscopy, and breast and lung biopsies are just a few examples.[191] Yet Texas law does not impose a duty to disclose any risk information to patients considering those procedures.

It is tempting to embrace *White*'s constitutional right to the disclosure of all information reasonably necessary to make informed treatment decisions when confronted with the woefully inadequate standards in Georgia, Pennsylvania, and Texas. Such a right could invalidate laws that fall below a national standard as articulated in *White*, at least whenever state action is present. But as argued above, doing so comes at a price. A substantive due process right is a powerful and blunt legal tool that is ill-suited to the task of balancing the various interests and norms at work in informed consent law.[192] Furthermore, it is not necessary to employ such a right, not even to remedy the inadequacies of the disclosure standards in Georgia, Pennsylvania, and Texas, because other options exist.

States' disclosure laws exist against a backdrop of other legal and nonlegal sources for encouraging and enforcing the communication of adequate information from doctor to patient, which diminishes the need for a substantive due process right to such information. For example, informed consent is a doctrine of medical ethics as well as law,[193] and the doctrine, including the ethical obligation of physicians to assure that patients are well informed, is a featured part of medical-ethics curricula that all U.S. medical schools, as a condition of their accreditation, are required to incorporate into their educational programs.[194] Additionally, many physician organizations have incorporated a commitment to fully informed medical decision making into their policy statements.[195] While such ethical standards are considered aspirational and do not establish standards of care enforceable through professional liability, they can form a basis for disciplinary action against physicians by state licensing agencies. For example, Pennsylvania's Board of Medical Examiners has the authority to discipline

191. *See* 25 TEX. ADMIN. CODE § 601.3(c)(1) (2007) (appendectomy); *id.* § 601.3(c)(9) (colonoscopy); *id.* § 601.3(i)(1) (breast biopsy); *id.* § 601.3(o)(3) (lung biopsy).

192. *See* Shoben, *supra* note 169, at 187 ("States can manage tort law with minimal supervision and should be allowed to do so.").

193. *See* AM. MED. ASSOC., CODE OF MEDICAL ETHICS 8.08 (2010–2011 ed. 2010), *available at* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion808.shtml ("A physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice."). *See generally* BERG ET AL, *supra* note 66; FADEN ET AL., *supra* note 61.

194. *See* LIAISON COMM. ON MED. EDUC., FUNCTIONS AND STRUCTURE OF A MEDICAL SCHOOL 10–11 (2010), *available at* http://www.lcme.org/functions2010jun.pdf.

195. *See* AM. MED. ASSOC., *supra* note 193.

physicians for "immoral or unprofessional conduct," which is defined to include "departure from or failing to conform to an ethical . . . standard of the profession."[196] Thus, a board of medical examiners could discipline a physician for failing to provide material treatment information to patients even when the failure to provide such information would not constitute professional negligence.

Hospital accreditation standards of the Joint Commission (formerly the Joint Commission on Health Care and Accreditation of Health Organizations) provide an even more compelling example of indirect, national regulation of informed consent disclosures. The Joint Commission is the leading private accreditation organization for health care institutions in the United States.[197] Hospitals with Joint Commission accreditation are deemed, by regulation, to satisfy Medicare's "conditions of participation."[198] The overwhelming majority of U.S. hospitals participate in Medicare, and most of them qualify for Medicare participation through Joint Commission accreditation.[199] Thus, the Joint Commission's accreditation standards have acquired the force of law through their endorsement by Medicare.

Joint Commission standards include standards related to informed consent and the disclosure of material treatment information in particular.[200] They require that a hospital have in place a policy and procedure to ensure that physicians practicing in the hospital discuss with patients the risks and benefits of proposed treatments, reasonable alternative treatments, and the risks and benefits of those alternatives.[201] Physicians, by accepting the privilege to admit patients to a hospital accredited by the Joint Commission, agree to abide by the hospital's policies and procedures, including those that incorporate this disclosure standard. In this way, a physician becomes contractually obligated

196. 63 PA. CONS. STAT. ANN. § 422.41(8) (West 2010).

197. *See* Jody Freeman, *The Private Role in Public Governance*, 75 N.Y.U. L. REV. 543, 610–12 (2000); Joint Comm'n, Facts About Joint Commission Accreditation and Certification (Oct. 13, 2009), http://www.jointcommission.org /AboutUs/Fact_Sheets/facts_jc_acrr_cert.htm.

198. *See* 42 C.F.R. § 488.5 (2009).

199. *See* Freeman, *supra* note 197, at 610–12. The publicly endorsed Joint Commission standards are an example of "shadow health law" in the sense that they regulate indirectly through a public-private relationship. *See* Sandra H. Johnson, *Regulating Physician Behavior: Taking Doctors' "Bad Law" Claims Seriously*, 53 ST. LOUIS U. L.J. 973, 992 (2009) (discussing the concept of shadow law in health law).

200. *See* JOINT COMM'N, "WHAT DID THE DOCTOR SAY?:" IMPROVING HEALTH LITERACY TO PROTECT PATIENT SAFETY 5 (2007), http://www.jointcommission.org /NR/rdonlyres/D5248B2E-E7E6-4121-8874-99C7B4888301/0/improving_health _literacy.pdf ("The Joint Commission's accreditation standards underscore the fundamental right and need for patients to receive information—both orally and written—about their care in a way in which they can understand this information.").

201. *See id.* at 5–7.

to provide material information to any hospital patient considering any form of treatment, even if the physician practices in a state where the disclosure of material treatment information is required for some, but not all, treatments.[202]

Even without the assurances provided by this backdrop of ethical and accreditation standards, the need for a substantive due process right to receive material treatment information is diminished by the availability of an equal protection claim, at least whenever there is state action. Although the legal obligation to disclose material treatment information in some states applies to only certain procedures, every state imposes such a duty of disclosure on physicians for at least some forms of treatment. Consequently, an equal protection argument can be used to expand the applicability of a state's own duty to disclose material treatment information.[203]

For example, consider how such a claim might be used to challenge Pennsylvania law.[204] There, the duty to disclose material treatment information has been interpreted to apply only to surgery, the use of anesthesia for surgery, radiation, chemotherapy, blood transfusions, inserting a surgical device or appliance, the administration of an experimental drug or an approved drug in an experimental manner, and the administration of an experimental device or an approved device in an experimental manner.[205] A review of the list does not reveal any reason why it contains the forms of treatment it does, or why it does not also contain others.[206] Certainly there are prescription medications that, even when used for their approved purpose, are as risky to a patient as chemotherapy or some other treatment on the list. The same can be said for a variety of diagnostic procedures. And yet patients considering those procedures are not afforded the same informational rights as patients considering listed procedures. Thus, even though the division of medical treatments into the categories of "on" or "off" the statutory list does not involve a suspect classification that would trigger strict scrutiny of the categorization, it is nonetheless susceptible to attack on equal protection grounds because the categorization appears to lack even a rational basis.[207]

202. *See, e.g.*, Linkous v. United States, 142 F.3d 271, 276 (5th Cir. 1998) (recognizing that an informed consent policy can create minimal standards enforceable against the physician by the patient).

203. *See* Vacco v. Quill, 521 U.S. 793, 799 (1997) (explaining an equal protection claim).

204. Georgia's informed consent law is also subject to an equal protection challenge. *See generally* Gatter, *supra* note 185.

205. *See* 40 PA. CONS. STAT. ANN. § 1303.504 (West 2010).

206. Although Pennsylvania's statutory list irrationally distinguishes between treatments that trigger a disclosure duty and those that do not, a state could create a rational distinction, perhaps based on degrees of risk.

207. *See* Vacco, 521 U.S. at 799–801.

Accordingly, the claim could be used to extend the informational protections associated with some treatments to other treatments with similar risk profiles.

The value of an equal protection claim is that it addresses a state's uneven application of its requirement that physicians disclose material treatment information, and it does so without deciding whether such a disclosure standard is inherent in the Constitution. The Equal Protection Clause "creates no substantive rights."[208] Instead, it draws its substance from existing state law and inquires whether similarly situated cases are being treated similarly under that law.[209]

CONCLUSION

White and its progeny recognize a substantive due process right to treatment information that mimics the disclosure rules that determine liability under state informed consent law. It is claimed to be a right derived from the right to refuse treatment that was acknowledged by *Cruzan* as a fundamental liberty interest that could be inferred from the Supreme Court's substantive due process rulings, and it would require state actors to ensure that individuals receive (whether or not they ask for it) all information reasonably necessary for informed medical decision making.

As this Article has argued, the doctrinal grounds for the claimed right are weak, and public policy considerations counsel against it. Moreover, there exist other avenues for protecting the interest of prisoners in receiving material treatment information and for correcting inadequate disclosure standards in states like Georgia, Pennsylvania, and Texas. Consequently, *White* and its progeny should be overruled.

While a constitutional right to material treatment information is a tempting fix for disclosure laws that are grossly inadequate in a few states, such a right is unnecessary and comes at too high a price. Other legal and nonlegal means for ensuring that patients are well informed as they make treatment decisions, and the availability of an equal protection claim in states where disclosure rules are most lacking, provide sufficient protection.

208. *Id.* at 799.
209. *Id.*