AID IN DYING IN NORTH CAROLINA*

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INTRODUCTION

Modern medicine can extend the dying process so long that a patient dying of a terminal illness may feel trapped in a torturously slow, lingering decline. Some patients will want to achieve a swifter, gentler end by ingesting medications prescribed to precipitate a

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peaceful death. This option is known as aid in dying ("AID").[1] For a complex array of reasons, the practice of AID did not evolve organically within the practice of medicine. This Article will discuss why this is so and what it has meant for the medical practice of AID, both in terms of physicians' willingness to provide it and patients' ability to access it. Further, this Article suggests that in states without a prohibition of the practice, such as North Carolina, it is both possible and desirable for the practice to develop subject to the standard of care.

This Article proceeds as follows. Part I addresses why AID did not evolve organically and the resulting impact for this medical practice. Part II explores legislative approaches to permitting and regulating AID and discusses the problems created by these approaches. Part III examines the laws of North Carolina pertinent to medical decisionmaking in the context of end-of-life care, and, in light of that landscape, considers the legality of AID in North Carolina. Part IV argues AID should be governed by the standard of care in North Carolina. Finally, Part V considers how to define the standard of care for AID.

I. WHY AID DID NOT EVOLVE ORGANICALLY AND WHAT THIS HAS MEANT FOR THIS MEDICAL PRACTICE

One reason AID did not evolve organically in medical practice is that physicians and others assumed that ancient state statutes prohibiting assisted suicide would bar the practice, despite the fact that these statutes say nothing of the act of a physician in providing care to a terminally ill patient confronted by horrific suffering.

1. This term is widely accepted, including by the American Medical Women's Association, the American Medical Students' Association, and the American Public Health Association, among others. *See* Kathryn L. Tucker, *At the Very End of Life: The Emergence of Policy Supporting Aid in Dying Among Mainstream Medical & Health Policy Associations*, 10 HARV. HEALTH POL'Y REV. 45, 45 (2009) [hereinafter Tucker, *At the Very End of Life*]. In the past, this option was sometimes referred to as "physician-assisted suicide," but that term has since been rejected as inaccurate and pejorative. In fact, the American Association of Suicidology recently recognized that the choice of a dying patient for a peaceful death is not, and ought not be referred to as, suicide. AM. ASS'N OF SUICIDOLOGY, STATEMENT OF THE AMERICAN ASSOCIATION OF SUICIDOLOGY: "SUICIDE" IS NOT THE SAME AS "PHYSICIAN AID IN DYING" 4 (Oct. 30, 2017), http://www.suicidology.org/Portals/14/docs/Press%20Release/AAS%20PAD%20Statement%20Approved%2010.30.17%20ed%2010-30-17.pdf [https://perma/cc/PN3S-35GD]. Most recently, the American Academy of Family Physicians adopted a more progressive policy regarding AID, explicitly rejecting the term "assisted suicide" and embracing the term "medical aid in dying." *See* Marcia Frellick, *AAFP Breaks from AMA, Adopts Neutral Aid-in-Dying Stance*, MEDSCAPE (Oct. 10, 2018), https://www.medscape.com/viewarticle/903218 [https://perma.cc/D742-9C3H (dark archive)].

Moreover, most such statutes were enacted long before the advent of medical care that can prolong the dying process as modern medicine now does.[2] There is a legitimate role for government in deterring assisting a suicide, and proper instances for application of these laws, but assisting a suicide is starkly different from providing AID. An example of the sort of conduct legislators were concerned about and determined to deter (or punish) with these statutes is found in the New York case *People v. Duffy*,[3] where an emotionally distraught teenager lamenting a breakup with his girlfriend asked a stranger to help him kill himself.[4] The stranger did so and was prosecuted under New York's assisted suicide statute.[5] Some states have passed legislation explicitly designed to outlaw AID by using specific language about the law's application to a physician's conduct.[6] This is within the purview of a state legislature, so long as the law does not impinge on privacy or liberty protected by that state's constitution. Nevertheless, because it is a basic principle of criminal law that prohibited conduct be clearly delineated, such specificity is necessary to impose criminal sanctions on a physician.[7]

II. RESPONDING TO UNCERTAINTY WITH LEGISLATION

To resolve uncertainty about the legality of AID, and to create an environment in which physicians feel safe providing it, advocates for the terminally ill have worked to enact statutes specifically

2. New York's assisted suicide prohibition, for example, has existed in various forms since 1881. *See* N.Y. PENAL LAW § 125.15(3) (McKinney 2018).

3. 595 N.E.2d 814 (N.Y. 1992).

4. *Id.* at 814–15.

5. *Id.* at 815.

6. *See, e.g.*, ARK. CODE ANN. § 5-10-106 (LEXIS through 2018 Fiscal Sess. & 2d Extraordinary Sess.) (making "physician-assisted suicide" a Class C felony); IDAHO CODE § 18-4017 (LEXIS through 2018 Reg. Sess.) (explaining that any physician who assists with a suicide is subject to a felony charge and license revocation).

7. For a cogent discussion of why a vague, antiquated statute prohibiting assisted suicide ought not encompass the act of a physician providing AID, see Brief for Amicus Curiae Nat'l Ass'n of Criminal Def. Lawyers in Support of Plaintiffs-Appellants at 1–11, Myers v. Schneiderman, 85 N.E.3d 57 (N.Y. 2017) (No. APL-2016-00129), 2017 WL 2837552 (arguing that the appellate court's broad reading of New York's assisted suicide statutes "threatens to criminalize the good faith conduct of physicians beyond the intention of the legislature and without sufficient notice" and "ignores established rules discouraging over-broad reading of criminal statutes"). The North Carolina legislature considered, but did not enact, a specific prohibition against physician AID in 2003. S.B. 145, 2003 Gen. Assemb., Reg. Sess. (N.C. 2003). For a discussion of the effort to enact a prohibition and its significance to understanding the landscape of the law in North Carolina, see generally Anne Dellinger & Aimee Wall, *A Brief Review of North Carolina's Law on Dying*, 65 N.C. MED. J. 221 (2004).

authorizing and regulating the practice.[8] However, enacting legislation to expressly permit AID is difficult. The Catholic Church, Catholic and Christian fundamentalist medical associations, and some disability organizations oppose such measures.[9] Thus, efforts to enact statutory permission for AID over the past twenty-five years have succeeded in only a handful of states and only when written with a "kitchen sink" approach to regulation of the practice, in order to survive opponents' claims that the measures lack sufficient safeguards.[10] The earliest states to adopt permissive measures did so not through the traditional legislative process but rather via direct democracy: Oregon, Washington, and Colorado utilized citizen initiatives to adopt "Death with Dignity" laws.[11] Following the

8. *See infra* notes 11–15 and accompanying text.

9. *See, e.g.*, *End of Life Issues*, CATH. MED. ASS'N, https://www.cathmed.org/programs-resources/health-care-policy/resolutions/end-of-life-issues/ [https://perma.cc/U8T9-7NXQ]. Nearly two decades of evidence showing that the availability of AID benefits patients, and presents no harms, has emerged from the states that authorize the practice by statute. *See, e.g.*, Margaret P. Battin et al., *Legal Physician-Assisted Dying in Oregon and the Netherlands: Evidence Concerning the Impact on Patients in "Vulnerable" Groups*, 33 J. MED. ETHICS 591, 594–97 (2007). An abundance of data and commentary has been published. *See, e.g.*, *id.* (concluding that there is no evidence that legalized euthanasia will have a disproportionate impact on vulnerable groups); Linda Ganzini et al., *Oregon Physicians' Attitudes About and Experiences with End-of-Life Care Since Passage of the Oregon Death with Dignity Act*, 285 [J]AMA 2363, 2365–66 (2001) (concluding that most Oregon physicians who care for terminally ill patients have made efforts to improve their ability to care for these patients); Melinda A. Lee & Susan W. Tolle, *Oregon's Assisted Suicide Vote: The Silver Lining*, 124 ANNALS INTERNAL MED. 267, 268–69 (1996) (emphasizing an improvement in end-of-life care due to raised awareness of this issue during the passage of Oregon's Death with Dignity Act); Timothy E. Quill & Christine K. Cassel, *Professional Organizations' Position Statements on Physician-Assisted Suicide: A Case for Studied Neutrality*, 138 ANNALS INTERNAL MED. 208, 209 (2003) (stating that data from Oregon suggests AID is used by a small number of patients and is associated with improved hospice and palliative care); Kathryn A. Smith et al., *Quality of Death and Dying in Patients Who Request Physician-Assisted Death*, 14 J. PALLIATIVE MED. 445, 449–50 (2011); Joseph B. Straton, *Physician Assistance with Dying: Reframing the Debate; Restricting Access*, 15 TEMP. POL. & C.R. L. REV. 475, 480–81 (2006) (stating that Oregon's Death with Dignity Act successfully permits assisted suicide for those whom a hastened death is appropriate).

10. The history of Oregon's Death with Dignity Act exemplifies this reality. Oregon's effort followed failed attempts to pass somewhat similar measures in Washington (1991) and California (1992). *See Oregon Death with Dignity Act: A History*, DEATH WITH DIGNITY, https://www.deathwithdignity.org/oregon-death-with-dignity-act-history/ [https://perma.cc/C87W-C7P4]. Having seen those efforts fail in campaigns where opponents claimed there were insufficient safeguards, the drafters of the Oregon measure included an array of procedural hurdles, including multiple written and oral requests, mandatory second opinions, and a lengthy waiting period, among others. *See* Oregon Death with Dignity Act, ch. 3, §§ 3.01–.08, 1995 Or. Laws 12, 13–14 (1994) (codified at OR. REV. STAT. ANN. §§ 127.815–.880 (Westlaw through 2018 Reg. Sess. & Spec. Sess. of 79th Legis. Assemb.)).

11. Access to Medical Aid-in-Dying Medication, prop. 106, 2017 Colo. Sess. Laws 2802 (2016) (codified at COLO. REV. STAT. §§ 25-48-101 to -123 (LEXIS through 2018

experiences of these pioneering states, where no adverse impacts had arisen, Vermont,[12] California,[13] and Hawaii[14] enacted permissive measures via traditional legislative processes, each modeled after the Oregon measure.[15] In contrast, Montana recognized that its citizens may freely choose AID through a state supreme court decision, *Baxter v. State*.[16] Practice in Montana is discussed below.

Legis. Sess.)); Oregon Death with Dignity Act, ch. 3, 1995 Or. Laws 12 (1994) (codified at OR. REV. STAT. ANN. §§ 127.800–.897 (Westlaw through 2018 Reg. Sess. & Spec. Sess. of 79th Legis. Assemb.)); Washington Death with Dignity Act, ch. 1, 2009 Wash. Sess. Laws 1 (2008) (codified at WASH. REV. CODE ANN. § 70.245.010–.903 (Westlaw through 2018 Reg. Sess.)).

12. Patient Choice at End of Life, No. 39, 2013 Vt. Acts & Resolves 292 (2013) (codified as amended at VT. STAT. ANN. tit. 18, §§ 5281–5293 (LEXIS through 2017 adjourned sess. & 1st spec. sess.)).

13. Act of Oct. 15, 2015, ch. 1, 2015 Cal. Legis. Serv. 6103 (codified at CAL. HEALTH & SAFETY CODE §§ 443–443.22 (West 2018)).

14. Our Care, Our Choice Act, act 2, 2018 Haw. Sess. Laws 20 (2018).

15. *Alohas and Goodbyes*, ECONOMIST, April 28, 2018, at 37, 37 ("Like the laws in California, Washington, Vermont, Colorado and Washington, DC, Hawaii's law is modelled on legislation in Oregon . . . ."). Though a statutory permission may have been necessary and useful when the practice was new, and data generated from a statutorily mandated system for collecting and reporting data about the practice has served a valuable purpose, it is now time to normalize the practice and allow it to be governed by the standard of care, rather than by statute. Enacting statutes modeled after the Oregon Death with Dignity Act serves no necessary or useful purpose at this point in time and indeed stifles the evolution of the practice that would occur in a standard of care environment. *See* Lois Shepherd, *The End of End-of-Life Law*, 92 N.C. L. REV. 1693, 1696 (2014) ("[T]he time has come to abandon this way of thinking—to put an end to end-of-life law . . . ."); Kathryn L. Tucker, *Aid in Dying: Guidance for an Emerging End-of-Life Practice*, 142 CHEST 218, 221–22 (2012) [hereinafter Tucker, *Guidance for Practice*] (suggesting that the medical community, not the government, should establish best practice guidelines and that it is timely to promulgate clinical practice guidelines). Some commentators have expressed the view that reducing legal distinctions between end-of-life and other healthcare decisions is desirable. *See, e.g.*, Shepherd, *supra*, at 1696 ("[Q]uestions about medical care at the end of life should be approached like other important questions about medical care—with consideration to patients' wishes, values, interests, and relationships, and without special laws, special burdens of proof, or unique requirements for documentation."). Unfortunately, it appears that the continued introduction of Oregon-style bills has resulted in even more restrictions being added to such measures, as seen in the 2018 Hawaii measure, the Our Care, Our Choice Act, which adds a mandatory counseling requirement and extends the mandatory waiting period from fifteen to twenty days. *Compare* Our Care, Our Choice Act, sec. 3, §§ 6, 11, 2018 Haw. Sess. Laws at 24–25 (requiring mandatory counseling and a mandatory waiting period of twenty days), *with* Oregon Death with Dignity Act, OR. REV. STAT. ANN. §§ 127.825, .850 (Westlaw through 2018 Reg. Sess. & Spec. Sess. of 79th Legis. Assemb.) (requiring a waiting period of fifteen days and requiring counseling only "[i]f in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment").

16. 2009 MT 449, ¶ 50, 354 Mont. 234, 224 P.3d 211. Somewhat similar litigation has not been successful in other states. *See, e.g.*, Sampson v. State, 31 P.3d 88, 98 (Alaska 2001); Donorovich-Odonnell v. Harris, 194 Cal. Rptr. 3d 579, 595 (Cal. Ct. App. 2015)

Though one might view the enactment of permissive statutes governing AID as progress toward expanding end-of-life options, this is only partially true. The heavy-handed intrusion of government, which these statutes force into the practice of medicine, creates barriers to physician participation and, in turn, to patient access.[17] It is reasonable to compare experiences in states with statutory permission to the one state with an open practice of AID without a governing statute, Montana. Thus, as will be fully discussed in Part V, Montana's common-law approach represents the preferred model for North Carolina.

III. END-OF-LIFE CARE LANDSCAPE AND THE STATUS OF AID IN NORTH CAROLINA

North Carolina has seen the introduction of measures both to prohibit and to permit AID, but none have been enacted.[18] However, failure to enact a permission does not equate to the enactment of a prohibition. Accordingly, North Carolina is among those states with neither a statutory prohibition against assisted suicide nor a

(holding, before California's AID statute was passed, that decriminalization of physician aid in dying was a matter for the legislative branch); Morris v. Brandenburg, 2016-NMSC-027, ¶ 58, 376 P.3d 836; Myers v. Schneiderman, 85 N.E.3d 57, 94–95 (N.Y. 2017).

17. *See, e.g.*, Mara Buchbinder, *Access to Aid-in-Dying in the United States: Shifting the Debate from Rights to Justice*, 108 AM. J. PUB. HEALTH 754, 754, 756 (2018) ("[F]indings from The Vermont Study on Aid-in-Dying (SAID), an ethnographic study of the implementation of Vermont's AID statute, indicate that terminally ill people can face a range of barriers to accessing AID in permissive jurisdictions."); Samantha Wohlfeil, *Life-Ending Medications Are Legal in Washington, but Getting Them Is a Whole Other Story*, INLANDER (Mar. 8, 2018), https://www.inlander.com/spokane/life-ending-medications-are-legal-in-washington-but-getting-them-is-a-whole-other-story/Content?oid=8529213 [https://perma.cc/XV2Z-BFCW] (exploring the difficulties patients face in accessing AID in Washington state despite the state's permissive AID statute).

18. *See* S.B. 145, 2003 Gen. Assemb., Reg. Sess. (N.C. 2003) (attempting to criminalize "physician-assisted suicide" but failing to get out of committee); Dellinger & Wall, *supra* note 7, at 221. North Carolina State Representative Pricey Harrison (D-Guilford) introduced House Bill 611, the Death with Dignity Act, in the 2015 legislative session, but it died without a hearing. H.B. 611, 2015 Gen. Assemb., Reg. Sess. (N.C. 2015); Lisa Snedeker, *Lisa Roach (JD '17) Addresses Legalization of Medical Aid-in-Dying at North Carolina Clinical Ethics Conference*, WAKE FOREST U. SCH. L. (Mar. 1, 2017), http://news.law.wfu.edu/2017/03/lisa-roach-jd-17-addresses-legalization-of-medical-aid-in-dying-at-north-carolina-clinical-ethics-conference/ [https://perma.cc/V3D2-SX2M]. House Bill 789, the End of Life Option Act, was introduced in April 2017 by Harrison and North Carolina State Representatives Susan Fisher (D-Buncombe), Graig Meyer (D-Orange), and Verla Insko (D-Orange). H.B. 789, 2017 Gen. Assemb., Reg. Sess. (N.C. 2017); Lisa Snedeker, *Lisa Roach (JD '17) Instrumental in Introducing N.C. 'Death with Dignity' Legislation*, WAKE FOREST U. SCH. L. (Apr. 18, 2017), http://news.law.wfu.edu/2017/04/lisa-roach-jd-17-helps-draft-introduce-n-c-death-with-dignity-legislation/ [https://perma.cc/UBZ3-EAY3].

permissive statute or court decision.[19] This Article examines the law of North Carolina pertinent to medical decisionmaking in the context of end-of-life care, and, in light of that landscape, considers whether a physician providing AID, subject to the standard of care, would be exposed to adverse action, including criminal prosecution.[20]

This Article concludes that the law of North Carolina vests citizens with broad autonomy over medical decisionmaking, including

19. North Carolina abolished the crime of suicide in 1974. Act of Apr. 8, 1974, ch. 1205, 1973 N.C. Sess. Laws 334 (codified at N.C. GEN. STAT. § 14-17.1 (2017)). In 2003, legislators introduced a measure to criminalize assisting a suicide; however, this bill was not enacted. *See* Dellinger & Wall, *supra* note 7, at 221. Absent an assisted suicide prohibition, which North Carolina does not have, there can be no common law crime for assisting an act that is not prohibited. *Cf.* State v. Bond, 345 N.C. 1, 24, 478 S.E.2d 163, 175 (1996) (stating that the commission of a crime by another is an element of aiding and abetting).

Another state without a prohibition against assisted suicide is Massachusetts. *See* Kathryn L. Tucker, *Give Me Liberty at My Death: Expanding End-Of-Life Choice in Massachusetts*, 58 N.Y. L. SCH. L. REV. 259, 267–68 (2013–2014). Indeed, this is the premise of a lawsuit working its way through the Massachusetts courts: following a public statement by a district attorney expressing the view that a prosecution could be pursued, a patient and a physician brought a declaratory judgment action seeking judicial recognition that there could be no criminal prosecution of a physician for providing AID. Kligler v. Healy, No. SUCV201603254F, 2017 WL 2803074, at *1, *3 (Mass. Super. Ct. May 31, 2017). The trial court refused to dismiss the case. *Id.* at *8 (holding that, although "[t]he complexity of establishing the parameters of a right to physician assisted suicide ultimately may militate against recognition of such a right," the court must "adjudicat[e] a properly presented constitutional claim" and "the plaintiffs have satisfied their minimal burden to allege jurisdiction over their complaint for declaratory relief"). While an early ruling, it establishes that the court will give plaintiffs full opportunity to present their case. Such a case could be brought in North Carolina, should a similar public position be taken by a prosecuting authority.

20. For an overview of assisted suicide law up to 2004, see Dellinger & Wall, *supra* note 7, at 221–23. That article expresses the view that, as of 2004, North Carolina had no law criminalizing assisted suicide, noting that legislators had attempted but failed to enact a prohibition. *Id.*

In a prior article I examined the AID landscape in another state without a prohibitory statute: Hawaii. *See generally* Kathryn L. Tucker, *Aid in Dying: An End of Life-Option Governed by Best Practices*, 8 J. HEALTH & BIOMEDICAL L. 9 (2012). Shortly after the article's publication, the Attorney General for the State of Hawaii stated the department's position that physician aid-in-dying was illegal under Hawaii criminal law. Jim Mendoza, *AG Denounces Aid in Dying Ad*, HAW. NEWS NOW (Sept. 24, 2013, 9:47 PM), http://www.hawaiinewsnow.com/story/23521488/ag-denounces-aid-in-dying-ad [https://perma.cc/A5VP-4FE8 (dark archive)]. In the wake of this, advocates pursued both legislative enactment of a permissive measure and filed a case in state court. *See Circuit Court Dismisses Medical Aid-in-Dying Case*, MAUI NOW (July 16, 2017), http://mauinow.com/2017/07/16/circuit-court-dismisses-medical-aid-in-dying-case/ [https://perma.cc/H3MX-ZQBS]. The trial court, in an abdication of its responsibility, dismissed the case, stating, "the relief sought by the plaintiffs is political, not judicial, in nature and should be addressed by the political branches of government." *Id.* As noted above, the legislature enacted a (highly restrictive) permissive statute in 2018. Our Care, Our Choice Act, act 2, 2018 Haw. Sess. Laws 20 (2018).

at the end of life, and there is no statute prohibitive of AID. Accordingly, this Article asserts that, in this landscape, physicians providing care to mentally competent, terminally ill patients can provide AID, subject to the standard of care, without exposing themselves to viable criminal or disciplinary action. Emergence of AID practice subject to the standard of care in North Carolina should emulate the practice as it has developed in Montana, where no statute governs the practice of AID, yet it has been judicially permitted since 2009.[21] Such practice in North Carolina, as in Montana, would more closely resemble how all of medicine is practiced, offering benefits to patients and physicians.[22]

A change in law is not necessary for AID to be among the range of end-of-life options available to dying patients in North Carolina. Medical care is typically practiced subject to evolving professionally developed standards of care, not by statutes or court decisions that either prohibit or permit specific types of care.[23] North Carolina's existing statutory framework already empowers patients to make autonomous decisions regarding their end-of-life care and treatment, and the standard of care already accepts a variety of other life-ending practices such as withdrawing life-sustaining treatment, including nutrition and hydration, and administering palliative sedation.[24] This fact, combined with the absence of a criminal prohibition against AID, makes it reasonable to conclude, as discussed below, that North Carolina is a jurisdiction in which physicians should be able to provide AID, subject to the standard of care.

A. North Carolina Law Empowers Patients to Make Autonomous End-of-Life Treatment Decisions

North Carolina's statutory framework recognizes and respects the autonomy of patients in their decisions related to end-of-life care. A constellation of existing laws empowers patients to ensure they are able to effectively treat their pain and to refuse or withdraw life-sustaining treatment. North Carolina's Health Care Power of

21. *See Baxter*, 2009 MT ¶¶ 30, 49–50.

22. For a discussion of why it is beneficial, and indeed preferable, for AID to be regulated by the standard of care, see generally Shepherd, *supra* note 15; Tucker, *Guidance for Practice*, *supra* note 15; Kathryn L. Tucker, *Normalizing Aid-in-Dying Within the Practice of Medicine*, HASTINGS CTR. REP., Sept.–Oct. 2015, at 3.

23. 61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* § 187 (2012) ("Generally, a physician is held to the standard of care and skill of the average practitioner of the medical specialty in question, taking into account advances in the profession or the state of the medical profession at the time." (footnotes omitted)).

24. *See* Dellinger & Wall, *supra* note 7, at 221, 223.

Attorney statute empowers patients with the ability to appoint a healthcare agent to make decisions for their medical care, including to direct the withdrawal of any life-prolonging measures, even if doing so would precipitate the death of the patient.[25] The Advance Directive for a Natural Death statute empowers patients to declare their desire to have life-prolonging measures withdrawn upon the occurrence of certain triggering conditions, even where doing so will precipitate death.[26] The Advance Directive law also empowers patients to instruct that they be kept "as clean, comfortable, and free of pain as possible so that [the patient's] dignity is maintained, even though this care may hasten [the patient's] death."[27] In its commitment to ensuring that patient's wishes for end-of-life care are in fact respected, North Carolina has adopted a version of the

25. N.C. GEN. STAT. § 32A-19(a) (2017).

26. *Id.* § 90-321(d1). An Attorney General Opinion discussing this statute noted that its adoption was not to create new rights but to codify existing rights. *See* Dellinger & Wall, *supra* note 7, at 221. Moreover, the opinion recognizes that additional common law rights are retained by the people to control the circumstances of their deaths. Michael F. Easley, N.C. Attorney Gen., *Right to a Natural Death; Procedures for Natural Death in the Absence of a Declaration*, N.C. DEP'T JUST. (Jan. 5, 1995), https://www.ncdoj.gov/About-DOJ/Legal-Services/Legal-Opinions/Opinions/Right-to-a-Natural-Death;-Procedures-for-Natural-D.aspx [https://perma.cc/Q3CJ-JFK8]. Finally, the opinion recognizes that the provisions creating a safe harbor are not exclusive. *Id.* Care provided pursuant to the statute enjoys a safe harbor; in other words, there would be "an absolute defense for health care practitioners who act in accordance with those procedures." *Id.* A clinician acting outside the provisions set forth in the statute would not enjoy the safe harbor. Rather, the clinician's conduct would be judged in light of whether it comported with the standard of care:

> [I]t is not unlawful for a physician to deviate from the procedures set out in the Act. The physician who does so will, however, lose the benefit of the absolute defense provided in the Act. As a result, the standard of care by which the physician's acts or omissions will be judged will be the general standard of care . . . .

Id. This reflects that the Attorney General of North Carolina accepts that when there is not a statutory safe harbor for medical conduct, the governance of that conduct is subject to the standard of care.

27. § 90-321(d1). This statute notes that it ought not be construed to authorize action to end life: "Nothing in this Article shall be construed to authorize any affirmative or deliberate act or omission to end life other than to permit the natural process of dying." *Id.* § 90-320(b). This statement, however, is not equivalent to the enactment of a prohibition of AID and is not sufficient to constitute a prohibition. Indeed, this is clear from the failed attempt to pass a prohibition in 2003. *See* Dellinger & Wall, *supra* note 7, at 221. Though that effort failed, the attempt to enact such a provision reflects an understanding that absent such a prohibition, there is no bar to a physician providing AID in North Carolina. Section 90-320(b) was enacted well before the 2003 introduction of a prohibition of "physician-assisted suicide," which did not proceed out of committee and has never been the law of North Carolina. *See* S.B. 145, 2003 Gen. Assemb., Reg. Sess. (N.C. 2003).

Physicians Orders for Life Sustaining Treatment form, referred to as Medical Orders for Scope of Treatment ("MOST").[28] The North Carolina Medical Society's guidance on MOST recognizes: "According to the ethical principle of respect for patient autonomy and the legal principle of patient self-determination, individuals have the right to make their own healthcare decisions."[29]

Given that this policy expressed by the North Carolina Medical Society is nearly identical to Montana's public policy regarding autonomy in end-of-life decisions, North Carolina should look to Montana for guidance on interpreting laws pertaining to end-of-life care. As mentioned above, Montana's supreme court concluded that AID is a choice within the public policy of the state; hence a physician will not be subject to prosecution for prescribing medication to bring about the peaceful death of a competent, terminally ill patient.[30] Moreover, the court held that Montana's Rights of the Terminally Ill Act "clearly provides that terminally ill patients are entitled to autonomous, end-of-life decisions," even when such decisions "involve[] the direct acts [of] a physician."[31] *Baxter* suggests that

28. N.C. GEN. STAT. § 90-21.17(a) (2017) (recognizing that empowering patients to direct withholding of life-prolonging interventions is "to avoid loss of dignity and unnecessary pain and suffering").

29. *See* N.C. MED. SOC'Y, USING THE MOST FORM—GUIDANCE FOR HEALTHCARE PROFESSIONALS 1, http://www.ncmedsoc.org/non_members/public_resources/eol/MOST InstructionsProviders9-08.pdf [https://perma.cc/FVG4-WUAV].

30. Baxter v. State, 2009 MT 449, ¶¶ 26, 49–50, 354 Mont. 234, 224 P.3d 1211. The court emphasized that "a physician who aids a terminally ill patient in dying is not directly involved in the final decision *or* the final act" but rather is "only provid[ing] a means by which a terminally ill patient *himself* can give effect to his life-ending decision." *Id.* ¶ 23. Moreover, in analyzing the Montana Rights of the Terminally Ill Act, the court found no suggestion that physician AID is against public policy as homicide because of the homicide statute's limited scope, which only applies to one who "purposely or knowingly causes the death of another human being." *Id.* ¶ 26 (quoting MONT. CODE ANN. § 45-5-102(1)(a) (Westlaw through Oct. 1, 2017 sess.)). The court noted that the terminally ill patient's decision to self-administer medication causing his or her own death would not cause the death of "another" within the homicide statute but the death of oneself, which was not within the statute. *Id.* Further, the court noted that the Act expressly "does not condone, authorize, or approve mercy killing or euthanasia" but also does not expressly prohibit "physician aid in dying." *Id.* ¶ 36 (quoting MONT. CODE ANN. § 50-9-205(7) (Westlaw through Oct. 1, 2017 sess.)). In distinguishing physician AID from mercy killing and euthanasia, the court looked to the definitions of "euthanasia" and "mercy killing," highlighting that neither is consent-based, nor do they involve a patient's "decision to self-administer drugs that will cause his own death." *Id.*

31. Montana's Act differs from North Carolina's Right to Natural Death Act in that Montana expressly "does not condone, authorize, or approve mercy killing or euthanasia," *id.* (quoting § 50-9-205(7)), where North Carolina's statute expressly does not "authorize any . . . act or omission to end life other than to permit the natural process of dying," § 90-320(b). Although North Carolina's disclaimer is broader than Montana's, this does not by any means prohibit AID; it simply means that if a *Baxter*-type case were tried in North

North Carolina's laws should be seen as reflecting that the policy of the state is to support autonomy in medical decisionmaking, including at the end-of-life, and that this reasonably extends to the choice of a mentally competent, terminally ill patient to seek AID.

B. Criminal Prohibitions Pertinent to End-of-Life Care

There are crucial differences between AID and euthanasia, sometimes referred to as "mercy killing," the principle difference being that with AID the patient is the one who administers the medication to achieve death.[32] Alternatively, with euthanasia another person takes the action precipitating the patient's death.[33] North Carolina, like other states that have considered the matter, holds those who engage in euthanasia criminally liable. For example, in the case of *State v. Forrest*,[34] a grief-stricken son shot his critically ill father in the hospital and was convicted of murder.[35] The North Carolina Supreme Court upheld the conviction.[36] These sorts of cases are prosecuted as homicide, although juries may not always follow the law in the most sympathetic cases.[37]

The obvious but critical legal difference between euthanasia and AID is the identity of the person who precipitates the death of the decedent: in cases like *Forrest*, someone other than the terminally ill patient pulls the trigger or administers the drug. In AID, the patient fills the prescription and self-administers the medication, if he or she chooses.[38] Euthanasia can remove the patient's autonomy in his or her

Carolina, the Right to Natural Death Act would likely not be viewed as a significant "plus factor" for the public policy determination as was the case in Montana. *See Baxter*, 2009 MT ¶ 36 (noting that the statute does not support "mercy killing or euthanasia" but does not mention physician AID).

32. *See supra* note 30.

33. *See supra* note 30.

34. 321 N.C. 186, 362 S.E.2d 252 (1987).

35. *Id.* at 188–89, 362 S.E.2d at 253–54. These sorts of cases arise when a patient is suffering in the final throes of terminal illness and a person close to the patient feels compelled to assist the patient in dying, regardless of criminal prohibition. It is possible that these sorts of cases are less likely to occur when a patient can choose a peaceful death via AID.

36. *Id.* at 188, 362 S.E.2d at 253.

37. *See* Timothy Paul Brooks, Comment, State v. Forrest*: Mercy Killing and Malice in North Carolina*, 66 N.C. L. REV. 1160, 1168–69 (1988).

38. Some patients who obtain the prescription for AID do not ingest the medication, instead dying of their underlying illness. For example, of the 204 patients who received the prescription in Oregon in 2016, 36 did not ingest the medication and then died of their terminal illness. OR. HEALTH AUTH., OREGON DEATH WITH DIGNITY ACT: DATA SUMMARY 2016, at 5 (2017), http://www.oregon.gov/oha/ph/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year19.pdf [https://perma.cc/9CJ8-

end-of-life decisions; even if the patient in *Forrest* had previously communicated to his son his wish for death in such a situation, the patient could not communicate at the time the son acted, foreclosing any opportunity to change his mind. This sort of concern is not found with AID, as the patient must have capacity and controls the process every step of the way.

Though AID should not be considered a form of suicide,[39] state suicide laws are nevertheless potentially relevant because patients self-administer the medication. Before 1974, suicide was a crime in North Carolina.[40] Like many other crimes, it was developed through the common law, dating back to Blackstone's England.[41] Even though the successful commission of suicide was not actually punishable under North Carolina law, it was still considered a criminal act for purposes of attempt and accomplice liability.[42] The common law crime of aiding and abetting a suicide was derivatively based on the culpability of the person who actually committed the suicide, not through any independent crime of "aiding a suicide."[43] In 1974, the North Carolina General Assembly passed a law stating that "[t]he common-law crime of suicide is hereby abolished as an offense."[44] Because suicide is no longer a crime at common law in North Carolina, aiding and abetting a suicide cannot be considered a crime at common law in North Carolina either.[45] Removing the underlying crime also removes any derivative liability that could arise from a suicide.

Neither North Carolina's homicide statutes nor common law crimes could be properly applied to prosecute a physician for providing AID.[46] Both first- and second-degree murder require

V4CT]. This subset of patients is comforted to have the prescription; it serves an important palliative purpose.

39. *See* AM. ASS'N OF SUICIDOLOGY, *supra* note 1, at 1.

40. *See* N.C. GEN. STAT. § 14-17.1 (2017).

41. *See* State v. Willis, 255 N.C. 473, 474–75, 121 S.E.2d 854, 855 (1961); *see also* Washington v. Glucksberg, 521 U.S. 702, 712 (1997) (noting that Blackstone referred to suicide as "self-murder" and that those in nineteenth century England "ranked [suicide] among the highest crimes" (quoting 4 WILLIAM BLACKSTONE, COMMENTARIES *189)).

42. *Willis*, 255 N.C. at 477, 121 S.E.2d at 856–57 ("Since suicide is a crime, one who aids and abets another in, or is accessory before the fact to, self-murder is amendable to the law.").

43. *See id.*

44. Act of Apr. 8, 1974, ch. 1205, § 1, 1973 N.C. Sess. Laws 334, 334 (codified at N.C. GEN. STAT. § 14-17.1 (2017)).

45. *See supra* note 19.

46. North Carolina uses a combination of statutes and common law to govern homicide. Though the first- and second-degree murder statute establishes some of the elements of those crimes, N.C. GEN. STAT. § 14-17 (2017), they are more clearly laid out in

"malice aforethought."[47] Whatever one's view about AID, it appears untenable to suggest that a physician following the wishes of a terminally ill patient acted with any "malice" in providing a prescription for medication the patient could ingest to achieve a more peaceful death. Similarly, the crime of voluntary manslaughter requires the state to prove that the defendant killed the victim "by an intentional and unlawful act."[48] Involuntary manslaughter is an unintentional killing proximately caused by either (1) an unlawful act that does not amount to a felony, or (2) culpable negligence.[49] Because aiding and abetting a suicide can no longer be considered a crime or an "unlawful act," as noted above, a physician could not be prosecuted for either crime of manslaughter.

One might consider the potential for adverse action against a physician for prescribing medication for AID under the Controlled Substances Act ("CSA").[50] However, the ability to sanction a physician or revoke her power to prescribe controlled substances turns on whether the physician is prescribing for a "legitimate medical practice."[51] In a case that challenged the ability of the United States Attorney General to nullify the Oregon Death with Dignity Act by declaring prescriptions for AID to be outside "legitimate medical practice," the United States Supreme Court, affirming the lower courts, made clear that the determination of what constitutes a "legitimate medical practice" is a matter left to the states and recognized that prescribing medication for AID could indeed be a "legitimate medical practice."[52] That case involved prescribing as specifically authorized by a state statute[53]; however, medical practice is rarely governed by statute. The practice of medicine is most commonly regulated by the standard of care, which is informed by multiple sources, as discussed in this Article.[54] Accordingly, the question would be whether prescribing was within the standard of

cases interpreting that statute, *see, e.g.*, State v. Coble, 351 N.C. 448, 449, 527 S.E.2d 45, 46 (2000). Similarly, the manslaughter statute only explains which class of felony voluntary and involuntary manslaughter will be punished under, N.C. GEN. STAT. § 14-18 (2017), so any description of the elements of those crimes appears in the common law.

47. *Coble*, 351 N.C. at 449, 527 S.E.2d at 46 (defining both first- and second-degree murder as requiring the act be done "with malice").

48. State v. Coleman, __ N.C. App. __, __, 803 S.E.2d 820, 823 (2017) (quoting State v. English, 241 N.C. App. 98, 105, 772 S.E.2d 740, 745 (2015)).

49. State v. Hudson, 345 N.C. 729, 733, 483 S.E.2d 436, 439 (1997).

50. 21 U.S.C. §§ 801–904 (2012).

51. *See* Gonzales v. Oregon, 546 U.S. 243, 243 (2006).

52. *Id.* at 243–44, 260–63, 270–74.

53. *Id.* at 243–44.

54. *See infra* Parts IV and V.

care. If so, adverse action under the CSA would not be viable. The CSA, as case law makes clear, is intended to reach clinicians prescribing for purposes of illicit drug use.[55] A physician prescribing for AID, as recognized by the United States Supreme Court in *Gonzales v. Oregon*,[56] is clearly not engaging in "illicit drug dealing and trafficking."[57] The North Carolina Attorney General recognizes that practicing within a statutory safe harbor is not the only proper practice of medicine,[58] so prescribing drugs for AID should also be judged by the applicable standard of care.

There are no statutory or common law crimes that might provide a basis to prosecute a physician for providing AID in a manner consistent with the standard of care. Given North Carolina's laws that seek to empower patients to make autonomous decisions about end-of-life care, and the state's lack of criminal prohibitions that could reach AID, it is reasonable to conclude that North Carolina physicians can practice AID without fear of a viable prosecution, subject to best practices.

IV. AID SHOULD BE GOVERNED BY THE STANDARD OF CARE

Most medical care is not governed by statute or court decision but rather by the standard of care, also referred to as best practices.[59] The standard of care is an objective one. A physician has a duty to have and to utilize the knowledge and skill ordinarily possessed by a physician practicing in the same field with similar training and experience, situated in a similar community under similar circumstances, as established by expert testimony.[60] Additionally,

55. *See, e.g.*, Volkman v. DEA, 567 F.3d 215, 223 (6th Cir. 2009) ("Congress regulates medical practice insofar as it bars doctors from using their prescription-writing powers as a means to engage in illicit drug dealing and trafficking." (quoting *Gonzales*, 546 U.S. at 246)).

56. 546 U.S. 243 (2006).

57. *See id.* at 269–75.

58. *See* Easley, *supra* note 26 (concluding that when there is not a statutory safe harbor for medical conduct, the governance of that conduct is subject to the standard of care).

59. *See* 61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* § 187 (2012).

60. *See* N.C. GEN. STAT. § 90-21.12(a) (2017) (holding a physician liable for medical malpractice action if "the care of such health care provider was not in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities under the same or similar circumstances at the time of the alleged act"); Crocker v. Roethling, 363 N.C. 140, 142, 675 S.E.2d 625, 628 (2009); *see also* Chumbler v. McClure, 505 F.2d 489, 492 (6th Cir. 1974); Borja v. Phx. Gen. Hosp., Inc., 727 P.2d 355, 358–59 (Ariz. Ct. App. 1986); Schwab v. Tolley, 345 So. 2d 747, 753 (Fla. Dist. Ct. App. 1977); Hood v. Phillips, 537 S.W.2d 291, 294 (Tex. Civ. App. 1976), *aff'd*, 554 S.W.2d 160 (Tex. 1977).

most jurisdictions have adopted some form of "respectable minority" (also referred to as "two schools of thought") standard of care as a defense to medical negligence.[61] This allows a physician to engage in one of several recognized courses of treatment without falling outside the standard of care merely because he or she pursued a treatment that is followed by only a minority of physicians.[62]

It is unknown what percent of physicians practicing medicine in North Carolina support the practice of AID, as no polling has been done. Nationwide, a strong and growing majority of physicians support the practice.[63] North Carolina physicians may support the practice in similar numbers. Even if only a minority of North Carolina physicians support it, no doubt the numbers would be sufficient to constitute a respectable minority.[64] Though North Carolina does not appear to have considered the "respectable minority" rule in a reported case, it might well do so if the issue came before a court. AID certainly qualifies as a "recognized course of treatment," as the practice has become increasingly accepted among medical and health policy organizations, with many of these organizations adopting policies in support of the practice.[65] It is likely that, at this point in

61. *See, e.g.*, *Chumbler*, 505 F.2d at 492.

62. *See id.* ("Where two or more schools of thought exist among competent members of the medical profession concerning proper medical treatment for a given ailment, each of which is supported by responsible medical authority, it is not malpractice to be among the minority in a given city who follow one of the accepted schools.").

63. *See* Robert Lowes, *Assisted Death: Physician Support Continues to Grow*, MEDSCAPE (Dec. 29, 2016), https://www.medscape.com/viewarticle/873844 [https://perma.cc/QM6G-ULTR] (indicating that 57% of physicians believe AID "should be available to terminally ill patients"). Some state medical societies have surveyed their physicians for views on AID with results showing strong support. For example, nearly 60% of Massachusetts physicians either support or strongly support the practice. *See Medical Aid in Dying Survey*, MASS. MED. SOC'Y, http://www.massmed.org/advocacy/state-advocacy/maid-survey-2017/ [https://perma.cc/S9AM-8GFU (dark archive)].

64. Because North Carolina law looks to medical practices in "similar communities" to define the standard of care, it might be that physicians practicing in the more progressive communities in North Carolina would have the strongest case that their conduct in providing AID met the standard of care. *See* § 90-21.12(a).

65. *See* Tucker, *At the Very End of Life*, *supra* note 1, at 46. Organizations with policies supportive of AID include the American Medical Women's Association, the American Medical Student Association, the American College of Legal Medicine, and the American Public Health Association. *See* Brief of Amicus Curiae Am. Med. Students Ass'n et al. at 9–10, Myers v. Schneiderman, 85 N.E.3d 57 (N.Y. 2017) (No. APL-2016-00129); *Patients' Right to Self-Determination at the End of Life*, AM. PUB. HEALTH ASS'N (Oct. 28, 2008), https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/29/13/28/patients-rights-to-self-determination-at-the-end-of-life [https://perma.cc/LJ3H-D2Y8]. Other associations of physicians have dropped policies opposing the practice of AID, leaving the decision of whether to provide it "to the conscientious judgment of its members acting on behalf of their patients." James A.

time, a respectable minority of North Carolina physicians who provide end-of-life care support the practice of AID.[66]

Physicians may be concerned that providing AID could lead to adverse action by the Medical Board, which has the authority to sanction physicians.[67] North Carolina, however, does not allow its Medical Board to discipline a physician simply because a practice is "nontraditional" or departs from "prevailing medical practices":

> The Board shall not revoke the license of or deny a license to a person, or discipline a licensee in any manner, solely because of that person's practice of a therapy that is experimental, nontraditional, or that departs from acceptable and prevailing medical practices unless, by competent evidence, the Board can establish that the treatment has a safety risk greater than the prevailing treatment or that the treatment is generally not effective.[68]

Russell et al., *Lawful Physician-Hastened Death*, 90 NEUROLOGY 420, 421 (2018) (stating the American Academy of Neurology's position on AID). In October 2018, the American Academy of Family Physicians adopted a new position of "engaged neutrality" on the issue of medical aid in dying. Compassion & Choices, *American Academy of Family Physicians Adopts New Position of "Engaged Neutrality" on Medical Aid in Dying*, PR NEWSWIRE (Oct. 9, 2018), https://www.prnewswire.com/news-releases/american-academy-of-family-physicians-adopts-new-position-of-engaged-neutrality-on-medical-aid-in-dying-300728230.html [https://perma.cc/W6BP-WUBM]. The United States Supreme Court has recognized that AID may be a legitimate medical practice. Gonzales v. Oregon, 546 U.S. 243, 267–69 (2006); *see also* Kathryn L. Tucker, *U.S. Supreme Court Ruling Preserves Oregon's Landmark Death with Dignity Law*, 2 NAT'L ACAD. ELDER L. ATT'YS J. 291, 291–94 (2006). As of early 2018, ten state medical societies had dropped opposition to AID. Peg Sandeen, *Toward the Tipping Point*, DIGNITY REP., Winter 2018, at 3, 3, https://www.deathwithdignity.org/wp-content/uploads/2018/01/2018_Winter_Newsletter_FINAL.pdf [https://perma.cc/VS8N-K6ZX].

66. Dellinger and Wall discussed the significance of the views of medical professionals on the practice as it might impact possible exposure to medical board sanction. Dellinger & Wall, *supra* note 7, at 223. At the time of their article, a much smaller fraction of physicians supported the practice. In the nearly fifteen years since, and with a generation of voluminous data about the practice in states with open practice, a strong and growing majority of physicians now support it, which would suggest no grounds exist for medical board disciplinary action against a physician providing AID in a manner consistent with the standard of care. *See supra* note 63 and accompanying text.

67. The North Carolina Medical Board was established in 1859 by the legislature "to regulate the practice of medicine and surgery for the benefit and protection of the people of North Carolina." N.C. GEN. STAT. § 90-2(a) (2017). The Board licenses, monitors, and disciplines physicians "to protect[] the people of North Carolina, and the integrity of the medical profession." *About the Board: Mission & Mandate*, N.C. MED. BOARD, https://www.ncmedboard.org/about-the-board/mission [https://perma.cc/HJ6G-WH72].

68. N.C. GEN. STAT. § 90-14(a)(6) (2017). North Carolina, as reflected in this provision, is among the states which have passed legislation to protect a patient's right to access alternative remedies from licensed physicians. *See* Anna M. Richardson, Student

Neither of the two exceptions to this protection would appear to fit AID. A patient choosing AID avoids harm (that of a more lingering and horrific death), and AID, when provided subject to the standard of care, is nearly always effective in achieving the desired result (the swift and peaceful death of the patient).

As discussed, North Carolina's statutory framework contains no enactment prohibiting AID. Instead, it clearly both empowers patients and respects patients' autonomy to make decisions regarding end-of-life care. Accordingly, physicians who receive a request for a prescription to bring about a peaceful death from their mentally competent, terminally-ill patient, believe AID to be a medically appropriate option, and are willing to provide such treatment should be able to do so subject to the standard of care.

V. STANDARD OF CARE FOR AID

Physicians in North Carolina who wish to respond to the requests of their suffering, dying patients by offering AID as an end-of-life option can find guidance on the practice. One place to look is to states with open practice of AID. Of course, practice in states with a permissive regulatory statute must comport with the statute. In other words, in those states, the standard of care must incorporate the statutory requirements. In some of these states, detailed guidance on the practice has been published by authoritative bodies.[69] Among the states with open practice of AID, currently only Montana employs a more traditional approach, where the standard of care governs practice and there is no regulatory statute.[70] Thus, of most interest to proponents of AID in North Carolina is the practice as it has unfolded in Montana.

AID has been openly practiced in Montana since 2009, following the decision by the Montana Supreme Court in *Baxter v. State*,

Article, *Informed Patients Go Homeo Happy: Applying the Doctrine of Informed Consent to Homeopathic Practitioners*, 34 OHIO N.U. L. REV. 593, 595 & n.15 (2008).

69. *See, e.g.*, TASK FORCE TO IMPROVE THE CARE OF TERMINALLY-ILL OREGONIANS, THE OREGON DEATH WITH DIGNITY ACT: A GUIDEBOOK FOR HEALTH CARE PROFESSIONALS § 1 (Patrick Dunn & Bonnie Reagan eds., 5th ed. 2008), https://www.ohsu.edu/xd/education/continuing-education/center-for-ethics/ethics-outreach/upload/Oregon-Death-with-Dignity-Act-Guidebook.pdf [https://perma.cc/TJ59-FA3Q]; WASH. STATE PSYCHOLOGICAL ASS'N, THE WASHINGTON DEATH WITH DIGNITY ACT: WSPA GUIDELINES FOR MENTAL HEALTH PROFESSIONALS 1 (2009), https://endoflifewa.org/wp-content/uploads/2014/08/WSPA-DWD_Guidelines_6-3-09.pdf [https://perma.cc/XGJ9-PCLP].

70. *See supra* notes 11–16 and accompanying text.

recognizing the right of its citizens to freely choose AID.[71] Robert Baxter, a seventy-five-year-old man dying of cancer, sued the State of Montana to establish his right to choose AID.[72] Baxter argued that (1) Montanans have a right to AID arising from Montana's constitutional guarantees of privacy and individual dignity,[73] and alternatively, (2) physicians who provide AID could not be subject to prosecution under the state's homicide statute.[74]

The Montana Supreme Court declined to reach the constitutional issues[75] and instead resolved the case on the alternative statutory grounds: because homicide could not be charged when the deceased consented to the act precipitating death, no charge could prevail against a physician who provided a patient with a prescription for AID.[76] The court noted that Montana statutes vest patients with broad autonomy over medical decisionmaking, reflecting the policy of the state to leave these decisions to the individual.[77] Further, the court held that AID is consistent with that public policy.[78] Accordingly, it would be improper to prosecute a physician for homicide for providing AID.[79]

Under this ruling, physicians can provide AID to mentally competent, terminally ill patients without fear of homicide prosecution.[80] Montana physicians are not subject to statutory

71. Baxter v. State, 2009 MT 449, ¶ 50, 354 Mont. 234, 224 P.3d 1211.

72. *See id.* ¶¶ 5–6. Additional plaintiffs included four Montana physicians who treat terminal illness. *Id.*

73. *Id.* ¶ 6.

74. *Id.*; *see* MONT. CODE ANN. § 45-2-211(1) (Westlaw through Oct. 1, 2017 sess.). Montana had no statute prohibiting assisting suicide. The possible basis for a criminal charge would have been under the homicide statute, which included the proviso that the "consent of the victim to conduct charged to constitute an offense or to the result thereof is a defense." *Id.* Since a patient seeking AID was consenting to the physician's conduct in providing the prescription for AID, there could be no grounds to prosecute a physician for such conduct.

75. *Baxter*, 2009 MT ¶ 10. The lower court had found a state constitutional right, founded on guarantees of privacy and dignity, for competent terminally ill patients to choose AID. *Id.* ¶ 7.

76. *See id.* ¶ 50 ("[A] terminally ill patient's consent to physician aid in dying constitutes a statutory defense to a charge of homicide against the aiding physician . . . .").

77. *Id.*

78. *See id.*

79. *See id.*

80. *See id.* Physicians need not fear disciplinary action either, at least no more than in the case of providing any other medical procedure or intervention. This was made clear by a policy adopted by the Montana Board of Medical Examiners on AID in January 2011, stating that the Board would treat complaints regarding AID as it would any other complaint. *See Medical Board Won't Change Assisted Suicide Policy*, BILLINGS GAZETTE (Nov. 12, 2012), https://billingsgazette.com/news/state-and-regional/montana/medical-board-won-t-change-assisted-suicide-policy/article_da54bbe0-ee74-57c9-9203-c5357ebd5fd7.html

governance when providing AID. Still, the *Baxter* court recognized certain boundaries similar to those in permissive statutes: a patient must be terminally ill and mentally competent, and the physician's conduct is limited to providing a prescription, which a patient may choose to ingest.[81] Beyond these bright lines, the practice of AID is governed by the standard of care. In nearly a decade since *Baxter* was decided, there has been no suggestion and no evidence that the standard of care has been insufficient to govern the practice.[82]

Other resources for clinicians seeking guidance on the standard of care for a particular practice are clinical practice guidelines and journal literature.[83] Such guidelines and literature have been published for AID.[84] Non-profit groups supportive of AID offer information to physicians seeking to know the standard of care.[85]

[https://perma.cc/GHY4-F4EQ]. This policy was, along with all Montana Medical Board of Examiners policies, withdrawn subsequently, but with no reason to believe the position changed. Such approach by a medical board reflects that the practice is becoming normalized and governed as all other medical practice.

81. *Baxter*, 2009 MT ¶ 26.

82. Following the *Baxter* decision, legislators in Montana introduced competing bills, one to regulate the practice, S.B. 202, 64th Leg., Reg. Sess. (Mont. 2015), the others to outlaw it, H.B. 328, 64th Leg., Reg. Sess. (Mont. 2015) (providing that patient consent to AID is not a defense for a homicide charge); H.B. 477, 64th Leg., Reg. Sess. (Mont. 2015) (providing that AID is against Montana public policy). None of these were enacted, leaving the practice subject to governance as virtually all medicine is practiced: subject to the standard of care. In a case in New Mexico, *Morris v. Brandenburg*, 2016-NMSC-027, 376 P.3d 836, a leading provider of end-of-life care in Montana, Dr. Eric Kress, provided testimony at trial about the practice of AID as it was evolving in Montana in the wake of the *Baxter* decision. *Id.* ¶ 9. Dr. Kress's testimony reflected that this end-of-life option is now available to patients and provided by willing providers subject to the standard of care. *See id.* Additionally, physicians across Montana have publicly expressed support for AID publicly. *See, e.g.*, James Bonnet et al., *Access to Medical Aid in Dying for Terminally Ill Montanans Upheld Again*, INDEP. REC. (Mar. 21, 2017), https://helenair.com/opinion/columnists/access-to-medical-aid-in-dying-for-terminally-ill-montanans/article_b2e2412a-02ce-5410-9d44-d5fafa4373b0.html [https://perma.cc/D8JG-C74U (dark archive)]. A symposium will be held at the University of Montana Law School in the fall of 2019 to examine AID practice in Montana in the decade following *Baxter*.

83. "Clinical practice guidelines are statements that include recommendations intended to optimize patient care. They are informed by a systematic review of evidence, and an assessment of the benefits and harms of alternative care options." *Clinical Practice Guideline Manual*, AM. ACAD. FAM. PHYSICIANS, https://www.aafp.org/patient-care/clinical-recommendations/cpg-manual.html [https://perma.cc/S62T-JHTG].

84. *See, e.g.*, David Orentlicher et al., *Clinical Criteria for Physician Aid in Dying*, 19 J. PALLIATIVE MED. 259, 259–61 (2016); Lonny Shavelson, *Best Practices for Aid in Dying: Recommendations from the Bedside*, 91 S.F. MARIN MED. 17, 17–19 (2018).

85. For example, the "Doc2Doc" program of the patient rights group Compassion & Choices offers practicing physicians a "readily available, free, confidential telephone consultation with [a] seasoned medical directors, each with years of experience in end-of-life medical care." *Doc2Doc*, COMPASSION & CHOICES, https://compassionandchoices.org/d2d/ [https://perma.cc/W3T8-UYPP].

CONCLUSION

Enacting legislation to create an affirmative permission for AID is difficult and unnecessary in the absence of a prohibitive statute. The wisdom and utility of enacting such measures is in doubt in light of the adverse impact that statutory governance has had on physician practice and patient access. Medical practice of AID over the past twenty years, and a growing number of medical and health policy organizations with policies supportive of it, demonstrate that this practice is increasingly accepted. Clinical practice guidelines and best practices literature have been published, further reflecting acceptance of the practice and setting forth guidelines and information to help clinicians understand how best to provide this to their patients.[86] The emergence of these policies, guidelines, literature, and the practice in other states will certainly influence best practices elsewhere, including in North Carolina.

Physicians providing end-of-life care to patients in North Carolina should be able to provide AID as an option governed by best practices, extending an important additional choice to mentally competent, terminally ill North Carolinians who confront a dying process that they find unbearable. Under existing North Carolina law, there is no basis for a criminal, medical board, or civil action to be brought against any physician providing AID, so long as practice is within the standard of care.[87] It is time for AID to be governed like all other medical practices: subject to the standard of care.

86. *See generally* Orentlicher et al., *supra* note 84 (providing clinical practice guidelines to physicians who practice AID).

87. Supporters of AID might consider advancing legislation that provides a clear safe harbor for physicians who provide it consistent with the standard of care, making it clear that there is no criminal, civil or professional exposure to a physician who provides it. Such a measure would be an improvement over a heavily regulatory but permissive statute and would allow the practice to evolve within the practice of medicine, thereby normalizing the practice. This would be preferable for multiple reasons. As noted, it would allow for evolution of the practice and for best practices to develop in the provider community, and it would also likely increase the number of physicians willing to provide AID, since the burdensome regulatory scheme imposed by the Oregon-style statutes adversely impacts provider participation.