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Individual Worth

Alan B. Handler
INDIVIDUAL WORTH

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DIG-NI-TY . . . n. . . I: the quality or state of being worthy: intrinsic worth . . . .1

I. INTRODUCTION

A surprising number of intense human dramas have recently played on the judicial stage. In the guise of court decisions, they have presented very poignant themes, involving the most sensitive kinds of personal concerns—procreation, birth, health, survival, and dying.2 What seems unusual about all of this is not the drama of these episodes but that they have been produced and directed by courts.

In view of the thematic concerns of these litigated dramas, it is no wonder that courts have gone well beyond the firm ground of set-

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1. WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 632 (1986).

tled law. Many of these decisions appear to rest more on precarious
tenets of social policy and individual morality than familiar legal
foundations. Among the most visible of these are the right-to-die
cases. Also in this theater of law are cases involving wrongful birth
and wrongful life, informed consent with respect to critical medical
treatment, organ donation, and sterilization of the mentally handi-
capped. Each case dramatizes deep dilemmas reflecting the human
condition. In recent right-to-die cases, courts have struggled with the
issue of whether a decision can be made to terminate medical treat-
ment when this will inevitably bring about a person's death. The
underlying question in these cases is: When does such a decision
verge on unlawful killing? In other cases courts have dealt with such
questions as: How do we treat the deprivation of one's choice to con-
tinue or end a pregnancy involving a congenitally defective fetus?
Following birth, how should the interests of the defective child and
its parents be addressed? Under what circumstances can a de-
ceased person's organs be removed and given to others, and if so, are
there any considerations relating to the deceased person, as well as
the surviving family, that outweigh the interests of institutions seek-
ing the organs for the wellbeing of others? Should a chronically
mentally handicapped person be sterilized? Can we ever determine
whether this will diminish or enhance that person's life? Is the
treatment of developmentally disabled persons compatible with their
constitutional and other legal rights? In variant forms, all of these
cases have forced courts to confront the meaning of individual worth
in a technologically advanced society. Consequently, these cases pose
difficult jurisprudential questions: Have courts decided these issues

   (noting that courts which allow recovery for wrongful birth “take a step into entirely untradi-
tional analysis . . . .” (emphasis in original)).
4. See infra notes 54-108 and accompanying text.
5. See infra notes 26-53 and accompanying text; see also Procanik, 97 N.J. at 347-48,
6. See infra notes 53-131 and accompanying text.
7. See infra notes 131-37 and accompanying text (discussing Strachan v. John F. Ken-
nedy Memorial Hosp., 109 N.J. 523, 538 A.2d 346 (1988)).
8. See infra notes 139-53 and accompanying text.
9. See infra notes 53-108 and accompanying text.
10. See infra notes 26-52 (discussing the validity of wrongful birth and wrongful life
    causes of action); see also Botkin, The Legal Concept of Wrongful Life, 259 J. A.M.A. 1541,
11. See infra notes 26-43.
12. See infra notes 132-38 and accompanying text.
13. See infra notes 139-54 and accompanying text.
with solutions that fall beyond the bounds of established law and, in addressing the moral and policy issues, have they espoused a philosophy of individualism that should be clearly identified and expressed?

Current judicial experience reveals that courts have had to deal with perplexing and controversial policy and moral issues. Addressing these issues, courts have drawn on established law but, inescapably, have had to consider decisional grounds influenced strongly by principles of public policy as well as moral values. In particular, courts have been forced to explore philosophical concepts of individualism or individual worth. The cases disclose that courts have come to focus on individual worth as embracing personal autonomy, that is, the right in each individual to self-determination and personal choice. The cases also suggest that individual worth encompasses another fundamental interest: dignity and the concomitant right to be free from the intrusion of others. Although originating from common law and constitutional notions of rights of privacy, the judicial perception of individual worth is not always clearly or aptly explained. It is, nonetheless, manifested in both the courts' exposition of individual worth and in the legal solutions adopted to protect the interests that comprise individual worth. These cases also raise questions concerning the role and function of the courts. Have courts


15. For example, the difficult moral choice of avoiding the birth of a defective child by aborting the fetus belongs to the potential parents. See Roe v. Wade, 470 U.S. 113, 116 (1973). In Roe, the Supreme Court noted that "one's exposure to the raw edges of human existence, one's religious training, one's attitudes towards life and family and their values and the moral standards one establishes and seek to observe, are all likely to influence and to color . . . conclusions about abortion." Id. at 116. There remains, however, questions of whether public policy and morality confers upon potential parents the right to prevent, either before or after conception, the birth of a defective child. Harbeson v. Parke-Davis, 98 Wash. 2d 460, 472, 656 P.2d 483, 491 (1983). These decisions raise the question of whether "these developments [are] the first steps towards a 'Fascist-Orwellian societal attitude of genetic purity,' or Huxley's brave new world? Or do they provide positive benefits to individual families and to all society by avoiding the vast emotional and economic costs of defective children?" Id. (citation omitted).

16. See infra notes 26-40 and accompanying text (discussing the courts' focus on the right of an individual to self-determination and personal choice in the context of wrongful life, and right-to-die cases).

17. See infra notes 132-54 and accompanying text (discussing the courts' concern with an individual's interest in dignity and privacy).

18. See infra notes 66-87 and accompanying text (discussing right-to-die cases where the critical interest is the basic common law right of self-determination).

19. See infra notes 54-65 and accompanying text (discussing right-to-die cases where the critical interest is a constitutional right to privacy).
stretched judicial authority beyond acceptable limits? Have courts acted as a social arbiter deciding controversial matters of policy and morality that are better left to others?

The courts' decisions, while innovative, are cast for the most part in the conventional judicial adjudicatory mode. In a traditional sense, courts have done nothing more than treat these cases as controversies properly brought before them by contesting litigants. In this setting, courts act on the belief that law embodies a societal consensus on how certain factual situations should be handled. This traditional approach, however, vanishes when the facts of a case go beyond the existing societal consensus. In such cases the courts act alone against a background of uncertainty and disagreement. In the cases that have attracted our attention, courts have decided disputes with strong moral overtones providing solutions which purport to settle questions that society itself has not yet answered.

Courts have proffered judicial answers to these dilemmas, at the same time acknowledging the responsibility of others in these matters. In these cases courts have not pursued the role of social arbiter, but of social catalyst.

II. JUDICIAL PERCEPTIONS OF INDIVIDUAL WORTH

The right-to-die and wrongful birth and wrongful life cases

20. See Azzolino v. Dingfelder, 315 N.C. 103, 116, 337 S.E.2d 528, 536 (1985); see also Handler, supra note 14, at 3 (arguing that right-to-die cases "challenge the [courts'] competency . . . by straining classical techniques and categories of legal reasoning; and by testing the institutional flexibility of the judiciary."). The Supreme Court of North Carolina noted in Azzolino that:

claims for wrongful life and wrongful birth can be resolved properly only by a legislative body. They have not been and will not be resolved properly by courts attempting to apply "traditional" tort notions which simply do not fit or which courts steadfastly refuse to apply with full vigor.

Azzolino, 315 N.C. at 116, 337 S.E.2d at 536.


22. See infra notes 54-108 and accompanying text.

23. Wrongful birth is an action in tort by the parents of a deformed child to recover for negligent failure to allow an informed choice concerning the continuance of pregnancy. See Berman, 80 N.J. at 431-34, 404 A.2d at 14-15. Instances where a wrongful birth cause of action may arise are: negligent counseling, see Gallagher v. Duke Univ., 638 F. Supp. 979 (M.D.N.C. 1986), failure to mention the value of an amniocentesis test, see Berman, 80 N.J.
deal with matters of intense human concern that uniquely touch our deepest feelings as persons. An initial and primary focus on these two groups of cases as examples of our themes—cases involving the right to create life and the right to end life—are both instructive and appropriate. As Professor Laurence Tribe observed, "[o]f all decisions a person makes about his or her body, the most profound and intimate relate to two sets of ultimate questions: first, whether, when, and how one's body is to become the vehicle for another human being's creation; second, when and how—this time there is no question of 'whether'—one's body is to terminate its organic life."^26

Recent wrongful birth and wrongful life decisions from New Jersey are illustrative of these profound judicial dilemmas. In *Berman v. Allan,*^26 a physician failed to exercise reasonable care by not informing his patients, an expectant mother and her husband, of the need to undergo amniocentesis, a diagnostic procedure that would serve to determine whether the fetus was congenitally defective.^27 The couple allowed the pregnancy to go to term ignorant of the availability of such a test and the information it would reveal.^28 Thereafter, their baby was born with Down's Syndrome.^29 In *Schroeder v. Perkel,*^30 for four years the attending physician failed to diagnose a child as having cystic fibrosis.^31 During the delay in diagnosis, the parents chose to conceive another child.^32 Unfortu-
nately, the mother was in her eighth month of pregnancy with her second child when the diagnosis was made thus preventing the parents from making an informed choice as to whether they should have assumed the risk of conceiving another child.\(^3\) Tragically, the second child also developed cystic fibrosis.\(^4\) In *Procanik v. Cillo*,\(^5\) a mother who was exposed to German measles early in her pregnancy was not properly diagnosed and, therefore, not advised by her physician of the congenital risk to her fetus or the desirability of amniocentesis to determine its condition.\(^6\) Without this necessary counselling, the mother gave birth to a child with the terribly severe defect of congenital rubella syndrome.\(^7\)

In none of these cases was the physician at fault for causing the particular congenital defect. In each case, however, the physician was remiss in not having given the parents available information concerning the genetic risks to their unborn children, and the opportunity either to terminate the pregnancy or to prepare for an acutely distressing birth and life.\(^8\) In these cases, the New Jersey Supreme Court ruled that the negligence of the physician deprived the mother of the opportunity to decide whether or not to initiate or continue her pregnancy.\(^9\) The court concluded that the negligent deprivation of this opportunity was wrongful, and stressed that the critical individual interest that had been violated was that of personal choice belonging to the parents.\(^10\) Further, the court held that this wrong—the deprivation of choice—was protectable and compensable.\(^11\) In *Berman*, the court determined that damages could be

\[\begin{align*}
33. & \text{ Id.} \\
34. & \text{ Id.} \\
35. & \text{ 97 N.J. } 339, 478 A.2d 755 (1984); \text{ see Comment, Right Not To Be Born—New Jersey Becomes the Third State to Recognize Wrongful Life as a Cause of Action, 15 Seton Hall L. Rev. 880 (1985) (authored by Rollin A. Stearns, Jr.).} \\
36. & \text{ Procanik, 97 N.J. at 344-44, 478 A.2d at 758.} \\
37. & \text{ Id. at 344, 478 A.2d at 758.} \\
38. & \text{ See id. at 343, 478 A.2d at 758; Schroeder v. Perkel, 87 N.J. 53, 64-66, 432 A.2d 834, 839-40 (1981); Berman v. Allan, 80 N.J. 421, 426, 404 A.2d 8, 11 (1979).} \\
39. & \text{ Procanik, 97 N.J. at 344, 478 A.2d at 758; Schroeder, 87 N.J. at 64-66, 432 A.2d at 839-40; Berman, 80 N.J. at 432, 404 A.2d at 14.} \\
40. & \text{ See Procanik, 97 N.J. at 345-47, 478 A.2d at 759-60 (analyzing the development of parents' rights to make an informed decision to conceive or terminate a pregnancy within New Jersey).} \\
41. & \text{ Schroeder, 87 N.J. at 67-68, 432 A.2d at 840-41; Berman, 80 N.J. at 434, 404 A.2d at 15; cf. Procanik, 97 N.J. at 355-56, 478 A.2d at 764. In Procanik, the court recognized that a wrongful birth cause of action was compensable, but held that the parents were time-barred from bringing the cause of action. Id. Moreover, even if they were not time barred, recovery for extraordinary expenses would not have been permitted since the infant was previously}\]
awarded based on the emotional distress of the parents, 42 and in *Schroeder* the court also permitted recovery for the special and extraordinary medical expenses of the parents necessary to care for the handicapped child. 43

The significance of these decisions is underscored when they are contrasted with *Gleitman v. Cosgrove*, 44 an influential earlier case decided by the New Jersey Supreme Court. The court in *Gleitman* inferred that it was malpractice for a doctor to fail to inform a pregnant patient of her option to continue or terminate a pregnancy where it was a certainty or strong probability that the unborn child would be congenitally defective. 45 The court ruled, however, the wrong was not legally cognizable because it was not against public policy. 46 The majority held the wrong could not be recognized because there was no legal right to terminate a pregnancy through abortion. 47 In addition, the wrong could not be recognized because the court believed damages were impossible to ascertain. 48 Determining damages would require a comparison between existence and non-existence, between no life at all and an impaired life, a judgment beyond the ken of the court. 49

These cases are examples of the judicial treatment of a profound human dilemma, involving the moral choice of whether one should create new life when that life will be seriously defective. It is, therefore, hardly surprising that litigation involving issues of wrongful life and wrongful birth stir controversy and polarize opinion. Consequently, some courts have denied wrongful birth or wrongful life claims because they continue to view the obstacles raised by *Gleitman* as insurmountable. 50 Other courts have deferred to legisla-

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42. *Berman*, 80 N.J. at 434, 404 A.2d at 15.
43. *Schroeder*, 87 N.J. at 70-71, 432 A.2d at 842.
44. 49 N.J. 22, 227 A.2d 689 (1967).
45. *Id.* at 24-26, 227 A.2d at 690-91.
46. *Id.* at 28-31, 227 A.2d at 692-93.
47. *Id.* at 30-31, 227 A.2d at 693.
48. *Id.* The court in *Gleitman* stated that the “intangible, unmeasurable, and complex human benefits of parenting made it impossible to measure the damages to the parents of a child born with birth defects.” *Id.* at 29, 227 A.2d at 693.
49. *Id.* at 28, 227 A.2d at 692.
50. See, e.g., *Turpin v. Sortini*, 31 Cal. 3d 220, 233, 643 P.2d 954, 962, 182 Cal. Rptr. 337, 345 (1982) (stating that “at least in some situations—public policy supports the right of each individual to make his or her own determination as to the relative value of life and death.”); *Azzolino v. Dingfelder*, 315 N.C. 103, 337, 533 S.E.2d 528 (1985) (holding that wrongful birth claims shall not be recognized unless the legislature clearly states their intention to recognize such actions), cert. denied, 479 U.S. 835 (1987); cf. *Becker v. Schwartz*, 46
tures as a better forum for dealing with such causes of action.\textsuperscript{51} Nevertheless, while many jurisdictions have rejected either wrongful birth and/or wrongful life claims, all that have considered it have struggled mightily with its perplexing legal and moral issues.\textsuperscript{52}

N.Y.2d 401, 411-13, 386 N.E.2d 807, 812-13, 413 N.Y.S.2d 895, 900-01 (1978) (dismissing a wrongful life action because there was no legally cognizable injury to the infant and validating a wrongful birth action but denying recovery for the parents' pain and suffering).

51. Most legislation disallows actions which seek damages for wrongful life and wrongful birth. \textit{See}, e.g., IDAHO CODE \textsection 5-334 (Supp. 1986); MO. ANN. STAT. \textsection 188.130 (Vernon 1986); MINN. STAT. ANN. \textsection 145.424 (West 1989); S.D. CODIFIED LAWS ANN. \textsection 21-55-2 (Supp. 1986). \textit{But see}, e.g., ME. REV. STAT. ANN. tit. 24, \textsection 2931(3) (1986) (permitting damages for wrongful life and wrongful birth actions); \textit{see also} Note, \textit{Wrongful Birth Actions: The Case Against Legislative Curtailment}, 100 HARV. L. REV. 2017 (1987) (criticizing the constitutionality of wrongful birth statutes).

Decisions that have allowed some kind of recovery have unmistakeably acknowledged the “right of individual autonomy that involves personal choice and self-determination” as the singular indi-
The significance of personal choice with respect to the creation of life should suggest that at the opposite end of life's spectrum, when life terminates, personal choice is just as important.

One of the first contemporary right-to-die cases, *In re Karen Ann Quinlan,* addressed the issue of an individual's right to end life. In *Quinlan,* the New Jersey Supreme Court considered the plight of a young woman in an irreversible, comatose, and vegetative condition. Her life was sustained by a respirator. The question arose whether, at the request of the woman's parents, the doctor and hospital could disconnect the respirator without incurring criminal or civil liability for the patient's inevitable death. The court addressed this issue in terms of the patient's right of privacy.

In its formulation of the privacy issue, the court in *Quinlan* was influenced by the Supreme Court's decisions in *Griswold v. Connecticut* and *Roe v. Wade.* In these two cases, the Supreme Court ruled that an individual had a constitutional right of privacy that included the right of self-determination and personal choice over matters concerning procreation and pregnancy—the creation of life. The court in *Quinlan* concluded that the individual's constitutional right of privacy, encompassing personal choice in matters concerning the creation of life, also extended to a personal choice concerning the termination of life. Privacy that encompassed dominion over one's body included the right to refuse medical treatment relating directly to survival itself. The court in *Quinlan* then sought to

55. *Id.* at 23-25, 355 A.2d at 654-55.
56. *Id.* at 51-52, 355 A.2d at 669-70.
57. *Id.* at 38-42, 355 A.2d at 662-64
58. 381 U.S. 479 (1965). *Griswold* is the seminal constitutional decision involving personal choice with respect to procreation. The Supreme Court ruled that a married couple had the right not to procreate or conceive, in effect, not to initiate a pregnancy. *Id.* at 485-86. This right was subsequently extended to unmarried individuals. Eisenstadt v. Baird, 405 U.S. 438 (1972).
59. 410 U.S. 113 (1973). In *Roe,* the Court recognized that the right of privacy, with respect to procreation, encompassed the right to choose whether to have an abortion, in effect, to terminate or discontinue a pregnancy. *Id.* at 152-56.
60. *Id.* at 154; *Griswold,* 381 U.S. at 485-86.
61. *Quinlan,* 70 N.J. at 40, 355 A.2d at 663.
62. *Id.* at 40, 355 A.2d at 663.
determine how the right of individual choice could be effectuated when the individual was incapable of making any decision or exercising any control over her own body. In the court's view, the right of choice would be lost if it were not exercised. Thus, because Karen Ann Quinlan could not exercise her individual privacy right, the court delegated that right to her father who, as her guardian, could make the decision for his daughter and thereby vindicate her right of choice.

As later commentary has pointed out, the court in Quinlan spoke of the individual right in terms of constitutional privacy, viewing privacy primarily as the right of personal choice or self-determination. In a subsequent case, In re Conroy, the New Jersey Supreme Court also viewed the critical individual interest to be that of self-determination, but clarified the legal basis of the right. The patient in Conroy was an elderly woman in a semi-conscious state with irreversible physical and mental impairments. Her life was being sustained through forced feeding by a nasogastric tube; death was imminent. Although Ms. Conroy died while the case was pending, the court decided the case and held that life-sustaining treatment could be discontinued in certain circumstances. The court concluded that what was truly at stake was the fundamental right of personal choice or self-determination. This individual right of personal choice, however, was not the constitutional right of privacy but the basic common-law right of self-determination with respect to

63. Id. at 41-42, 355 A.2d at 664.
64. Id. at 41, 355 A.2d at 664.
65. Id. The court made clear, however, that the parents in this case were loving, trust-worthy and unselfish persons. Id. at 54, 355 A.2d at 667. Moreover, the decision would be a joint one involving the judgment of the hospital's "Ethics Committee." Id.
69. Id. at 337, 486 A.2d at 1217.
70. Id. at 336-37, 486 A.2d at 1216-17.
71. Id. at 342, 486 A.2d at 1219.
72. Id. at 359-60, 486 A.2d at 1229. The court stated that "life-sustaining treatment may be withheld or withdrawn from an incompetent patient when it is clear that the particular patient would have refused the treatment under the circumstances involved." Id. at 360, 486 A.2d at 1229.
In three recent New Jersey right-to-die cases, the court's thinking about this aspect of individual worth has been further clarified. In In re Farrell, a competent, dying middle-aged woman, whose existence was totally helpless and hopeless, sought to die naturally instead of prolonging her life artificially. Although Mrs. Farrell died before the court could consider her appeal, the court ruled that she would have had the right to choose the termination of her life-support medical treatment. The court's holding was predicated squarely on the individual interest of self-determination protectable as a common law right. In In re Peter, the companion case to Farrell, the incompetent patient was an old woman whose comatose condition was irreversible. Although death was not imminent, she had previously expressed her desire to have another person make the life-or-death decision for her. The court permitted this person, acting pursuant to a trustworthy and durable power of attorney that had been executed by the patient while competent, to decide whether to continue or discontinue the life-support treatment. The court thereby effectuated the patient's right of self-determination. In the third case, In re Jobes, the court considered the plight of a young woman in an irreversible comatose state, but whose death was not imminent. She was kept alive through artificial respiration, hydra-
The court permitted the termination of medical treatment, emphasizing the patient’s right of self-determination and the need to effectuate this right.

The right-to-die cases exemplify the court’s perception of individual worth as encompassing the right of personal autonomy. The significance of personal autonomy is further underscored by the range of situations in which personal autonomy is deemed to be the core interest that demands protection, and by the remedies that the court develops. Thus, if the patient is competent as in Farrell, the patient is entitled to make the decision herself, by exercising informed consent in conjunction with her physician. Personal autonomy also explains why a competent person may execute a living will or durable power of attorney that permits a surrogate decisionmaker, who may either be the person’s designee, family member or close friend, to exercise that person’s right of self-determination after he or she has become incompetent. Finally, even when an incompetent patient is unable to exercise intelligent, informed choice or has not executed an “advance directive,” the right of personal autonomy can be vindicated through a decision made by other persons by a process of substituted-judgment.

In Conroy, the court sought to chart these remedial paths. It articulated a comprehensive standard for defining the substituted-judgment methodology in the case of an incompetent person whose wishes are unknown with respect to the continuation of life-sustaining medical treatment. The primary application was called the

86. Id. at 402, 529 A.2d at 438.
87. Id. at 426-27, 529 A.2d at 453.
88. 108 N.J. at 354-59, 529 A.2d at 413-16.
89. See, e.g., In re Peter, 108 N.J. 365, 378-80, 529 A.2d 419, 426-27 (1987) (stating that a living will is “a written statement that specifically explains the patient’s preferences about life-sustaining treatment”); see also The Hastings Center, Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying 140, 141 (1987) [hereinafter Hastings Guidelines] (providing that a living will is a “treatment directive” and a durable power of attorney is “an individual’s written designation of another person to act on his or her behalf”). The President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research refers to both living wills and durable powers of attorney as “advance directives.” President’s Comm’n for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forgo Life-Sustaining Treatment 5 (1983) [hereinafter President’s Comm’n].
91. 98 N.J. at 358-68, 486 A.2d at 1228-33; see also Note, supra note 67, at 375-79 (discussing the three tests enumerated in Conroy).
"purely-subjective" test and was intended to be followed when there was clear and convincing evidence of the patient's preferences that could serve as the exclusive standard for reaching a particular decision. A second standard, called a "limited-objective" test, depended on a combination of some trustworthy evidence of the patient's preferences and a determination based on objective factors relating to the patient's condition. This test involved a weighing of benefits as well as burdens, including the element of pain, in connection with continued treatment and the prolongation of life. The court also required that the substituted judgment be shared not only by physicians and family members or friends but also by the Office of the Ombudsman for the Elderly. The court also proffered a third standard, the "purely-objective test." This standard was to be invoked when there was no trustworthy evidence of the patient's preferences, requiring only a balance of benefits and burdens relating to the patient's objective condition. It was, in effect, a best-interests test since a decision is made according to what is presumed to be in the

92. 98 N.J. at 360-64, 486 A.2d at 1229.
93. Id. To ascertain the wishes of a patient, the court may consider many different sources including the execution of a living will, a patient's oral directive, a durable power of attorney, deductions from the patient's religious beliefs and the tenets of that religion, and inferences "from the patient's consistent pattern of conduct with respect to prior decisions about his own medical care." Id. at 361-62, 486 A.2d at 1229-30.


95. Id.

96. Id. at 365, 486 A.2d at 1232. The court concluded that the limited-objective standard "permits the termination of treatment for a patient who had not unequivocally expressed his desires before becoming incompetent, when it is clear that the treatment . . . would merely prolong the patient's suffering." Id.

97. Id. at 383-84, 486 A.2d at 1241-42. The New Jersey Legislature established the Office of the Ombudsman for the Institutionalized Elderly by statute in 1977. N.J. Stat. Ann. § 52:27G-3 (West 1986). The purpose of this agency is "to receive, investigate and resolve complaints concerning certain health care facilities serving the elderly, and to initiate actions to secure, preserve and promote the health, safety and welfare, and the civil and human rights of the elderly patients, residents and clients of such facilities." Id. § 52:27G-1. In Conroy, the New Jersey Supreme Court required that this office be notified if an incompetent patient's life-sustaining treatment is being withdrawn or withheld, treat every notification as a possible "abuse," investigate the situation, and concur in the decision of the guardians and the doctors before life-sustaining treatment is withheld or withdrawn. 98 N.J. at 383-84, 486 A.2d at 1241-42.

In Conroy, the court recognized that at some point, as evidence of the patient's subjective intent becomes less trustworthy, the exercise of substituted judgment shades into a best-interests analysis. Hence, persons purporting to exercise substituted judgment based ostensibly on the patient's preferences may, in fact, decide to terminate the treatment on grounds indistinguishable from those based on the best interests of the patient. Thus in Jobes, the court relied on evidence of the patient's general personal values as revealed through family members and friends. The court, as it originally did in Quinlan, invoked a substituted judgment methodology, delegating to the patient's family the right to exercise the choice on behalf of the patient. Nevertheless, the life-sustaining treatment being administered to the patient was highly invasive; her condition was

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99. Id. at 366-67, 486 A.2d at 1232. The court set forth two conditions that must be satisfied under the purely-objective test. First, "the net burdens of the patient's life with the treatment should clearly and markedly outweigh the benefits that the patient derives from life." Id. Secondly, "recurring, unavoidable and severe pain of the patient's life with the treatment should be such that the effect of administering life-sustaining treatment would be inhumane." Id.

100. Id. at 368, 486 A.2d at 1233.


102. In re Jobes, 108 N.J. 394, 409-11, 529 A.2d 434, 442 (1987). This evidence consists of "the patient's prior statements about and reactions to medical issues . . . with, of course, particular reference to his or her relevant philosophical, theological and ethical values . . . ." Id. at 414-15, 529 A.2d at 444; see also In re Severns, 425 A.2d 156, 158-59 (Del. Ch. 1980) (utilizing the substituted judgment test based on the incompetent patient's previously expressed wish that "she did not want to be kept alive in a vegetative state . . . ."); Brophy v. New England Sinai Hosp., 398 Mass. 417, 427-29, 497 N.E. 626, 631-32 (1986) (substituted judgment based on, among other things, patient's religious convictions and his views of the Quinlan case, including an alleged preference of refusing treatment if he was ever in Quinlan's condition); Delio v. Westchester County Medical Center, 129 A.D.2d 1, 5-6, 26, 516 N.Y.S.2d 677, 681, 693 (2d Dep't 1987) (patient's views and wishes expressed repeatedly over years were clear and convincing evidence that patient would have refused treatment); In re Grant, 109 Wash. 2d 545, 566-68, 747 P.2d 445, 456-57 (1987) (commenting that the patient's mother believed the patient would not want to have her life sustained artificially based on the patient's past dislike of medical treatment).


104. Jobes 108 N.J. at 412-13, 529 A.2d at 443. As the court noted in Jobes, "the term 'substituted judgment' is commonly used to describe our approach in Quinlan." Id. at 414, 529 A.2d at 444.
wretched.\textsuperscript{105} There was some acknowledgment that, even in the absence of an expression of the patient’s preference, a surrogate decisionmaker could properly conclude that it would be in the patient’s best interests to withdraw life-sustaining treatment under such circumstances.\textsuperscript{106}

It is nevertheless evident that the primary, perhaps favored, aspect of individual worth acknowledged by the court in these cases is personal autonomy. The substituted-judgment approach, which attempts to effectuate personal autonomy, is the solution of first resort. It draws content from the patient’s wishes, views, values and life style manifested while the patient was competent. Thus, in \textit{Jobes}, as in \textit{Quinlan}, the court focused on those persons, who through personal knowledge, informed intuition, and familiarity, could best assess the patient’s wishes, and who, by virtue of their relationship with the patient, could most be trusted to make an unselfish decision on her behalf.\textsuperscript{107} In each case the court allowed the family of the incompetent patient to act as the surrogate decisionmaker.\textsuperscript{108}

In all these right-to-die and wrongful birth and life cases, courts have confronted the meaning of individuality; having identified personal autonomy as the primary individual interest at stake, they have sought to clarify the right of self-determination or personal choice.

Individuality and personal autonomy, the direct impetus underlying the notions of self-determination and personal choice can be traced in the common law doctrine of informed consent.\textsuperscript{109} In \textit{Far-}

\textsuperscript{105} Id. at 401-04, 529 A.2d at 438 (describing the treatments administered and the physical condition of Mrs. Jobes).

\textsuperscript{106} Id. at 441-43, 529 A.2d at 458-59 (Handler, J., concurring); \textit{Id.} at 450, 529 A.2d at 463 (Pollock, J., concurring).

\textsuperscript{107} Id. at 409-11, 529 A.2d at 442-43; \textit{Quinlan}, 70 N.J. at 38-39, 355 A.2d at 663.

rell, the court explained that the right-to-die decision belonged to the dying but competent patient based on her “informed consent.” The case parallels the California case of Bouvia v. Superior Court, in which the court determined that a competent person in a condition of physical helplessness was entitled to make a personal decision, a choice based on “informed consent,” as to whether she would continue to be fed in order to survive.

In jurisdictions that have acknowledged personal autonomy, it is not entirely coincidental to find as a core interest in defining individual worth, a parallel decision that expands the related common law principle of informed consent. In a recent New Jersey case, Largey v. Rothman, the court once again explained the standard of care owed by a physician to a patient in terms of informed consent and adopted an enhanced disclosure standard for “informed consent” as articulated in the earlier and influential decision of Canterbury v. Spence. The court in Canterbury decided to change the duty of disclosure from one based on a “professional” standard to one based on the patient’s wishes and needs. The court stated that “[t]he respect for the patient’s right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves.”

112. Id. at 1138-39, 225 Cal. Rptr at 301-02.
115. Id. at 209-14, 540 A.2d at 507-09.
117. The majority of the jurisdictions that adopted the “professional” standard required a physician to make disclosures that comport with prevailing medical standards in the community or “the disclosure of those risks that a reasonable physician in the community of like training, would customarily make in similar circumstances.” Largey, 110 N.J. at 209, 540 A.2d at 507. A minority of jurisdictions that adopt the “professional” standard do not utilize a community standard but require only “such disclosures as would be made by a reasonable medical practitioner under similar circumstances.” Id.
118. Canterbury, 464 F.2d at 784 (citations omitted). The court explained that the right
In effect, this standard evidences a greater value placed on the right of self-determination.\footnote{119} Another aspect of individuality or individual worth, which is distinguishable from personal autonomy, is reflected in the right-to-die cases.\footnote{120} In re Conroy\footnote{121} acknowledged the situation that confronted health-care providers responsible for the treatment and survival of a person whose wishes were unknowable, or a person who was unknown.\footnote{122} Logically, no decision to continue or discontinue life-support treatment could ever be shown to fulfill that individual’s personal wishes or to approximate her views and values; in no sense could any decision affecting such a patient effectuate her personal choice or constitute self-determination. The court, in that situation, devised a standard that did not look to the individual right of self-determination or personal choice. It articulated a purely-objective test based solely on the medical condition of such a patient.\footnote{123} Similarly, In re Jobses\footnote{124} foreshadowed the situation of an individual who is unknown or unknowable.\footnote{125} The court’s decision intimates that when health providers are confronted with this situation, the individual interest to be protected is the right to be free from intru-

\begin{footnotes}
\begin{footnote}{119} Canterbury applied the long standing common law doctrine that medical treatment should not be administered to someone without the patient’s consent. 464 F.2d at 780 & n.15; see, e.g., Schloendorff v. Society of the N.Y. Hosp., 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914) (Cardozo, J.) (stating that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.”).\end{footnote}

\begin{footnote}{120} See supra notes 54-108 and accompanying text.\end{footnote}

\begin{footnote}{121} 98 N.J. 321, 486 A.2d 1209 (1985).\end{footnote}

\begin{footnote}{122} See supra notes 98-99 and accompanying text (discussing the “purely-objective” test).\end{footnote}

\begin{footnote}{123} Conroy, 98 N.J. at 366, 486 A.2d at 1232.\end{footnote}

\begin{footnote}{124} 108 N.J. 394, 529 A.2d 434 (1987).\end{footnote}

\begin{footnote}{125} If the patient has no family or close friends to act as a surrogate decision maker, the court will appoint a guardian to so act. Id. at 419, 529 A.2d at 447. The court set forth mandatory guidelines in the absence of clear and convincing evidence of the patient’s personal inclination toward withdrawal of life support, regardless of who the decision maker was. Id. First, a hospital prognosis committee must determine if there is any reasonable possibility of recovery to a cognitive state. Id. at 419-20, 529 A.2d at 447-48. If the committee determined there was no possibility of recovery, life support may be withdrawn without judicial review. Id. at 421, 529 A.2d at 448.\end{footnote}
\end{footnotes}
sion, a right to preserve personal integrity and dignity.\textsuperscript{128}

The best-interests test, with a more extended reach than the substituted-judgment approach, has been invoked to address these situations.\textsuperscript{127} There is, however, no consensus for defining the best-interests test. In \textit{Conroy}, the court attempted to define the best-interests test in terms of balancing the benefits of continued life against the burdens of continued treatment.\textsuperscript{128} The court stressed, however, that the individual interest to be protected by this standard was not based on quality-of-life.\textsuperscript{129} The test involves consideration of objective factors such as the patient's age, prognosis, the imminence of death, feelings of pain, level of consciousness, medical condition, and isolation, together with the restrictions on the patient's physical freedom and how intrusive the medical treatment has been.\textsuperscript{130} Since the best-interest standard takes into account so many factors, it may arguably entail a decision as to what a reasonable person in the patient's circumstances would choose.\textsuperscript{131}

\textsuperscript{126} \textit{See id.} at 440-45, 529 A.2d at 457-60 (Handler, J., concurring); \textit{Id.}, 108 N.J. at 448-50, 529 A.2d at 461-63 (Pollock, J., concurring); \textit{Conroy}, 98 N.J. at 365, 486 A.2d at 1232; Rasmussen v. Fleming, 154 Ariz. 200, 221-22, 741 P.2d 667, 688-89 (1986); \textit{Conroy}, 98 N.J. at 365, 486 A.2d at 1232.

\textsuperscript{127} \textit{See Rasmussen}, 154 Ariz. at 221-22, 741 P.2d at 688-89. The substituted-judgment test attempts to reach the decision the incapacitated person would make if he or she could make a determination. \textit{Id.} at 221-22, 741 P.2d at 688. This standard is guiding if the patient has made known his or her intent while competent. \textit{Id.} Using the best-interests test, the decision-maker has to evaluate the medical treatment that would be in the patient's best interest. \textit{Id.} at 222, 741 P.2d at 689.

\textsuperscript{128} \textit{Conroy}, 98 N.J. at 365, 486 A.2d at 1232.

\textsuperscript{129} \textit{Rasmussen}, 154 Ariz. at 221-22, 741 P.2d at 688-89.

\textsuperscript{130} \textit{Conroy}, 98 N.J. at 365, 486 A.2d at 1232. The dissent argued that the individual interest protected by this standard involved dignity and the right to be free from intrusion. \textit{Id.} at 393-99, 486 A.2d at 1246-50 (Handler, J., concurring in part and dissenting in part) (stressing that "a decision to focus exclusively on pain as the single criterion ignores and devalues other important ideals regarding life and death."); \textit{see also Rasmussen}, 154 Ariz. at 222, 741 P.2d at 689; Jobes, 108 N.J. at 437, 529 A.2d at 456 (Handler, J., concurring); \textit{Id.}, 108 N.J. at 449, 529 A.2d at 462 (Pollock, J., concurring); \textit{President's Comm'n, supra} note 89, at 135; \textit{Hastings Guidelines, supra} note 89, at 28-29.

\textsuperscript{131} \textit{See President's Comm'n, supra} note 89, at 136 (noting that "[w]hen a patient's likely decision is unknown . . . a surrogate decisionmaker should use the best interests standard and choose a course that will promote the patient's well-being as it would probably be conceived by a reasonable person in the patient's circumstances."); \textit{Hastings Guidelines, supra} note 89, at 28 (explaining that "[i]f there is not enough known about the patient's direction, preferences, and values to make an individualized decision, the surrogate should choose as to promote the patient's interests as they would probably be conceived by a reasonable person in the patient's circumstances, selecting from within the range of choices that reasonable people would make."); N. Cantor, \textit{Legal Frontiers of Death and Dying} 79 (1987) (commenting that "[t]he more oblique or distant the patient's expressions or behavior, the more decision-makers must consider what course of treatment common human dignity suggests under the circumstances."). \textit{But see In re Storar}, 52 N.Y.2d 363, 380-82, 420 N.E.2d 64, 72-73, 438
The conceptualization of individual worth that has surfaced with respect to a true stranger in the right-to-die cases encompasses the concerns of dignity and privacy as distinguished from personal autonomy or self-determination. This distinction can perhaps be highlighted by shifting the decisional context. The case of *Strachan v. John F. Kennedy Memorial Hosp.* presented a situation where parents were denied the right to reclaim the body of their dead son, a sudden suicide, while the hospital endeavored to secure their permission to remove his organs for transplant. The New Jersey court concluded that the hospital, its administrator and its physicians acted unreasonably by failing to honor “the [family’s] legitimate request to turn over their son’s dead body.” The court recognized “that in reality the personal feelings of the survivors are being protected,” not just a quasi-property right to bury the dead, and that “[t]he failure of defendants to honor the family members’ request posed a plain affront to their dignity and autonomy and exposed them to unnecessary distress at a time of profound grief.” The parents were forced to view their son’s dead body maintained by machines in an artificial life-like condition. Was this not an indignity inflicted on the boy’s dead body and vicariously suffered by the parents? The severity and genuineness of the parents’ emotional distress in this context seemingly reflects our deep-seated feelings and common belief in the basic dignity that inheres in every person—an aspect of individual worth so powerful that it endures even in death.

N.Y.S.2d 266, 274-76 (finding if a patient was never competent, and therefore a substituted judgment would be impossible, life-sustaining treatment must be continued even though “someone as close as a parent or sibling, feels that [terminating the treatment] is best for one with an incurable disease.”) cert. denied, 454 U.S. 858 (1981); *The New York State Task Force on Life and the Law, Life-Sustaining Treatment: Making Decisions and Appointing a Health Care Agent* 26-27 (1987) (providing that under New York law, “[f]or persons never capable of expressing their wishes, life-sustaining treatment cannot be discontinued, whatever burden it imposes.”).

133. *Id.* at 526-28, 538 A.2d at 347-48. The plaintiff’s son was kept alive on a respirator while the hospital, which was actively involved in organ transplants, tried to convince the parents to donate their son’s organs. *Id.*
134. *Id.* at 538, 538 A.2d at 353.
135. *Id.* at 531, 538 A.2d at 350 (quoting W. Prosser & W. Keeton, *supra* note 51, § 12, at 631).
137. *Id.*
138. Professor Rhoden argues that “duties” are owed to persons in death. Rhoden, *Litigating Life and Death*, 102 HARV. L. REV. 375, 418 (1988). Professor Rhoden stresses the need to respect the subjective wishes expressed in a “living will” or “advanced directive” and observes the following:
Another case suggesting that individual worth extends beyond the values encompassed by personal autonomy is *In re Grady*. The New Jersey Supreme Court focused on personal autonomy and, more specifically, individual control over one's own reproductive capacity. The court defined this in constitutional terms as a "privacy right," and explained that it was not simply a right to obtain contraception or a right to attempt procreation but "the right to make a meaningful choice between them."

Read literally, *Grady* focuses on individual worth in its dominant sense of personal autonomy or self-determination, harkening to the decisional harbingers such as right to privacy that influenced the *Quinlan* court. The court prescribed standards under which a choice was to be made by others. Because the court defined the...
individual right as "personal choice" and effectuated the right by authorizing others to make the choice, its rationale approximates that of substituted judgment. Still, the sterilization decision is to be made objectively in the incompetent person's "best interests."

This approach was not unlike the path followed by courts in some of the right-to-die cases in which a best interest analysis was cloaked in a substituted-judgment formulation.

266, 426 A.2d at 483; see infra note 150 and accompanying text (discussing the factors to be evaluated in determining what is in a person's best interests).

148. Grady, 85 N.J. 235, 250-52, 426 A.2d 467, 474-75. The court recognized that the right to choose between sterilization and procreation was constitutionally protected. Id. at 250, 426 A.2d at 474. The fact that the individual faced with the choice was incompetent "should not result in the forfeit of this constitutional interest." Id. Therefore, when the incompetent individual lacks the mental capacity to make the choice, the court determined that "a court should exercise the right on behalf of the incompetent in a manner that reflects his or her best interests." Id. at 252, 426 A.2d at 475; see supra note 147 and accompanying text (discussing the procedures a court must follow to determine whether to authorize the sterilization of an incompetent).

149. The court did not "pretend that the choice of her parents, her guardian ad litem, or a court is her own choice. But it is a genuine choice nevertheless—one designed to further the same interests she might pursue had she the ability to decide herself." Grady, 85 N.J. at 261, 426 A.2d at 481.

150. The standard that the court prescribed for the decision concentrated solely on objective factors that related to the incompetent person’s well-being. These factors included: (1) The possibility that the incompetent person can become pregnant . . . . (2) The possibility that the incompetent person will experience trauma or psychological damage if she becomes pregnant or gives birth, and conversely, the possibility of trauma or psychological damage from the sterilization operation . . . . (4) The inability of the incompetent person to understand reproduction or contraception and the likely permanence of that inability . . . . [and] (7) The ability of the incompetent person to care for a child.

Id. at 266, 426 A.2d at 483. Factors relevant to the sterilization of a mentally handicapped person in another context would have no bearing upon the final analysis. In Grady the court noted that the interests of the parents who could be burdened with the care of an infant, the interests of a potential child whose fate is indeterminable, and the interests of society, were legitimate concerns but irrelevant to the decision affecting the the mentally handicapped woman. Id. at 267, 426 A.2d at 484.

Implicit in *Grady* is the premise that a young woman's right of personal autonomy and self-determination was really not at stake. By freeing her from the terror and burdens of a pregnancy and child birth with which she could not cope, sterilization could improve the young woman's opportunity to live a better, happier, and more secure life—concerns that comport fully with individual dignity, self-esteem and personal integrity.

Viewing this constellation of decisions one can glean an emerging judicial doctrine of individual worth. Individual worth is conceptualized both in terms of personal autonomy and personal dignity. Autonomy is perhaps the most recurrent principle of individual worth present in judicial decisions, involving essentially the right of self-determination and personal choice. Dignity invokes the values inherent in the integrity of one's own personality and the right to be free from intrusion.

Obviously these are not mutually exclusive concepts. Each has been understood as an aspect of "privacy," a concept that traditionally has been an umbrella for a number of the interests vital to our understanding of individuality. As noted, constitutional privacy historically has been imbued strongly with the sense of the right of personal choice or self-determination. It is significant, however, that the decisional context in which autonomy or personal choice received

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152. *Grady*, 85 N.J. at 261, 426 A.2d at 481; see supra note 149. The court was not pretending to know what the incompetent person's decision would be, but rather was protecting her best interests for a fulfilling life. *Id.* at 85 N.J. at 266-67, 426 A.2d at 483.

153. *Id.* at 250, 426 A.2d at 474; compare *Grady*, 85 N.J. at 250-52, 426 A.2d at 474-75 (recognizing that the choice between sterilization and procreation is constitutionally protected) with *In re Eve*, 31 D.L.R. (4th) 1 (1986) (Supreme Court of Canada ruling that a mentally retarded woman could not be sterilized). In *Eve*, the court determined that the "substituted judgment" test was unacceptable in that it was an "obvious fiction" to suggest that a decision of the court was the decision of the competent. *Id.* at 35. The court also ruled that the "best interests" test was not "a sufficiently precise or workable tool" in exercising the *parens patriae* jurisdiction. *Id.* at 33. Instead, the court chose to draw the line between therapeutic and non-therapeutic sterilization and ruled that the *parens patriae* power does not extend to authorizing non-therapeutic sterilization of the mentally retarded. *Id.* at 32. The court also commented that judges are generally not well prepared to decide such cases and that it is the role of the legislature to decide whether the sterilization of the mentally incompetent is socially desirable. *Id.* at 33.

154. Accord *Grady*, 85 N.J. at 266-67, 426 A.2d at 483. The court noted that "[t]he ultimate criterion is the best interests of the incompetent person." *Id.*

155. See supra note 58-60 and accompanying text.
judicial consideration presented matters of extraordinary personal physical intimacy: sexual relations, reproduction, pregnancy and childbirth. These are the concerns that are most associated with the human need and expectation of the right to be left alone. It is, therefore, understandable in light of the continuing influence of these cases, that the separable strands of individual worth—autonomy and dignity—are frequently intertwined.

The conceptual blurring of the several aspects of individual worth appears in the aforementioned cases. For example, it has been observed with respect to the right-to-die cases that when a patient's individual right to self-determination is exercised, the person exercises the "right to privacy and personal dignity." However, this formulation of individual worth considers "personal dignity" in its subjective sense—in terms of the patient's own individual sense of personal dignity. Personal dignity in this sense is simply a factor comprising the person's subjective values, wishes and preferences. It is an element of self-determination which undergirds personal autonomy and the substituted-judgment approach.

There are significant subjective and objective complexities inherent in both autonomy and dignity. These complexities, nevertheless, are important to consider when seeking to overcome the shortcomings of a purely-subjective standard, which measures self-determination or autonomy, as well as correcting the deficiencies of

156. Griswold v. Connecticut, 381 U.S. 479 (1965) (recognizing that the right of privacy extends to a married couple's choice to use contraception); Eisenstadt v. Baird, 405 U.S. 438 (1972) (extending the right of privacy in matters of contraception to unmarried individuals as well as married).
157. Skinner v. Oklahoma, 316 U.S. 535 (1942) (recognizing that the right to procreate is constitutionally protected).
158. Roe v. Wade, 410 U.S. 113 (1973) (recognizing a woman's right to choose to have an abortion as part of her right to choose whether or not to procreate).
159. Id.
160. See, e.g., Eisenstadt v. Baird, 405 U.S. 438, 453 (1972). The Supreme Court made clear that the right to prevent procreation by using contraceptives is grounded on the "right of the individual married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child." Id.
161. See supra notes 54-108 and accompanying text.
163. See supra notes 90-99 and accompanying text (discussing the substituted judgment approach).
an objective or best-interests test that addresses dignity.\textsuperscript{164}

It has been suggested that subjective feelings are always relevant even with respect to the unknowable person; communal values can be used to develop substantive criteria for addressing the subjective feelings of such persons.\textsuperscript{165} Imputing subjective feelings becomes the predicate for community or reasonable person standards in order to give meaning to the basic individual values at stake.\textsuperscript{166}

It is clear, however, that personal dignity has a definition beyond its subjective meaning to the patient. "The question of dignity is obviously separate from any claim based on autonomy. A claim based on dignity is more amorphous, harder to ground in traditional legal analysis and perhaps more controversial once translated into specific criteria."

An insight into dignity in its broader reach may be gained by considering privacy in its sense of the right to be left alone.\textsuperscript{167} This involves more than being free to make personal decisions, although it includes the right to make a personal choice without interference.\textsuperscript{168} Rather, this kind of privacy encompasses a right not to be interfered with in all matters that distinctively surround one's basic individuality.\textsuperscript{169} At its core is the notion that each individual has a personality that is unique, a special sense of self that should be inviolate.\textsuperscript{170}

\begin{itemize}
\item \textsuperscript{164} See Rhoden, \textit{supra} note 138, at 377-78, 406-07. According to Professor Rhoden, the subjective test is limited because it "views a barely conscious person as the competent person that she was . . . . " \textit{Id.} at 396. The objective test is limited since it focuses only on "the benefits and burdens that beset the patient in [the patient's] current state." \textit{Id.} at 396-97. Instead, a perspective of individual worth that draws on notions of dignity and privacy separate from self-determination and autonomy is necessary. Dignity and privacy include considerations of a patient's past history, values and relationships to determine that person's perception of the present condition even in the absence of that person's explicit directive. \textit{See id.} at 413-15 (arguing that personal identity is founded in part by external societal forces).
\item \textsuperscript{166} \textit{Id.} Professor Minow notes that "[a]utonomy . . . is not a precondition for any individual's exercise of rights. The only precondition is that the community is willing to allow the individual to make claims and to participate in the shifting of boundaries which define the rights and interests among individuals." \textit{Id.}
\item \textsuperscript{167} Bix, Book Review, 18 \textit{Seton Hall L. Rev.} 523, 531 (1988) (reviewing N. Can-
\item \textsuperscript{168} tor, \textit{supra} note 131.)
\item \textsuperscript{169} Justice Brandeis defined the right of privacy as "the right to be let alone." Olm-
\item \textsuperscript{170} stead v. United States, 227 U.S. 438, 478 (1928) (Brandeis, J., dissenting).
\item \textsuperscript{171} L. Tribe, \textit{supra} note 25, § 15-1, at 1302 (citing Whalen v. Roe, 429 U.S. 589 (1977) when defining the right as "interest in independence in making certain kinds of important decisions . . . . ").
\item \textsuperscript{170} See L. Tribe, \textit{supra} note 25, § 15-1, at 1303.
\item \textsuperscript{171} \textit{Id.}, § 15-1, at 1303-04 (discussing privacy, personhood, and their relation to both outward and inward-looking dimensions of personality).
\end{itemize}
privacy protects our personalities; intrusions violate those personalities. Personal dignity and freedom from intrusion thus complement one another. They are integrally related dimensions of the same inherent value.

The dignity aspect of individual worth is not as well understood and is more elusive than the personal autonomy aspect. However, even if the dignity dimension of individuality has escaped precise definition, it has not escaped labels. It has been encompassed by terms such as "privacy" and "personhood." The difficulty we encounter in defining privacy in the sense of individual dignity is not simply a linguistic obstacle or semantic puzzle. A genuine conceptual complexity exists. Moreover, this complexity has practical ramifications. The inability to understand and define the sense in which privacy involves notions of dignity imperils our ability to devise standards by which we can both identify and protect this aspect of individuality. This failure can be particularly important when the only aspect of individuality at stake is that of dignity, as when we are dealing with the life of a true stranger.

A partial solution to the conceptual conundrum can be extracted from our own experiences, which may suggest a subtle and intuitive consensus about personal dignity. Thus, like the light by which we see, personal dignity is most often appreciated only when it is removed. The subjection of a person to a "body search," the public exposure of a person's private diary, the uninvited scrutiny of personal items, such as one's records, writings, or things, the unexpected gaze into a living room or bedroom window, the overhearing of an intimate conversation, the unsolicited opening of one's mail—all of these are examples of invasions of privacy that diminish and destroy dignity. These kinds of experiences and the universality of our reactions to them prompted Professor Bloustein, President of Rutgers University, to characterize such intrusive conduct as an insult to the individual, an "affront to personal dignity," and as "demeaning to

172. See generally id., ch. 15, at 1302-435 (examining the right to privacy and personhood).
173. See supra notes 127-51 and accompanying text (discussing right-to-die cases involving true strangers and explaining the application of the "best-interests" test).
174. See Bloustein, Privacy as an Aspect of Human Dignity: An Answer to Dean Prosser, 39 N.Y.U. L. REV. 962, 972-77 (1964), reprinted in PHILOSOPHICAL DIMENSIONS OF PRIVACY: AN ANTHOLOGY 156, 163-67 (F. Schoeman ed. 1984) [hereinafter PHILOSOPHICAL DIMENSIONS] (categorizing these types of experiences as "intrusion cases", where the "defendant has used unreasonable or illegal means to discover something about the plaintiff's private life.").
Can common experiences lead to an understanding of individual dignity as a shared communitarian concept? Is it possible to devise an objective or reasonable-person standard of dignity? The belief that everyone has a basic personality that is unique and special seems to be universal. And is it not also believed that each individual's personality is inviolate, and that every person should be granted a modicum of dignity? Personal dignity may, therefore, be a value or a quality that we can attribute to every individual.

The quality of dignity that society will impute to others may be different from the sense of dignity that individuals ascribe to themselves. It may be different from each person's subjective feelings that serve to define his or her own level of dignity. Everyone, for example, has a different feeling about his or her own personal dignity, perhaps measured crudely by that person's threshold of embarrassment. Is this not what is meant by references to how thick or thin skinned a person is? Nevertheless, every human being has basic dignity and a concomitant entitlement to privacy, wholly apart from each person's own subjective perception of personal dignity. Thus, it can be understood that a dead person's body should not be desecrated, that both the exhibitionist and the voyeur have no place in society. We intuitively know that a private room need not be invaded by the uninvited or occupied by its owner to remain private, and that one's personal mail, whether or not read by another, is private. Awareness of the infliction of indignity is not required for dignity to be violated anymore than hearing a tree fall in an empty forest is necessary to create sound.

These considerations suggest that dignity is not hopelessly subjective, or, indeed, only subjective. We regularly can—and do—attribute rights of privacy and dignity to other persons. Thus, Ferdinand Schoeman noted the observations of James Fitzjames Stephen, the English jurist and philosopher, in his classic work, *Liberty,*
Equality and Fraternity, that privacy is a shared value that relates centrally to the intimate aspects of a person’s life.\textsuperscript{177}

Perhaps what is sought to be captured through pursuit of the apt label for this aspect of individual worth is the idea of personhood, traceable in part to the classic treatment of privacy by Justices Brandeis and Warren and their articulation of the “inviolate personality.”\textsuperscript{178} Schoeman finds the significance of this articulation to be the connection of “[privacy] with various other values, including an individual’s right to be left alone and the respect due an individual’s inviolate personality.”\textsuperscript{179} Others have described this idea of fundamental personality or personhood in different ways, concentrating on, for example, the individual’s moral autonomy or moral title to one’s existence.\textsuperscript{180} Stanley Benn has pointed out that there are “realms of life that are inherently private,” and “therefore deserving of more respect.”\textsuperscript{181}

With a perception of individual worth that embraces dignity—the special sense of self ascribed to every human being—the illustrative cases can again be examined to determine whether these ideas have permeated or influenced decisions. If individual worth imports the notions of privacy and dignity, how can these values be recognized and protected? Attempts to answer this perplexing question may be embedded in the courts’ attempt to articulate and apply a best-interest standard in dealing with fundamental individual interests in those situations when personal autonomy, the individual’s right of self-determination and personal choice, can in no sense be effectuated and, therefore, is itself not at stake.\textsuperscript{182} We can see this

\begin{itemize}
\item \textsuperscript{177} Schoeman, Privacy: Philosophical Dimensions of the Literature, in PHILOSOPHICAL DIMENSIONS, supra note 174, at 10-12.
\item \textsuperscript{178} Warren & Brandeis, The Right of Privacy, 4 HARV. L. REV. 193, 205 (1890); see also Craven, Personhood: The Right to Be Let Alone, 4 DUKE L.J. 699-720 (1976) (evaluating personhood in light of more recent rulings on the privacy issue).
\item \textsuperscript{179} Schoeman, supra note 177, at 14 (emphasis in original).
\item \textsuperscript{180} See Reiman, Privacy, Intimacy, and Personhood, in PHILOSOPHICAL DIMENSIONS supra note 174, at 310.
\item \textsuperscript{181} Benn, supra note 176, at 224-32. Benn explains as follows:
To respect someone as a person is to concede that one ought to take account of the way in which his enterprise might be affected by one’s own decisions. By the principle of respect for persons, then, I mean the principle that every human being, insofar as he is qualified as a person, is entitled to this minimal degree of consideration. \textit{Id.} at 229 (emphasis in original).
\item \textsuperscript{182} See supra notes 93-108 and accompanying text (discussing the guidelines utilized when making medical treatment decisions where a patient’s personal choice cannot be determined).
\end{itemize}
foreshadowed in the cases of Conroy\textsuperscript{183} and Jobes,\textsuperscript{184} in which the court considered the worth of the individual whose only remaining interest concerned bodily integrity and freedom from physical intrusiveness.\textsuperscript{185} And we may find, in a case such as Strachan,\textsuperscript{186} an analogy to the wrongful intrusion cases in which the gist of the wrong is not the intentional infliction of mental distress but rather a blow to human dignity which is an assault on human personality.\textsuperscript{187} Such intrusions "are wrongful because they are demeaning of individuality."\textsuperscript{188} Thus, in a case such as Grady,\textsuperscript{189} the court was truly more concerned with the best interests and the happiness of the young woman, which might be better achieved by sterilization and its resultant tranquility, than in effectuating a fictional personal choice.\textsuperscript{190}

These judicial efforts mean, even if only by implication, that in particular settings individual worth, even in its most elusive aspect of personal dignity, is the interest that must be preserved, and that it may be capable of protection under a reasonably objective standard.\textsuperscript{191}

\begin{itemize}
  \item \textsuperscript{183} In re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985); see supra notes 67-73, 91-101, 123, 128-29 and accompanying text (discussing Conroy).
  \item \textsuperscript{184} In re Jobes, 108 N.J. 394, 529 A.2d 434 (1987); see supra notes 85-87, 102-08, 126 and accompanying text (discussing Jobes).
  \item \textsuperscript{185} See supra notes 92-108 (analyzing the substituted-judgment methodology articulated in the cases).
  \item \textsuperscript{186} Strachan v. John F. Kennedy Memorial Hosp., 107 N.J. 523, 538 A.2d 346 (1988); see supra notes 131-37 (discussing Strachan).
  \item \textsuperscript{187} See supra notes 132-37 and accompanying text (exploring the concept of dignity as developed in Strachan).
  \item \textsuperscript{188} Bloustein, supra note 174, at 165. By way of illustration, Professor Bloustein observes that "[w]hen a newspaper publishes a picture of a newborn deformed child, its parents are not disturbed about any possible loss of reputation as a result. They are rather mortified and insulted that the world should be witness to their private tragedy." Id. at 169. Bloustein provides another illustration:
    A woman's legal right to bear children without unwanted onlookers does not turn on the desire to protect her emotional equanimity, but rather on a desire to enhance her individuality and human dignity. When the right is violated she suffers outrage or affront, not necessarily mental trauma or distress. And, even where she does undergo anxiety or other symptoms of mental illness as a result, these consequences themselves flow from the indignity which has been done to her.
    Id. at 164.
  \item \textsuperscript{189} In re Grady, 85 N.J. 235, 426 A.2d 467 (1981); see supra notes 139-54 (discussing the case).
  \item \textsuperscript{190} See supra notes 139-54 and accompanying text (interpreting Grady as a case regarding the protection of human dignity where incompetance precludes individual choice).
  \item \textsuperscript{191} Professor Cantor suggests that "it may be possible to gradually discern acceptable societal norms of human handling of moribund patients . . . . Shared notions of human dignity will ultimately govern decision-making on behalf of incompetent moribund patients." N. Cantor, supra note 131, at 76-77.
\end{itemize}
Nevertheless, it would be misstating the matter to indicate that these particular characterizations of privacy have clearly entered our decisional law. Rather, what might be extrapolated from these cases are judicial views reflecting a greater awareness and somewhat sharper perception of the interests that serve to define individual worth.

III. JUDICIAL/NONJUDICIAL TREATMENT OF INDIVIDUAL WORTH

Against the backdrop of an emerging doctrine of individual worth, it may be useful to consider not only what courts have said about individual worth, but also what they have done about it. This inquiry, as much as the judicial word, may elucidate the judicial understanding of individual worth and also define more pointedly the role that courts have assumed in dealing with broad concerns of public policy and individual morality.

The illustrative cases provide us with different vantage points by which to gauge the role of courts. At one level we can see that courts can be viewed primarily in terms of adjudicating the claims of private litigants in the context of adversary proceedings. Additionally, the courts can be seen as refraining from the definitive adjudication of competing claims. Instead structuring a framework within which interested parties can make these important determinations. Finally, the judiciary can be examined in relationship to other branches of government, formulating their decisions as a springboard for the continuing development of the law.

By allowing recovery of damages in the wrongful birth and life cases, courts have, in effect, recognized that the wrongful deprivation of the right of personal choice was a wrong that should be redressed. In providing a remedy and compensation, the courts' actions were not remarkable. The decision to award compensatory damages takes on added significance, however, when considered against the historical refusal of courts to provide a remedy for this kind of wrong. In effect, the court would be denying that a fundamental individual right was at stake. The courts, however, were unwilling to persist in such denials.

192. See supra notes 26-53 and accompanying text (surveying wrongful birth and life cases and examining their implications in free choice terms).

193. See supra note 50 and accompanying text (citing cases which have denied wrongful birth or life claims).

194. See supra text accompanying note 53 (interpreting the limited right of self-determination).
In these particular cases the judicial role can readily be reconciled with traditional judicial functions. The courts' efforts were confined to adjudicating the claims of the private litigants. Moreover, there is ample precedent for courts, engaging in the common law decisional process, to find a remedy where one previously did not exist. The cases thus demonstrate how courts reflect changing attitudes, recognizing that interests that historically did not merit protection should now be protected.

The wrongful birth and life cases also evince a greater willingness to use the legal tools of remedy and redress. In doing so, the judiciary reflects the importance ascribed to the underlying interests that constitute individual worth. Thus, the deprivation of personal choice with respect to the decision to continue or discontinue a pregnancy involving a congenitally defective fetus—a portentous individual moral issue—was deemed so horrendous that it significantly outweighed the countervailing concerns engendered by the attempted measurement of inherently speculative damages. Similarly, in Strachan v. John F. Kennedy Memorial Hospital, the court believed that the offensive treatment of the decedent's body seriously distressed the surviving parents. Their anguish arose in part from the indignity inflicted on their son by being kept involuntarily alive in an unnatural but life-like state. The significance of this interest called not only for recognition of the offense—the tortious infliction of emotional distress—but its vindication. Implicit in this analysis


196. See, e.g., Gleitman v. Cosgrove, 49 N.J. 22, 227 A.2d 689 (1967) (denying an award of damages and discussing the reasons why damages could not be awarded in a wrongful life or birth action).

197. 109 N.J. 523, 538 A.2d 346, (1988); see supra notes 134-37 and accompanying text (evaluating the case and the issue of personal dignity involved therein).

198. Id. at 534, 538 A.2d at 351.

199. Id. The court emphasized the parents' suffering:

[F]or three days after requesting that their son be disconnected from the respirator plaintiff's continued to see him lying in bed, with tubes in his body, his eyes taped shut, and foam in his mouth. Had Jeffrey's body been removed from the respirator when his parents requested, a scene fraught with grief and heartache would have been avoided, and plaintiffs would have been spared additional suffering.

Id.

200. Id. at 538, 538 A.2d at 353 (stating that "the plaintiff's need not demonstrate physical manifestations of emotional distress" in order to recover damages). The court felt it necessary, however, to remand for a retrial on damages. Id. at 538-39, 538 A.2d at 354. This was necessary because the original jury had been instructed on two causes of action, where the appellate court held that only one cause of action existed. Id.
may be the assumption that the basis of the distress was the assault on the dignity of the family, including, inferentially, the respect and consideration still due the dead. In *In re Grady* the court was not importuned to fashion conventional relief, but rather to exercise its *parens patriae* judicial powers to protect the well-being of a helpless person and to identify and vindicate her critical individual interests. It is significant that the interest involved was deemed so important, despite doctrinal ambivalence, that a remedy was fashioned. The court struggled to define the interest in terms of personal autonomy, but nevertheless devised standards calculated to further the best interests of the young woman. It eschewed the route later taken by the Canadian Supreme Court in *In re Eve* and adopted a stance that provided a standard and an adjudicatory framework for protecting the individual's well-being. The court clearly evinced its concern for the person's opportunity to live a life with dignity, security and self-esteem, thereby enhancing her chances for personal happiness.

These cases—in tort and in equity—reflect in large measure the creative application of traditional judicial remedies in reaction to new issues or to new perceptions of recurrent issues. In other cases, however, we can also detect some repositioning of the judicial role. Courts sense that the problems posed by conflicts, such as in the right-to-die cases, are perhaps intractable, the dilemmas insolvable. The *way* in which such problems are handled, more than *how* they are solved, has become a prominent consideration.


202. See id. at 250-51, 538 A.2d at 474-75 (authorizing certain parties to assert the right of meaningful decision on behalf of the incompetent person).

203. Id. at 262-67, 426 A.2d at 481-83 (discussing the "best-interests" standard and procedure); see supra notes 147, 150 and accompanying text (describing the standards set forth in *Grady* to determine an incompetent patient's "best interests").

204. 31 D.L.R. 4th 1 (1986) (prohibiting the sterilization of a mentally retarded woman); see supra note 153 (contrasting *Grady* with *Eve*).

205. See supra note 150 (analyzing the standards set forth in *Grady* relating to the individual's well-being).

206. See supra notes 152-54 and accompanying text (analyzing the implications of the *Grady* decision).

207. See *In re Jobes*, 108 N.J. 394, 429, 529 A.2d 434, 452 (1987) (Handler, J., concurring) (indicating that the issues in right-to-die cases "are intrinsically to the human condition and thus are not susceptible to judicial resolution."); *In re Conroy*, 98 N.J. 321, 343, 486 A.2d 1209, 1220 (1985) (noting that the case raised "moral, social, technological, philosophical and legal questions involving the interplay of many disciplines. No one person or profession has all the answers.").
Courts have come to believe that it may be more important to identify the right decisionmaker than it is to reach the right decision. There has been a greater tolerance of the delegation of decisional responsibility and as a consequence courts have started down the road of judicial deregulation. In these cases, the courts have begun to look to the persons or institutions most familiar with the issues they engender and having actual day-to-day responsibility for dealing with these profound problems.  

This development can be tracked by following the courts' solutions in the right-to-die cases. In the case of the fully competent patient, such as in In re Farrell and Bouvia v. Superior Court, the patient herself is entitled to be the primary decisionmaker. Courts insist that the decision be informed and voluntary, and, because the patient's physical and mental condition is critical, that it be shared with a physician. These decisions are paralleled by Largey, in which the court, with greater appreciation of the importance of personal autonomy, redefined the informed consent rule with respect to medical treatment that effectuates the patient’s right of self-determination.

The identification and selection of the appropriate decisionmakers becomes more difficult in the case of the incompetent patient. If the patient is incompetent but knowable, the court can, in some measure, effectuate the patient’s right of self-determination by delegating decisionmaking to those who “know” the patient or to the person to whom the patient herself delegated this responsibility, as was done in In re Peter through an “advance directive.” With

208. See supra note 97 and accompanying text (explaining that a decision made through substituted-judgment must be shared by physicians, family members or friends, and a state agency designed to protect the individuals in question).


210. 179 Cal. App. 3d 1127, 225 Cal.Rptr. 297 (1986); see supra note 111-12 and accompanying text (reviewing Bouvia).

211. See supra notes 110-11 and accompanying text (indicating that both Farrell and Bouvia granted dying but competent persons their right-to-die decision based on their “informed consent”).

212. See, e.g. Farrell 108 N.J. at 354, 529 A.2d at 413 (1987) (requiring the competent person's decision to be "informed" and "voluntary").

213. Largey v. Rothman, 110 N.J. 204, 540 A.2d 504 (1988); see supra notes 114-16 and accompanying text (discussing Largey).

214. See Largey, 110 N.J. at 210-14, 540 A.2d at 507-09.

215. 108 N.J. 365, 529 A.2d 419 (1987); see supra notes 80-84, 89 (discussing In re Peter).

216. See supra note 89 and accompanying text (explaining the process through which an
respect to the incompetent-probably knowable patient, such as was arguably involved in Quinlan\textsuperscript{217} and Jobes,\textsuperscript{218} the decisionmaker will be the person who is most likely to have relevant knowledge of the patient, who can best understand or intuit her wishes, and who can be trusted because of love and unselfishness to make an optimum decision on behalf of the patient.\textsuperscript{219} These persons will most often be family members and close friends.\textsuperscript{220} However, the problem of structuring and allocating sound and reliable decisionmaking is infinitely more complicated and problematic in dealing with the incompetent-barely knowable patient, as in Conroy.\textsuperscript{221} It is therefore understandable that the court devised an elaborate standard involving three possible tests which included the State Ombudsman in the decisionmaking team and which, in its third application involving objective standards, would attempt to protect the best interests of the patient.\textsuperscript{222}

The search for the right decisionmaker must take a different direction in dealing with the incompetent-unknowable person. Courts and others have begun to acknowledge an imperative to help the strangers among us. They have, inferentially, adopted a doctrine of individual worth that encompasses personal dignity. The approach is represented in the formulation of an objective or best-interests standard.\textsuperscript{223} It might be argued that when best-interests are measured by a standard of objective reasonableness, the decision to terminate treatment in such a case is an exercise of the patient’s right of self-

\footnotesize{\textsuperscript{217} In re Quinlan, 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976); see supra notes 54-66 (discussing the case).}\n
\footnotesize{\textsuperscript{218} In re Jobes, 108 N.J. 394, 529 A.2d 434 (1987).}\n
\footnotesize{\textsuperscript{219} See supra notes 63-65 and accompanying text (examining the court’s decision in Quinlan).}\n
\footnotesize{\textsuperscript{220} See supra note 65 and accompanying text (explaining that Karen Quinlan’s father was delegated the exercise of her right of self-determination).}\n
\footnotesize{\textsuperscript{221} In re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985); see supra notes 67-73, 90-100 (discussing Conroy).}\n
\footnotesize{\textsuperscript{222} See supra notes 91-99 and accompanying text (describing the three tests articulated in Conroy).}\n
\footnotesize{\textsuperscript{223} See Hastings Guidelines, supra note 89, at 2-9, 18-29; President’s Comm’n, supra note 89, at 2-6; see, e.g., Rasmussen v. Fleming, 154 Ariz. 207, 222, 741 P.2d 674, 689 (1987) (stating that in the absence of evidence of a patient’s wishes, the patient’s “best interests would be served by the placement of DNR [do not resuscitate] and DNH [do not hospitalize] orders on her medical chart.”); In re Grant, 109 Wash. 2d 545, 553, 747 P.2d 445, 449 (1987) (finding that even though evidence of patient’s preferences was weak, the withholding of life-sustaining treatment should be approved; the court relied on both the patient’s constitutional right of privacy and her common law right to be free of bodily invasion).}
determination as viewed by a reasonable person. Nevertheless, even as formulated, such a best-interests standard is markedly different from an exercise of the patient's right of self-determination based on the patient's own subjective views or wishes.

Recourse to a best-interests test arises out of necessity because the patient is, or has become, a stranger, yielding not the slightest clue as to her preferences concerning the medical exigencies entailed in her continued existence. Consequently, in such necessitous straits, a test seeking to ascertain the best-interests of the patient and thereby preserve personal dignity should only be the test of last resort.

Therefore, the difficulty posed in this last setting—that of the true stranger—is that the individual interest in personal autonomy, as expressed by self-determination or personal choice, is simply not protectable. Knowledge of the patient's wishes is not available; it is not possible to know or even to guess the person's wishes or personal values. As a result, it is not possible to make an informed choice on the patient's behalf. Hence, this aspect of individual worth cannot realistically be vindicated. Yet, the thought that because a person is unknown to us she has no individual worth is a notion that invites rebellion.

The individual interests that are at stake are personal dignity or integrity of the self, the concomitant entitlement to privacy, and freedom from intrusion. The courts are or should be asking: How can this interest be described or defined? When is it being violated? Who can best protect this interest? How can the right decisionmaker be identified in this situation? The best-interests test, which encompasses the dignity aspects of individual worth, is heavily burdened by antecedent conceptual difficulties. Persons in a heterogeneous society understandably have different moral values, particularly with respect to something as basic as death. Professor Tribe has pointed out that a best-interests test is but another form of substituted-judgment, and that the infirmity of a best-interest test inheres in the fact that it "imposes highly contested societal values paternalistically on the individual."²²⁴

²²⁴ L. Tribe, supra note 25, § 15-11, at 1369. Professor Cantor has formulated a decisional standard based on common notions of dignity and humane treatment concerning treatment of the moribund. See N. Cantor, supra note 131, at 119-23. This standard could arguably be criticized "for being premature in [its] prediction of a developing consensus and perhaps a little too optimistic about the ability of judges to find the best answers." Bix, supra note 167, at 530.
The lack of societal agreement counsels courts to proceed with caution and with due respect for the continuation of life when basing a decision of last resort on a best-interests analysis. The best-interests test traces its origins to the *parens patriae* jurisdiction of the courts. Nevertheless, in this area, permitting a surrogate decisionmaker to refuse treatment for an incompetent unknowable patient implicitly recognizes that their best interests may not be served by continuing treatment. Courts, however, have not readily recognized or expressly acknowledged that they are permitting surrogates to terminate treatment in the absence of a reliable evidence of the patient's preferences. Such concerns have impelled courts to limit the discretion involved by imposing countervailing conditions when the patient's wishes are not available. These limits serve, perhaps, as a rationalization to support and instill confidence in the final decision.

Thus, in right-to-die matters, in the case of the competent patient, and in any informed-consent setting, it is the patient and doctor who are the decisionmakers. In the case of the incompetent-

225. As the New Jersey Supreme Court observed in *Conroy*, "[t]o 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." 98 N.J. 321, 343, 486 A.2d 1209, 1220 (1985). Nonetheless, it is best to err, if at all, in favor of preserving life.

226. See, e.g., Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 745, 730 N.E.2d 417, 427 (1977) (discussing the state's power under the doctrine of *parens patriae*); *Conroy*, 98 N.J. at 364-65, 486 A.2d at 1231 (stating "the state's *parens patriae* power supports the authority of its courts to allow decisions to be made for an incompetent that serve the incompetent's best interests . . . .").

227. *In re Torres*, 357 N.W.2d 332, 337 (Minn. 1984) (allowing the probate court to empower a conservator to order the removal of life support systems when they are no longer in the patient's best interests).

228. This may be expressed as inherent limitations on the rights of individuality. Such limitations can be traced to the decisional origins in the privacy field. Thus, *Roe* rejected the view that the federal constitution vests a pregnant woman with an absolute right of procreative choice. *Roe v. Wade*, 410 U.S. 113, 155 (1973). Instead, the Supreme Court declared that the right was "not absolute" so that "at some point the state interests as to protection of health, medical standards, and pre-natal life become dominant." *Id.*

Similarly, in the termination-of-treatment cases, courts have viewed a patient's right to terminate his or her treatment as constrained by state interests. See, e.g., *In re Farrell*, 108 N.J. 335, 352, 529 A.2d 404, 412 (1987) (stating that "[w]hen courts refuse to allow a competent patient to decline life-sustaining treatment, it is almost always because of the state's interest in protecting innocent third parties who would be harmed by the patient's decision"); *Conroy*, 98 N.J. at 353, 486 A.2d at 1225 (concluding that "the right to self-determination ordinarily outweighs any countervailing state interests . . . .").

229. See supra text accompanying note 88 (noting that such a result was found in *Farrell*).
knowable or barely knowable patient, it is the actually-designated surrogate of the patient or her family or friends who, together with the doctor, can function as decisionmakers. Finally, in the case of the incompetent-unknowable patient, the doctor, responsible health-care providers and experienced ethicists could be called on to make or participate in the ultimate decision. If indeed privacy embraces a common understanding of personal dignity that demands humane and considerate treatment, and if it is founded on a shared belief in "respect for persons," it should be possible to locate a decisionmaker that can be unanimously accepted.

In its promulgation of standards and its placement of procedures to advance these situations, the courts' decisions can be seen as a form of judicial deregulation, that is a cautious withdrawal of judicial oversight from the decisions of private parties. There is greater awareness that the conventional adversary framework is counterproductive in achieving resolution of such issues. Thus,

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230. See supra note 65 and accompanying text (analyzing this result in In re Quinlan, 70 N.J. 10, 355 A.2d 677, cert. denied, 429 U.S. 922 (1976)).

231. This approach was acknowledged in Quinlan, the first court nationwide to rule that life-sustaining treatment could be legally withdrawn if the guardian and doctor's decision to end treatment was reviewed and concurred by an ethics committee. 70 N.J. 10, 54, 355 A.2d 647, 671 (1976). Other state courts have also given some type of informal legal status to ethics committees in the decisionmaking process. See, e.g., Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 758-59, 370 N.E.2d 417, 434 (1977) (discussing the desirability of the findings and advice of an ethics committee in court making a decision); In re Torres, 357 N.W.2d 332, 335 (Minn. 1984) (stating that reports of Biomedical Ethics Committees were used in making the court's determination); In re Colyer, 99 Wash. 2d 114, 134-36, 660 P.2d 738, 749-50 (1983) (recommending a unanimous concurrence from a "prognosis board or committee").


232. See generally, Minow, Beyond State Intervention in the Family: For Baby Jane Doe, 18 U. Mich. J.L. Ref. 933, 970-78 (1985) (discussing the differentiation between "substance" and "procedure" as a "classic" legal concern and noting that; courts can often avoid mandating specific substantive outcomes by establishing a procedure for delegating who will have final decisionmaking power, rather than determining what the final decision should be).

233. See id. (discussing the shortcomings of current legal models for decisionmaking to
Professor Minow characterizes the kinds of relationships people experience when working within an adversarial context as polarized, defensive, and distrustful. She believes that an alternative framework can encourage creative, consensual decisionmaking, and that it can expand the range of choices available. It may be necessary to expand knowledge and communication by focusing on "ambivalence" in order to make explicit the problems and conflicts each interested party has when making a decision.

Decisionmaking in this framework should also be informed by an understanding of the "connection" between the decisionmaker and the person affected, even when those connections or relationships themselves may be riddled with ambivalence. This is true because there is no other available standpoint, including a court's, that is not rooted in ambivalence. By exposing and confronting ambivalence about developing objective criteria based on concerns over relief from pain or, in the alternative, based on the relationship that intrusive bodily invasion has to a person's dignity, the necessity for articulating criteria for "distrust" becomes more apparent.

Thus, when we do not know the patient's actual wishes, the most important judicial decision is deciding on who is a trustworthy decisionmaker and in what structure the decision should be reached—not what decision should be made. Instead of arrogating

cope with the issues involved in withdrawing life support from a defective newborn); see also J. Handler, Dependent People, The State, and the Modern/Postmodern Search for the Dialogic Community, 35 UCLA L. Rev. 999 (1988) (analyzing the weaknesses inherent in using traditional legal principles to govern "dependent" relationships involving doctors and patients, students with special educational needs, and the elderly poor).

234. Minow, supra note 232, at 934-35.

235. Id. With regard to the withdrawal of life support form defective newborns, Professor Minow suggests a more productive alternative to a "polarized" decisionmaking structure might emerge by confronting sources of conflict and ambivalence the newborn's parents experience in a context in which the parents are not "blamed" for these feelings. Id. at 934, 998-1004; see also J. Handler, supra note 233, at 1042-49 (exploring alternative problem-solving structures that emphasize cooperation, flexibility, and contextualization in order to expand and improve alternative solutions).

236. Minow, supra note 232, at 1000.

237. Id., at 940-98 Professor Minow notes that sources of distrust and ambivalence for the public's reaction to the parents of Baby Jane Doe lie in an identification with the ambivalence that parents experience in their position as "separate" but "connected" to the child. Id. Professor Minow suggests responding to this identification by creating conditions for trusting the parents' ability to make the right decision, rather than by removing them from the decision altogether. Id. at 998-1008.

238. See id. at 990-94 (arguing that human beings identify with the extreme vulnerability of the newborn and/or the awesome responsibility and pain of the parents, and therefore, cannot be free from "ambivalence").
decisional responsibility over answering these fundamental questions in the concrete, the courts have moved toward a "procedural" solution involving the delegation of this responsibility to other individuals and institutions.\textsuperscript{239} Professor Handler has stressed the dynamics of such innovative decisionmaking, which requires establishing conditions in which communication, trust, and participation can flourish—fostering a "dialogic community."\textsuperscript{240} Under ideal circumstances, the full participation of interested parties would be assured, the expression and exchange of all views would be encouraged, and mutual respect would be required. Surely though, the fulcrum for such a communicative/decisional process must remain the dignity of the individual whose well-being is at stake. However, instead of treating potential decisionmakers with skepticism or hostility in an effort to protect the "unknowable" patient's dignity, there is a need to develop both a basis for trust and confidence in the decisionmakers' relationship to one another, and connection to and identification with that "unknowable" patient; and a need to create a structure that will encourage full exposure of considerations relevant to any decision.

Finally, judicial withdrawal or deregulation has taken another form. These cases underscore the role of the courts in relation to other branches of government and social institutions. Courts understand that, although it is necessary for them to act in a given case or controversy, the subjects of these disputes have significant implications that can eclipse the interests of the individual litigants. The dilemma that confronts the judiciary in its exercise of authority is that these contemporary legal disputes present both the conflicting claims of litigating parties which must be settled and broad issues of

\textsuperscript{239} See supra notes 228-31 and accompanying text (examining the procedural choice of decisionmaker in right-to-die cases).

\textsuperscript{240} See Handler, supra note 233, at 1108-13 (advocating structures for decisionmaking based on "trust," "power-sharing" and "participation," and defining these structures as a "dialogic community"). This is similar to Professor Minow's analysis, where "trust" can only be developed after confronting sources of "distrust," Minow, supra note 232, at 998-1004, Handler's analysis is directed toward expanding decisional power by confronting, and not by ignoring, power inequalities. Handler, supra note 233, at 1009. Professor Handler criticizes traditional legal rights analysis directed toward treating people "equally" for failing to take account of palpable inequalities and great maldistributions in power. Id., at 1108-09. His analysis demonstrates how these inequalities in power were compounded by polarized decision-making structures that sought to protect clients by "objectifying" their needs. Id. In fact, however, these "dependent" clients required a discretionary subjective approach not built on equality in the abstract, but on individual treatment in the concrete. Id.; see also J. Handler, THE CONDITIONS OF DISCRETION (1986) (amplifying these themes).
public policy, which are most suitably addressed by others.\textsuperscript{241}

These decisional dramas have an added impact because they can serve to arouse a quiescent legislature. They may not only goad legislatures to move in areas of political peril, but also cause a reordering of legislative priorities.\textsuperscript{242} In addition, because the subject matter of these cases is inescapably controversial and the issues indelibly moral, any judicial resolutions will appear to be aggressive and overreaching.

That appearance, however, is misleading. Courts have not made any preemptive strikes. The judiciary has acted boldly, but has remained mindful of the legislative competence to deal with this kind of subject matter.\textsuperscript{243} Courts in this arena have not been timid or hesitant to exercise their judicial authority in the pursuit of proper solutions to difficult issues raised by cases that hinge on the evaluation and protection of individual worth. However, they have at the same time been prepared to encourage and accommodate legislative responses, understanding that societal consensus must be reached for more enduring resolutions of the profound social issues that have given rise to these unique legal controversies.

\textbf{IV. CONCLUSION}

What general conclusions can be drawn from this experience? Do these cases represent the crystallization of a distinctive legal doctrine of individual worth? The doctrine may be found in the cluster of values that courts posit as constituting the most significant aspects of individuality or individual worth. One aspect is personal autonomy, the right of self-determination and personal choice.\textsuperscript{244} Another aspect is individual dignity, the right to preserve one's intrinsic worthiness and the concomitant right to be left alone and free from intrusion.\textsuperscript{245} The doctrine is distinctive not because it is original or novel, but rather because it is becoming better understood, more

\begin{itemize}
\item \textsuperscript{241} See Handler, supra note 14, at 24-25 (1987) (analyzing the relative positions of the legislature and the judiciary in relation to right-to-die cases).
\item \textsuperscript{242} See G. Calabresi, A Common Law for the Age of Statutes 31-32 (1982).
\item \textsuperscript{243} See \textit{In re} Farrell, 108 N.J. 335, 341-43, 529 A.2d 404, 407 (1987) (recognizing that the legislature is the proper branch "to set guidelines in this area . . . ."); \textit{In re} Peter, 108 N.J. 335, 341-43, 529 A.2d 419, 429 (1987) (recognizing that the legislature is the appropriate branch); \textit{In re} Conroy, 98 N.J. 321, 344-45, 486 A.2d 1209, 1220-21 (1985) (indicating that "the Legislature is better able than any other social institution to reflect the social values at stake . . . ."). But see Moore, supra note 66, at 993-97 (questioning whether the courts' deference to the legislature is appropriate).
\item \textsuperscript{244} See supra notes 53-130 and accompanying text.
\item \textsuperscript{245} See supra notes 131-60 and accompanying text.
\end{itemize}
It is important to note, however, that the dimension of individual worth that encompasses the concept of dignity has not been consistently recognized or fully explained in the right-to-die and other cases. These cases have thus far given primary emphasis to personal autonomy as expressed through self-determination and personal choice. However, these decisions do point to considerations that are relevant when it may not be possible to make a determination based on personal autonomy because one cannot know the person's wishes, views, or feelings. Of overarching importance is the belief, implicit in the case law, that individual worth is intrinsic; it cannot be lost even though personal autonomy is beyond our protective reach.

Another conclusion that we can fairly draw concerning the judicial perception of individual worth is that courts are willing to protect these values. This can be seen in a willingness, in appropriate cases, to award compensatory damages to redress this interest when it has been violated. This can also be seen in the court's understanding that these interests require protection and effectuation, not merely vindication in the form of compensatory remedies. In many cases when compensation is irrelevant or meaningless, courts, in exercising their equity instincts, have pursued solutions that attempt to leave the individual with essential autonomy and dignity, no matter how dismal the person's physical and mental condition.

The role of the courts may also be shifting. With respect to the judicial function, it is important to take into account the easy and ready criticism that courts are being pugnacious and too activist. It is possible to rejoin by urging that courts are doing what they have always done. The judicial function has not changed—the problems, the issues and controversies have changed. The function of the courts is to adjudicate cases and controversies properly brought before them. While a court is not an orphanage for foundling cases, when cases land at the courthouse steps, they must be taken in. This has meant that in many situations the court has been called on to reach decisions on matters with respect to which there has not yet evolved a societal consensus. It is, therefore, understandable that judicial

246. See supra notes 161-90 and accompanying text.
247. See text accompanying notes 182-91.
248. See supra notes 26-53 and accompanying text.
249. See supra notes 25-52 and accompanying text.
250. See supra notes 54-108 and accompanying text.
251. See supra notes 52-159 and accompanying text.
resolution of such a matter stirs controversy and perhaps resentment.

The court's willingness to turn to other decisionmakers is a form of judicial deregulation. The judiciary has recognized that others may be more competent and trustworthy in terms of reaching right or acceptable decisions.\textsuperscript{252} Courts in similar fashion have acknowledged that other branches of government, as well as social institutions, can more suitably deal with the broader range of policy concerns.\textsuperscript{253} In presenting these legal dramas, courts fulfill their traditional adjudicative role, but in a manner conducive to the broader institutional treatment and resolution of the difficult social and moral questions. By inviting larger participation in the resolution of the issues posed by cases that come to the courthouse by default, courts serve as social catalysts rather than social arbiters.

Is there some direction or guidance for the future? The right-to-die cases involving the incompetent and unknowable patient will impel courts to deal with notions of individual worth, personal dignity and fundamental humanity. The notions of individual worth will be presented by other cases as well. The challenge continues to grow as we consider the troubling issues that are being generated by the survival of profoundly impaired newborns and other medical and biological advances that have engendered new forms of artificial procreation, gestation, and parental surrogacy. In such cases, courts will be required to consider whether there can be a collective judgment or an objective assessment of the intangible values that provide a sense of individual worth. From current experiences, it can be expected that courts will not only conscientiously try to deal with the challenge, but will also be mindful that the challenge is one to be taken up by all of society.

\textsuperscript{252} See supra notes 208-43 and accompanying text.
\textsuperscript{253} See supra notes 51, 90-99 and accompanying text.