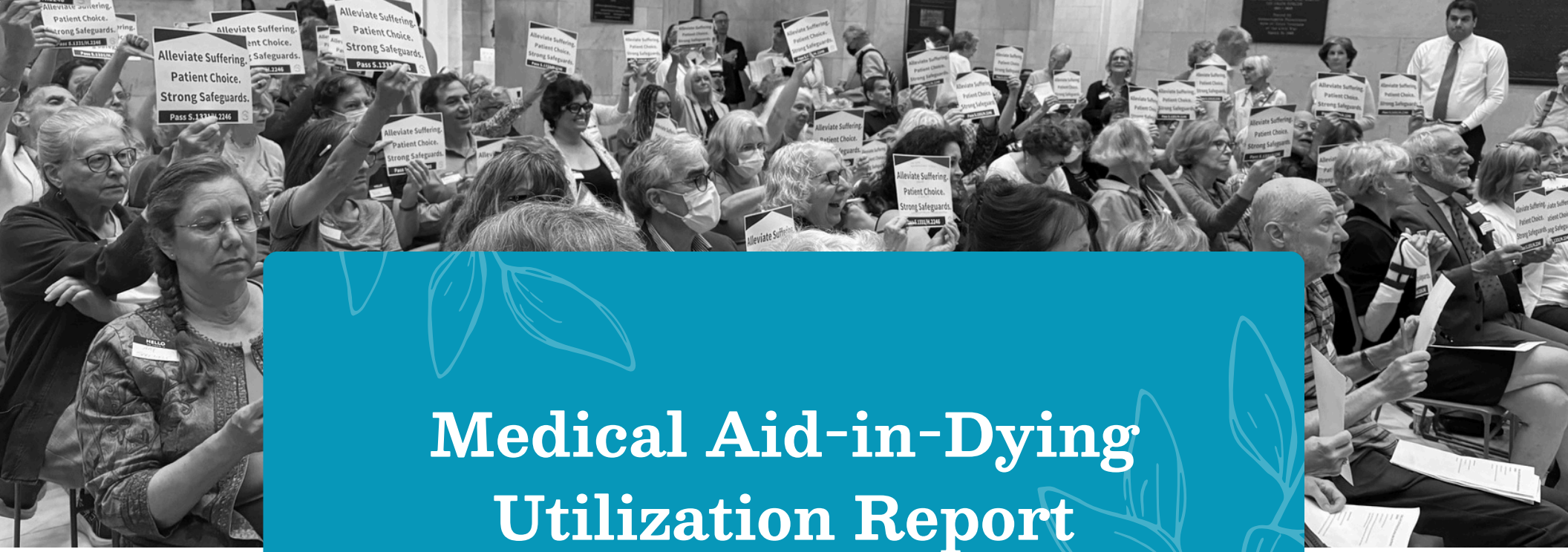

Medical Aid-in-Dying Utilization Report

2026

compassion & choices

February 2026

Just over 30 years ago, in November 1994, a majority of Oregon residents passed the nation's first law giving mentally capable, terminally ill adults the end-of-life care option of medical aid in dying. The law survived legal challenges and a repeal measure referred to the ballot by the Oregon Legislature. Oregon voters chose to retain the law, which was officially implemented in 1997.

Today, more one in three people — 32.80% — live in a jurisdiction where medical aid in dying is authorized. This list includes 13 states: Oregon (1994), Washington (2008), Montana (2009), Vermont (2013), California (2015), Colorado (2016), Hawaii (2018), New Jersey (2019), Maine (2019), New Mexico (2021), Delaware (2025), Illinois (2025), New York (2026), as well as the District of Columbia (2016). Finally, Oregon, Vermont, and Montana do not have a residency requirement, meaning an adult residing in another jurisdiction and who meets the eligibility criteria, if they are able to travel, may access medical aid in dying in these jurisdictions.

We no longer have to hypothesize about what will happen if this medical practice is authorized. We have almost 30 years of data since Oregon implemented its law in 1997 and years of experience from other authorized jurisdictions, including statistical reports from nine jurisdictions. This report is a compilation of data reports from the authorized jurisdictions that issue reports as of February 12, 2026. While this report only reflects the data published as of that date, the attached data tables are updated periodically as new data is published.

Across the authorized jurisdictions that report data, 12,425 individuals to date have chosen to use medical aid in dying. While few people use the option, many gain peace of mind and comfort simply knowing it exists. Further, medical aid in dying creates a shift within our end-of-life care system to one that is resoundingly person-driven—leading to improvements in hospice care, palliative care, and pain and symptom management. We have reassuring data, strong public support, and evidence that medical aid in dying is a desirable and politically viable option.

Individuals confronting terminal illness, often in one of the most vulnerable periods of their lives, deserve the autonomy to choose how and where they spend their final moments. While some jurisdictions have removed residency requirements, no one should be compelled to leave the comfort of their home and the presence of their loved ones to access the end-of-life care they seek. Terminally ill people in jurisdictions that have not yet authorized medical aid in dying need and deserve this option now.

If you have any questions about this report, please contact Chief Legal Advocacy Officer Bernadette Nunley at policy@compassionandchoices.org for more information.

Sincerely,

Kevin Díaz
President & CEO
Compassion & Choices

Context and methods

Currently, nine of the 14 authorized jurisdictions' Departments of Health have issued reports regarding the use of medical aid in dying laws: Oregon,[1] Washington,[2] Vermont,[3] California,[4] Colorado,[5] Hawai'i[6], the District of Columbia[7], New Jersey,[8] and Maine.[9] In all jurisdictions where medical aid in dying was authorized by legislation or ballot measure, there are statistical reporting requirements for administrative agencies, such as state health departments. However, the reported data is not standardized, and the report formats can change from year to year. In addition, the New Mexico Department of Health has not issued an official report as of this writing, so data from New Mexico is not included.[10, 11] Montana also does not issue utilization reports, so no data from Montana is included.

Below are data points that demonstrate how medical aid in dying is being used and where there are opportunities to improve access.

- People who received a prescription and people who died after ingestion provide two pieces of information: how many people made it through the process to obtain a prescription for medical aid in dying and how many of those individuals decided to ingest the medication.
- Race, gender, and age data points indicate where disparities exist. Race and ethnicity are not reported universally or consistently across jurisdictions, nor are these categories always reflective of all the ways people identify.
- Insurance information illustrates the impacts of cost and healthcare coverage on access to medical aid in dying. Due to the Assisted Suicide Funding Restriction Act (ASFRA), individuals reliant on federally funded insurance programs cannot use their insurance to cover the costs associated with medical aid in dying.
- Underlying illness reports the most common diseases and diagnoses for individuals who request medical aid in dying.

This report aggregates utilization data published on or before February 12, 2026, which includes data from calendar year 2024. Although differences exist in how each jurisdiction collects and reports data about medical aid in dying, Compassion & Choices records all reported data from each jurisdiction in the aggregate to provide a picture of access to medical aid in dying in the United States. Key findings are below.

[1] Oregon Health Authority. (1998-2024). *Oregon Death with Dignity Act Annual Reports.* https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ar-index.aspx.
[2] Washington State Department of Health. (2009-2023). *Washington Death with Dignity Data.* https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData.
[3] Vermont Department of Health. (2018-2022). *Patient Choice & Control at End of Life.* (2018-2022). https://www.healthvermont.gov/systems/end-of-life-decisions/patient-choice-and-control-end-life.
[4] California Department of Public Health. (2016-2024). *California End of Life Option Act Annual Reports.* https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act-.aspx.
[5] Colorado Department of Public Health & Environment. (2017-2024). *Colorado End-of-Life Options Act Annual Statistical Reports.* https://www.colorado.gov/pacific/cdphe/medical-aid-dying.
[6] Hawai'i Department of Health. (2019-2024). *Hawai'i Our Care, Our Choice Act Legislative Reports.* https://health.hawaii.gov/opppd/ococ/legislative-reports/.
[7] DC Health. (2017-2022). *District of Columbia Death with Dignity Act Annual Reports.* https://dchealth.dc.gov/publication/death-dignity-annual-reports.
[8] New Jersey Department of Health. (2019-2024). *New Jersey Medical Aid in Dying for the Terminally Ill Act Data Summary.* https://nj.gov/health/advancedirective/maid/.
[9] Maine Department of Health and Human Services. (2019-2024). *Maine Death with Dignity Act Annual Reports.* https://www.maine.gov/dhhs/data-reports/reports.
[10] New Mexico Department of Health. (2021). *Elizabeth Whitefield End-of-Life Options Act.* https://www.nmhealth.org/about/erd/bvrhs/vrp/maid/.
[11] Although the New Mexico Department of Health has not yet released a report, End of Life Options New Mexico publishes utilization data on its website: https://endoflifeoptionsnm.org/.

Medical aid in dying jurisdiction usage reports

Based on reported data, the following is known:

- Over the past nearly three decades, across all jurisdictions, more than 20,000 eligible individuals have received prescriptions for medical aid in dying, with 12,425 going on to ingest them.
- While data is not collected on patients who only discuss medical aid in dying with their healthcare providers but do not begin the statutory process, nor on patients who begin the process but do not receive a prescription, these unreported events represent an important group. They are individuals who have engaged in meaningful conversations with their providers to better understand all of their end-of-life care options and to make informed decisions that reflect their values, priorities, and desire for a peaceful death.
- Less than 1% of the adults who die in each jurisdiction choose medical aid in dying each year.[12]
- Only 61% (just under two-thirds) of people with prescriptions ingest the medication and die. Up to 39% of people who go through the process and obtain the prescription may never take it. This group consists of people who die without using the medication, whether from illness, another cause of death, or an unreported reason. In any case, we hear from terminally ill adults that they derive peace of mind simply from knowing they have the option if their suffering becomes too great.
- The majority of terminally ill adults who utilize medical aid in dying (89%) are enrolled in hospice or palliative care services at the time of their deaths.
- There is nearly equal utilization of medical aid in dying among men and women. There is no data yet on the utilization of medical aid in dying by nonbinary or gender non-conforming people. However, New Jersey began including a category for nonbinary people with its 2023 report.
- The rate at which Asian, Black, Hawaiian, Pacific Islander, Indigenous American, Alaskan Native, Latino/a/x, Hispanic, and multi-race people access medical aid in dying is consistently lower than white populations across all years and jurisdictions.[13]
- Year after year, reports indicate that the utilization of medical aid in dying is increasing among people of color. Since 2022, many jurisdictions have reported increases in the percentage of people of color utilizing medical aid in dying.

[12] According to the Center for Disease Control, in 2022 in jurisdictions that authorized medical aid in dying, 598,151 people died in total. In 2022, authorized jurisdictions report 1,904 people died after being provided with a prescription for medical aid in dying – less than 0.3% of total deaths in 2022. CDC has not released an updated *Deaths: Final Data* report since 2022. Xu, J., Murphy, S., et al. (2025). (rep.). *Deaths: Final Data for 2022*. National Vital Statistics Report, 74(4). https://www.cdc.gov/nchs/data/nvsr/nvsr74/nvsr74-04.pdf.

[13] In all jurisdictions and across all years, Asian populations have represented 3.51% of patients utilizing medical aid in dying and Latinx and Hispanic populations have comprised 2.31%. Patients from all other racial and ethnic groups accounted for less than 1%. Additionally, 1.13% of patients were classified as "other" or "unknown."

- Terminal cancer accounts for the vast majority of qualifying diagnoses (67.7%), with neurodegenerative diseases such as ALS or Huntington's disease following as the second-leading diagnosis (11.2%). In recent years, many jurisdictions have seen growing numbers of patients with cardiovascular diseases seeking medical aid in dying.
- Over 79% of people who use medical aid in dying are able to die at home. According to various studies, that is the preference of most Americans.[14]
- Differences in data collection and reporting among jurisdictions do not allow for thorough comparisons of the use of medical aid in dying across the United States.
- Increased access to medical aid in dying is observed in jurisdictions that have improved their laws by removing residency requirements, adjusting waiting periods and waivers, and allowing advanced practice registered nurses (APRNs, including nurse practitioners) and other qualified healthcare providers to participate. This change is observed across years of increased access to medical aid in dying in California, Colorado, Hawaii, Oregon, and Washington, beginning in 2018 with the amendment to Oregon's law.

[14] Riutta, S., Puig, N., & Wankowski, D. (2024). Documenting and Honoring Preferred Place of Death in Oncology Hospice Patients. *The Annals of Family Medicine*, *22*(1), 6887. https://doi.org/10.1370/afm.22.s1.6887; Pinto, S., et al. (2024). Patient and Family Preferences About Place of End-of-Life Care and Death: An Umbrella Review. *Journal of Pain and Symptom Management*, *67*(5). https://doi.org/10.1016/j.jpainsymman.2024.01.014.

Authorized Jurisdiction (a)(b)	Oregon	Washington	Vermont	California	Colorado	Washington, DC	Hawaii	New Jersey	Maine	Cumulative
Date Effective	Oct 27, 1997	Mar 5, 2009	May 20, 2013	Jun 9, 2016	Dec 16, 2016	Feb 18, 2017	Jan 1, 2019	Aug 1, 2019	Jun 12, 2019	
Law	Death with Dignity Act	Death with Dignity Act	Patient Choice at the End of Life Act	End of Life Option Act	End-of-Life Options Act	Death With Dignity Act	Our Care, Our Choice Act	Medical Aid in Dying for the Terminally Ill Act	Death With Dignity Act	
Data Period	1997 - 2024	2009 - 2023	2013 - 2025	2016 - 2024	2017 - 2024	2017 - 2022	2019 - 2024	2019 - 2024	2019 - 2024	1997 - 2024
Total Years Effective as of 1/1/2026	28	16	12	9	9	8	7	6	6	28
Summary Data										
Individuals who received prescriptions (written or filled) (c)	4,881	3,704	390	8,242	1,995	31	361	443	318	20,365
Individuals who were dispensed medication (c)		3,704			1,458			443		5,605
Individuals who died after ingesting (a)	3,243	2,768	294	5,423		23	195	409	218	12,573
Individuals who died without having ingested or died from other causes	953	409	80	1,062		8	27	33	70	2,642
Individuals who ingested medication in a calendar year following their prescription's written date	303			282						585
Individuals whose ingestion status is unknown	741	361	16	1,450			24	11	16	2,619
Individuals who received prescriptions and for whom a death certificate was subsequently registered (d)		3,570	378		1,825		299		288	6,360
Unique providers who prescribed the medication (e)	168	207		341	288	4	21			1,029
Prescription rate per provider (f)	2.10	1.73		3.20	3.27	1.60	3.69			2.60
Unique pharmacists who dispensed the medication (e)		68			37					105
Characteristics/Demographics										
Gender (h)										
Female	1,522 46.93%	1,686 47.43%		2,661 49.07%	937 51.34%	13 54.17%	79 40.51%	198 48.41%	27 54.00%	7,123 48.38%
Male	1,721 53.07%	1,869 52.57%		2,762 50.93%	888 48.66%	11 45.83%	115 58.97%	211 51.59%	23 46.00%	7,600 51.62%
Other										
Unknown							1 0.51%	0 0.00%		1 0.01%
Total	**3,243 100.0%**	**3,555 100.0%**		**5,423 100.0%**	**1,825 100.0%**	**24 100.0%**	**195 100.0%**	**409 100.0%**	**50 100.0%**	**14,724 100.0%**
Age Breakdown										
18-64	721 22.23%	809 22.72%			414 22.68%	9 36.00%	24 15.29%	100 24.45%	25 20.83%	2,102 22.51%
65-74	988 30.47%	1,122 31.52%			557 30.52%	6 24.00%	51 32.48%	86 21.03%	33 27.50%	2,843 30.44%
75-84	947 29.20%	956 26.85%			510 27.95%	6 24.00%	57 36.31%	138 33.74%	42 35.00%	2,656 28.44%
85+	587 18.10%	673 18.90%			344 18.85%	4 16.00%	25 15.92%	85 20.78%	20 16.67%	1,738 18.61%
Total	**3,243 100.0%**	**3,560 100.0%**			**1,825 100.0%**	**25 100.0%**	**157 100.0%**	**409 100.0%**	**120 100.0%**	**9,339 100.0%**
Age Breakdown (CA)										
Under 60				503 9.28%						503 9.28%
60-69				1,032 19.03%						1,032 19.03%
70-79				1,689 31.15%						1,689 31.15%
80-89				1,379 25.43%						1,379 25.43%
90+				820 15.12%						820 15.12%
Total				**5,423 100.0%**						**5,423 100.0%**

Authorized Jurisdiction (a)(b)	Oregon		Washington		Vermont	California		Colorado		Washington, DC		Hawaii		New Jersey		Maine		Cumulative	
Age Median & Range																			
Median	73					77		74						72				73	
Range	21-102		20 - 101			23-107						44-101		19-100		31-101		19-107	
Race/Ethnicity (i)																			
Asian	57	1.76%	65	1.84%		344	6.34%					30	19.11%	19	4.65%			515	3.51%
Asian/Native American/Pacific Islander							0.00%	29	1.59%									29	0.20%
Black	5	0.15%				46	0.85%	9	0.49%	1	4.35%			3	0.73%			64	0.44%
Hawaiian, Pacific Islander	2	0.06%				8	0.15%					9	5.73%	0	0.00%			19	0.13%
Indigenous American, American Indian, Alaskan Native	11	0.34%				13	0.24%	3	0.16%					0	0.00%			27	0.18%
Latinx, Hispanic	48	1.48%				222	4.09%	55	3.01%	1	4.35%	5	3.18%	7	1.71%			338	2.31%
Multi-race (two or more races)	12	0.37%				33	0.61%					5	3.18%	0	0.00%			50	0.34%
Non-white, Hispanic and/or Non-white			20	0.57%														20	0.14%
Other, Unknown	17	0.52%	108	3.06%		19	0.35%	15	0.82%			5	3.18%	2	0.49%			166	1.13%
White	3,091	95.31%	3,338	94.53%		4,738	87.37%	1,714	93.92%	21	91.30%	103	65.61%	378	92.42%	49	100.0%	13,432	91.62%
Total	**3,243**	**100.0%**	**3,531**	**100.0%**		**5,423**	**100.0%**	**1,825**	**100.0%**	**23**	**100.0%**	**157**	**100.0%**	**409**	**100.0%**	**49**	**100.0%**	**14,660**	**100.0%**
Education (j) (k)																			
High School Diploma, GED, or Less	884	27.26%	886	25.09%		1,254	23.12%	426	23.34%	0	0.00%	21	13.38%	123	30.07%	16	23.88%	3,610	24.59%
Some College	632	19.49%	1,609	45.57%		951	17.54%	250	13.70%	1	4.00%	11	7.01%	30	7.33%	9	13.43%	3,493	23.79%
Associate's, Bachelor's, Master's, Doctorate or Professional Degree	1,700	52.42%	1,007	28.52%		3,172	58.49%	1,138	62.36%	22	88.00%	67	42.68%	256	62.59%	43	64.18%	7,405	50.44%
Unknown	27	0.83%	29	0.82%		46	0.85%	11	0.60%	2	8.00%	58	36.94%	0	0.00%	0	0.00%	173	1.18%
Total	**3,243**	**100.0%**	**3,531**	**100.0%**		**5,423**	**100.0%**	**1,825**	**100.0%**	**25**	**100.0%**	**157**	**100.0%**	**409**	**100.0%**	**67**	**100.0%**	**14,681**	**100.0%**
Marital Status																			
Married, Domestic Partner	1,459	44.99%	1,632	46.22%				837	45.86%					202	49.39%			4,130	45.85%
Widowed	693	21.37%	708	20.05%				375	20.55%					107	26.16%			1,883	20.90%
Divorced, Separated	818	25.22%	865	24.50%				463	25.37%					66	16.14%			2,212	24.56%
Never Married, Single, Other, Unknown	273	8.42%	326	9.23%				150	8.22%					34	8.31%			783	8.69%
Total	**3,243**	**100.0%**	**3,531**	**100.0%**				**1,825**	**100.0%**					**409**	**100.0%**			**9,008**	**100.0%**
End-of-Life Care																			
Hospice and/or Palliative Care																			
Enrolled	2,924	90.16%	1,010	83.13%		4,985	91.92%	1,535	84.11%			130	97.01%					10,584	89.39%
Not Enrolled	285	8.79%	151	12.43%		373	6.88%											809	6.83%
Unknown	34	1.05%	54	4.44%		65	1.20%	2	0.11%			4	2.99%					159	1.34%
Not under hospice care or unknown								288	15.78%									288	2.43%
Total	**3,243**	**100.0%**	**1,215**	**100.0%**		**5,423**	**100.0%**	**1,825**	**100.0%**			**134**	**100.0%**					**11,840**	**100.0%**

Authorized Jurisdiction (a)(b)	Oregon		Washington		Vermont		California		Colorado		Washington, DC		Hawaii		New Jersey		Maine		Cumulative	
Insurance (l)																				
Private/Commerical		0.00%	296	8.70%			684	12.61%			12	48.00%	21	13.38%					1,013	8.27%
Medicare, Medicaid, and/or Other Governmental		0.00%	774	22.74%			150	2.77%			10	40.00%	48	30.57%					982	8.02%
Combination of Governmental and Private/Commercial			196	5.76%			2,982	54.99%					62	39.49%					3,240	26.45%
Insured (unspecified)	975	30.06%	1,416	41.61%			1,355	24.99%					10	6.37%					3,756	30.66%
None, Other, Unknown	2,268	69.94%	721	21.19%			252	4.65%			3	12.00%	16	10.19%					3,260	26.61%
Total	**3,243**	**100.0%**	**3,403**	**100.0%**			**5,423**	**100.0%**			**25**	**100.0%**	**157**	**100.0%**					**12,251**	**100.0%**
Underlying Illness (m)(n)																				
Cancer, Malignant Neoplasms	2,244	69.20%	2,496	73.30%	275	70.51%	3,590	66.20%	1,195	59.90%	20	74.07%	152	70.37%	256	62.59%	166	66.40%	10,394	67.68%
Neurological Disease	370	11.41%	308	9.05%	48	12.31%	546	10.07%	302	15.14%	4	14.81%	23	10.65%	81	19.80%	34	13.60%	1,716	11.17%
Respiratory Disease	213	6.57%	227	6.67%	15	3.85%	363	6.69%	179	8.97%	1	3.70%	16	7.41%	23	5.62%	18	7.20%	1,055	6.87%
Cardiovascular, Circulatory Disease	249	7.68%	218	6.40%	8	2.05%	552	10.18%	183	9.17%	2	7.41%	17	7.87%	34	8.31%	18	7.20%	1,281	8.34%
Other illnesses	167	5.15%	156	4.58%	44	11.28%	372	6.86%	136	6.82%	0	0.00%	8	3.70%	15	3.67%	14	5.60%	912	5.94%
Total	**3,243**	**100.0%**	**3,405**	**100.0%**	**390**	**100.0%**	**5,423**	**100.0%**	**1,995**	**100.0%**	**27**	**100.0%**	**216**	**100.0%**	**409**	**100.0%**	**250**	**100.0%**	**15,358**	**100.0%**
MAID Process																				
Place of Death/Where Medication Ingested																				
Private Home, Residence	2,944	90.78%	1,069	40.85%			4,832	89.10%	1,494	81.86%					381	93.15%			10,720	79.31%
Hospice Facility	21	0.65%					73	1.35%	66	3.62%					17	4.16%			177	1.31%
Hospital, Acute Care Hospital	11	0.34%	1	0.04%			8	0.15%	23	1.26%									43	0.32%
Long Term Care, Assisted Living, Foster Care Facility	185	5.70%	99	3.78%			335	6.18%								0.00%			619	4.58%
Nursing Home	23	0.71%					110	2.03%	145	7.95%					10	2.44%			288	2.13%
Other, Unknown	59	1.82%	1,448	55.33%			65	1.20%	97	5.32%					1	0.24%			1,670	12.35%
Total	**3,243**	**100.0%**	**2,617**	**100.0%**			**5,423**	**100.0%**	**1,825**	**100.0%**					**409**	**100.0%**			**13,517**	**100.0%**
Patient Informed Family of Decision																				
Yes	2,951	91.00%	1,353	42.83%			4,589	84.62%											8,893	75.21%
No, No Family to Inform	292	9.00%					182	3.36%											474	4.01%
Unknown			1,806	57.17%			652	12.02%											2,458	20.79%
Total	**3,243**	**100.0%**	**3,159**	**100.0%**			**5,423**	**100.0%**											**11,825**	**100.0%**

See endnotes on next page

Endnotes

(a) Incomplete Data: In certain jurisdictions, not all data forms and documentation of death were returned prior to the publishing of the most recent report. Further, some individuals will receive their prescription later in a previous calendar year but not ingest the medication until the next calendar year. Some jurisdictions correct this data in later reports, others do not or do not do so in totality. Accordingly, slight variations may occur in numbers from year to year. For further information, please consult the specific jurisdictional reports.

(b) Maine: During the first three years of authorization in ME, data was mostly released in graphs without exact labeled data points. As of 2022, ME has begun labelling the data points. Accordingly, many of the data points from ME's first three years of authorization are not captured here.

(c) Prescriptions & Medication: Some jurisdictions only report the number of prescriptions dispensed. To obtain a minimum aggregate count across all jurisdictions and years, we assumed that a prescription had to have been written in order to be dispensed, and that a prescription had to have been written and dispensed in order to have been ingested. Due to the jurisdictions that only report dispensal and our method of aggregation, the number of prescriptions written, filled, or dispensed is invariably higher than the data shows.

(d) Death Certificates: It is important to note that these statistics reflect all deaths identified among individuals prescribed aid-in-dying medication, whether or not they used this medication, and irrespective of whether their death was caused by ingestion of medication, the underlying terminal illness or condition, or some other cause.

(e) Unique Providers/Pharmacists: The only jurisdictions that report an aggregate total number of unique providers across all years are Oregon and Colorado. Other jurisdictions only report the number of unique providers in a single year. Therefore, to arrive at a minimum aggregate count across all jurisdictions, we used the largest number of unique pharmacists/physicians in a jurisdiction across any single year for the aggregate number of unique physicians/pharmacists where necessary.

(f) Prescription Rate Per Provider: This number is our own calculation and is not reported by any jurisdiction: individuals who received prescriptions (written or filled) ÷ unique physicians who prescribed medication = prescription rate per provider. To arrive at an aggregate prescription rate per provider for each jurisdiction, we averaged the prescription rate per provider across all years for each jurisdiction.

(h) Gender: All jurisdictions that report data do so in categories of only "male" and "female," which excludes transgender, non-binary, and gender non-comformative individuals. Though Compassion & Choices does not agree with this approach, our reporting reflects jurisdictional categorization.

(i) Racial/Ethnic Demographics: Though Compassion & Choices does not agree with the way this demographic data is presented, we are not involved in the reporting categorization process in any jurisdiction and must present the data as it is reported.

(j) Education - Oregon: For Oregon's data from 1998-2002, "high school grad/some college" was recorded as "high school diploma or GED or less."

(k) Education - Washington: For 2019-2021, "some college" also includes patients holding collegiate degrees or higher.

(l) Insurance: While jurisdictions report whether or not a patient had insurance, no data is collected on whether insurance actually covered or reimbursed for medical aid in dying.

(m) Underlying Illness: More than one illness may be reported, and some jurisdictions do not provide information for how illness is reported. Therefore, the number of total illness will vary from the total number of patients utilizing medical aid in dying.

(n) Underlying Illness - Hawaii: In 2023, Hawaii began publishing Underlying Illness data for patients who died after taking a medication for aid in dying along with data for patients who received a prescription but died from other causes. From 2019-2022, Hawaii only published Underlying Illness data for patients who took the medication. For consistency across all years, we include only the patients who took the medication.

Appendix: Medical Aid in Dying Authorization Information

Jurisdiction	Law / Court Case	Authorization Date	Authorization Mechanism	Effective Date	Data Period	Years Effective as of 1/1/2026
Oregon	Death with Dignity Act	Nov 8, 1994	Ballot Initiative	Oct 27, 1997*	1997 - 2024	28
Washington	Death with Dignity Act	Nov 4, 2008	Ballot Initiative	Mar 5, 2009	2009 - 2023	16
Montana	*Baxter v. Montana*	Dec 31, 2009	MT Supreme Court	Dec 31, 2009	n/a	16
Vermont	Patient Choice at the End of Life Act	May 20, 2013	Legislation	May 20, 2013	2013 - 2022	12
California	End of Life Option Act	Oct 5, 2015	Legislation	June 9, 2016**	2016 - 2024	9
Colorado	End-of-Life Options Act	Nov 8, 2016	Ballot Initiative	Dec 16, 2016	2017 - 2024	9
Washington, D.C.	Death With Dignity Act	Dec 20, 2016	Legislation	Feb 18, 2017	2017 - 2022	8
Hawaii	Our Care, Our Choice Act	Apr 5, 2018	Legislation	Jan 1, 2019	2019 - 2024	7
New Jersey	Medical Aid in Dying for the Terminally Ill Act	Apr 12, 2019	Legislation	Aug 1, 2019	2019 - 2024	6
Maine	Death With Dignity Act	Jun 12, 2019	Legislation	Jun 12, 2019	2019 - 2024	6
New Mexico	End-of-Life Options Act	Jun 18, 2021	Legislation	Jun 18, 2021	n/a	4
Delaware	End of Life Option Act	May 20, 2025	Legislation	Jan 1, 2026	n/a	0
Illinois	End-of-Life Options for Terminally Ill Patients Act	Dec 12, 2025	Legislation	Sept 2026	n/a	0
New York	Medical Aid in Dying Act	Feb 6, 2026***	Legislation	Aug 5, 2026	n/a	0

Notes:

* Oregon's Death with Dignity Act was passed by ballot initiative in 1994. Shortly thereafter, Lee v. Oregon was filed, challenging the law and putting a halt on implementation. The case was dismissed in February 1997, and the law went into effect on October 27, 1997.

** Access to California's End of Life Option Act was temporarily interrupted when, at a hearing on May 15, 2018, the Court ruled that the End of Life Option Act was unconstitutional because it was passed outside the scope of the special legislative session. The Act was reinstated on June 1, 2018, when Compassion & Choices filed its Notice of Appeal, however, many clinicians were unsure of the legal status of the law until July 18, 2018, when the California Court of Appeals issued its opinion on the matter.

*** New York Senate Bill 138 / Assembly Bill 136 was passed by the legislature on June 9, 2025. In December 2025, the Governor announced her intention to sign with chapter amendments. On February 6, 2026, the Governor signed the law with amendments.