# Aid in Dying in North Carolina

*John Carbone, Aditi Sethi-Brown, Beth Rosenberg, Haider Warraich*

**To the Editor**—The request for a hastened death is not uncommon among individuals dying from a terminal, debilitating, and progressive illness. Reasons for this request for a planned death vary and include having uncontrolled pain despite palliative interventions, and significant loss of independence and dignity. Some patients implore their physician to provide a prescription for medication they can ingest to precipitate a swift, peaceful death. This practice, known as aid in dying (AID), is becoming more widely available and is increasingly supported by the medical community. Six states (Oregon, Washington, Vermont, California, Colorado, Hawaii) have enacted statutes specifically authorizing and regulating it. Montana has recognized that physicians can provide AID through a state supreme court decision [1].

Support for AID among North Carolina physicians is unknown, as no targeted survey has been done. Nationwide, a majority of physicians support it [2]. Because ample data has shown that when AID is available end of life care improves and no harm results, many medical and health policy organizations have adopted policies supportive of the practice [2]. Measures have been introduced in the North Carolina legislature both to prohibit and to permit AID, but no measure has been enacted into law.

North Carolina respects the autonomy of patients in medical decision-making. Standard of care already accepts a variety of other life-ending practices, including withdrawing life-sustaining treatment, provision of palliative sedation, and voluntarily stopping eating and drinking [2]. North Carolina is in a somewhat unusual situation, as there is no statutory prohibition of AID. According to a January 2019 law review article by Kathryn Tucker in the *North Carolina Law Review*, physicians can provide AID to their mentally competent terminally ill patients who request it, subject to standard of care, without risk of a viable criminal or disciplinary action [2]. The United States Supreme Court has ruled that physicians cannot be punished for prescribing medication for AID under the Controlled Substances Act (CSA) [3].

North Carolina physicians who wish to include AID among the end-of-life options they provide patients can readily find guidance on the practice. Clinical practice guidelines have been developed and published [4]. The medical literature discusses best practices. Advocacy groups provide information. Montana has had standard-of-care governance for the practice for nearly a decade, and peer outreach can offer North Carolina physicians insights from Montana physicians. Certain guidelines similar to those in states with permissive statutes are operative in Montana: the patient must be terminally ill and mentally competent, and a physician's conduct is limited to providing a prescription, which a patient may choose to ingest to precipitate a peaceful death [2]. Because the practice is governed by standard of care, other regulations that are operative in states with statutes governing the practice, such as a mandatory waiting period, are not required. In the decade of practice in Montana, there has been no evidence that standard of care has been insufficient to govern the practice. There have been no cases of prosecutions of a physician in Montana for providing AID in the decade it has been practiced.

In light of the legal analysis of North Carolina law, we feel confident that AID can be provided to patients who request it. The medical community can respond supportively and compassionately to a final act of autonomy by patients who are confronted by a dying process which they find unbearable despite best palliative efforts. NCMJ

**John Carbone, MD** clinical professor of psychiatry, Brody School of Medicine, East Carolina University, Greenville, North Carolina.
**Aditi Sethi-Brown, MD** hospice and palliative medicine physician, CarePartners Hospice, Asheville, North Carolina.
**Beth Rosenberg, MD** physician, Piedmont Health SeniorCare, Burlington, North Carolina; clinical assistant professor, Department of Internal Medicine, Division of Cardiology, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina.
**Haider Warraich, MD** fellow in advanced heart failure and transplantation, Duke University Medical Center, Durham, North Carolina.

## Acknowledgments

These beliefs are those of the individual authors and not the organizations they work with.

Potential conflicts of interest. The authors have no relevant conflicts of interest.

## References

1. Baxter v State of Montana, 224 P3d 1211, 1221 (Mont. 2009).
2. Tucker KL. Aid in Dying in North Carolina. N.C. L. Rev. 2019;97:Addendum 1.
3. Gonzales v Oregon, 546 US 243 (2006).
4. Orentlicher D, Pope TM, Rich BA, Physician Aid-in-Dying Clinical Criteria Committee. Clinical criteria for physician aid in dying. J Palliat Med. 2016;19(3), 259–262.

Electronically published March 11, 2019.

Address correspondence to Aditi Sethi-Brown aditi.sethi-brown@msj.org

**N C Med J. 2019;80(2):128.** 
0029-2559/2019/80217