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SOCIAL DILEMMAS, JUDICIAL (IR)RESOLUTIONS

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I. PRELIMINARY THOUGHTS

In the movie "The Paper Chase," Professor Kingsfield promises the students in his Contracts class that they will emerge from the class "thinking like a lawyer." "Thinking like a lawyer," apparently, is a form of logic and reasoning that grants its owner a keen insight into human nature and an ability to analyze all kinds of disputes. The idea that there is a specialized and magical process called legal reasoning that can be applied equally well and with equal ease to whatever problems may be imagined was once the basic premise of the common law.

However, advances in scientific knowledge, technology and social theory, as well as drastic changes in social structure, have brought before the courts with increasing regularity ideas, theories, and claims that the courts have never heard before. These complex novel cases have challenged some of the basic elements of faith within the judicial system: that traditional methods of analysis and traditional legal categories would always be suffi-

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In this endeavor, I want to acknowledge the fine substantive and editorial contributions of my law clerks: Brian Bix, particularly as to the right-to-die materials, and Anthony Bartell and John Farmer, with respect to the treatment of judicial history and traditions.

cient to resolve all legal problems, and that the judicial role is well-defined and easily sequestered from the roles of other branches of government.

This kind of new litigation has posed unique challenges to the courts and has engendered a fair amount of commentary concerning the role of courts and the correctness of their actions. There is a substantial lack of consensus and understanding within and without the judiciary as to the judicial function in the contemporary setting, generating some unease among judges. Judges do not take special comfort in Emerson's insight that being misunderstood is a measure of greatness.[1] This has prompted me to reconsider and share with you some thoughts on the nature of the judiciary in this modern time.

Few legal subjects have been more extensively and repeatedly addressed than the subject of the judicial function. Nevertheless, what makes the subject topical is that it must be addressed anew by each generation; there simply is no escape. In each era, courts must on their own terms come to grips with their role, reexamine and reacquaint themselves with the nature of judicial power, and renew their understanding of the judiciary as an institution. Because each generation is confronted with different problems, the answers given from generation to generation are bound to be different.

Today we are confronted with problems of unusual difficulty, problems that will yield only problematic and indeterminate solutions. Moreover, we are confounded by novelty at every turn. Truly perplexing controversies arise in the fields of education, domestic relations, the economy, communications, the environment, medical treatment and health care, and on and on.

We can cite a host of forces that are spawning this new kind of legal controversy, exposing and forming new frontiers of the law. We can mention, among others, technological breakthroughs, the expansion of general knowledge, developments in scientific fields, demographic changes, shifts in political power, and changes in the nature and quantity of valued resources. The legal milieu itself has changed, encouraging new cognitions of individual and group rights and interests, and governmental and institutional responsibilities and duties.

My thesis is that the social dilemmas that have arisen as a re-

1. R.W. EMERSON, SELF RELIANCE (1841).

sult of these forces at once defy the competence of courts and demand resolution in specific cases. They challenge the competence of courts in two ways: by straining classical techniques and categories of legal reasoning; and by testing the institutional flexibility of the judiciary.

To illustrate this thesis, I will mention first some cases that raise issues of characteristic perplexity. These cases will suggest that the new legal challenges posed by contemporary society demand innovative solutions and are recasting, as it were, traditional formulations of the judicial role and power.

I will then focus on one type of case that epitomizes the kinds of dilemmas experienced by contemporary society, and the nature of the legal controversies and issues they present to courts: the so-called right-to-die case. This discussion will illustrate the extent to which judicial traditions are being stretched, the realignment between the judiciary and the branches of government, and the kinds of judicial resolutions or ir-resolutions that are being offered to answer these dilemmas.

The idea that social change tests the adaptability of legal institutions is, of course, not new; Judge Hand spoke of life overflowing its universals, and Justice Cardozo, before him, characterized legal evolution by quoting Matthew Arnold: "There is not a creed which is not shaken, not an accredited dogma which is not shown to be questionable, not a received tradition which does not threaten to dissolve."[2] What is new with each generation, however, is the specific way in which legal doctrines and institutions are challenged. Accordingly, I conclude by offering some observations about the role of the court and of jurisprudence in contem-

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2. B. CARDOZO, THE NATURE OF THE JUDICIAL PROCESS 25-26 (1921) (quoting M. ARNOLD, ESSAYS IN CRITICISM, 2d series, 1 (1888)). Justice Cardozo elaborated:

> Hardly a rule of today but may be matched by its opposite of yesterday. Absolute liability for one's acts is today the exception; there must commonly be some tinge of fault, whether willful or negligent. Time was, however, when absolute liability was the rule. . . . Mutual promises give rise to an obligation, and their breach to a right of action for damages. Time was when the obligation and the remedy were unknown unless the promise was under seal. Rights of action may be assigned, and the buyer prosecute them . . . though he bought for purposes of suit. Time was when the assignment was impossible, and the maintenance of the suit a crime. It is no basis today for an action of deceit to show, without more, that there has been the breach of an executory promise; yet the breach of an executory promise came to have a remedy in our law because it was held to be a deceit.

Id. at 26-27.

porary society in the wake of this new brand of litigation. I also pass on Professor Grant Gilmore's humbling warning: "We do not, by our conscious deliberate act, ever 'change the law.' The law changes itself, in response to mysterious and largely unperceived forces, of which we can take account only by hindsight."[3]

II. Contemporary Legal Controversies

The basic premise of common-law adjudication is that established general legal principles, through the process of legal reasoning, can be applied to find the appropriate answer to new legal problems. In recent decades, however, advances in technology, scientific knowledge, social theory, and the social sciences have brought problems to the courts that have sorely strained conventional analyses as a means for solving them.

Some examples should make the point. One, of course, is the right-to-die cases which I will discuss more pointedly in just a while. Suffice it to say that these cases have brought forcefully to the courtroom door the fact that medical technology can now be used to keep the body functioning even after a person has lost all higher brain functions, posing the question of when life ceases—a question which, in the context presented, is no longer self-evident.

The right-to-die cases have had some curious offshoots. In one case, *Strachan v. John F. Kennedy Memorial Hospital*,[4] which is currently before our court, a hospital refused the request of the parents of a brain-dead patient to disconnect the patient from life-support systems. The life-support systems were maintained in part to enable the hospital, if the parents' consent could be obtained, to reclaim the victim's organs for later transplants. The parents sued the doctors, the hospital and its administrator, claiming negligence in their refusal to deliver the body of their son. This case underscores the unpredictable ways in which technology and medical science have created bewildering problems.

In the now-famous *Baby M* case, the courts are faced with the validity and enforceability of surrogate mother contracts. Surrogate motherhood involves couples who cannot have children of their own paying a woman to be impregnated with the husband's

3. Gilmore, *Products Liability: A Commentary*, 38 U. Chi. L. Rev. 103, 106 (1970).
4. 209 N.J. Super. 300, 507 A.2d 718 (App. Div. 1986) (appeal pending).

sperm, carry the baby to term, and relinquish custody of the child. The technology and science that have made this form of parenting possible appear to have pushed legal controversy beyond the bounds set by conventional contract law or traditional custody law analyses.[5]

I do not think that I would be reflecting or reinforcing anti-law stereotypes in stating that every major medical advance brings before the courts a set of novel claims. The more doctors are able to do, the more the law expects them to do. The ability to diagnose or predict a child's birth defects before the child is even born has given rise to the "wrongful life" and "wrongful birth" cases, cases where the parties claim that it was a legal injury, caused by negligent "genetic counseling," for a child to have been born.[6]

The court has hesitated to recognize a claim of wrongful life, but it did respond somewhat to the intuitive power of the parties' claim for compensation for the suffering that was associated with the doctor's malfeasance. Nevertheless one is left with the feeling that legal theory has not caught up with medicine's advances.

Gains in scientific knowledge enable us to trace diseases back to environmental or chemical causes. As a result the net of tort liability is now cast over a larger and larger group of both plaintiffs and defendants. Our greater knowledge of causation begins to distort the tight fit that once existed between the tort system and our intuitive notions of justice.

With the toxic tort cases, the court confronts the complex problems created by modern technology: injuries that the victim may not discover until years after the exposure. In the noted case of *Ayers v. Jackson Township*,[7] which is presently being consid-

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5. On March 31, 1986, the validity of the surrogate parenting contract was upheld; custody was awarded to the biological father and adoptive mother. The trial court's opinion applied conventional contract analysis to the surrogate-parenting context, but emphasized that

> existing laws did not apply to the facts sub judice. The concept being tried here did not exist or was not considered when . . . adoption, termination of parental rights or custody [statutes] were legislated. To make a new concept fit into an old statute makes tortured law with equally tortured results.

In re Baby "M", 217 N.J. Super. 313, 399, 525 A.2d 1128, 1173 (Ch. Div. 1987) (appeal pending).

6. *See, e.g.*, Procanik v. Cillo, 97 N.J. 339, 478 A.2d 755 (1984); Schroeder v. Perkel, 87 N.J. 53, 432 A.2d 834 (1981); Berman v. Allan, 80 N.J. 421, 404 A.2d 8 (1979).

7. 202 N.J. Super. 106, 493 A.2d 1314 (App. Div.), *certif. granted*, 102 N.J. 306, 508 A.2d 191 (1985). *See infra* text accompanying note 76.

ered by the court, plaintiffs were township residents whose water supply had been contaminated by toxic chemicals, the contamination caused by the township's negligent maintenance of a landfill. Their suit sought damages for the enhanced risk of catastrophic illness, the heightened probability that they would get cancer or some other disease. Current scientific knowledge allowed the plaintiffs to know that they were imperiled, but scientific experts were unable to measure the peril, frustrating the ability to award reasonable compensation. *Ayers* is a case where limitations in technology have combined with advances in technology to confound traditional tort principles.

These cases illustrate the extent to which stunning advances in human knowledge, science and technology can dislodge courts from traditional positions, challenging conventional wisdom. They surely invite us to question whether traditional constraints on judicial responsibility and power can still guide us to correct results.

III. The Judicial Function

The social dilemmas that have been created by society's expanding knowledge—exemplified by these cases—not only strain the process of legal reasoning, they challenge the integrity of the judicial function itself. Judicial authority has always been easier to define than to confine. However, today's extraordinary legal challenges appear to have metamorphosed the judicial role beyond the point of mere evolutionary adaptation. This impression bears closer examination.

Generally, the traditions that guide courts in determining their proper role consist of criteria that inform us whether the court should accept, consider and decide a particular dispute. These criteria are the traditional constraints of jurisdiction, standing, controversy, mootness, and the like.

The requirement of standing to initiate an action serves to assure the court that it is dealing with individual interests rather than with matters of only general policy.[8] The presence of an ac-

8. In New Jersey Chamber of Commerce v. New Jersey Election Law Enforcement Comm'n, 82 N.J. 57, 69, 411 A.2d 168, 174 (1980), we articulated the purposes of New Jersey's standing doctrine as follows:

> These are to assure that the invocation and exercise of judicial power in a given case are appropriate. Further, the relationship of plaintiffs to the subject matter of the litigation and to other parties must be such to generate confidence in the

tual controversy indicates that the court's action is essential, while mootness, or rather its absence, assures that this action is timely and relevant.

In passing upon a plaintiff's standing to maintain a cause of action, courts have traditionally weighed questions of remoteness and degree. This assures that the judicial power will be invoked only when there exists some interest to be protected beyond a mere abstraction. We have consistently prohibited the rendering of advisory opinions, requiring that plaintiffs be more than mere strangers to the dispute.

These justiciability criteria also demonstrate the non-legislative quality of judicial power. Courts deal with the individual, the particular, the concrete; they invoke their power only when individuals are in actual conflict. Hence, these criteria help to keep the court from interfering in matters that are primarily legislative in nature. "Rules of standing," we have said, "are necessary if the courts are to properly respect the legislature's prerogatives with respect to its law-making functions."[9]

However, while we speak of "traditional principles" governing the judicial role and judicial power, these principles are not immutable; there is necessary elasticity in the judicial role. For example, our courts have consistently held a pragmatic and flexible view of "standing." While standing exists only when a plaintiff has a genuine stake in the outcome of the proceedings, we have frequently held that in cases of great public interest, any slight additional private interest will be sufficient to afford standing. In this vein, we have also recognized that the doctrine of mootness should not prevent the meritorious consideration of a case of substantial public interest.[10] However, contemporary legal controversies—exemplified most clearly by the right-to-die cases—have strained this traditional flexibility to its absolute limit.

The proper exercise of judicial authority is further confined by notions relating to the allocation and separation of government

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ability of the judicial process to get to the truth of the matter and in the integrity and soundness of the final adjudication. Also, the standing doctrine serves to fulfill the paramount judicial responsibility of a court to seek just and expeditious determinations on the ultimate merits of deserving controversies.

9. State v. Saunders, 75 N.J. 200, 208, 381 A.2d 333, 336 (1977).

10. *In re* Application of Boardwalk Regency Corp. for a Casino License, 90 N.J. 361, 368, 447 A.2d 1335, 1339 (1982): "[W]here the parties lack a legally cognizable interest because the issues presented are technically moot, they may nonetheless obtain judicial review when the matter involves an area of particular concern to the public interest."

powers. These standards serve to measure the validity of the court's consideration of a particular case by assuring that when the court acts it will constitute the exercise of *judicial* and not other governmental powers. As with standing, we have traditionally harbored a flexible attitude toward the separation of powers doctrine. This flexibility leaves the court well-suited to address issues whose resolution resists classification as legislative, executive, or judicial.

At its core, the separation of powers doctrine serves to prevent "oppressive action by the government. Its premise is that the concentration of unlimited power inevitably results in tyranny."[11] We have observed, however, that the separation of powers doctrine also accommodates "interdependence among the branches of government," that there is "a symbiotic relationship between the separate governmental parts so that the governmental organism will not only survive but flourish . . . ." The reason for this interdependence is that

> [i]t occasionally happens that an underlying matter defies exact placement or neat categorization; it may not always be possible to identify a subject as belonging exclusively to a particular branch. In those situations responsibility is joint and governmental powers must be shared and exercised by the branches on a complementary basis if the ultimate governmental objective is to be achieved.[12]

One of the perplexities of litigation resulting from expanding knowledge and new technologies is precisely this resistance to classification along traditional separation of powers lines. Social change occurs so quickly in such cases that individual interests are affected, thus implicating the judiciary; before general policies are formulated, thus implicating the legislature; or before general policies are implemented, thus implicating the executive. This has been recognized in the right-to-die cases where the court has implored the legislature to take action even as it has moved to resolve the claims of the parties before it.[13] In this sense, modern

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11. Worthington v. Fauver, 88 N.J. 183, 206, 440 A.2d 1128, 1140 (1982).

12. Knight v. Margate, 86 N.J. 374, 388, 431 A.2d 833, 840 (1981) (citing State v. Leonardis, 73 N.J. 360 (1977)). *See also In re* Salaries for Probation Officers, 58 N.J. 422, 425, 278 A.2d 417, 418 (1971); Mount Laurel Township v. Public Advocate, 83 N.J. 522, 530-34, 416 A.2d 886, 890-92 (1980); David v. Vesta Co., 45 N.J. 301, 321-28, 212 A.2d 345, 355-59 (1965).

13. *See In re* Conroy, 98 N.J. 321, 344-46, 486 A.2d 1209, 1220-21 (1985). This has also

social dilemmas are vindicating the view taken by this court that even as governmental functions are distinct, they are complementary.

The great risk of such a view, of course, is that the exceptions may swallow the rule, that the exigencies of the moment—which strain the distinction between legislation, administration, and adjudication—may be allowed to collapse the distinction entirely.[14] Thus, the court finds itself walking more and more frequently the fine line between allowing the complementary exercise of governmental power and policing the separateness of governmental branches. The judiciary's role as both "a supporting and separating arch between the other branches of government"[15] has never been more vital.

IV. The Right-to-Die Cases: Social Dilemmas and Judicial (Ir)resolutions

There is a class of cases that particularly elucidate our central theme: that courts are in fact being presented with problems of novelty and unusual complexity, that traditions of judicial power and responsibility must be tempered or extended, that conventional legal doctrine may be inadequate to determine the solutions to these cases, and that judicial dispositions may entail more than simply adjudicating the rights and duties of particular parties. The "right-to-die" cases implicate all of these concerns.

Our two most famous cases are *In re Quinlan*[16] and *In re Conroy*.[17] In *Quinlan*, the court held that if a patient is in a coma facing imminent death, the attending physicians conclude that the comatose state is irreversible, and a hospital's ethics committee agrees with that prognosis, then upon the concurrence of the patient's guardian and family, the patient's life support systems

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occurred in the context of surrogate parenting. In its *Baby M* decision, the trial court stressed the need for both legislation to set general policy and a decision in the specific case, even in the absence of legislation: "With an increasing number of surrogate births, legislation can avoid harm to society, the family and the child. . . . Today, however, this court can only decide what is before it." *In re* Baby "M", 217 N.J. Super. 313, 334, 525 A.2d 1128, 1138 (Ch. Div. 1987).

14. It was to prevent such a collapse that the court held invalid, in General Assembly v. Byrne, 90 N.J. 376, 448 A.2d 438 (1982), the sweeping legislative veto provisions of the Legislative Oversight Act, N.J. Stat. Ann. §§ 52:14B-4.1 to 4.9 (West 1986).

15. Handler, *A Matter of Opinion*, 15 Rutgers L.J. 1, 13 (1983).

16. 70 N.J. 10, 355 A.2d 647 (1976).

17. 98 N.J. 321, 486 A.2d 1209 (1985).

can be withdrawn without civil or criminal liability. In *Conroy*, the court held that life-sustaining treatment can be withheld from a nursing home patient in a persistent vegetative state facing imminent death if certain standards are met and certain procedures followed. The standards vary according to what kind of evidence exists regarding what the patient would have wanted done regarding medical treatment. The procedures involve the notification of and participation by the Office of the Ombudsman for the Institutionalized Elderly. We have currently before the court three other right-to-die cases, *In re Farrell*,[18] *In re Peter*,[19] and *In re Jobes*,[20] involving similar problems affecting individuals in variant circumstances. Because the right-to-die cases present such far-ranging issues, in which the judicial role is primarily catalytic as much as clarifying, these cases can also be used to amplify our thesis.

It is clear that we have these cases because—and only because—of the astounding advances in medical science and health-care technology. Persons who could not otherwise survive because of the destruction or deterioration of their vital bodily functions now can survive in some lifelike condition because of available medical technology.[21]

Some persons have challenged the legitimacy of judicial inter-

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18. Kathleen Farrell was a 37-year-old, competent, terminally ill patient, suffering from amyotropic lateral sclerosis (ALS) when she sought to be disconnected from her respirator. Her decision was made after consulting with her husband and her two teenage children and with their support. She died while her case was pending before the New Jersey Supreme Court. *See infra* text accompanying note 77.

19. Hilda Peter is a 65-year-old nursing home patient who is in a persistent vegetative state but who is not expected to die in the near future. Ms. Peter had earlier executed a power of attorney which authorized a good friend of hers to make medical decisions on her behalf. This friend seeks authorization to remove Ms. Peter's nasogastric feeding tube. There was also some testimony at trial that Ms. Peter had earlier expressed a wish not to have that kind of medical treatment. *See infra* text accompanying note 78.

20. Nancy Jobes is a 31-year-old nursing home resident who is in a persistent vegetative state but who is not expected to die in the near future. Her husband and parents seek authorization to remove her jejunostomy tube. At trial, there was some testimony to the effect that Mrs. Jobes would not have wanted that kind of medical treatment continued. *See infra* text accompanying note 79.

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> Now, however, we are on a threshold of new terrain—the penumbra where death begins but life, in some form, continues. We have been led to it by the medical miracles which now compel us to distinguish between "death" as we have known it, and death in which the body lives in some fashion but the brain (or a significant part of it) does not.

Severns v. Wilmington Medical Center, 421 A.2d 1334, 1344 (Del. 1980).

vention in this area. But the most obvious justification for judicial intervention is that the plaintiffs have come to the courts, and the courts may not turn them away. As we observed in *Conroy*:

> Meanwhile, in the absence of specific legislation on the termination of life-sustaining treatment, we may not properly avoid the issue that we have been asked to resolve merely because it is troubling or difficult. Every day, and with limited legal guidance, families and doctors are making decisions for patients like Claire Conroy. The courts, as guardians of our personal rights, have a special responsibility to place appropriate constraints on such private decision-making and to create guideposts that will help protect people's interests in determining the course of their own lives.[22]

Moreover, the question of state intervention is usually misconstrued. The issue is too often phrased as if what was at stake is whether government—or, more particularly, the courts—should enter where they have been absent before. In fact, the state has been involved all along, and the only question is the nature of its "intervention."[23]

In *Quinlan*, for example, Joseph Quinlan was not asking the state to intervene in the medical treatment decision. He was asking the state to modify the way it had already intervened—by enjoining the local prosecutor from bringing criminal actions against any person involved in the choice to discontinue medical treatment.[24]

The right-to-die cases generally involve a patient who wants to refuse or discontinue medical treatment necessary to keep her alive; or a guardian who wishes, on behalf of the patient, to refuse or discontinue medical treatment necessary to keep the patient alive. In a conventional setting, treatment decisions are ordinarily left to the unreviewable discretion of the patient. It is a common-law doctrine of long standing that medical treatment should not be administered to someone without her informed consent.[25] If medical treatment is done without such consent, even if the treat-

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22. *Conroy*, 98 N.J. at 345, 486 A.2d at 1221.

23. *See* Minow, *Beyond State Intervention in the Family: For Baby Jane Doe*, 18 U. MICH. J.L. REF. 933, 936-38, 951-53 (1985).

24. *See Quinlan*, 70 N.J. at 18-19, 355 A.2d at 651-52.

25. In emergencies, consent is implied. *See* PROSSER AND KEETON ON THE LAW OF TORTS § 18, at 117 (Keeton 5th ed. 1984).

ment would be medically advisable, that treatment is considered legally as a tortious act.[26] A patient can also refuse to consent to medical treatment. The complexity of the right-to-die cases is that in these cases the refusal to consent to treatment leads to death.

Two conceptual tensions are joined in the right-to-die issues. First, the right to refuse medical treatment is an established part of the common law; but in these cases, it conflicts with the common law's long-standing refusal to condone a person's taking of her own life. Second, both sides in the right-to-die debate can call upon arguments and imagery of individualism, a powerful doctrine in the American political and philosophical tradition. One side argues for an individual's right to have full control over the medical treatment to which she will be subject. The other side wants to ensure that weak and vulnerable individuals will not be harmed by indifferent or hostile institutions or governments.

The tension arising from the conflict between the right to refuse medical treatment and the wrong of suicide has spurred legal analysis more curious than helpful.[27] Consider the following characterizations: (1) the patient did not want to die; he wanted to live, but only without extraordinary medical treatment;[28] (2) it is not the removal of treatment that causes death, but the underlying disease;[29] and (3) the patient knew that removal of treatment

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26. *See* Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 105 N.E. 92 (1914); PROSSER AND KEETON, *supra* note 25, at 104-05.

27. Labels seem particularly crucial to both the persuasiveness and the acceptability of judicial decisions in this area. For example, the courts seem reluctant to characterize the discontinuation of treatment as the ending of life. *See In re* L.H.R., 253 Ga. 439, 445, 446, 321 S.E.2d 716, 722, 723 (1984) ("Under these circumstances, we find that the life support system was prolonging her death rather than her life. . . . While the state has an interest in the prolongation of life, the state has no interest in the prolongation of dying."); Severns v. Wilmington Medical Center, 421 A.2d 1334, 1344 (Del. 1980) ("[T]he penumbra where death begins but life, in some form, continues . . . the medical miracles which now compel us to distinguish between death as we have known it, and death in which the body lives in some fashion but the brain (or a significant part of it) does not."); Leach v. Akron Gen. Medical Center, 68 Ohio Misc. 1, 6, 426 N.E.2d 809, 812 (C.P. 1980) ("She is on the threshold of death, and man has, through a new medical technology, devised a way of holding her on that threshold."); *In re* Eichner, 102 Misc. 2d 184, 204, 423 N.Y.S.2d 580, 593 (Sup. Ct. 1979), *modified*, 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980) ("a treatment which, in these circumstances, serves only more or less briefly to extend the process of dying."), *modified*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

28. *See* Satz v. Perlmutter, 362 So. 2d 160, 163-64 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 259 (Fla. 1980).

29. *See Conroy*, 98 N.J. at 351, 486 A.2d at 1224; N. CANTOR, LEGAL FRONTIERS OF DEATH AND DYING 38-45 (1987).

would cause death, but his intent to remove treatment was not an intent to cause death. These distinctions are not entirely persuasive,[30] but they reflect our convictions that differentiations can be made; a terminal patient's refusal of extraordinary medical care seems to us an action different in kind from someone shooting herself in the head.[31]

The foundation for our decisions in the right-to-die cases has been the concept of individual self-determination. The objective of legislative and judicial action in medical treatment decisions has been to insure that, to the extent possible, the patient's right to self-determination is protected. The right to self-determination has been described as an individual's "strong[] personal interest in directing the course of his own life," and "an individual's right to behave and act as he deems fit, provided that such behavior and activity do not conflict with the precepts of society."[32]

In medical treatment decisions, the law developed the doctrine of informed consent as the primary means for protecting the right of self-determination. "The doctrine of informed consent [requires that medical decisions be made in a context where] the patient has the information necessary to evaluate the risks and benefits of all the available options and is competent to do so."[33]

Self-determination in its purest form thus includes elements of knowledge as well as volition.[34] The assurances and safeguards used to protect a competent patient's self-determination are not available when the patient whose treatment decision is at question is no longer competent. Serious difficulties arise when we ap-

30. If only for their insistence that human decisions are based on simple, unitary motivations.

31. *See* Capron, *Borrowed Lessons: The Role of Ethical Distinctions in Framing Law on Life-Sustaining Treatment*, 1984 ARIZ. ST. L.J. 647, 650-53.

32. *Conroy*, 98 N.J. at 350, 358, 486 A.2d at 1223, 1228.

33. *Conroy*, 98 N.J. at 347, 486 A.2d at 1222.

34. Voluntariness is itself a difficult concept. The line between motivations we consider normal and legitimate and those we consider distorting or coercive is not always clear. If a patient refusing medical treatment is depressed, should that asserted choice be disregarded because the patient might change her mind when she overcomes her depression? *See* Bartling v. Superior Court (Glendale Adventist Medical Center), 163 Cal. App. 3d 186, 209 Cal. Rptr. 220, 223-24 (1984). Should we respect the wishes of a patient who makes a treatment decision based partly on the pain her suffering brings her family? *Cf.* Bouvia v. Superior Court (Glenchur), 179 Cal. App. 3d 1127, 1145, 225 Cal. Rptr. 297, 306 (1986) (review denied June 25, 1986) (ordering a hospital to comply with a patient's request to discontinue treatment): "If a right exists, it matters not what 'motivates' its exercise. We find nothing in the law to suggest the right to refuse medical treatment may be exercised only if the patient's *motives* meet someone else's approval."

ply those standards, which promote the value of self-determination for competent persons, to incompetent persons.[35] We cannot make elaborate inquiries of incompetent patients to satisfy ourselves that their treatment decisions—or, more accurately, their earlier expressed opinions about such decisions—were thoroughly autonomous, voluntary, and informed. Nevertheless, we strongly cling to the belief that we can and should effectuate "self-determination" for the incompetent. At best it is only an optimistic approximation. As the court stated in *Conroy*:

> The right of an adult who . . . was once competent, to determine the course of her medical treatment remains intact even when she is no longer able to assert that right or to appreciate its effectuation.
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> . . . .
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> Since the condition of an incompetent patient makes it impossible to ascertain definitively her present desires, a third party acting on the patient's behalf often cannot say with confidence that her treatment decision for the patient will further rather than frustrate the patient's right to control her own body. Nevertheless, the goal of decision-making for incompetent patients should be to determine and effectuate, insofar as possible, the decision that the patient would have made if competent.[36]

Because we cannot be as sure with treatment decisions made for incompetent patients as with decisions made by competent patients that the decisions further the value of self-determination, we try to compensate by adding substantive standards and procedural safeguards. For example, in *Quinlan*, the court offered a balancing test.[37] In *Conroy*, the court posited a series of tests ranging from pure self-determination to one based on objective factors reflecting the degree of doubt concerning the patient's wishes or views. It also established elaborate protective procedures for decisions to discontinue treatment for incompetent elderly nursing home patients.[38]

The balancing test in *Quinlan* described patients' right to refuse medical treatment in a waxing and waning metaphor: "the State's interest *contra* weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the

35. *See In re* Grady, 85 N.J. 235, 426 A.2d 467 (1981).
36. *Conroy*, 98 N.J. at 359-60, 486 A.2d at 1229.
37. *Quinlan*, 70 N.J. at 41, 355 A.2d at 664.
38. *Conroy*, 98 N.J. at 381-85, 486 A.2d at 1240-42.

prognosis dims."[39] While this balancing structure may have been inappropriate,[40] it can be seen as reflecting a basic aspect of right-to-die cases. In treatment decisions made in the name of incompetent patients, no matter how much evidence we have of subjective intent, how well the guardian knew the patient, and how well-intentioned the patient's guardian, family, and physician may be, there will always be some residual doubt that the decision expresses the patient's right of self-determination. In less optimal circumstances, the doubt is even greater. As doubt grows, other factors necessarily intrude upon decision-making.

An "objective approach" intrudes subtly upon the subjective approach depending upon the circumstances. When the patient is suffering under conditions that are so extreme that discontinuation of treatment seems to be in her best interests, the courts are less troubled by the doubt that this treatment decision does not express the patient's right to self-determination. Courts consider—either explicitly or implicitly—objective factors like the patient's age, whether she is terminally ill, how intrusive the treatment is, and how much pain the patient is suffering, in deciding whether to authorize discontinuation of treatment.[41] The question is whether courts can and should extrapolate from the objective factors that inform and affect their application of a subjective approach to the creation of a purely objective approach for those cases where no subjective evidence is available. In *Conroy*, we did establish one such objective approach.[42]

The emotional power that the right-to-die cases evoke comes in part from our ability to identify with the actors in the legal drama.[43] We can identify with the patient—competent or incompetent—who wants to discontinue medical treatment but whose wish is thwarted by state action. It is this identification that gives the force to the following comment in a Florida right-to-die case:

> It is all very convenient to insist on continuing Mr. Perlmutter's

39. *Quinlan*, 70 N.J. at 41, 355 A.2d at 664.

40. *See* Capron, *supra* note 31, at 656-58.

41. *See, e.g.*, *Conroy*, 98 N.J. at 342, 486 A.2d at 1219 (limiting holding to elderly nursing home residents who suffer from serious and permanent mental and physical impairments and who will probably die within a year); Delio v. Westchester County Medical Center, 134 Misc. 2d 206, 510 N.Y.S.2d 415 (Sup. Ct. 1986) (refusing to apply right to refuse treatment to patient in chronic vegetative state because he was not terminally ill and because he was only 33 years old), *rev'd*, 129 A.D.2d 1, 516 N.Y.S.2d 677 (1987).

42. *Conroy*, 98 N.J. at 366-68, 486 A.2d at 1232-33.

43. *See* Minow, *supra* note 23, at 990-94.

> life so that there can be no question of foul play, no resulting civil liability and no possible trespass on medical ethics. However, it is quite another matter to do so at the patient's sole expense and against his competent will, thus inflicting never ending physical torture on his body until the inevitable, but artificially suspended, moment of death.[44]

At the same time, we can imagine ourselves as a patient whose medical treatment is discontinued before we want it to be.[45] We can identify with the feeling of vulnerability that may come to a patient when isolated from family in a nursing home, or to a patient facing a painful terminal disease alone.[46] We can also relate to the doctors and nurses who have devoted their lives to caring for others and to curing the sick, who are deeply bothered by now being asked *not* to do everything within their power to keep a patient alive, or even being asked to help hasten the moment of death.[47] We identify also with the friends and relatives of the patient, who often must face not only the loss of a loved one but also the responsibility for a difficult decision.[48] Because we identify with the actors, we become caught up in the drama of the situation, a drama only heightened by the adversarial situation unfortunately imposed on the situation by the legal system.

There are basically two approaches or standards the courts have followed in decision-making in treatment decisions for in-

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44. Satz v. Perlmutter, 362 So. 2d 160, 164 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980).

45. *Cf. Conroy*, 98 N.J. at 343, 486 A.2d at 1220 ("To err either way—to keep a person alive under circumstances under which he would rather have been allowed to die, or to allow that person to die when he would have chosen to cling to life—would be deeply unfortunate.").

46. *See id.* at 375, 486 A.2d at 1237.

47. *See Quinlan*, 70 N.J. at 42-51, 355 A.2d at 664-69.

48. *See id*, at 29-30, 355 A.2d at 657:

> The character and general suitability of Joseph Quinlan as guardian for his daughter, in ordinary circumstances, could not be doubted. The record bespeaks the high degree of familial love which pervaded the home of Joseph Quinlan and reached out fully to embrace Karen, although she was living elsewhere at the time of her collapse. The proofs showed him to be deeply religious, imbued with a morality so sensitive that months of tortured indecision preceded his belated conclusion (despite earlier moral judgments reached by the other family members, but unexpressed to him in order not to influence him) to seek the termination of life-supportive measures sustaining Karen. A communicant of the Roman Catholic Church, as were other family members, he first sought solace in private prayer looking with confidence, as he says, to the Creator, first for the recovery of Karen and then, if that were not possible, for guidance with respect to the awesome decision confronting him.

competent patients. The first endeavors to effectuate the wishes of the patient, furthering the notion of self-determination. If the patient had when competent stated what decision she would have wanted made in this situation, those wishes are usually followed.[49] If there is no direct evidence of the patient's preferences, and if there is a relative or friend who was close enough to the patient to be able to surmise how she would have decided, this relative or friend is often allowed to choose in the name of the patient. However, for many incompetent patients a subjective approach is unavailable.[50] The second standard purports to rest the determination on objective factors, recognizing the elusiveness of self-determination. If there is no basis for deciding what the patient would have decided, a decision is made according to what would be in the patient's "best interests," as defined by the court, the patient's family, or a court-appointed guardian.

Frequently, the self-determination standard rests upon the decision of relatives or close friends. Professor Martha Minow has characterized this substituted judgment approach, where a decision-maker inquires into what the affected person would choose if he or she could choose, as an "effort . . . fraught with guesswork."[51] To the extent that this "imaginative effort" will necessarily fall short of certainty about what the patient would have decided, it may be that "[a]t its best the substituted judgment approach may express concerns and sympathy for the patient,

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49. *Conroy*, 98 N.J. at 360-64, 486 A.2d at 1229-31. Of course there is a difference between even the most considered judgment about a hypothetical decision and actually deciding in the face of the particular circumstances. This may be especially true when, as here, the decision touches upon basic factors: if one is to go on living and in what manner. The difference between the hypothetical decision and the real one should give us some pause before we claim that decisions made for incompetent patients always fully respect those patients' right of self-determination.

50. *See* Minow, *supra* note 23, at 973: "[W]hatever the success of efforts by family and friends to imagine the past wants of a now comatose eighty-year old, substituted judgment makes little sense for a newborn who has no history nor prior expression of wants."

51. *See id.* at 972-73:

> Under substituted judgment, the decisionmaker inquires into what the affected person would choose if he or she could choose. Evidence about the person's prior wants and express or implied direction inform the decisionmaker's judgment. This effort is fraught with guesswork. The substituted judgment approach claims to operate objectively through efforts to find evidence of the wants and concerns of the patient, but it also searches for the subjectivity of the patient by inquiring into what the patient personally would want, which in turn depends on who the patient is. It relies on the imaginative effort of the decisionmaker to construct what the patient would want, given what the surrogate knows.

rather than actually divining that person's unknown wishes."[52] In *Quinlan*, though the court claimed to be explicating Ms. Quinlan's constitutional right to choose, the court's opinion focused on the trustworthiness of the guardian. It went to great lengths to present Ms. Quinlan's father as a devoted family member, a religious person, someone who had thought long and hard before he sought court authorization to discontinue treatment, and someone who had no improper reason for deciding to discontinue treatment.[53] That the opinion focused on the virtue of the guardian may illustrate that where it is at best awkward to claim that a treatment is based solely on effectuating the patient's right to self-determination, the question of trust and distrust becomes especially important.

There are also problems with the second approach, "best interests" analysis. These are straightforward. In our society—where persons have different ideas about how the value of life is affected by the loss of brain function, the loss of cognitive abilities, or unrelievable extreme pain—how is a judge to choose—indeed, *who* is the judge, that she should be the one to choose—among the possible criteria? A best-interests approach for making a treatment decision arguably imposes societal values paternalistically on the individual.

In *Conroy* we held that in some circumstances a best-interests analysis would justify the refusal of medical treatment for a legally incompetent patient.[54] Those circumstances were situations of great unavoidable pain accompanied by prognoses of little time left to live, even with treatment.[55] The majority opinion in *Conroy* distanced itself from any claim of judging a patient's quality of life. The majority sought a factor that all persons would consider as detriment—the factor of pain; consensus turning the subjective choice (what *a given patient* would have wanted) into an objective standard (what choice we can impute to *any* patient).[56]

This move in the argument responds to a problem in the best-interests analysis:[57]

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52. *Id.* at 973; *see* N. CANTOR, *supra* note 29, at 58-76.

53. *See Quinlan*, 70 N.J. at 29-30, 355 A.2d at 657-58.

54. This was described in the majority opinion as the "limited-objective test." *Conroy*, 98 N.J. at 365, 366, 486 A.2d at 1232.

55. *Id.* at 365-66, 486 A.2d at 1232.

56. *See id.* at 367-68, 486 A.2d at 1232-33.

57. We also have a strong visceral reaction against the idea that death can ever be in someone's best interests. *See, e.g.*, Berman v. Allan, 80 N.J. 421, 429, 404 A.2d 8, 12 (1979)

> [A]ssessment of . . . best interests is also problematic because no one can be certain of another's interests. The Western liberal commitment to individual autonomy and self-determination relies on a view that only the self can have the self's interests at heart.[58]

The majority's position in *Conroy* was based on the idea that avoidance of pain is one standard we can be confident in ascribing to another person.

The concurring opinion in *Conroy* criticized the majority opinion's focus on pain:

> I harbor the most serious doubts as to the justice, efficacy, or humaneness of [the majority's] standard . . . . The Court should, therefore, formulate a standard that would, in these circumstances, permit a natural death with dignity and compassion. Such a standard should not give determinative weight to the element of personal pain, which necessarily obviates other extremely important considerations. Rather it should accommodate as comprehensively, fairly, and realistically as possible all concerns and values that have a legitimate bearing on the decision whether to provide particular treatment at the very end of an individual's life.[59]

The question is, what concerns and values should be considered to "have a legitimate bearing on the decision"? One sensitive factor is "quality of life."[60] From a reading of the right-to-die deci-

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(refusing to recognize a claim for "wrongful life": "One of the most deeply held beliefs of our society is that life—whether experienced with or without a major physical handicap—is more precious than nonlife."); Becker v. Schwartz, 46 N.Y.2d 401, 412, 386 N.E.2d 807, 812, 413 N.Y.S.2d 895, 901 (1978) (refusing to recognize a claim for "wrongful life").

58. Minow, *supra* note 23, at 973-74 (footnotes omitted).

59. *Conroy*, 98 N.J. at 391-92, 486 A.2d at 1246 (Handler, J., concurring in part and dissenting in part) (footnote omitted).

60. A number of commentators have argued that "quality of life" factors—factors other than physical pain—should be considered in medical treatment decisions when there is insufficient evidence of the patient's wishes. *See, e.g.*, Merritt, *Equality for the Elderly Incompetent: A Proposal for Dignified Death*, 39 STAN. L. REV. 689 (1987). That commentator's proposal is as follows:

> If no clear evidence of intent exists, a court must become involved in the decisionmaking. Life-sustaining treatment can be withheld or withdrawn if the court finds that such action would serve the patient's best interests and result in a dignified, humane death. At this stage, the court should appoint a guardian *ad litem* to present all reasonable arguments why the treatment should not be terminated.
>
> . . . .
>
> The court should first consider the probable duration of the patient's life with treatment and the quality of that life. Quality is not measured by social utility

sions, there seems to be no agreement on what "quality of life" encompasses, a fact which may go far towards explaining the disagreements over whether it should be considered in treatment decisions.[61]

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or degree of intelligence, but is instead determined by the patient's current level of conscious functioning as compared to the level of functioning that the individual has enjoyed during the majority of his life. The court can measure this by examining testimony about the patient's level of brain activity, self-awareness, and awareness of others. . . . The potential for abuse is circumscribed by the . . . requirement that the . . . court first find that death is imminent and irreversible . . . .

A court must weigh the duration and quality of life provided by treatment against the physical suffering, the extent of bodily intrusion required by treatment, and the resultant loss of patient dignity.

Id. at 734-35 (footnotes omitted).

61. These conceptual differences may be exemplified by the following passages from the *Conroy* majority, the *Conroy* concurrence, and a recent Massachusetts case:

[W]e expressly decline to authorize decision-making based on assessments of the personal worth or social utility of another's life, or the value of that life to others. We do not believe that it would be appropriate for a court to designate a person with the authority to determine that someone else's life is not worth living simply because, to that person, the patient's "quality of life" or value to society seems negligible. The mere fact that a patient's functioning is limited or his prognosis dim does not mean that he is not enjoying what remains of his life or that it is in his best interest to die. More wide-ranging powers to make decisions about other people's lives, in our view would create an intolerable risk for socially isolated and defenseless people suffering from physical or mental handicaps.

Conroy, 98 N.J. at 367, 486 A.2d at 1232-33 (citations omitted).

The exclusive pain criterion denies relief to that class of people who, at the very end of life, might strongly disapprove of an artificially extended existence in spite of the absence of pain. Thus, some people abhor dependence on others as much, or more, than they fear pain. Other individuals value personal privacy and dignity, and prize independence from others when their personal needs and bodily functions are involved. Finally, the ideal of bodily integrity may become more important than simply prolonging life at its most rudimentary level.

. . . .

I share the Court's discomfiture with a standard that does not attempt to identify reasonably verifiable measures of a person's quality of life. However, there is no intrinsic reason why a quality-of-life standard must remain any more vague and undefined than a standard that includes pain.

Id. at 395-96, 397, 486 A.2d at 1248, 1249 (Handler, J., concurring in part and dissenting in part) (citations omitted).

[W]e must recognize that the State's interest in life encompasses a broader interest than mere corporeal existence. In certain, thankfully rare, circumstances the burden of maintaining the corporeal existence degrades the very humanity it was meant to serve. The law recognizes the individual's right to preserve his humanity, even if to preserve his humanity means to allow the natural processes of a disease or affliction to bring about a death with dignity. In stating this we make no judgment based on our view of the value of Brophy's life, since we do not approve of an analysis of State interests which focuses on Brophy's quality

What is significant is that the language in past right-to-die opinions seems directed more at reassuring the public than at answering the parties' arguments. To my knowledge, no party or *amicus* to a right-to-die case has ever argued—as was implied in one opinion—that medical treatment decisions should be "based on assessments of the personal worth or social utility of [the patient's] life, or the value of that life to others."[62] These opinions are trying to distance their conclusions from subjectivity, and from the distrust and loss of confidence that would emerge if we thought that medical treatment decisions were being made for patients in a way contrary to the way that the patients would have wanted those decisions made. The extreme quality-of-life position is used in these opinions as a "straw man" argument, to make the court's standards seem more objective and more untroubling than they may actually be.[63] The courts cannot finesse the inevitable doubt that comes when we try, albeit diligently and in good faith, to guess what someone else would have wanted.

There are other factors that are so controversial and emotion-laden that they are mentioned only hesitantly, if at all. For example, the emotional and financial burdens that an irreversibly comatose patient would place on her family are part of the reality in the right-to-die cases; but are these factors illegitimate?[64] Most of us, when we consider what choices we would want made for us, were we ever in a permanent vegetative state, would consider important the fact that we might become a burden to those we love.

Yet if we ask the decision-maker—a relative or friend of the patient—to consider the problem of cost, do we not pose an insoluble conflict? If we ask that costs be ignored, are we not asking the decision-maker to ignore factors that the patient would have

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of life.

Brophy v. New England Sinai Hosp., 398 Mass. 417, 434, 497 N.E.2d 626, 635 (1986) (footnote omitted).

The Massachusetts court, at the same time that it disavows a "quality of life" approach, accepts a position that the *Conroy* majority would probably label as a "quality of life" approach. This exemplifies the fact that different persons have different concepts in mind when they discuss a "quality of life" approach to treatment decisions.

62. *Conroy*, 98 N.J. at 367, 486 A.2d at 1232.

63. For example, though the *Conroy* majority labeled its pain standard as an "objective standard," it is not self-evident that every decision made for a patient under that standard will be made exactly as the patient would have wanted. Some patients may have wanted life-sustaining treatment continued even under the extreme circumstances involved in *Conroy*'s objective test.

64. *See* N. CANTOR, *supra* note 29, at 87-91.

wanted considered?[65] Our analysis should appreciate that the decision to refuse medical treatment occurs within a complex factual context and has many long-term consequences.

The appeals now before the court may yield greater clarity in terms of approaches to the elusive questions, decisional approaches, and standards in right-to-die cases.[66]

Judicial intervention in these cases can be seen not merely as an attempt to elaborate the distinction between the right to refuse treatment and suicide in order simply to delineate what will be legal for the litigants. In these cases, the courts have begun to recognize that what must be decided is *who* shall have the discretion to decide whether medical treatment is terminated.

We can understand the response of this court and of other courts to the right-to-die cases as searches for procedural and

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65. How can the State demand that the problems of the future be ignored, when the State may be able to do little to solve these future care problems? As Professor Minow noted in the context of the analogous problem of medical treatment decisions for severely handicapped infants:

> A serious form of state insensitivity appears in the unrealistic and abstract legal analysis that addresses the medical treatment decision disconnected from other issues about the child's future. State decisionmakers, or hospital review committees permitted by the state to second-guess parental choices, may assume that the parents will continue to care for the infant at home, while the parents may assume that they will ultimately send the child to an institution. Whether the parents or the state have the final words on the medical treatment decision, and whether or not that decision directs treatment, the severely handicapped child faces a possible destiny in a poorly maintained and staffed institution. These issues—and the child's ultimate destination—are obscured by the usual frameworks of analysis because the questions about state intervention, right to life versus quality of life, and who should decide, all neglect the relationships between the infant and those who will care for him or her. The usual analysis fails to address this matter of care even when the state itself may become the caretaker with its own conflicting interests. The state's own goals include protecting life and reducing budgets. These goals pose a conflict that makes the state no less free from bias and conflicting interests than the parents.

Minow, *supra* note 23, at 1001-02 (footnote omitted).

66. The facts of the cases now before the Court do not fit the standards promulgated by the Court in *Quinlan* and *Conroy*. These cases will probably prompt the Court to establish more general standards for future refusal-of-treatment situations. The Court can choose among various standards—"best interests," "subjective intent," and "substituted judgment"; different amounts of deference to those who are deciding in the name of an incompetent patient; and different amounts of supervision by government agencies, hospital committees, and the courts. Many questions are presented by these cases, not all of which need to be answered to resolve the cases, but all of which will eventually require judicial (or legislative) resolution. For example, what standards must a patient's family follow when it makes a treatment decision for the patient? What role should doctors play in these treatment decisions? Who should make the treatment decision, and under what standards, when there are no close relatives or close friends of an incompetent patient?

substantive solutions that will increase public confidence in particular treatment decisions and in the procedures by which such decisions are made and overseen.[67] The courts are searching for procedures that will at the same time respect the common-law right to refuse medical treatment and assure the general public that such decisions are being made for legitimate reasons. It is a difficult and delicate balance. If the court's approach is too deferential, the procedures may be abused and (less importantly) the public may lose respect for the judicial system. On the other hand, when the court establishes thorough and protective standards, the resulting procedures may prove so cumbersome that those affected may seek ways to circumvent them. There is evidence that this form of circumvention has occurred with the standards promulgated in *Conroy*.[68]

In the promulgation of standards and placement of procedures, the court's decisions can be seen as a form of judicial deregulation, as a cautious withdrawal of judicial oversight from the decisions of private parties. They can also be seen as a form of delegation, entailing a deference to the medical and health-care professions, as a belief that the standards governing the doctor-patient relationship, and the procedures developed by hospitals

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67. State-created rules and procedures influence the way we act and the way we interact with other persons. The law also affects the way we think about various issues in our lives. There is evidence that the state courts' gradual recognition of a right to die affected the standards and practices of the medical profession. In *Quinlan*, the background assumption was that authorizing the discontinuance of treatment was contrary to prevailing medical standards. *See Quinlan*, 70 N.J. at 42-51, 355 A.2d at 664-69. By contrast, in the cases now before the court, plaintiffs were able to cite standards promulgated by the American College of Physicians, New Jersey Chapter, and by the American Medical Association in support of their right to discontinue treatment. At the very least, the legal opinions in the right-to-die area have prompted doctors, patients, and hospitals to rethink the issue of discontinuing medical care. In the subjective and limited-objective test the court established in *Conroy* for authorizing the termination of medical treatment, 98 N.J. at 360-66, 486 A.2d at 1229-32, the court gave great weight to comments the patient made in the past "stating the person's desire not to have certain types of life-sustaining treatment administered under certain circumstances." *Id.* at 361, 486 A.2d at 1229 (footnote omitted). In recent right-to-die cases, evidence that the patient would have wanted treatment discontinued often comes in testimony about how the patient reacted to the situation in *Quinlan*. The subjective standard in *Conroy* can thus be seen to depend in a way on the fact that these cases do prompt us to rethink our views on the issues.

68. We are informed that "well over 100" persons have inquired with the office of the Ombudsman for the Institutionalized Elderly regarding the procedures *Conroy* requires before medical treatment can be withdrawn from nursing home patients, yet only one case has been officially brought to the Ombudsman's attention. Sullivan, *Curbs on Ending Life Supports Are Ignored*, N.Y. Times, Nov. 28, 1986, at B15, col. 1.

are together sufficient to allow us to trust the resulting treatment decisions.

The right-to-die decisions cannot be either easily dismissed or quickly applauded. Given the nature and the complexity of the issues in the right-to-die area, courts cannot overemphasize the importance of developing a sound process for dealing with individual cases. Yet we must also acknowledge that no substantive or procedural standard will ever be able completely to dispel or hide the doubt and distrust involved in these treatment decisions.[69] These cases therefore exemplify the kind of ultimate challenges to the judicial function presented by contemporary litigation.

V. Additional Observations

The right-to-die cases thus illustrate the challenge of traditional modes of legal analysis to adapt to new and perplexing social dilemmas. As we have seen, an effect of these dilemmas is not limited to modes of reasoning, for the inability of courts to construct adequate standards necessarily implicates their institutional integrity.

However, standards drawn from tradition still define for us when it is appropriate for the court to entertain a particular case and how far it should go in granting relief. These standards also define the alignment of the judiciary with the legislative and executive branches of government, identified by traditional labels of separation of governmental powers.

Courts must understand that, although it is necessary for them to act in a given case or controversy, the subject matter of the dispute and the effect of any judicial disposition can have social implications that truly overwhelm the individual interests involved. Contemporary legal disputes assume importance because of the broad principles and public policy issues that must be considered and resolved in settling the rights of the parties.

The judiciary must, therefore, appreciate the legislative priority in dealing with this kind of subject matter. Courts in this setting must not be hesitant to exercise their judicial authority; at the same time they must be prepared as an institution to accommo-

69. *See* Minow, *supra* note 23, at 998-99: "[T]rust cannot be announced, but must be achieved. . . . No new substantive rule, procedural technique, or new position on the state intervention debate will promote trust between people concerning this subject that so invokes personal vulnerabilities."

date legislative responses and even to encourage and cooperate in legislative resolutions of the particular social problems that gave rise to the legal controversy.

Moreover, the judiciary must be mindful that even when the legislature does not act in an area already covered by legislation, such inaction—particularly in the face of subsequent social change—does not necessarily reflect legislative indifference or simple inertia. Instead, legislative silence may reflect a popular or majoritarian feeling that no statutory change is necessary, notwithstanding the changes in society. Inaction may also indicate that the entire subject matter does not have a high priority on the legislative agenda. Of course, legislative silence might also indicate the presence of an effective special interest group or lobby that has succeeded in deflecting legislative and public consideration of an issue.

Thus, when a court decides a case that forces the legislature to respond, it can have the effect of reordering legislative priorities and reshuffling the legislative agenda.[70] When the court takes action in a case that has predominant public policy implications, and provokes a legislative response, the court's decision obliquely serves as a kind of "judicial initiative and referendum." When this occurs, however, it is because the court has acted in response to the needs of particular individuals in a single case. This does not make it wrong or inappropriate. Given the nature of judicial power, there is nothing in this judicial avenue to legislation that in the slightest undermines the theory or practice of separation of powers. It is simply another way in which government branches interact.

This interaction between the judiciary and the legislature raises another important consideration. If the subject matter of a particular dispute implicates social policy even more than the particular interests of the individuals involved, the courts ought to weigh carefully whether the determination of those individual interests should be based more appropriately on judicial common-law grounds or on constitutional doctrine. The benefit of basing a decision on common-law grounds is that this leaves the determina-

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70. *See* G. CALABRESI, A COMMON LAW FOR THE AGE OF STATUTES 31-32 (1982). *Cf.* Johnson v. Transportation Agency, 107 S. Ct. 1442, 1451 n.7 (1987) (discussing implications of congressional inaction in face of United States Supreme Court's affirmative action decisions: "The fact that inaction may not always provide crystalline revelation . . . should not obscure the fact that it can be probative to varying degrees.").

tion amenable to subsequent legislative consideration. In resolving this question, one basic inquiry should be whether the individual right is so fundamental, so important, that its preservation cannot be assured with any confidence unless it is found to inhere in the organic law of the Constitution. In posing this inquiry, courts may appropriately assume that, in most cases, the interest can be adequately addressed on the basis of common law and subsequent statutory codification or modification.

There may be disadvantages in "constitutionalizing" social policy. The *Quinlan* decision, for example, prompted Professor Tribe to observe: "Viewed as a prod to intensive legislative consideration, the decision's guidelines seem defensible. But by casting its holding in federal constitutional terms, the New Jersey court may have needlessly foreclosed more intelligent legislative solutions in that state."[71] In contrast, the *Conroy* decision was based on common-law foundations, leaving the standards open to judicial and legislative modification.

The resolution of an issue by recourse to common law permits an ongoing dialogue between the judiciary and the legislature in dealing with issues in which individual rights and social policy intersect. It enables the legislature, unconstrained by constitutional edict, to deal flexibly and comprehensively with difficult and complex social problems.

VI. PARTING THOUGHTS

What Cardozo said over sixty years ago has special pertinency:

> [We] have grown to see that the [judicial] process in its highest reaches is not discovering, but creating; and the doubts and misgivings, the hopes and fears are part of the travail of mind, the pangs of death and the pangs of birth, in which principles that have served this day expire, and new principles are born.

Some cases are better resolved by a process or procedure that encourages an ongoing dialogue rather than by an inflexible decision that purports to fix individual rights and duties but simply will not stay in place because of the intractable complexity of the underlying problems. The cases that have been mentioned to illustrate the novel complexity of contemporary social problems suggest that traditional adjudication may not suffice. As to cer-

71. L. TRIBE, AMERICAN CONSTITUTIONAL LAW § 15-11, at 937 (1978) (footnote omitted).

tain kinds of interests, however, too much process may be brought to bear in their accommodation.

In analogous fields, such as securing the well-being of institutionalized persons who are only marginally impaired, mentally or emotionally, and educating the handicapped, it has been pointed out that legal and due process requirements can frustrate the objectives sought. What is really needed is not an adversary framework designed unrealistically to bring out the "truth," but a framework within which the individuals whose interests are truly affected can participate fully and cooperatively on a regular and continuing basis.[72]

As Professor Minow pointed out regarding the analogous area of treatment of severely handicapped infants, the root problem in the right-to-die cases is one of trust and distrust.[73] All of the right-to-die opinions deal, on the surface or just below the surface, with the problems of trust and distrust. Can we trust someone who is very close to the patient to make a judgment in the patient's name or in the patient's best interests? On the other hand, can we trust someone who has a connection or only a limitation connection with the patient to make such a decision? Even when the patient is making her own decision, can we trust that she is making the decision based on appropriate and acceptable motivations?[74] Do we really meet the problem of trust and confidence at the decisional or regulatory level by a "bureaucratization of due process"? Professor Gilmore, considering the problems of morality and justice in a broader context, observed:

> Law reflects but in no sense determines the moral worth of a society. A reasonably just society will reflect its values in a rea-

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72. *See* J. HANDLER, THE CONDITIONS OF DISCRETION (1986); *In re* S.L., 94 N.J. 128, 462 A.2d 1252 (1983).

73. *See* Minow, *supra* note 23, at 974-78, 989-98.

74. Discussing treatment decisions for elderly incompetent patients, one commentator stated:

> The aged, especially nursing home residents, are an extremely vulnerable population because of their physical and mental impairments and their dependence on others in their daily lives. Many elderly patients have few or no surviving relatives and are socially isolated. . . . Watching a relative die can be emotionally draining; families may want not to prolong the end but to begin to grieve and resign themselves to their loss. Even those with more altruistic intentions cannot help but project their suffering onto the incompetent. The family that suffers with a relative in a debilitated condition may assume that the patient must be similarly miserable.

Merritt, *supra* note 60, at 724-25 (footnotes omitted).

tain kinds of interests, however, too much process may be brought to bear in their accommodation.

In analogous fields, such as securing the well-being of institutionalized persons who are only marginally impaired, mentally or emotionally, and educating the handicapped, it has been pointed out that legal and due process requirements can frustrate the objectives sought. What is really needed is not an adversary framework designed unrealistically to bring out the "truth," but a framework within which the individuals whose interests are truly affected can participate fully and cooperatively on a regular and continuing basis.[72]

As Professor Minow pointed out regarding the analogous area of treatment of severely handicapped infants, the root problem in the right-to-die cases is one of trust and distrust.[73] All of the right-to-die opinions deal, on the surface or just below the surface, with the problems of trust and distrust. Can we trust someone who is very close to the patient to make a judgment in the patient's name or in the patient's best interests? On the other hand, can we trust someone who has a connection or only a limitation connection with the patient to make such a decision? Even when the patient is making her own decision, can we trust that she is making the decision based on appropriate and acceptable motivations?[74] Do we really meet the problem of trust and confidence at the decisional or regulatory level by a "bureaucratization of due process"? Professor Gilmore, considering the problems of morality and justice in a broader context, observed:

> Law reflects but in no sense determines the moral worth of a society. A reasonably just society will reflect its values in a rea-

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72. *See* J. HANDLER, THE CONDITIONS OF DISCRETION (1986); *In re* S.L., 94 N.J. 128, 462 A.2d 1252 (1983).

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> sonably just law. The better the society, the less law there will be. In Heaven, there will be no law and the lion will lie down with the lamb. An unjust society will reflect its values in an unjust law. The worse the society, the more law there will be. In Hell there will be nothing but law, and due process will be meticulously observed.[75]

Because our society is still far away from being a utopian community, there is still need to inject law, to inject procedure, when we deal with difficult moral problems.

The challenges for the courts in cases such as the right-to-die cases will be to fashion by their dispositions not final decisions that provide an illusory protection and have no real finality, but frameworks within which those best able to decide are given the opportunity to decide. The challenge for the courts will be to evolve innovative and flexible processes by which affected individuals can participate comfortably and confidently to secure the vindication of the interests we all seek to protect. Courts will have to trust if there is to be trust.

VII. POSTSCRIPT

Since the delivery of this lecture, a number of the cases mentioned in the lecture and then pending before the New Jersey Supreme Court have been decided. In *Ayers v. Jackson Township*,[76] the court held that the plaintiffs, who had been subjected to contaminated well water, could recover for diminished quality of life and for future medical surveillance, but could not recover for emotional distress or for unquantified enhanced risk of disease.

In a trio of cases, the New Jersey Supreme Court elaborated on the right of patients to discontinue life-sustaining treatment. In *In re Farrell*,[77] the court upheld the right of a competent patient to choose to discontinue such treatment. *In re Peter*[78] and *In re Jobes*[79] involved patients who were no longer competent. In *Peter*, the court held that where a patient had left clear evidence that she would have wanted the treatment discontinued, her wishes must be respected, regardless of her life expectancy. In *Jobes*, the court held that the patient's right to discontinue treat-

75. Gilmore, *The Storrs Lectures: The Age of Anxiety*, 84 YALE L.J. 1022, 1044 (1975).
76. 106 N.J. 557, 525 A.2d 287 (1987).
77. 108 N.J. 335, 529 A.2d 404 (1987).
78. 108 N.J. 365, 529 A.2d 419 (1987).
79. 108 N.J. 394, 529 A.2d 434 (1987).

ment may be exercised by the patient's family or close friend. The *Baby M* case was accepted by the New Jersey Supreme Court on direct certification. The case was argued in September 1987 and is pending decision.