

A Brief Review of North Carolina's Law on Dying¹

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Ten years after Oregon voters first approved the "Death with Dignity Act,"² contentious debate continues throughout the country regarding the legal and ethical issues surrounding end-of-life care, particularly on the issue of assisted suicide.³ Just last year, the North Carolina General Assembly considered legislation proposing to criminalize assisted suicide.⁴ The bill did not pass, but the issue is likely to arise in future legislative sessions. In considering how North Carolina should approach end-of-life issues, it is useful to review our state's current law and policy regarding life-sustaining treatment, euthanasia, suicide, assisted suicide, and pain relief. The summaries below are not intended to be comprehensive, but rather provide a basic overview of the legal environment surrounding each of these important issues.⁵

Life-Sustaining Treatment

Refusal, withholding, and withdrawal of life-sustaining treatment all are legal choices under federal and state law. A patient has long had the ability to express his or her wishes regarding life-sustaining treatment orally or in the form of a written document often referred to as an "advance directive" or "living will." Refusal of life-sustaining treatment and advance directives are governed primarily by state law, but the federal government has weighed in on a few important points. While not directly stating it, the United States Supreme Court seems to acknowledge that competent people have a constitutional right to refuse medical treatment.⁶ Also, Congress recognized the concept of advance directives in 1991 when it enacted the Patient Self-Determination Act.⁷ The law 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. The law does not require providers to comply with advance directives, but they must at least initiate conversations with patients about their wishes.

North Carolina's history of recognizing patient autonomy in end-of-life decisions goes back even further. The state enacted

the Right to Natural Death Act⁸ in 1978, not so much to create new rights related to advance directives as to recognize existing ones.⁹ The law includes a form by which a person may express his or her preferences regarding extraordinary medical interventions, including artificial nutrition and hydration.¹⁰ State law also permits residents to name an agent to make those decisions on their behalf in certain circumstances.¹¹ In 2001, the state enacted two laws related to patient autonomy. The first is a law that shields providers from liability if they withhold cardiopulmonary resuscitation from a person having a "portable do-not-resuscitate order" on a form developed or approved by the state.¹² The second is a law establishing a voluntary state registry for advance healthcare directives.¹³

Whether North Carolina doctors and hospitals or other facilities must carry out a patient's stated wishes is not settled. Some states require this by statute, subjecting noncompliant providers to criminal or civil penalties and/or professional disciplinary actions.¹⁴ A North Carolina 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 civilly liable for assault and battery if they force treatment on a patient.¹⁵ The North Carolina Medical Board, on the other hand, states that "physicians are ethically obligated to follow the wishes of the terminally ill or incurable patient as expressed by and properly documented in a declaration of desire for a natural death" or transfer the patient to another physician's care.¹⁶ Based on this statement, a physician could be subject to disciplinary action if he or she refuses to follow the patient's wishes and fails to transfer the patient.

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."¹⁷ This act very likely is murder under North Carolina law. North Carolina's highest court has dealt very harshly with "mercy killing." For shooting his father in a

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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 malice¹⁸ (though they did not have to do so) from the defendant's use of a deadly weapon, and further instructed that the defendant's knowing 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 lesser sentence than that for first-degree murder because the son's intentions were good.¹¹

Personally administering lethal medication to a patient could be first-degree murder, either as "murder by poison" or simply as deliberate and premeditated killing. Like the man who shot his father, a doctor or a nurse would likely not escape punishment because she or he meant to help the patient—not even if the patient had asked for death.

Suicide

"Suicide" is "the act or an instance of taking one's own life voluntarily and intentionally."¹⁹ 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 state Supreme Court found the act criminal,²⁰ 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 as well.²¹ In 1973 the North Carolina General Assembly abolished the crime of committing suicide and thereby, implicitly, the crime of attempting suicide. The status of providers' acts assisting patients to commit suicide is more complicated.

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).²² Much of the public and a significant minority of physicians do not distinguish meaningfully between assisted suicide and euthanasia.²³ Most people, however, continue to draw a moral distinction between responding affirmatively to "Help me kill myself" and responding affirmatively to "Kill me."²⁴ 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 (DEA)]. 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 a desperate stranger or holds a ladder for that person to reach a window ledge should have no legal problem. 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

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relationships—such as parent and minor child or doctor and patient—one party is legally obligated to protect the other to some extent.²⁵ Based on the current state of the law, we simply do not know whether or when a healthcare provider in North Carolina will be seen as failing to protect a patient if she or he helps the patient die. In other words, we do not know whether a provider's decision to help a patient die will subject the provider to civil or criminal liability.

The means of assistance most often discussed is providing medication for a patient to administer to herself or himself.²⁶ As discussed above, Oregon law now authorizes a physician to prescribe a lethal dose of medication for a person suffering from a terminal disease if the person requests the prescription and certain other requirements are met.²⁷ This law came under attack recently when United States Attorney General John Ashcroft issued a directive explaining that assisting a person to commit suicide does not qualify as a "legitimate medical purpose" under the Controlled Substances Act (CSA) and therefore a physician who prescribes, dispenses, or administers a controlled substance for such a purpose would be in violation of federal law.²⁸ The attorney general directed the DEA to enforce the CSA in Oregon despite the existence of the state law authorizing such prescriptions. In May of this year, however, a federal court of appeals invalidated the attorney general's directive on the grounds that Congress did not provide him with the authority to make such an expansive interpretation of the CSA.²⁹

While it appears (for the time being) that terminally ill Oregon residents may be allowed to request physician assistance for suicide, many other states have expressly prohibited providers from providing such assistance.³⁰ The United States Supreme Court has upheld such prohibitions in two states, finding in both cases that the state laws did not infringe upon constitutional rights.³¹ It is not clear, however, how North Carolina courts would interpret and apply this state's law in such a situation. No law expressly prohibits assisted suicide, as was proposed this past legislative session. In laws governing living wills, however, the North Carolina General Assembly

declared 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.”³² The state courts have not been called upon to review this statement, but it may be possible to infer from the language that suicide assistance by a healthcare provider is illegal in this state.

It is also possible that a physician or pharmacist providing medication to assist a suicide could be found in violation of the state’s controlled substances law. Like the federal CSA, the state law provides that a prescription must be for a “legitimate medical purpose.”³³ While the recent federal court of appeals decision invalidated Attorney General Ashcroft’s interpretation of that language, it did not place any limits on the states’ ability to interpret and apply the same or similar language in their own laws. The North Carolina Department of Justice has not released a formal opinion on this issue.

Based on the policies, position statements, and resolutions adopted by many national and state professional organizations, it appears that many members of the medical profession in this country object to the principle of assisting a person in committing suicide.³⁴ While these policies do not have the force of law, they are likely to be persuasive to healthcare professionals in states, such as North Carolina, where clear legal guidance is lacking. In some instances, such policies could form the basis for disciplinary action by licensing boards.

Pain Management

Pain management 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.³⁵ 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. 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,³⁶ 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.³⁷

There is clear support for pain management at the federal level. Federal law encourages the use of controlled substances to relieve pain, even if doing so jeopardizes the patient’s life. The law requires doctors who prescribe medication for purposes of treating a drug addict to register with the DEA,³⁸ 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.³⁹ In his 2001 directive, Attorney General Ashcroft reiterated the distinction between assisted suicide and “providing sufficient dosages of pain medication

necessary to eliminate or alleviate pain.”⁴⁰ National professional organizations, such as the American Medical Association and the American Nurses Association, also support and encourage active management of pain in dying patients.⁴¹

At the state level, the scope and type of legal guidance related to pain management varies. Many states expressly approve the use of pain-relieving medication, even though it may shorten life.⁴² Some states do this by amending their controlled substances laws while others enact freestanding statutes. North Carolina has done neither. In the absence of state law on the issue, providers may rely on guidance from their licensing boards. In the fall of 1999, North Carolina’s Boards of Nursing, Pharmacy, and Medicine issued a joint statement on pain management in end-of-life care. The statement identified issues of concern to members of the three professions. Of particular interest is the section of the statement directed toward physicians. It expressly provides that:

“Opioid use... is appropriate if the responsible physician is familiar with and abides by acceptable medical guidelines regarding such use, is knowledgeable about effective and compassionate pain relief, and maintains an appropriate medical record that details a pain management plan. Because the Board is aware of the inherent risks associated with effective pain relief in such situations, it will not interpret their occurrence as subject to discipline by the Board.”⁴³

The Medical Board also adopted two other statements discussing opioid use for the management of pain; one applies to pain during end-of-life care⁴⁴ and the other applies to chronic non-malignant pain.⁴⁵ The Board took care to assure physicians that they will not be disciplined for pain management, saying “no physician need fear reprisals from the Board for appropriately prescribing...even large amounts of controlled substances indefinitely for chronic non-malignant pain.”

Even in the absence of state statutes or regulations on the issue, these strongly worded position statements from professional licensing boards should go a long way toward encouraging healthcare providers in North Carolina to provide adequate pain relief in end-of-life care. Without further action by the North Carolina General Assembly, though, providers (and their attorneys) will likely continue to be concerned about potential liability under the state controlled substances law and basic tort law.

Conclusion

North Carolina is clear on a few issues related to end-of-life care: an individual has the right to refuse life-sustaining treatment; euthanasia (or “mercy killing”) would likely be considered murder; and suicide is not a crime. The law related to two of the most controversial issues—assisted suicide and pain management—is less clear. Healthcare providers, patients, advocates, and policymakers interested in continuing to develop the state’s legal landscape related to end-of-life care have a tremendous opportunity to provide guidance and clarity in these essential components of patient care. **NCMJ**

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- 3 See, e.g., Robeznieks, A. Assisted-suicide bills falter in 4 states. *American Medical News*, May 19, 2003. (Accessed July 7, 2004, at <http://www.ama-assn.org/amednews/2003/05/19/prsd0519.htm>) (Discussing proposals in three states to legalize physician-assisted suicide and North Carolina's proposal to criminalize it).
- 4 Physician Assisted Suicide. SB 145 (introduced February 24, 2003). (Accessed July 7, 2004, at <http://www.ncga.state.nc.us/html2003/bills/CurrentVersion/Senate/Sbil0145.full.html>).
- 5 See also Cantor, NL. Twenty-five Years After Quinlan: A Review of the Jurisprudence of Death and Dying. *J.L. Med. & Ethics* 2001;29:182-194.
- 6 *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 278-79 (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, 719 (1997).
- 7 42 U.S.C. §§ 1395cc (Medicare), 1396a (Medicaid).
- 8 N.C. Gen. Stat. Art. 23, Ch. 90 (hereinafter N.C.G.S.).
- 9 Formal Opinion of Attorney General to C. Robin Britt, Sr., Secretary, N.C. Dept. of Human Resources. Ref. No. fop11. Jan. 5, 1995. (Accessed July 7, 2004, at <http://www.ncdoj.com/DocumentStreamerClient?directory=AGOpinions/&file=fop11.pdf>). The act and its amendments emphasize that North Carolinians retain additional common-law rights to control the circumstances of their death. N.C.G.S. § 90-320.
- 10 N.C.G.S. § 90-321. While the law refers to a written document and includes a statutory form, it provides that the law establishes a "nonexclusive" method for creating such a directive. N.C.G.S. § 90-320(a). For a discussion of oral advance directives, see Meisel, A, Snyder, L, and Quill, T. Seven Legal Barriers to End-of-Life Care: Myths, Realities, and Grains of Truth. *JAMA* 2000;284:2495-2501.
- 11 N.C.G.S. §§ 32A-15 through -26. The law names dire circumstances (terminal illness, permanent coma, severe dementia, and persistent vegetative state) (N.C.G.S. 32A-25(3)(g)), but the person appointing an agent is free to identify other circumstances in which the agent would begin to act (N.C.G.S. 32A-25(4)). For further discussion of advance directives in North Carolina, see King, NMP, Davis, AM. Advance Directives for Medical Decision Making in North Carolina: Rights, Duties, and Questions, Parts One and Two. *Popular Government* 1997, 62/2:2-11 and 62/3:38-49.
- 12 N.C.G.S. § 90-21.17.
- 13 N.C.G.S. Chap. 130A, Art. 21.
- 14 For example, if a Nevada physician refuses either to comply with an advance directive or transfer the patient the physician may be subject to criminal penalties. *Nev. Rev. Stat. Ann.* § 449.660(1). In South Carolina, a physician's refusal either to comply with a directive or transfer the patient constitutes unprofessional conduct and may subject the physician to disciplinary action by the state's licensing board. *S.C. Code Ann.* § 44-77-100.
- 15 Advisory opinion of senior deputy attorney general Ann Reed and special deputy attorney general James A. Wellons to R. Marcus Lodge, general counsel, N.C. Dept. of Human Resources. Ref. No. 265. May 23, 1996. (Accessed July 7, 2004, at <http://www.ncdoj.com/DocumentStreamerClient?directory=AGOpinions/&file=265.pdf>).
- 16 North Carolina Medical Board. Position Statement: Advance Directives and Patient Autonomy. (Adopted July 1993; amended May 1996). (Accessed June 9, 2004, at <http://www.ncmedboard.org/advance.htm>).
- 17 *Stedman's Medical Dictionary* (27th ed.) (Baltimore: Lippincott, Williams & Wilkins, 2000), s.v. "euthanasia."
- 18 Malice is an element of first- and second-degree murder. G.S. 14-17. Malice is not a necessary element in some circumstances, such as when a person is killed by poisoning or starvation. See Farb, RL (ed.). *North Carolina Crimes*. 5th ed. Chapel Hill, N.C.: Institute of Government, The University of North Carolina at Chapel Hill, 2001:65-71.
- 19 *Merriam-Webster's Collegiate Dictionary* (10th ed.) (Springfield, Mass.: Merriam-Webster, 1997), s.v. "suicide."
- 20 *State v. Willis*, 255 N.C. 473, 121 S.E.2d 854 (1961).
- 21 "Since suicide is a crime, one who aids or abets another in, or is accessory before the fact to, self murder is amenable to the law." *Willis*, 255 N.C. at 477, 121 S.E.2d at 856-57.
- 22 Meisel, A, Cerminara, KL. Criminal Liability: Assisted Suicide and Active Euthanasia. In: *The Right to Die*. 3rd ed. New York, NY: Aspen Publishers, Inc., 2004:§12.01-.04.
- 23 Filene, PG. In the Arms of Others: A Cultural History of the Right-to-Die in America. Chicago: Ivan R. Dee, 1998:195; Emanuel EJ, Daniels, ER, Fairclough, DL, Clarridge, BR. The Practice of Euthanasia and Physician-Assisted Suicide in the United States: Adherence to Proposed Safeguards and Effects on Physicians.. *JAMA* 1998;280:507-13.
- 24 Emanuel, EJ. Euthanasia and Physician-Assisted Suicide: A Review of the Empirical Data from the United States. *Arch. Intern. Med.* 2002;162:142-152.
- 25 The closeness and the intensity of the relationship are not the issue. Spouses, for example, do not have such protective obligations to each other.
- 26 As used here, "providing" means prescribing, filling a prescription, or, in the case of a nurse, delivering a dose ordered by a doctor.
- 27 Or. Rev. St. § 127.800 et seq.
- 28 Notice: Dispensing of Controlled Substances to Assist Suicide. *Fed. Reg.* 2001; 66:56607-08. See also Statement of Attorney General Reno on Oregon's Death with Dignity Act. Statement #259. June 5, 1998. (Accessed July 7, 2004, at <http://www.usdoj.gov/opa/pr/1998/June/259ag.htm.html>) (reaching a different conclusion regarding the scope of the Controlled Substances Act).
- 29 *Super. Ct. Div. 89CVS64* (Hertford County, N.C. Nov. 20, 1990).F.3d 1118, (9th Cir. 2004).
- 30 See Meisel, A, Cerminara, KL. Criminal Liability: Assisted Suicide and Active Euthanasia. In: *The Right to Die*. 3rd ed. New York, NY: Aspen Publishers, Inc., 2004:§12.09 (table collecting state statutes).
- 31 *Washington v. Glucksberg*, 521 U.S. 702 (1997) (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).
- 32 N.C.G.S. § 90-320(b).
- 33 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." 10A N.C. Admin. Code 26E .0108. Likewise, federal

regulations (incorporated into the state's code at 10A N.C. Admin. Code 26E .0301) provide:

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.

- 34 See, e.g., North Carolina Medical Society. Physician-Assisted Suicide. Substitute Report PP-1992 (adopted Nov. 8, 1992); Reaffirmed Report H-2002 (adopted Nov. 17, 2002); American Medical Association Code of Ethics, § E-2.211 (Updated July 22, 2002) (Accessed July 9, 2004, at <http://www.ama-assn.org/ama/pub/category/8459.html>); American Nurses Association. Position Statement: Assisted Suicide (Accessed July 7, 2004, at <http://nursingworld.org/readroom/position/ethics/etsuic.htm>) (effective Date Dec. 8 1994); Snyder, L and Sulmasy, DP for the Ethics and Human Rights Committee, American College of Physicians-American Society of Internal Medicine. Physician-Assisted Suicide. *Ann. Intern. Med.* 2001;135:209-216. But see, e.g., Meisel, A, Cerminara, KL. Criminal Liability: Assisted Suicide and Active Euthanasia. In: *The Right to Die*. 3rd ed. New York, NY: Aspen Publishers, Inc., 2004:§12.04[F] (listing many articles and surveys identifying healthcare provider support for assisted suicide).
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- 39 21 C.F.R. § 1306.07(c).
- 40 Notice: Dispensing of Controlled Substances to Assist Suicide. *Fed. Reg.* 2001; 66:56607-08.
- 41 American Medical Association, Statement: Elements of Quality Care for Patients in the Last Phase of Life. Element 2. (May 1, 2003) (Accessed July 8, 2004, at <http://www.ama-assn.org/ama/pub/category/7567.html>); American Nurses Association. Revised Position Statement: Pain Management and Control of Distressing Symptoms in Dying Patients. (Effective Dec. 5, 2003) (Accessed July 7, 2004, at <http://www.ana.org/readroom/position/ethics/etpain.pdf>).
- 42 See, e.g., Fla. Stat. § 458.326; Neb. Rev. Stat. § 71-2419; Tex. Rev. Civ. Stat. Ann § 4496c. See Pain and The Law: State Pain Relief Acts. (Accessed July 8, 2004, at http://www.painandthelaw.org/statutes/state_pain_acts.php); Pain and Policy Studies Group. Achieving Balance in State Pain Policy: A Progress Report Card. 2004. (Accessed July 7, 2004, at www.medsch.wisc.edu/painpolicy).
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North Carolina Voluntary State Registry of Advance Healthcare Directives

In 2001, the North Carolina General Assembly passed legislation authorizing the NC Secretary of State to create a voluntary on-line registry of advance healthcare directives for the benefit of the citizens of the state and their healthcare providers under circumstances where immediate access to such directives would be needed. Citizens wishing to register their notarized directives may place three types of healthcare directives and an organ donor card on the Internet web site maintained by the Office of the Secretary of State at the following Internet location:

<http://www.secretary.state.nc.us/ahcdr/>

Those wishing to take advantage of this service by filing their information by mail may get information to facilitate their registration by calling 1-919-807-2000. Forms are provided for:

- Health Care Power of Attorney
- Declaration of Desire for Natural Death (Living Will)
- Advance Instruction for Mental Health Treatment
- Organ Donor Card