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# How We Die in North Carolina

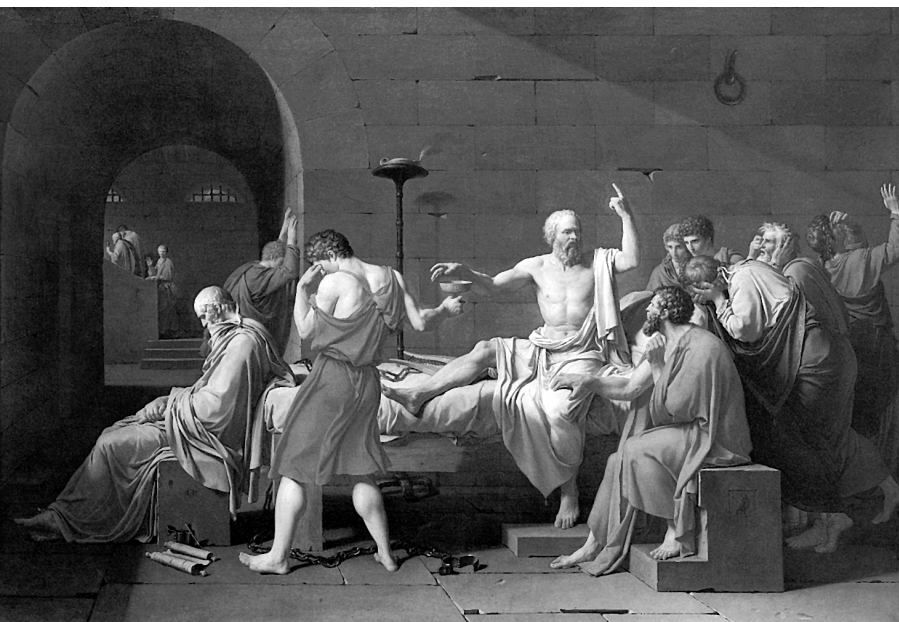
ANNE DELLINGER

In June 1998 the *Wall Street Journal* reported on seventy-year-old North Carolinian Claude Marion, who thought that he had prepared for death ten years ahead of time, but still did not receive the care he wanted.<sup>1</sup> After he died, one of his daughters described the experience of acting as his advocate. Speaking of the divisions that emerged among patient, family, and physician, and eventually within the family, she said,

[My father] just tried really hard to do the right thing. And he died in a very undignified way. I felt so helpless. . . . My sister and I felt we had been to war. . . . I don't think there's a good guy and a bad guy here. . . . I think people were doing what they were taught.<sup>2</sup>

Following Mr. Marion's emergency surgery at Wake Forest University Baptist Medical Center in Winston-Salem, he slipped in and out of consciousness, unable to make his wishes known. Although four successive complications repeatedly brought him close to death, the attending physician would not honor the living will, believing that Mr. Marion was not "terminal" (defined by the physician as having no chance for recovery).<sup>3</sup> A hospital ethics council was convened, which agreed with Mr. Marion's daughters that his condition was terminal. Rejecting the council's opinion, the physician said he would continue to treat aggressively. A

judge appointed Mr. Marion's daughters his guardians. Meanwhile, though, some of their aunts and uncles took the physician's side, and the family began arguing. While his daughters were finding another physician, Mr. Marion passed the point before which he might have been sustained at home. Still in the hospital, he was eventually freed from the feeding tube and given morphine for comfort. He died fifty-seven days after admission, during a third bout of pneumonia.



The Death of Socrates, painted by Jacques Louis David in 1787, depicts the Greek philosopher about to drink hemlock in a classic act of suicide. Grieving friends and admirers surround him.

The Metropolitan Museum of Art, Catharine Lorillard Wolfe Collection, Wolfe Fund, 1931. (31.45). Photograph © 1995 The Metropolitan Museum of Art

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The author, an Institute of Government faculty member who specializes in health law, participated in the forum described in this article. The article takes part of its title from the best-selling book *How We Die: Reflections on Life's Last Chapter*, by Sherwin B. Nuland (New York: Alfred A. Knopf, 1994).



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*Modern medicine's high-tech treatments inspire awe, but they also may induce fear of overly aggressive care when there is little or no chance of recovery.*

A health care power of attorney giving decision-making power to a daughter might have prevented most of these problems, but like most people, Mr. Marion did not have one. Tailoring the language of his living will to make it effective earlier probably would have helped too. Simply by having a living will, he did more to plan for his death than most North Carolinians have done. Yet clearly his living will was not enough.

In October 1998 three North Carolina licensing boards—medicine, nursing, and pharmacy—met to consider how to help people avoid their worst nightmares surrounding death.<sup>4</sup> The meeting examined people's needs, current state and federal law, and both actual and ideal health care for the terminally ill. This article summarizes the law on suicide, assisted suicide, euthanasia, treatment, and withdrawal of treatment for those who are seriously ill. It also describes the

three licensing boards' first step toward what may be a historic collaboration.<sup>5</sup>

## **BACKGROUND**

To understand how we die in North Carolina today, as well as what choices we may have in the future, some history is useful. It is surprising how recently suicide and suicide attempts were crimes in this state. In fact, North Carolina was the last of the states to prosecute an attempt at suicide. In 1961 the supreme court found the act criminal,<sup>6</sup> as it had been for centuries under the common law of England and was later in the American colonies and states. Because suicide was a crime, helping someone carry it out was too.<sup>7</sup>

In 1973 the General Assembly abolished the crime of committing suicide and thereby, implicitly, the

crimes of attempting and assisting in a suicide.<sup>8</sup> Still, these acts continue to carry a substantial stigma. For instance, in August 1998 a *Raleigh News & Observer* reporter interviewed a terminally ill person as he prepared to kill himself. (The reporter declined to be present at the death, however.) Later her editors debated whether publishing the account would “implicitly endorse” the man’s act. The executive editor did decide to publish it but pointedly denied any endorsement. Instead, with careful neutrality he called the

or assisted suicide. The defendant, an elderly woman, said that, in accord with her sister’s wishes, she had connected a hose to a car’s exhaust and left the garage so that her sister could turn on the ignition. Investigators from the sheriff’s department accepted this account.<sup>12</sup> The medical examiner, however, called the death a homicide, carried out against the victim’s will. In his opinion, “a person who’d taken that drug dosage—particularly a cardiac patient dependent on a walker to move about—would not have been able to carry out the suicide that reportedly took place.”<sup>13</sup> Nearly a year after her sister’s death, the defendant was charged with second-degree murder but allowed to plead guilty to voluntary manslaughter. She received a six-year suspended sentence, a \$2,000 fine, and probation for five years.<sup>14</sup>

A member of the state attorney general’s staff may have played an important part in the decision to prosecute, although the office issued no formal opinion. According to news reports, Lester Chalmers, special deputy attorney general, advised the local prosecutor that an indictment for second-degree murder would be appropriate.<sup>15</sup> Chalmers also implied doubt about the legality of assisted suicide.<sup>16</sup> State and local medical examiners involved in the inquest urged a murder prosecution.<sup>17</sup> Initially inclined against any charge, much less murder, the prosecutor finally did bring the second-degree murder charge, noting, “Suicide is legal, and so is aiding and abetting a suicide. But the thin line between suicide and homicide in such a case is a legal dilemma.”<sup>18</sup> Fixing that line continues to be a problem.

At least once, a decade ago, the state boards of medicine and nursing reviewed actions by a doctor and a nurse that raised the possibility of euthanasia.<sup>19</sup> An elderly, terminally ill woman who had a living will was removed from a respirator at her request and her family’s. Just before and for some time after removal, she received morphine.<sup>20</sup> When that did not “stop the struggling and suffering,”<sup>21</sup> a nurse recommended that the doctor use Pavulon.

According to the board of nursing,

Pavulon is a paralytic agent whose action works on the respiratory muscles. Its primary use is in anesthesia. The drug is used in some instances in which patients on respirators are “fighting” the respirators, and for the purposes of controlling the patient’s breathing. There is no clinical usage for Pavulon in a patient that is not on a respirator.<sup>22</sup>

Indeed, the nurses assigned to the patient would not administer the drug after the doctor ordered it. The



Andrew Watry, Mary P. “Polly” Johnson, and David Work, executive directors of the state boards of medicine, nursing, and pharmacy, respectively. The boards jointly sponsored the End-of-Life Decisions Forum in October 1998.

story “a fair and honest account of one man’s search for what he believed was a dignified death.”<sup>9</sup>

North Carolina’s highest court has dealt very harshly with “mercy killing,” or euthanasia. For shooting his father in a hospital bed, a man was convicted of first-degree murder and received a mandatory life sentence, which was upheld on appeal. At trial the judge told the jury that they could infer malice<sup>10</sup> (though they did not have to do so) from the defendant’s use of a deadly weapon, and that the defendant’s knowledge that his father was at the brink of death was not a defense (though they could consider that knowledge). Both instructions were challenged on appeal. The supreme court upheld them but not unanimously. The chief justice urged a distinction in punishment because the son’s intentions were good.<sup>11</sup>

In 1982 Asheville was the scene of a prosecution that was particularly troubling because the event on which it was based was hard to classify as euthanasia

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supervising nurse, who had made the recommendation, then administered four doses of Pavulon within seven minutes. The patient was pronounced dead within two minutes of the last injection.

Both boards reviewed the circumstances of the death, questioning the appropriateness of several aspects of the care. The board of medicine formally revoked the physician's license but immediately restored it without further penalty.<sup>23</sup> The board of nursing was more severe. It suspended the nurse's license for eighteen months for three reasons: administering excessive morphine, suggesting that the doctor use Pavulon, and administering it.<sup>24</sup>

## THE PRESENT

There is no social consensus now on most of the issues surrounding dying—not even pain relief. Moreover, the risk of disapproval from some quarters is not the only or even the most serious problem. More troubling is the frequent confusion about the nature of acts that might lead to a wished-for death and the uncertainty about their legality. For example, polls indicate that the public sees little difference between assisted suicide and patient-requested euthanasia and would like both available.<sup>25</sup> A study of physicians shows similar results: physicians, and therefore probably other health professionals, often confuse assisted suicide and euthanasia.<sup>26</sup> On the other hand, judges, prosecutors, and the law sharply distinguish between the two acts (although the evidence may not clearly reveal which was committed).

The following sections describe the current legal status of certain aspects of dying.

### Suicide

"Suicide" is "the act or an instance of taking one's own life voluntarily and intentionally."<sup>27</sup> Committing or attempting to commit suicide is not a crime in North Carolina.

### Assisted Suicide

A leading treatise on death and dying discusses at length what "assisted suicide" means and how it differs from euthanasia and homicide (if it does).<sup>28</sup> The treatise cites a source that says the difference is illusory, and, as noted earlier, much of the public and a significant minority of physicians do not distinguish meaningfully between assisted suicide and euthanasia.

Most people, however, continue to draw a moral distinction between responding affirmatively to "Help me kill myself" and responding affirmatively to "Kill me." How to treat the two acts, and what constitutes each, are problems for all interested parties (patients, health providers, courts, district attorneys, health licensing boards, legislatures, the United States attorney general, and the Drug Enforcement Agency). For present purposes, though, a loose definition of "assisted suicide" may be helpful: it can be thought of as the act of providing a competent person with the means to take his or her own life.

In general, assisting someone in committing suicide is legal. That is, an ordinary person who hands a knife to someone who is desperate or holds a ladder for that someone to reach a window ledge should have no legal problem. But the situation can be more complicated if there is a special, legally recognized relationship between the helper and the person wanting to die. In certain relationships—parent and minor child, bank trustee and depositor, and doctor and patient, to name a few—one party is legally obligated to protect the other to some extent.<sup>29</sup>

We simply do not know whether or when a health professional will be seen as failing to protect a patient if he or she helps the patient die. (Some patients and professionals think that the professional's duty to the patient should include easing death in a variety of ways.) The means of assistance most often discussed—now legal in Oregon—is providing medication for a patient to administer to herself or himself.<sup>30</sup> A legal question for all health professionals is whether helping patients die is a normal, appropriate part of their practice. If not, then their doing so might make them liable under tort law.

For physicians and pharmacists, there is a second legal problem. If they provide prescription drugs to a patient outside "the usual course of . . . professional practice," they are guilty, like anyone else, of violating state and federal controlled substances acts.<sup>31</sup> The severe penalties associated with violations are in addition to any discipline imposed by licensing boards or any tort actions filed by a patient's estate or family.

Two voluntary associations, the North Carolina Medical Society<sup>32</sup> and the North Carolina Licensed Practical Nurses Association,<sup>33</sup> are on record as opposing their members' helping with suicides, but no state appellate court has passed on the issue, and the North Carolina Department of Justice has not issued a formal opinion.<sup>34</sup> Health practitioner licensing boards, especially the boards of medicine, nursing, and pharmacy,

could help clarify the situation for their members, but so far they have not done so.

Medicine's and nursing's practice acts, which authorize the boards to issue and revoke licenses, contain language that they might use to forbid their licensees from assisting in suicides. The board of medicine could find, for instance, that a doctor who provided a lethal prescription or instructed a patient in a suicide technique was guilty of "unprofessional conduct" or "departure from . . . the standards of acceptable and prevailing medical practice, or the ethics of the medical profession." Because both are grounds for disciplining physicians, the board could then suspend or revoke a doctor's license to practice.<sup>35</sup>

The definition of nursing in the Nursing Practice Act does include helping patients to "the achievement of a dignified death."<sup>36</sup> Another part of the act, however, allows board action against a nurse who "[e]ngages in conduct that endangers the public health,"<sup>37</sup> and a court has held that the section may apply to a case involving a single patient.<sup>38</sup> The statute also lets the board discipline a nurse who "[i]s unfit or incompetent to practice nursing by reason of deliberate or negligent acts or omissions" or "[e]ngages in conduct that . . . harms the public in the course of any professional activities or services."<sup>39</sup> In addition, regulations under the statute forbid a nurse's "practicing . . . beyond the scope permitted by law."<sup>40</sup>

The state board of pharmacy would have more difficulty using its practice statute to prevent pharmacists from filling a lethal prescription for a patient. The Pharmacy Practice Act is more specific about what is improper practice, and none of its language seems easily applicable to suicide. The most nearly relevant provision allows adverse action if someone is "negligent in the practice of pharmacy."<sup>41</sup>

### **Euthanasia**

"Euthanasia" may be defined as "the intentional putting to death of a person with an incurable or painful disease intended as an act of mercy."<sup>42</sup> This act very likely is murder under North Carolina law. In fact, personally administering lethal medication to a patient could be first-degree murder, either as "murder by poison" or simply as deliberate and premeditated killing.<sup>43</sup> In other words, like the man who shot his father, a doctor or a nurse would not escape punishment because she or he meant to benefit the patient—not even if the patient had asked for death.

### **Pain Relief**

Pain relief is probably the most important of the end-of-life issues because of the effect of pain on dying people and the fear it engenders in nearly everyone who contemplates dying in the United States today. Despite efforts from several directions to clarify the legality of giving pain-relieving medication that may shorten life or even kill, the matter is not yet clear enough.

Health professionals know that a number of drugs may depress breathing, especially opioids (derivatives of opium or similar, synthetic narcotics), which are among the most effective painkillers.<sup>44</sup> They also know that relieving pain is among the highest goals of their professions, that United States medicine has been widely criticized by its practitioners and others for failing in that regard,<sup>45</sup> and that a major malpractice suit for failure to relieve pain succeeded in North Carolina. In that case a Hertford County jury returned a verdict of \$15 million against Hillhaven Corporation for a nursing home's refusal to administer pain medication ordered by a physician for a man dying of cancer.<sup>46</sup>

About twenty states expressly approve the use of pain-relieving medication, even though it may shorten life.<sup>47</sup> North Carolina has no statute, regulation, or case law to that effect. However, in a recent position statement, North Carolina's board of medicine addressed one of the most difficult areas of pain management, the use of opioids to treat chronic nonmalignant pain. The board said, "It should be understood that the Board recognizes opioids can be an appropriate treatment for chronic pain."<sup>48</sup> Because the board takes that position for the harder question of chronic illness, perhaps its doing so for terminal illness should be assumed. In the position statement on chronic illness, the board does call attention to federal guidelines encouraging greater use of opioids for the terminally ill, but it makes no further comment. If the board approves North Carolina physicians' use of the federal guidelines, its saying so explicitly—perhaps by incorporating the guidelines into its own position statement—would be helpful.

Because of the fear of severe penalties for violating controlled substances acts, pharmacists and physicians would pay close attention to any position announced by the North Carolina Board of Pharmacy. The pharmacy board has not spoken, however. A single item in its newsletter (not a report of a board action or even of a board discussion) is the only indication of the ex-

tent to which the board wants pharmacists to help relieve the pain of the terminally ill. The statement reads,

[T]he alleviation of pain through prescription drugs, including narcotics, is a normal part of medical care. In short, pharmacists should not fear action from the Board of Pharmacy if they are dispensing substantial amounts of narcotics for a legitimate medical need, such as to relieve pain for patients who will not be with us six months or one year hence due to their deteriorating health.<sup>49</sup>

The federal controlled substances act points practitioners in the same direction—that is, toward relieving pain, even if doing so jeopardizes the patient's life. The act requires doctors who prescribe medication for purposes of maintaining a drug addict to register with the Drug Enforcement Agency,<sup>50</sup> but regulations state that the act is not meant to limit a physician who prescribes opioids for intractable pain when no relief or cure is possible or has been found after reasonable effort.<sup>51</sup> Some states have amended their controlled substances acts to make the same assurance. North Carolina has not. If the General Assembly wanted to encourage physicians to relieve pain without fear of legal consequences, one avenue would be to amend the definition of "Drug dependent person" in state law<sup>52</sup> to exclude the dying.

### Life-Sustaining Treatment

Refusal, withholding, and withdrawal of life-sustaining treatment all are legal choices under state law. (As noted earlier, the difficulty may lie in getting the choices honored.) North Carolina has long allowed residents to express preferences about how they die. The state enacted the Right to Natural Death Act<sup>53</sup> in 1978, not so much to create new rights as to recognize existing ones.<sup>54</sup> A person may refuse extraordinary medical interventions, including artificial nutrition and hydration, or ask to have them discontinued.<sup>55</sup> State law also permits residents to name an agent to choose their health care in certain circumstances.<sup>56</sup>

On the other hand, the statutes creating patient rights in terminal care caution that the state does not "authorize any affirmative or deliberate act or omission to end life other than to permit the natural process of dying."<sup>57</sup> Furthermore, whether North Carolina doctors and hospitals or other facilities must carry out a patient's wishes is not settled. Some states require this by statute. An attorney general's opinion advises that a physician or a facility need not follow a patient's

wishes or transfer the patient to caretakers who will. But the opinion also says that providers may be liable for assault and battery if they force treatment on a patient.<sup>58</sup>

The United States Supreme Court seems to acknowledge that competent people have a constitutional right to refuse medical treatment.<sup>59</sup> A federal statute requires health facilities, as a condition of Medicare or Medicaid participation, to ask every patient about advance directives and to explain the options available under state law for creating them.<sup>60</sup>

### THE FUTURE

The receptivity of North Carolina law to letting people control important aspects of their death is comforting. However, a writer (and North Carolinian) recently referred to laws like those described earlier as being for some Americans only "feeble protections against their dread of modern dying."<sup>61</sup> Health professionals, and each person considering her or his own death, want expanded rights—or at least opportunities—as well as enough certainty about the law to exercise the rights that are nominally available. It was to pursue those goals that the End-of-Life Decisions Forum met on October 23, 1998, in Raleigh.

The approximately 120 participants in the forum were members of the boards of medicine, nursing, and pharmacy; the boards' staffs, including legal counsel; employees of other state agencies; health professionals who work directly with dying people; a few interested citizens; and invited speakers. In most ways the group was typical: everyone, after all, is "competent" to discuss dying. In a few ways, though, the group's greater-than-average expertise and concern about the subject were evident. For example, when a speaker asked how many had an advance directive, everyone raised a hand. Among Americans in general, fewer than 10 percent have taken that step.

The forum's principal speaker, Lawrence Gostin,<sup>62</sup> established the context for the meeting. He described social and historical forces, and mistakes and fears, that have made it hard in the United States to regulate dying. He noted that many Americans fear too much care at the end of life, accurately sensing a strong bias in American medical education and practice toward continuing treatment. The bias may be traced to (1) the technological imperative—that is, pressure to use the marvelous lifesaving machines and techniques that the United States health care system has perfected; (2) defensive medicine—that is, health

care providers' misuse of treatment to protect themselves against liability; and (3) confusion about who may decide for the (incompetent) dying person.

In recent decades the law has resolved two important issues by abandoning the distinctions between not beginning treatment and stopping it, and between ordinary and extraordinary care. In 1997 the United States Supreme Court gave the states permission to retain a third distinction, between letting nature take its course and actively helping someone die.<sup>63</sup> At the same time, by declining to review the Oregon statute allowing physician-assisted suicide, the Court indicated that states are free to make the opposite choice. Clearly, every state may decide a range of issues about how people die.

The ultimate goal of law and medicine in this area is helping people die well, and an essential component of the goal is pain relief. The keynote speaker urged forum participants to debate the nature of a high-quality death: What resources are needed? How can every person's pain be made tolerable? How can the mental anguish and the mental disabilities of dying be addressed? His own recommendations included a closer relationship among the medical, nursing, and pharmacy professions.

After brief presentations by other speakers,<sup>64</sup> participants divided into seven small groups, each with a mix of experience and interests, to discuss the following questions:

- Should North Carolina licensing boards set standards for end-of-life care? Should health professions' practice acts or rules further define the standards? If so, what should the standards be?
- Are patterns of practice (treatment) changing? How? If not, should they be?
- What are the major barriers to patient choice with respect to dying?
- What aspects of end-of-life care in North Carolina need attention to bring about policy development, education, or regulation?

The seven groups split three ways on whether licensing boards should adopt standards. Some thought it essential so that professionals could treat pain adequately and help patients fulfill their last wishes. Others were cautious because of political risks and a feeling that state regulation of dying is antidemocratic. They preferred that the three boards follow rather than lead society in its evolution on these matters. A middle group wanted flexible standards, or none at all,



Courtesy of National Hospice Organization

*Family offer emotional comfort to a dying relative receiving hospice care.*

for the time being. To them, process seemed more important now than answers.

All the groups believed, however, that professional standards for terminal care *are* changing, mostly for the better. They credited the hospice movement, patients' insistence on "palliative" care (treatment intended to reduce the severity of symptoms without curing the disease), the emergence of nursing as a more independent profession, and recognition of that development by medicine.

The groups offered a number of reasons for patients' wishes being overlooked so often: patients' and health care providers' reluctance to plan for death; time pressures and the cost of care; a perception that abandoning aggressive treatment is immoral; and the difficulty of communicating patients' preferences to the necessary parties.

On the last question, there was again more agreement. All participants supported education in end-of-life choices for the public, legislators, other policy makers, and health professionals. Many preferred permissive rather than mandatory legal regulation of these issues. Above all, they hoped that the forum itself would be reconvened and that the boards of medicine, nursing, and pharmacy would establish procedures for cooperating on behalf of the terminally ill and the dying.

## NOTES

1. Becky Bull, "Best-Laid Plans: Living Wills Are Supposed to Eliminate Many Painful Decisions for Family Members. So Why Don't They?" *Wall Street Journal Interactive Edition*, June 1, 1998, available at <http://www.wsj.com>.
2. Bull, "Best-Laid Plans."
3. Bull, "Best-Laid Plans."
4. End-of-Life Decisions Forum, Raleigh, N.C., Oct. 23, 1998.

5. The forum itself was a milestone in the boards' relationship. Although they have met together occasionally in recent years, the forum was the first time they agreed to explore jointly an issue with serious implications for regulation by all three. Together they planned what the objectives of the forum would be, what points should be covered, and who would speak. The focus of the meeting was what board members needed to know about their profession's role in the process of dying and what more needed to be done in North Carolina to bring about desirable change. Telephone conversation with Mary P. Johnson, executive director, North Carolina Board of Nursing, Jan. 12, 1999.

6. *State v. Willis*, 255 N.C. 473, 121 S.E.2d 854 (1961).

7. "Since suicide is a crime, one who aids or abets another in, or is accessory before the fact to, selfmurder is amenable to the law." *Willis*, 255 N.C. at 477, 121 S.E.2d at 856-57.

8. "Such offenses [assisting suicide], in the absence of statute to the contrary, would not be criminal offenses in a jurisdiction in which suicide is not a crime." *Willis*, 255 N.C. at 477, 121 S.E.2d at 857.

9. Martha Quillin, "A Good Death: The Last Days of Sam Niver," *Raleigh News & Observer*, Aug. 23, 1998, available at <http://search.news-observer.com>. The editorial note is by Anders Gyllenhaal.

10. Malice is a necessary element of murder.

11. According to the dissent,

Almost all would agree that someone who kills because of a desire to end a loved one's physical suffering caused by an illness which is both terminal and incurable should not be deemed in law as culpable and deserving of the same punishment as one who kills because of unmitigated spite, hatred or ill will. Yet the court's decision in this case essentially says there is no legal distinction between the two kinds of killing.

*State v. Forrest*, 321 N.C. 186, 200, 362 S.E.2d 252, 260 (1987).

12. United Press International, "'Mercy Killing' Trial to Begin Today," *Asheville Citizen*, May 25, 1982.

13. Ron DuBois, "Woman Indicted in Sister's Death," *Asheville Citizen*, April 8, 1982.

14. Barbara Blake, "Sentence Suspended in 'Mercy Killing,'" *Asheville Times*, May 26, 1982.

15. United Press International, "'Mercy Killing' Trial."

16. AP Wire Service, "Murder Trial May Address Mercy Killing," *Asheville Times*, April 19, 1982.

17. AP Wire Service, "Murder Trial."

18. DuBois, "Woman Indicted."

19. North Carolina Board of Nursing, Order in the Matter of \_\_\_\_\_ [name omitted by author], RN, Certificate #59124, June 16, 1989, p. 5 (hereinafter "Order").

20. 44 mg. of Morphine IV-push in 45 minutes. "Order," p. 3.

21. In its investigation the board of nursing found that the patient's "struggle was with breathing. She did not appear to be having discomfort or pain." "Order," p. 3.

22. "Order," p. 4.

23. Telephone conversation with James Wilson, general counsel, North Carolina Medical Board, Sept. 15, 1998.

24. "Order," pp. 7-9.

25. Peter G. Filene, *In the Arms of Others: A Cultural History of the Right-to-Die in America* (Chicago: Ivan R. Dee, 1998), 195.

26. Ezekiel Emanuel et al., "The Practice of Euthanasia and Physician-Assisted Suicide in the United States," *JAMA* 280 (Aug. 12, 1998): 507-13.

27. *Merriam-Webster's Collegiate Dictionary* (10th ed.) (Springfield, Mass.: Merriam-Webster, 1997), s.v. "suicide."

28. Alan Meisel, "Criminal Liability: Assisted Suicide and Euthanasia," chap. 18 in *The Right to Die* (2d ed.), vol. 2 (New York: Wiley Law Publications, 1995).

29. The closeness and the intensity of the relationship are not the issue. Spouses, for example, do not have such protective obligations to each other.

30. As used here, "providing" means prescribing, filling a prescription, or, in the case of a nurse, delivering a dose ordered by a doctor.

31. According to regulations under North Carolina's statute, anyone "dispensing" (writing or filling a prescription for) controlled substances must register, but doctors and pharmacists are exempt when practicing and when licensed in North Carolina "by their respective boards to the extent authorized by their boards." 10 N.C. ADMIN. CODE 45G.0108. Likewise, federal regulations (incorporated into the state's code at 10 N.C. ADMIN. CODE 45G.0301) say,

A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. An order purporting to be a prescription issued not in the usual course of professional treatment or in legitimate and authorized research is not a prescription within the meaning and intent of section 309 of the Act (21 U.S.C. 829) and the person knowingly filling such a prescription, as well as the person issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances.

21 C.F.R. § 1306.04.

32. North Carolina Medical Society, *Physician-Assisted Suicide*, Substitute Report PP-1992, adopted Nov. 8, 1992. The society's office is in Raleigh, N.C.

33. North Carolina Licensed Practical Nurses Association, *Position Statement on Assisted Suicide*, adopted May 1, 1998. The association's office is in Durham, N.C.

34. Telephone conversation with Gayl Manthei, special deputy attorney general, Health and Public Assistance Section, Aug. 1998.

35. The language is from N.C. Gen. Stat. § 90-14(a)(6). Hereinafter the North Carolina General Statutes will be cited as G.S.

36. G.S. 90-171.20(7). The statement was probably meant to recognize the important role of nursing in hospice care. Telephone conversation with Howard Kramer, general counsel to the North Carolina Board of Nursing, Sept. 2, 1998.



37. G.S. 90-171.37.
38. *In re Cafiero v. North Carolina Board of Nursing*, 102 N.C. App. 610, 403 S.E.2d 582 (1991).
39. G.S. 90-171.37(5), (6).
40. 21 N.C. ADMIN. CODE 36.0217(7).
41. G.S. 90-85.38(9).
42. *Stedman's Medical Dictionary* (26th ed.) (Baltimore: Williams & Wilkins, 1995), s.v. "euthanasia."
43. G.S. 14-17. See also Thomas H. Thornburg (ed.), *North Carolina Crimes* (4th ed.) (Chapel Hill, N.C.: Institute of Government, The University of North Carolina at Chapel Hill, 1995), 61-65.
44. Law enforcement concerns on this point may be exaggerated, however. A federal government panel concluded, [R]espiratory depression is infrequently a significant limiting factor in pain management because, with repeated doses, tolerance develops. This tolerance allows adequate pain treatment without much risk of respiratory compromise. [A dying patient] should not be allowed to live out life with unrelieved pain because of a fear of side effects; rather, appropriate, aggressive, palliative support should be given.
- A. Jacox et al., *Management of Cancer Pain*, Clinical Guideline No. 9, AHCPR Publication No. 94-0592 (Rockville, Md.: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services, March 1994), 8.
45. See North Carolina Medical Board, *Position Statement: Management of Chronic Non-Malignant Pain* (Raleigh, N.C.: NCMB, adopted Sept. 13, 1996). The statement begins, "It has become increasingly apparent to physicians and their patients that the use of effective pain management has not kept pace with other advances in medical practice."
46. "Hillhaven Is Ordered to Pay \$15 Million to Ex-Patient's Estate," *Wall Street Journal*, Nov. 26, 1990. The case, brought by the administrator of Henry James's estate, was *Falson v. Hillhaven Corporation*. The parties reached a private settlement, and the verdict was not appealed. Telephone conversation with Ronald Manasco, plaintiff's attorney, Rocky Mount, N.C., Sept. 23, 1998.
47. Thomas R. Reardon, Statement of the American Medical Association to the Subcommittee on the Constitution of the House Judiciary Committee, July 14, 1998, available at <http://www.ama-assn.org>.
48. NCMB, *Position Statement: Management of Chronic Non-Malignant Pain*.
49. N.C. Board of Pharmacy 13, no. 4 (April 1992): 1.
50. 21 U.S.C. § 823(g).
51. 21 C.F.R. § 1306.07(c).
52. G.S. 90-87(13). The Uniform Commission on State Laws recommends such amendments. Jacox et al., *Management of Cancer Pain*, 14.
53. G.S. Art. 23, Ch. 90.
54. See Opinion of Attorney General to C. Robin Britt, Sr., secretary, N.C. Dept. of Human Resources, Jan. 5, 1995. \_\_\_ N.C.A.G. \_\_\_, available at [www.jus.state.nc.us](http://www.jus.state.nc.us). The act

and its amendments emphasize that North Carolinians retain additional common-law rights to control the circumstances of their death. G.S. 90-320.

55. G.S. 90-321.
56. G.S. 32A-15 through -26. The law names dire circumstances (terminal illness, permanent coma, severe dementia, and persistent vegetative state) [G.S. 32A-25(3)(e)], but the person appointing an agent is free to identify other circumstances in which the agent would begin to act [G.S. 32A-25(4)].
57. G.S. 90-320(b).
58. Advisory opinion to R. Marcus Lodge, general counsel, N.C. Dept. of Human Resources, from Ann Reed, senior deputy attorney general, and James A. Wellons, special deputy attorney general, N.C. Dept. of Justice, May 23, 1996.
59. *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990). Justice Sandra Day O'Connor's concurrence states the point more forcefully than the majority opinion, which merely assumes a liberty interest for purposes of the specific case. In a later case, a majority of the Supreme Court shows the same reluctance to acknowledge this right fully: "We have . . . assumed, and strongly suggested, that the Due Process Clause protects the traditional right to refuse unwanted lifesaving medical treatment." *Washington v. Glucksberg*, 521 U.S. 702 (1997).
60. Patient Self-Determination Act, 42 U.S.C. §§ 1395cc (Medicare), 1396a (Medicaid).
61. Filene, *In the Arms of Others*, 184. Filene notes that the most commonly used forms of living wills do not apply to those dying slowly of severe chronic illnesses or to people living in a persistent vegetative state. He also points out that "both a living will and a proxy can be thwarted by doctors, hospital administrators, or right-to-life groups." Filene, *In the Arms of Others*, 185.
62. Lawrence O. Gostin, professor of law, Georgetown University; professor of law and public health, Johns Hopkins University; formerly, executive director, American Society of Law, Medicine & Ethics.
63. *Glucksberg*, 521 U.S. 702 (holding that Washington's ban on assisted suicide does not violate fundamental liberty interest); *Vacco v. Quill*, 521 U.S. 793 (1997) (holding that New York's ban on assisted suicide does not violate Equal Protection Clause).
64. Nancy King, associate professor, Dept. of Social Medicine, UNC-CH—"Bioethical Issues"; George C. Barrett, member, N.C. Medical Board, and chair, Committee on Ethics, N.C. Medical Society—"Medical Regulatory and Professional Issues"; William Campbell, dean, School of Pharmacy, UNC-CH—"Preparing Health Professionals in the Academic Setting"; Catherine Clabby, medical reporter, *Raleigh News & Observer*—"The Media"; Sharon Dixon, senior vice-president, Hospice at Charlotte—"The Hospice Perspective"; Joseph Buckwalter, past president, Hemlock Society—"The Hemlock Society Perspective"; David Swankin, president, Citizen Advocacy Center—"Consumer Protection"; and Anne M. Dellinger, professor, Institute of Government, UNC-CH—"North Carolina Law."