SETTING THE STAGE: FIFTY YEARS OF U.S. END-OF-LIFE CARE DEBATES

JOHN C. MOSKOP†

The topic of this issue of the Wake Forest Journal of Law & Policy, United States “Right to Try” legislation, offers one approach to obtaining investigational medical treatments for patients with life-threatening and terminal illnesses. Right to Try, therefore, falls within the much broader domain of end-of-life care. This article will set the stage for consideration of Right to Try laws by reviewing the history and current status of end-of-life care in the United States.

Part I of the article will offer three bold claims about U.S. end-of-life care. Part II will describe current choices for end-of-life care and contrast those choices with the available options fifty years ago. Part III will provide a brief review of prominent U.S. ethics and public policy debates about five end-of-life care issues: abortion, “brain death,” “natural death,” “physician-assisted suicide,” and futility. Part IV will revisit and defend the three claims of Part I and comment on future developments.

† John Moskop is Professor of Internal Medicine and holder of the Wallace and Mona Wu Chair in Biomedical Ethics at the Wake Forest School of Medicine. He is also Chair of the Clinical Ethics Committee at Wake Forest Baptist Medical Center and a core faculty member in the Wake Forest University Bioethics Graduate Program. The author is most grateful to Professor Christine Coughlin and the organizers of the Wake Forest University School of Law Right to Try Legislation Symposium for inviting him to participate and to contribute this article to the Wake Forest Journal of Law & Policy. He would also like to thank the editorial staff of the Journal for their able assistance in preparing the references for this article.


I. THREE BOLD CLAIMS

I begin with three sweeping claims about the evolution and bioethical significance of end-of-life care in the United States:

Claim 1. End-of-life care options in the United States have undergone an almost total transformation over the past half century.  
Claim 2. Controversies over end-of-life care played the leading role in launching the field of American bioethics. 
Claim 3. Controversies over end-of-life care remain the most visible, and some of the most vexing, issues in bioethics in the United States today.

The remainder of this article will provide evidence to support these claims, and Part IV will revisit the three claims and summarize the evidence for them.

II. END-OF-LIFE CARE—NOW, AND THEN

A. Today’s Choices

Consider, first, the current state of affairs in U.S. end-of-life care. Over the past half century, biomedical research has produced a multitude of life-sustaining treatment innovations, and the U.S. health care system has disseminated those new treatments widely to eligible patients. These treatments can significantly extend patient survival, but they can also inflict injury and cause suffering. Other treatment innovations during this time period can substantially enhance the quality of patients’ lives in their final stages.

Among the wide variety of current options for care as Americans approach the end of life are the following:

8. Id. at 101–05.
i. Aggressive life-prolonging treatments

Among these treatments are cardiopulmonary resuscitation, intensive care, artificial ventilation, artificial nutrition and hydration, cancer chemotherapy, renal dialysis, organ transplantation, and many others. Access to these life-prolonging treatments is limited virtually only by the willingness of physicians to provide them and of health insurers to pay for them.

ii. Refusal of any or all of the available life-prolonging therapies

iii. Requests for therapies under investigation that may prolong life through expanded access programs

Right to Try laws provide one of several pathways for asking product developers for access to these investigational products.

iv. Hospice care (for patients who meet hospice eligibility requirements)

---


15. Lainie Rutkow, Optional or Optimal?: The Medicaid Hospice Benefit at Twenty, 22 J. CONTEMP. HEALTH L. & POL’Y 107, 115 (2005) (explaining that to be eligible for the Medicare Hospice Benefit, “a person must be eligible for Medicare Part A, receive a prognosis of six months or less to live from his or her doctor and the hospice medical director, sign a statement electing the Medicare Hospice Benefit, and enroll in a Medicare-certified hospice program.”). See generally Tools and Guidelines for Determining Eligibility for Hospice, PROVIDENCE
v. Palliative treatments to relieve pain and suffering
vi. Physician “aid in dying” (in some jurisdictions)
vii. Voluntarily stopping eating and drinking

B. Options in 1970

What end-of-life care options were available to Americans fifty years ago, in 1970? Before the final thirty years of the twentieth century, health care could do relatively little to alter the time or manner of most deaths. Virtually all of the current end-of-life treatments mentioned above were either unknown or in their infancy. Consider the status in 1970 of the seven items in the list above:

i. Aggressive life-prolonging treatments

Each of the many current curative and life-prolonging treatments has its own history of research, development, and distribution. Intensive care units (“ICUs”), for example, have long been a standard treatment setting for patients with critical illness. To estimate when intensive care services first became available, I sought information about the establishment of the first ICU at my own teaching hospital. A search of medical library archives produced a copy of the April 1964 issue of Baptist Hospital Topics, the newsletter of the North Carolina Baptist Hospital (now called Wake Forest Baptist Medical Center). The first page of the newsletter features the headline “INTENSIVE CARE. . .a new service,” and the accom-
panying story includes photos of ICU beds with early models of defibrillators, cardiac monitors, and mechanical ventilators.\(^\text{22}\) Other hospital records suggest that this new twelve-bed unit was the only ICU at North Carolina Baptist Hospital until 1970, when a neonatal ICU was established.\(^\text{23}\) As this example illustrates, the hospital ICUs that patients have long taken for granted in the United States were just emerging as a treatment option for a few critically ill patients in the mid-to-late 1960s.\(^\text{24}\)

ii. Refusal of any or all of the available life-prolonging therapies

The legal duty to obtain the patient’s informed consent to treatment, first articulated in 1957,\(^\text{25}\) was gaining acceptance during the 1960s, but whether patients could refuse life-sustaining treatments was not a subject of discussion in the medical or legal literature, nor was that option established in U.S. statutory or common law in 1970.\(^\text{26}\)

iii. Requests for potentially life-prolonging therapies under investigation

Although the U.S. Food and Drug Administration (“FDA”) had, for many years prior to 1970, an informal practice of approving requests for access to investigational new drugs for treatment purposes outside of clinical trials, the FDA did not adopt the current formal regulations that govern this practice until 1987.\(^\text{27}\)

---

\(^\text{22}\) Intensive Care...a New Service, BAPTIST HOSP. TOPICS (North Carolina Baptist Hospital, Winston-Salem, N.C.), Apr. 1964, at 4.


\(^\text{24}\) Intensive Care...A New Service, supra note 22, at 4; Dr. Archie T. Johnson, supra note 23; Kelly et al., supra note 21, at 377.


iv. Hospice care

Dame Cicely Saunders, creator of the hospice model of care for dying patients, founded the world’s first modern hospice facility, St. Christopher’s Hospice in London, in 1967. United States hospice organizations first appeared in the 1970s, and the first hospice in North Carolina was established in 1979 in Winston-Salem.

v. Palliative treatments to relieve pain and suffering

The field of palliative care emerged out of the hospice movement in the 1980s. Hospice and palliative medicine was first recognized by the American Board of Medical Specialties as a certified medical subspecialty in 2006.

vi. Physician “aid in dying”


29. From Linda Darden, CEO/President, THE CIRCULAR (Trellis Supportive Care, Winston-Salem, N.C.), May 2019, at 2.
vii. Voluntarily stopping eating and drinking

Despite its centuries-long cultural and religious recognition as an end-of-life option in India, voluntarily stopping eating and drinking was a virtually unknown practice in the Western world in 1970.35

III. FIVE PROMINENT U.S. ETHICS AND PUBLIC POLICY DEBATES

As end-of-life treatment options increased in the United States over the past half century, they prompted five high-profile ethics and public policy debates over abortion, “brain death,” “natural death,” “physician-assisted suicide,” and medical futility. This Part will provide a brief, chronological review of each of those five end-of-life care debates.

A. The Abortion Debate

The first of the five debates arose over the practice of induced abortion. Although abortion occurs near the beginning of life, it also causes the death of the fetus,36 and so it merits inclusion and brief review in this list of end-of-life debates.

i. The issue: Should ethics and public policy recognize a woman’s right to choose abortion, the termination of an unwanted pregnancy?

ii. The status quo in 1970: A few U.S. states had enacted statutes that permitted abortion, and many others prohibited most abortions.37 There was clear evidence of fundamental disagreement between staunch pro-life and pro-choice advocates.38


In its signal 1973 decision in *Roe v. Wade*, the U.S. Supreme Court recognized a woman’s fundamental legal right to abortion of pre-viable fetuses and permitted regulation of abortion post-viability.\(^\text{39}\) Multiple subsequent Supreme Court decisions, and numerous federal and state statutes, further defined and (mostly) restricted abortion rights and public funding for abortion procedures.\(^\text{40}\) Despite more than fifty years of heated debate, there is little evidence of resolution of the ongoing abortion conflict.\(^\text{41}\) Within the past five years, several states have enacted statutes prohibiting virtually all abortions, thereby posing an explicit challenge to the abortion rights articulated in *Roe*.\(^\text{42}\) Supreme Court review of challenges to these statutes is pending, and President Donald Trump’s recent appointment of the conservative jurists Justice Neil Gorsuch and Justice Brett Kavanaugh to the Court, and the recent loss of Justice Ruth Bader Ginsberg, increase the prospect of a future Court decision to overturn *Roe*.\(^\text{43}\)

**B. The “Brain Death” Debate**

The next major end-of-life debate to emerge in the United States was over the determination of death.

i. The issue: Should society recognize new, brain-oriented criteria for pronouncing a person dead, when respiration and circulation are supported by medical technology?

ii. The status quo in 1970: The era of heart transplantation had just begun. Christiaan Barnard of South Africa was credited with performing the world’s first successful heart transplant in 1967, and Stanford University’s Norman Shumway performed the first

---


American heart transplant in 1968. Recovery of hearts for transplant from newly dead donors required prior cessation of donor heartbeat and breathing, and those requirements severely limited access to transplant organs.

In a seminal 1968 article in the *Journal of the American Medical Association*, an ad hoc committee of the Harvard Medical School proposed that “irreversible coma” be recognized as a “new criterion for death” and identified clinical tests to diagnose this condition. Over the next two decades, beginning with Kansas in 1970, every U.S. state enacted a statute recognizing that “brain death” constitutes death of a human person. The relevant passage in the North Carolina statute states that “[b]rain death, defined as irreversible cessation of total brain function, may be used as a sole basis for the determination that a person has died, particularly when brain death occurs in the presence of artificially sustained respiratory and circulatory functions.”

The universal adoption of this new definition of death paved the way for recovery of thousands of transplant organs annually from “brain dead” patients in the United States, and it might also suggest a conclusion that the debate over what constitutes human death had been resolved. That conclusion would be premature, however. In a 2001 article marking the twentieth anniversary of the Uniform Determination of Death Act, Alexander Morgan Capron, a prominent legal and bioethics scholar and an early proponent of brain-oriented criteria for death, made the following observation:

---


47. Christopher M. Burkle et al., *Why brain death is considered death and why there should be no confusion*, 83 NEUROLOGY 1464, 1466 (2014); see Alexander M. Capron, *Brain Death — Well Settled yet Still Unresolved*, 344 NEW ENG. J. MED. 1244, 1244 (2001). A number of commentators recommend that the term “brain death” be avoided, because it invites the misunderstanding that there is a difference between brain death and death of the person. See David M. Greer et al., *Determination of Brain Death/Death by Neurologic Criteria: The World Brain Death Project*, 2020 JAMA E1, E3–E4. Rather, brain-oriented criteria are used to determine that a person has died. See id. These commentators often recommend use of the term “death by neurologic criteria.” See id.


“If one subject in health law and bioethics can be said to be at once well settled and persistently unresolved, it is how to determine that death has occurred.”50 Despite the consensus recognition of neurological criteria for death in American law, critics questioned both the moral justification for “brain death” and the accuracy of its diagnosis.51 Some scholars argued that criteria for death should be expanded to include all patients with permanent unconsciousness;52 others defended the view that death occurs only when there is irreversible cessation of respiration and circulation.53 News stories reported the “miraculous” recovery of patients who had been pronounced dead by neurological criteria.54

In 2013, national media coverage of the case of Jahi McMath intensified the medical and bioethical debate over neurological criteria for death.55 After tonsillectomy surgery in an Oakland, California hospital, thirteen-year-old Jahi experienced severe bleeding and suffered a cardiac arrest.56 She received cardiopulmonary resuscitation and was placed on a ventilator, but three days later she was examined and pronounced dead by neurologic criteria.57 Her family challenged this decision, and a judge ordered a second examination, which confirmed the earlier finding that she met the established neurologic criteria for death.58 The family was nevertheless able to arrange Jahi’s removal from the Oakland hospital and air ambulance transportation to a hospital in New Jersey.59 New Jersey is unique among the fifty states—its determination of death statute permits families to reject neurologic criteria for death and to choose irreversible cessation of respiration and circulation as their

50. Capron, supra note 47, at 1244.
52. See, e.g., id.
56. Id.
57. Id.
58. Id.
59. Id.
only criterion for death. With ventilator and other medical support, Jahi survived for four and a half years in New Jersey before her “second death” in 2018. During this period, neurologist Alan Shewmon, a leading commentator on neurologic criteria for death, observed and examined Jahi on several occasions; Shewmon reported that Jahi made purposive movements in response to commands, which indicated that she had regained some neurologic function and had entered a minimally conscious state. If this report is credible, it raises clear questions about the ability of current neurologic criteria to determine conclusively that a person has died.

C. The “Natural Death” Debate

As noted in Part II.B of this article, medical technologies developed and disseminated in the last third of the twentieth century offered new prospects for significantly extending the lives of patients with catastrophic illness or injury. In many cases, however, these new technologies were not able to restore mental or physical function, and some were accompanied by significant suffering.

i. The issue: May, or should, physicians withhold or withdraw life-sustaining treatments at the request of patients or their families who prefer a “natural” or a peaceful death to prolongation of life by medical means?

ii. The status quo in 1970: This issue had not yet “surfaced” in either the medical literature or American public discourse.

In 1975, national news reports about a young New Jersey woman named Karen Ann Quinlan attracted major attention and initiated a new and vigorous public debate about decisions to forgo...
the use of life-sustaining treatment. Karen was discovered by friends in a state of respiratory arrest. She was resuscitated, hospitalized, and placed on a mechanical ventilator to support her breathing. Several months later, physicians determined that Karen was in a state of permanent unconsciousness, then called a “persistent vegetative state.” After reflection and consultation with religious advisors, Karen’s parents informed her physicians that she would not want her life to be prolonged in this condition; they requested that the ventilator be withdrawn and she be allowed to die. Karen’s physicians responded that the act of withdrawing the ventilator would kill her. The physicians viewed that act as both illegal and immoral and added that they could not honor the parents’ request.

Karen’s parents sought the court’s assistance in carrying out their request. The Superior Court of New Jersey, Chancery Division sided with Karen’s physicians and denied the parents’ request, but the New Jersey Supreme Court overturned that ruling on appeal. The New Jersey Supreme Court recognized Karen’s right to refuse life-sustaining treatment and affirmed that, because she was comatose and lacked the capacity to make or communicate treatment decisions, her father could exercise that right on her behalf.

A series of subsequent court decisions, culminating in a 1990 U.S. Supreme Court ruling in the case of Nancy Cruzan, and multiple state statutes, recognized and refined patient rights to refuse life-sustaining treatment. Among the established features of these rights are the following:

67. McFadden, supra note 64.
68. Id.
69. Id.
70. QUINLAN & QUINLAN, supra note 66, at 116.
71. Id.
72. Id. at 118.
73. Id. at 122.
75. Id. at 664.
i. Medically provided, or “artificial,” nutrition and hydration are types of life-sustaining treatment that may be refused.  

ii. Surrogate decision makers may exercise this right for patients who lack decision-making capacity.  

iii. Patients who retain decision-making capacity may complete advance directives to communicate their preferences regarding life-sustaining treatments and guide their future treatment.

As in the “brain death” debate, one might be tempted to conclude that recognition of rights to forgo life-sustaining treatment indicate that the “natural death” debate had run its course by the mid-1990s. Once again, however, that conclusion would be premature. The case of another young woman, Theresa Marie (Terri) Schiavo, revealed deep disagreement about end-of life care choices. In 1990, Terri Schiavo suffered a cardiac arrest, was resuscitated, and was hospitalized. Like Karen Ann Quinlan, Terri suffered severe anoxic brain damage and some months later received a diagnosis of persistent vegetative state. Although Terri was able to breathe without assistance, she required medically-provided tube feeding for nutritional support. In 1998, Terri’s husband Michael, who had also been appointed her legal guardian, sought and obtained a court order to remove her feeding tube and discontinue nutritional support. Terri’s parents, Robert and Mary Schindler, strongly opposed this action and obtained a court order to reinstate nutritional support. These events marked the beginning of a very public and bitter six-year legal battle between Terri’s husband and
her parents, including multiple court rulings, state and federal legislation, and intervention by then Florida Governor Jeb Bush and then President George W. Bush. The Schiavo case, which was avidly reported by national media from 1998 until Terri’s death in 2005, revealed deep and persistent public disagreement about end-of-life care choices. Despite established legal rights, some physicians still do not elicit or honor patients’ preferences regarding the use of life-sustaining treatment in specific medical conditions.

D. The “Physician-Assisted Suicide” Debate

The fourth prominent U.S. end-of-life care debate focused on a practice that was long called “physician-assisted suicide.”

i. The issue: Some terminally ill patients ask their physicians for assistance in hastening their deaths. Should physicians be permitted to provide this assistance?

ii. The status quo in 1970: There was virtually no public or professional discussion of this issue.

In 1990, Jack Kevorkian, a retired Michigan pathologist, publicly announced that he had helped Janet Atkins, a patient with Alzheimer’s disease, to end her life, using a “suicide machine” he had developed. Professional reaction to this announcement was

87. Gostin, supra note 86, at 2404–05.
89. Meisel, supra note 76, at 310–11.
90. Especially within the past decade, proponents of this practice have rejected the term “physician-assisted suicide.” These proponents argue that the practice is significantly different from suicide and that the negative connotations of the term “suicide” are therefore inappropriate. They recommend instead the use of more neutral terms like “physician aid in dying” and “physician-assisted death.” For a critique of the term “physician-assisted suicide,” see Timothy E. Quill et al., Responding to Patients Requesting Physician-Assisted Death: Physician Involvement at the Very End of Life, 316 JAMA 245, 245–46 (2016). Opponents of this practice, in contrast, argue that the negative connotations of the term “suicide” are appropriate and that the term ‘physician-assisted suicide’ should be retained; for an example of this position, see Y. Tony Yang & Farr A. Curlin, Why Physicians Should Oppose Assisted Suicide, 315 JAMA 247, 247–48 (2016).
swift and harshly critical; multiple responses by prominent physicians and ethicists condemned Kevorkian’s action. Public responses, however, were mixed, and vigorous national debate about this practice ensued.

In a 1994 state initiative, Oregon voters approved a “Death with Dignity Act” designed to legalize the practice of “physician-assisted suicide.” After several legal challenges, and voter approval in a second initiative in 1996, Oregon became the first state to implement a legal practice of physician-assisted suicide in 1997. Also in 1997, the U.S. Supreme Court handed down a pair of eagerly awaited decisions on this subject. In those decisions, the Court overturned federal appeals court rulings that patients had a fundamental constitutional right to assistance in suicide. Rather, the Supreme Court allowed individual states either to permit or prohibit this practice. As of June 2020, nine states and the District of Columbia have legalized the practice of “physician aid in dying” via provision of a prescription for a lethal medication to a terminally ill patient at the patient’s request.

E. The Futility Debate

As noted above, the “natural death” debate focused on patient control over decisions to forgo life-sustaining treatments. The last of the prominent U.S. end-of-life care debates also addressed patient control over life-sustaining treatments, but the focus this time was on obtaining, not forgoing desired treatments.

i. The issue: May physicians refuse patient or surrogate decision-maker requests for life-sustaining treatments on the grounds that those treatments would be futile?

94. See id.
96. Purvis, supra note 34, at 80.
98. Vacco, 521 U.S. at 796; Washington, 521 U.S. at 705.
99. Vacco, 521 U.S. at 796; Washington, 521 U.S. at 705.
ii. The status quo in 1970: There is no evidence that disagreements of this kind existed until the mid-1980s.\(^{102}\)

Beginning in the late 1980s, physicians and commentators began to assert physicians’ rights to refuse to provide treatments that they deemed to be futile, in response to patient and surrogate requests for initiating or continuing aggressive treatments.\(^{103}\) These assertions met with prompt replies arguing that appeal by physicians to futility judgments to deny requests for life-sustaining treatment was unjustified.\(^{104}\) A long period of vigorous debate followed, with some two thousand articles on futility published in the medical literature indexed in the PubMed database between 1990 and 2010.\(^{105}\)

Multiple articles during this period proposed definitions of medical futility and criteria for concluding that a treatment is futile.\(^{106}\) A widely-read 1999 report of the American Medical Association’s Council on Ethical and Judicial Affairs, however, concluded that “a fully objective and concrete definition of futility is unattainable.”\(^{107}\) Given the inability to achieve consensus on a definition of futility, this American Medical Association report proposed a “fair process approach” to resolving futility disputes.\(^{108}\) Also in 1999, the state of Texas enacted a statute that established a procedure physicians and hospitals could follow for addressing disputes with patients or their surrogates about the use of life-sustaining treatments.\(^{109}\) Following the process described in this Texas statute

---


104. See, e.g., John D. Lantos et al., The Illusion of Futility in Clinical Practice, 87 AM. J. MED. 81, 81 (1989); Robert D. Truog et al., The Problem with Futility, 326 NEW ENG. J. MED. 1560, 1560–64 (1992).


108. Id. at 939–40.

109. TEX. HEALTH & SAFETY CODE ANN. § 166.046 (West 2019).
provides immunity from liability for withholding or withdrawing life-sustaining treatments without patient or surrogate consent.\textsuperscript{110}

The role of appeals to futility in making medical treatment decisions remains a matter of debate in 2020.\textsuperscript{111} There is general consensus that physicians are not obligated to offer or provide clearly futile treatments, but no consensus on substantive general criteria for futility or on appropriate procedures to resolve futility disputes.\textsuperscript{112}

Controversy over the value of recent Right to Try legislation can be viewed as a specific instance of the ongoing futility debate.\textsuperscript{113} This legislation provides an avenue for patients to request investigational treatments that they may hope or believe will prolong their lives. That hope or belief may not be well founded, however. When patients request investigational treatments, physician investigators and pharmaceutical and medical device developers must decide whether to honor or deny those requests, presumably based at least in part on their assessment of the requested treatments’ prospects for benefitting or harming those patients.\textsuperscript{114}

IV. THE CLAIMS REVISITED, AND FUTURE CONSIDERATIONS

This article began with an assertion of three bold claims. I return now to those three claims and to brief consideration of the future of the end-of-life care debates described above.

A. The Claims Revisited

Claim 1. End-of-life care options in the United States have undergone an almost \textit{total transformation} over the past half century.

\begin{itemize}
\item \textsuperscript{110} Tex. Health & Safety Code Ann. § 166.045 (West 2019).
\item \textsuperscript{111} Laura Miller-Smith et al., Palliative care: Medically futile and potentially inappropriate therapies of questionable benefit, UpToDate (July 29, 2020), https://www.uptodate.com/contents/palliative-care-medically-futile-and-potentially-inappropriate-therapies-of-questionable-benefit.
\end{itemize}
The status of end-of-life care in 1970 in the United States, as described in Part II above, can be summarized as follows:

i. Very few effective life-sustaining treatments were available.115

ii. There was no established right to refuse life-sustaining treatments.116

iii. There was no formal mechanism for requesting access to investigational treatments.117

iv. Hospice care services did not exist.118

v. Palliative care services did not exist.119

vi. The practice of physician aid in dying, also known as physician-assisted suicide, did not exist.120

vii. The practice of hastening death by voluntarily stopping eating and drinking was still virtually unknown in the Western world.121

All of the above assertions are no longer accurate today.122 That is, I contend, a virtually total transformation!

Claim 2. Controversies over end-of-life care played the leading role in launching the field of American bioethics.

As described above, the abortion, “brain death,” and “natural death” debates of the late 1960s and 1970s, together with news reports of the abuse of human research subjects in the Tuskegee syphilis studies, focused explicit and sustained public and professional attention, for the first time, on moral issues in health care.123 The academic field of bioethics emerged to examine those moral issues in end-of-life care and to help health care professionals and trainees engage in careful moral reasoning about the clinical ethics.


119. Connor, supra note 30, at 89.


121. Ivanović et al., supra note 35, at 2.

122. Lee, supra note 7, at 98–99.

questions they confront. Clear evidence for the emergence of the field of bioethics at this time can be found in the establishment of bioethics professional societies, scholarly journals, and teaching programs in universities and professional schools.

Claim 3. Controversies over end-of-life care remain the most visible, and some of the most vexing, issues in bioethics in the United States today.

Prompted initially by the debates described above, major U.S. newspapers and newsmagazines now feature news stories and analyses of end-of-life care issues in virtually every issue. Daily attention to the controversial moral issues posed by worldwide efforts to limit the death toll of the current COVID-19 pandemic is a prominent example of the high visibility of end-of-life care. Ethical issues in end-of-life care are also featured in a number of best-selling U.S. books; recent examples include Atul Gawande’s Being Mortal, Paul Kalanithi’s When Breath Becomes Air, and Kate Bowler’s Everything Happens for a Reason, And Other Lies I’ve Loved. These multiple sources illustrate the visibility of end-of-life care issues, and the persistence of the end-of-life care debates described above provide persuasive evidence of their complexity.

B. A Look Ahead

What does the future hold for the five moral and public policy debates over end-of-life care described above? I conclude with tentative predictions about each debate.

i. The Abortion Debate: Because opposing positions on abortion are typically based on metaphysical and moral beliefs that are both deeply held and in conflict with one another, the moral debate over abortion remains intractable, with no clear resolution.

124. Id. at 17.
125. For more information about the emergence of bioethics as a field of scholarly inquiry, see id. at 20–21.
126. Lee, supra note 7, at 100.
129. See GAWANDE, supra note 128, at 1; KALANITHI, supra note 127, at 42; BOWLER, supra note 128.
in sight. As mentioned above, pending U.S. Supreme Court review of legal challenges to recently enacted, highly restrictive state abortion statutes\textsuperscript{131} may result in further erosion or rejection of the constitutional abortion rights recognized in \textit{Roe v. Wade} nearly half a century ago.

\textbf{ii. The “Brain Death” Debate:} Empirical questions about the accuracy of current methods for determining death by neurologic criteria, as well as ontological and moral questions about what constitutes human death, are likely to continue.\textsuperscript{132} Despite rejection of “brain death” by some Americans,\textsuperscript{133} however, the legal consensus that death can be determined by neurologic criteria has strong support and is unlikely to change.\textsuperscript{134}

\textbf{iii. The “Natural Death” Debate:} Long-established legal rights to refuse life-sustaining treatments are routinely honored, but personal preferences regarding end-of-life care remain highly variable, and many patients and families have misconceptions and express suspicion about the goals and values of hospice and palliative care.\textsuperscript{135}

\textbf{iv. The “Physician-Assisted Suicide” Debate:} Legalization of this practice is likely in a number of other western and northeastern states, but unlikely in the South and Midwest, due to strong faith-based opposition to the practice in those regions.\textsuperscript{136}

\textbf{v. The Futility Debate:} Few, if any, states are likely to follow Texas’ example in giving hospitals and physicians a statutory process enabling unilateral withdrawal of life-sustaining treatment,

\textsuperscript{131} See Nash, supra note 43, at 497–99.


\textsuperscript{134} See Capron, supra note 47, at 1245.


setting the stage

with immunity from liability for that action. Individual physicians will nevertheless continue to refuse patient and surrogate requests for aggressive treatments in circumstances where there is clear evidence of the ineffectiveness or harmfulness of those treatments.

These five longstanding moral and public policy debates have been joined, in recent years, by several additional debates. One such debate addresses issues of resource allocation for life-sustaining treatments. As the cumulative costs of the U.S. health care system continue to increase, both private and public payers for health care services confront difficult choices in funding those services. Given those growing cost pressures, must public and private health insurance programs cover new and very expensive treatments for advanced disease, even if those treatments offer only modest benefits? A related debate is the subject of this journal issue: Does recent Right to Try legislation provide essential or valuable access to investigational products for patients with life-threatening diseases, especially when there is no effective treatment for those diseases? The other articles in this issue of the Journal provide detailed analysis and evaluation of this debate.

