compassion & choices
Care and Choice at the End of Life

Medical Aid in Dying:
A Policy to Improve Care and Expand Options at Life's End

2025 Edition

January 2025

When crafting medical aid-in-dying legislation, lawmakers have nearly three decades of data and experience from authorized jurisdictions to guide them. This includes robust research, patient perspectives, and insights from healthcare providers. Medical aid in dying allows terminally ill, mentally capable adults with a prognosis of six months or less to request a prescription for medication they can self-administer to peacefully end their suffering.

With nearly 30 years of data from Oregon and 10 additional jurisdictions, the outcomes of authorizing medical aid in dying are well-documented. The evidence is clear: this practice protects patients, upholds individual autonomy, and improves the quality of end-of-life care. Moreover, medical aid in dying has consistently enjoyed broad public support. More than seven in ten people support this compassionate option, with majority support across virtually every U.S. demographic group. A 2021 national survey found that voters are more likely to support State Legislature candidates who champion medical aid-in-dying legislation.

Lawmakers in authorized jurisdictions have seen the benefits of these laws firsthand and are working to refine them by removing unnecessary barriers while maintaining safeguards. Nine of the 11 jurisdictions, including Oregon, have improved access by addressing procedural obstacles such as lengthy waiting periods and residency requirements.

States without medical aid in dying laws deny terminally ill patients a compassionate option, forcing many to endure unnecessary suffering. Lawmakers have the opportunity to move beyond outdated debates and bring relief to their constituents through thoughtful, evidence-based legislation.

This resource provides up-to-date, data-driven insights on medical aid in dying and addresses the most common questions, concerns, and hypothetical scenarios. It is offered in the spirit of partnership, with the hope that together we can build on the successes of authorized jurisdictions to pass legislation that respects patient directed medical care at the end of life.

Thank you for your attention to this vital issue, which transcends partisanship and embodies compassion and personal autonomy. Compassion & Choices stands ready to support your efforts to expand access to end-of-life care, empowering individuals to make decisions aligned with their values. Together, we can create policies that honor choice at the end of life.

If you have any questions or require additional information, please contact Bernadette Nunley, National Director of Policy, at policy@compassionandchoices.org. We look forward to collaborating with you to achieve meaningful progress on this vital issue.

Sincerely,

Kevin Díaz
Interim President and CEO
Compassion & Choices

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Section I: Introduction

Compassion & Choices is the nation's oldest, largest and most active nonprofit working to improve care, expand options and empower everyone to make informed decisions about their own end-of-life journey. For more than 40 years, Compassion & Choices and its sister organization, the Compassion & Choices Action Network, have worked nationwide to raise the voices of those nearing the end of life and to change attitudes, practices and policies so that everyone can access the full range of care options to direct and receive end-of-life healthcare that is consistent with their values and priorities. Compassion & Choices and our predecessor organizations have been at the forefront of advancing end-of-life autonomy in the United States. As the leaders in this arena, we want to ensure that you have all of the necessary information to draft informed legislation and take a proactive stance on medical aid in dying.

Medical aid in dying is the preferred term for the end-of-life care option by which a mentally capable, terminally ill adult with six months or less to live requests a prescription from their healthcare provider for medication that they can choose to self-ingest.[1] *Authorizing medical aid in dying provides terminally ill people with an additional end-of-life care option that may align with their values and priorities*.

We recognize that medical aid in dying can seem like a complex issue, but with almost 30 years of experience since the first such law was enacted in Oregon and decades of cumulative experience from all authorized jurisdictions, this compassionate option has proven not only to protect patients, but to improve care across the end-of-life spectrum.

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[1] While both the United States and Canada use the acronym MAID, U.S. "medical aid-in-dying" laws differ fundamentally from Canadian laws. In Canada, the definition of "medical assistance in dying,", the legal landscape, the Canadian healthcare system, and quality of care are not the same as in the U.S. Also, in Canada, euthanasia is allowed. To contrast, euthanasia is illegal in every U.S. state, and the core eligibility criteria for U.S. medical aid-in-dying laws have remained the same since Oregon implemented the nation's first medical aid-in-dying law in 1997.

Section II: Legislative Overview

Medical aid in dying refers to a practice in which a mentally capable, terminally ill adult may request a prescription from their healthcare provider for a medication that they can choose to ingest to die peacefully. The multi-step process, strict eligibility criteria and other safeguards embedded in medical aid-in-dying laws ensure that anyone pursuing the option is protected.

Eligibility Criteria, Core Safeguards and Established Process

Existing laws authorizing medical aid in dying in the U.S. establish strict eligibility criteria and practice requirements to ensure the highest standard of care, as described in the clinical criteria and guidelines published in the prestigious peer-reviewed Journal of Palliative Medicine.[2] To be eligible for aid-in-dying medication, a person must be:

- An adult (aged 18 or older).
- Terminally ill with a prognosis of six months or less to live.
- Mentally capable of making their own healthcare decisions.
- Able to self-administer the medication through an affirmative, conscious, voluntary act to ingest it.
  - Self-administration does not include injection or infusion via a vein or any other parenteral route by any person, including the healthcare provider, family member or patient themselves.

> Advanced age, disability and chronic health conditions alone are not qualifying factors for medical aid in dying eligibility.

In addition to the strict eligibility criteria, these laws include the following core safeguards:

- The attending healthcare provider must inform the terminally ill adult requesting medical aid in dying about all appropriate end-of-life care options. These other options include comfort care, hospice care, pain control and palliative care.
- The attending healthcare provider must inform the terminally ill adult requesting medical aid in dying that they can change their mind at any time, which includes deciding not to take the medication once they have obtained it.

These safeguards ensure that individual patient preferences, needs and values are honored and guide all clinical decisions, including the decision to use medical aid in dying.

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[2] *Clinical Criteria for Physician Aid in Dying.* Journal of Palliative Medicine; D. Orentlicher, T.M. Pope, B.A. Rich, (2015). Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4779271/

Additional Statutory Requirements

The U.S. jurisdictions that have authorized medical aid in dying through legislation modeled their bills after Oregon's Death With Dignity Act, with newer laws reflecting lessons learned. Jurisdictions' regulatory and procedural requirements are slightly different, but each requires the following:

- The terminally ill adult must make at least one request to their attending healthcare provider.
- The written request must be witnessed by at least one person who cannot be a relative or someone who stands to benefit from the person's estate upon their death.
- At least one healthcare provider must confirm the terminal diagnosis, prognosis of six months or less to live and the person's ability to make an informed healthcare decision prior to the attending healthcare provider writing a prescription.
- If a healthcare provider determines an individual may not be capable of making an informed decision, then the individual is required to undergo an additional mental capacity evaluation with a mental health professional (such as a psychiatrist, psychologist, licensed clinical social worker, psychiatric nurse practitioner or licensed clinical professional counselor). The request for aid-in-dying medication cannot proceed unless the mental healthcare professional affirms that the individual is capable of making an informed decision.
- Medical aid in dying laws are subject to all applicable state and federal laws and regulations, including those that require assistance to those who may require additional support to understand and navigate the process (for example language interpretation for patients who may not be able to read or speak English).

Voluntary Participation

The laws balance a patient's need to receive the information they are requesting while also respecting and establishing clear boundaries for healthcare providers who are unwilling or unable to participate in the medical aid-in-dying process. Each law also explicitly states healthcare provider participation is voluntary and that no provider is obligated to prescribe or dispense aid-in-dying medication. Further, federal law protects an individual's right to transfer their medical records to an alternate provider if their regular healthcare provider(s) opt out or cannot support them in the care option.[3] Generally, if the person requests that their healthcare provider transfer their medical records to an alternate healthcare provider, their healthcare provider is legally required to do so within a reasonable amount of time. Additionally, a healthcare provider must document the request for medical aid in dying in the patient's record.

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[3] *Health Insurance Portability and Accountability Act, Access of individuals to protected health information*, 45 CFR § 164.524 (2022) Available from: https://www.govinfo.gov/content/pkg/CFR-2011-title45-vol1/pdf/CFR-2011-title45-vol1-sec164-524.pdf

The laws ensure there is no risk for healthcare providers by providing explicit authorization for those who choose to participate (or not to participate) under the law. Qualified healthcare providers are protected from criminal liability, civil liability, and professional discipline, whether or not they choose to participate in medical aid in dying, provided they comply with legal requirements, act in good faith, and meet established medical standards of care. Similar immunities and protections are extended to other healthcare providers (such as mental health professionals and pharmacists) and caregivers of the terminally ill person.

Liability for Violating the Law

While those who comply with all aspects of the law and meet the standard of care are provided immunity from certain criminal prosecution (e.g., homicide, assisting suicide or elder abuse) or civil lawsuits (such as malpractice), the jurisdictions retain the ability to hold those who fail to adhere to these strict requirements and medical care standards criminally and civilly liable. Moreover, the existing laws establish that any attempt to pressure or coerce someone to request or use medical aid in dying is a felony.

Section III: A Solid Body of Evidence

Research has confirmed the experience across authorized jurisdictions that medical aid in dying protects patients and providers, affords dying people autonomy and improves end-of-life care. Support for medical aid in dying is growing among providers, patients, community members, and national groups.

A 2022 sample of Colorado physicians showed that many are willing and prepared to discuss medical aid in dying with patients and to provide referrals.[4] A 2022 survey of nurses in the United States showed that 49% would personally support the concept of medical aid in dying and 57% would support it professionally.[5] Furthermore, a 2023 national poll from Susquehanna Polling & Research showed that nearly 8 out of 10 of U.S. residents (79%) with a disability agree that medical aid in dying "should be legal for terminally ill, mentally capable adults who chose to self-ingest medication to die peacefully."[6]

Furthermore, a 2024 study found that while providers may initially feel unsure about medical aid in dying, their experiences often change after participating in a medical aid in dying case. Specifically, after having written an aid-in-dying prescription, 96% of clinicians reported that they were "hardly" or "not at all" morally conflicted.[7] Another study found that among consulting and attending physicians caring for patients who requested medical aid in dying, 75.5% felt their most recent case was emotionally fulfilling and professionally rewarding.[8]

Finally, another study looked at the impact of legalizing medical aid in dying on patient trust and found that legalizing medical aid in dying does not undermine patient trust in the medical profession. [9]

The evidence is clear: Medical aid-in-dying laws protect terminally ill individuals while giving them access to the full range of end-of-life options. The laws also provide appropriate legal protection for providers.

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[4] *Physicians' Attitudes and Experiences with Medical Aid in Dying in Colorado: a "Hidden Population" Survey*.Campbell EG, Kini V, Ressalam J, Mosley BS, Bolcic-Jankovic D, Lum HD, Kessler ER, DeCamp M. (2022) Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8751472/

[5] J Hosp Palliat Nurs. 2022 Feb 1. Nurses' Values and Perspectives on Medical Aid in Dying: A Survey of Nurses in the United States. A cross-sectional electronic survey was sent to American Nurses Association nurse members; 2390 responded; 2043 complete data sets were used for analysis. Accessed at: https://pubmed.ncbi.nlm.nih.gov/34840280/

[6] USA/National Public Opinion Survey of 1,004 respondents - Cross Tabulation Report, February 2023. Accessed at: https://bit.ly/SPRNatDisabilityPoll2023

[7] Pottash M, Saikaly K, Stevenson M, Krohmal B. *A Survey of Clinicians Who Provide Aid in Dying.* American Journal of Hospice and Palliative Medicine®. 2024;41(9):1045-1050. https://doi.org/10.1177/10499091231205841

[8] Campbell EG, Kini V, Ressalam J, et al. *Physicians' attitudes and experiences with medical aid in dying in Colorado: a "hidden population" survey*. J Gen Intern Med. 2022;37(13):3310-3317. https://doi.org/10.1007/s11606-021-07300-8

[9] Anderson, J. B., Cacciapuoti, M., Day, H., Taymour Hashemzadeh, & Krohmal, B. J. (2024). The Impact of *Legalizing Medical Aid in Dying on Patient Trust: A Randomized Controlled Survey Study. Journal of Palliative Medicine*. https://doi.org/10.1089/jpm.2023.0706

Medical Aid in Dying Protects Patients

A 2015 report from the Journal of the American Academy of Psychiatry and Law noted, “There appears to be no evidence to support the fear that [medical aid in dying] disproportionately affects vulnerable populations.” Vulnerable populations include the elderly, women, the uninsured, people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnic minorities, compared with background populations.[10]

Relatively Few Will Utilize Medical Aid in Dying, But Many Benefit From These Laws

People who utilize medical aid in dying account for less than 1% of annual deaths.[11] That said, the laws benefit more than the small number of people who ultimately decide to self-ingest the medication. In the jurisdictions that have already authorized medical aid in dying, people report significant relief from worry about future physical and emotional pain just from knowing the option is there, regardless of whether or not they choose to pursue it.[12] A 2022 article showed that access to medical aid in dying helped terminally ill people prepare for death and provided a sense of autonomy for their loved ones. Being able to support a patient’s wishes helped with the grieving process of those left behind.[13]

Medical Aid in Dying Improves End-of-Life Care

Oregon has long been at the forefront of end-of-life care, leading the nation in development of patient-directed practices, adherence to advance directives and hospice utilization. In fact, Oregon boasts among the highest number of people who die in their own homes rather than in hospitals.[14] The experience and data demonstrate that the implementation and availability of

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[10] *Physician-Assisted Suicide: Considering the Evidence, Existential Distress, and an Emerging Role for Psychiatry.* Journal of the American Academy of Psychiatry and the Law. Gopal, AA. 2015. Vol 43(2): 183-190. Available from http://jaapl.org/content/43/2/183.

[11] According to the Center for Disease Control, in 2021 in jurisdictions that authorized medical aid in dying, 622,035 people died in total. In 2021, authorized jurisdictions report 1,216 people died after being provided with a prescription for medical aid in dying – less than 0.002% of total deaths in 2019. Murphy, S., Kochanek, K., et al. (2024). (rep.). *Deaths: Final Data for 2021*. National Vital Statistics Report, 73(8). https://www.cdc.gov/nchs/data/nvsr/nvsr73/nvsr73-08.pdf.

[12] Shelby Marcuse. Compassion & Choices. (2023). https://www.compassionandchoices.org/stories/shelby-marcuse; Rita Florea. Compassion & Choices (2022). https://www.compassionandchoices.org/stories/rita-florea

[13] Singer, J., Daum, C., Evans, A., Schneider, S., Vugrin, M., & Loggers, E. (2023). *An examination and proposed theoretical model of risk and protective factors for bereavement outcomes for family members of individuals who engaged in medical aid in dying: A systematic review.* Palliative medicine, 37(7), 947–958. Available from: https://doi.org/10.1177/02692163231172242

[14] *Lessons from Oregon in Embracing Complexity in End-of-Life Care*. New England Journal of Medicine, S.W. Tolle, MD, J.M. Teno, MD, (2017). Available from: https://www.nejm.org/doi/10.1056/NEJMsb1612511

medical aid in dying further promote these practices and improve other aspects of end-of-life care.[15]

- A 2001 survey of physicians about their efforts to improve end-of-life care following authorization of the Oregon Death With Dignity Act showed 30% of responding physicians had increased the number of referrals they provided for hospice care, and 76% made efforts to improve their knowledge of pain management.[16]
- A 2015 Journal of Palliative Medicine study found that Oregon was the only state both in the highest quartile of overall hospice use and the lowest quartile for potentially concerning patterns of hospice use.[17] "Concerning patterns of hospice use" is defined as very short enrollment, very long enrollment or disenrollment. This same study suggested its medical aid-in-dying law may have contributed to more open conversations between doctors and patients about end-of-life care options, which led to the more appropriate hospice use.
- Hospice programs across Oregon, in fact, reported an increase in referrals following passage of the Oregon Death With Dignity Act.[18] Over 20 years later, according to a 2023 article in the Voices in Bioethics, more than 90% of those who used medical aid in dying were receiving hospice services at the time of their death.[19]
- Additionally, research shows that most patients who request medical aid in dying actively pursue palliative care, enroll in hospice and subsequently have good symptomatic relief.[20]

For Some, Comfort Care and Pain Management Are Not Enough to Relieve Suffering

Evidence from scientific studies confirms that despite the wide availability of hospice and palliative medicine, many patients experience pain at the end of life. One study found that the

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[15] *Oregon's Assisted Suicide Vote: The Silver Lining*. Annals of Internal Medicine, M.A. Lee, S.W. Tolle, (1996). Available from: https://www.acpjournals.org/doi/10.7326/0003-4819-124-2-199601150-00014?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed

[16] *Oregon Physicians' Attitudes About and Experiences With End-of-Life Care Since Passage of the Oregon Death with Dignity Act.* JAMA. L. Ganzini, H.D. Nelson, M.A. Lee, D.F. Kraemer, T.A. Schmidt, M.A. Delorit, (2001). Available from: https://pubmed.ncbi.nlm.nih.gov/11343484/

[17] *Geographic Variation of Hospice Use Patterns at the End of Life.* Journal of Palliative Medicine, S.Y. Wang, M.D, Aldridge, C.P. Gross, et al. (2015). Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4696438/

[18] *Id.*

[19] Hoffman, D. C., & Beer, E. (2023). *Have Arguments For and Against Medical Aid in Dying Stood the Test of Time? Voices in Bioethics*, *9.* https://doi.org/10.52214/vib.v9i.12079

[20] DeWolf, T., & Cazeau, N. (2022). *Medical Aid in Dying: An Overview of Care and Considerations for Patients With Cancer. Clinical journal of oncology nursing,* 26(6), 621–627. Available from https://doi.org/10.1188/22.CJON.621-627

prevalence of pain increases significantly at the end of life, jumping from 26% of patients experiencing pain in the last 24 months of life to 46% in the last four months of life.[21]

Additionally, breakthrough pain — severe pain that occurs even when a patient is already medicated — remains a nightmare experience for many. In the National Breakthrough Pain Study, among respondents who had cancer (at all stages), 83.3% reported breakthrough pain. For those cancer patients who experienced breakthrough pain, only 24.1% reported that using some form of pain management worked every time.[22]

For some people, the side effects of pain medication (sedation, nausea, obstructed bowels) are just as bad as the pain from their terminal illness. Even with pain medication, patients sometimes moan and grimace, suggesting pain may still be present. Many value their consciousness so highly that they bear extraordinary pain in order to be somewhat alert during their final days.

People Decide to Use Medical Aid in Dying for Many Reasons

What we hear directly from terminally ill people is that they decide to request medical aid in dying for multiple reasons all at once: pain and other symptoms such as breathlessness and nausea, loss of autonomy, and loss of dignity.[23] It is not any one reason, but rather it is the totality of what happens to one's body at the very end of life. For some people, the side effects of treatments such as chemotherapy or pain medication (sedation, relentless nausea, crushing fatigue, obstructed bowels, to name a few) are in addition to the agonizing symptoms of the disease. Others want the option of medical aid in dying so they can try another treatment with the peace of mind of knowing that if it results in unbearable suffering, they have a way to peacefully control an inevitable death..

Our experience aligns with years of data in Oregon and Washington, where doctors are asked to select from a pre-printed form the top reasons people decide to request aid-in-dying medication under the law. The most frequently reported end-of-life concerns for people in Oregon and Washington are loss of autonomy (87%), impaired quality of life (86%) and loss of dignity (69%).[24]

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[21] *The Epidemiology of Pain During the Last 2 Years of Life.* The Annals of Internal Medicine, A.K. Smith, I.S. Cenzer, S.J. Knight, K.A. Puntillo, E. Widera, B.A. Williams, W.J. Boscardin, K.E. Covinsky, (2010.) Available from: http://annals.org/aim/article/746344/epidemiology-pain-during-last-2-years-life

[22] *Impact of breakthrough pain on community-dwelling cancer patients: results from the National Breakthrough Pain Study.* Katz, N.P, Gajria, K.L, Shillington, A.C., et. al. (2016). Postgraduate Medicine, 129(1), 32-39. Available from: https://pubmed.ncbi.nlm.nih.gov/27846789/

[23] DeWolf, T., & Cazeau, N. (2022). *Medical Aid in Dying: An Overview of Care and Considerations for Patients With Cancer. Clinical journal of oncology nursing*, 26(6), 621–627. Available from: https://doi.org/10.1188/22.CJON.621-627

[24] Al Rabadi L, LeBlanc M, Bucy T, et al. *Trends in medical aid in dying in Oregon and Washington*. JAMA Network Open. 2019;2:1-7. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6692681/

The collective reasons total nearly 400%, which demonstrates that doctors are not selecting just one reason, but they are selecting multiple reasons.[25] Incidentally, the Oregon annual report indicates that doctors believe 34.3% of patients requested this option because of concerns about inadequate pain control, whereas concerns about finances were only noted for 8.2% of patients.[26]

Only the dying person can determine whether medical aid in dying is the right option for them. This law puts the decision in their hands, in consultation with their healthcare provider and those close to them, as it should be for such a deeply personal healthcare decision.

> “The last time I saw my partner, Jack, I could tell he was in so much pain despite the excellent hospice care he was receiving. I remember crying and Jack crying a little too. Jack was dying, imminently. There was no stopping that. But those final moments between us didn’t have to be wracked with pain. Jack could have avoided days of suffering if medical aid in dying were an option available to him. Instead, Jack suffered during his last days on earth. For what? I know that if I were in Jack’s shoes, with a terminal illness like cirrhosis of the liver, I would want the same option for myself. As someone living with a disability, I believe I should get to make my own decisions about what kind of medical care I receive when I reach the end of my life. No one else should get to make that decision.”
>
> – Verna O’Brien, Illinois advocate for medical aid in dying

People Want the Option of Medical Aid in Dying in Addition to Hospice and Palliative Care

Most people who request and obtain aid-in-dying medication are enrolled in hospice at the time of their death.[27]

Good hospice and palliative care do not eliminate the need for medical aid in dying. They are not mutually exclusive, and Compassion & Choices promotes the use of quality hospice care

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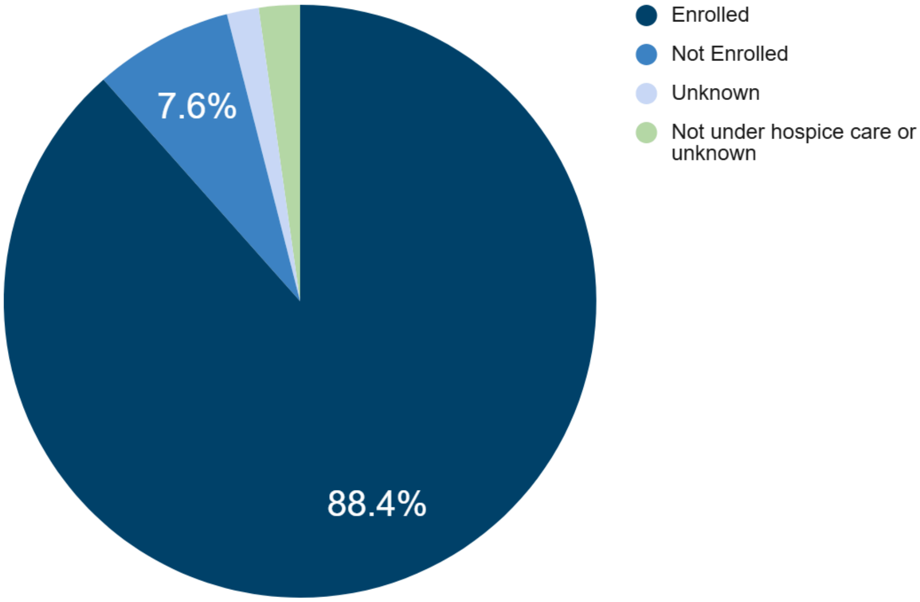
[25] *Id.*

[26] *Oregon Death with Dignity Act. Annual Report*, (2023). Available from: https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year26.pdf

[27] *Medical Aid-in-Dying Data Across Authorized States, 2025*. Compassion & Choices. Available from: https://compassionandchoices.org/resource/medical-aid-in-dying-utilization-report/; DeWolf, T., & Cazeau, N. (2022). *Medical Aid in Dying: An Overview of Care and Considerations for Patients With Cancer. Clinical journal of oncology nursing*, 26(6), 621–627. Available from: https://doi.org/10.1188/22.CJON.621-627

regardless of whether or not people want to pursue medical aid in dying. Terminally ill people should have a full range of end-of-life options, whether disease-specific treatment, palliative care, refusal or administration of life-sustaining treatment, hospice care, or medical aid in dying. The option of medical aid in dying puts the decision-making power where it belongs: with the dying person.

Hospice and Palliative Care Use Among Those Who Request Medical Aid in Dying*



*This graph reflects data from all jurisdictions that report on hospice use. Currently, public health departments in nine authorized jurisdictions have issued reports regarding the use of medical aid-in-dying laws: Oregon,[28] Washington,[29] Vermont,[30] California,[31] Colorado,[32] Hawai‘i,

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[28] *Oregon Death with Dignity Act Annual Reports* (1998-2023) Available from: https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ar-index.aspx

[29] *Washington Death with Dignity Data* (2009-2022). Available from: https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData

[30] *Vermont Report Concerning Patient Choice at the End of Life.* (2018-2022) Available from: https://www.healthvermont.gov/systems/end-of-life-decisions/patient-choice-and-control-end-life.

[31] *California End of Life Option Act Annual Report* (2016-2023) Available from: https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act-.aspx

[32] *Colorado End-of-Life Options Act Annual Report* (2017-2023) Available from: https://www.colorado.gov/pacific/cdphe/medical-aid-dying

[33] the District of Columbia,[34] Maine[35] and New Jersey.[36] More detailed reports can be provided upon request. Vermont, Washington, D.C., New Jersey, and Maine do not provide this data on hospice utilization in their reports on medical aid in dying. Montana authorized medical aid in dying through a court case, and a data report is not required by law.

Patients Involve Their Loved Ones in the Decision

Although not a requirement under existing laws, the majority of eligible patients involve their family in their decision-making process[37] and many share that they are able to spend their last moments surrounded by loved ones.

Evidence-Based Approach to Improve Access

The Oregon model, enacted in 1997, established the framework for all subsequent medical aid-in-dying laws. Its multistep process, however, can take several weeks or even months to complete. Too often, eligible individuals are unable to finish the process and obtain the prescription. In response to nearly three decades of evidence, nine of the 11 authorized jurisdictions have made key improvements to enhance access while maintaining strict eligibility criteria. These updates include:

1. **Reducing waiting periods** to prevent unnecessary delays for dying patients.
2. **Expanding eligible providers** to include advanced practice registered nurses (APRNs) and physician assistants, who are licensed to provide care similar to physicians.
3. **Removing residency requirements**, acknowledging that healthcare often crosses state lines.

These changes honor the original intent of the law by ensuring eligible patients can access this compassionate option more effectively. The following sections provide additional insights and lessons learned from these jurisdictions.

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[33] *Hawai'i Our Care, Our Choice Act Annual Report* (2019-2023) Available from: https://health.hawaii.gov/opppd/ococ/

[34] *District of Columbia Death with Dignity Act Annual Report* (2017-2022) Available from: https://dchealth.dc.gov/publication/death-dignity-annual-reports

[35] *Maine Death with Dignity Annual Report* (2019-2023) Available from: https://www.maine.gov/dhhs/data-reports/reports

[36] *New Jersey Medical Aid in Dying for the Terminally Ill Act Data Summary* (2019-2022) Available from: https://nj.gov/health/advancedirective/maid/

[37] Singer, J., Daum, C., Evans, A., Schneider, S., Vugrin, M., & Loggers, E. (2023). *An examination and proposed theoretical model of risk and protective factors for bereavement outcomes for family members of individuals who engaged in medical aid in dying: A systematic review. Palliative medicine*, 37(7), 947–958. Available from: https://doi.org/10.1177/02692163231172242

What the Data Demonstrates

Empirical and anecdotal data from Oregon and the other authorized jurisdictions suggests that medical aid in dying laws in the United States have significant procedural barriers for otherwise qualified dying patients to access the option, as indicated by the following examples:

> A study by Kaiser Permanente Southern California showed that one-third of patients who requested the option of medical aid in dying were unable to complete the process and obtain a prescription before they died. It's worth noting that Kaiser is a health system supportive of this practice, with dedicated patient navigators to assist people through the process.[38]

> Between 2019 and 2021, Hawaii's Department of Health's annual reports to the Legislature repeatedly found that some of the well-intentioned regulatory requirements outlined in the state's Our Care, Our Choice Act created unintended barriers for terminally ill patients. The 2021 report detailed that the 49 patients who died under the law endured an average waiting period of 41 days.[39] As part of all three annual reports, the Department made two recommendations to the Legislature: (1) adopt an Oregon-style amendment allowing doctors to waive the waiting period for patients whose death is imminent; and (2) give APRNs the authority to serve as attending providers under the law.[39]

> At a National Academy of Sciences two-day assisted-death conference in 2018, many speakers — including physicians, ethicists and scholars — concluded that the biggest problem with the law was not one of abuse or coercion; it was that the process is just too cumbersome for patients to get through.[40]

Unfortunately, many people die while attempting to navigate an unnecessarily burdensome process. Several factors contribute to this reality:

> **Late prognosis.** Many dying patients do not receive their six-month prognosis until they have far less than six months to live. In addition, most patients given a prognosis of six months or less do not reach the six-month mark, let alone live past it. One study of clinicians treating patients with advanced cancer found that only 41% of clinicians' prognosis predictions were accurate, and of the inaccurate prognoses, 85%

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[38] *Characterizing Kaiser Permanente Southern California's Experience With the California End of Life Option Act in the First Year of Implementation.* JAMA Internal Medicine, H.Q. Nguyen, E.J. Gelman, T.A. Bush, J.S. Lee, M.H. Kanter (2018). Available from: https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2665731

[39] *Hawai'i Our Care, Our Choice Act Annual Report* (2021). Available from: https://health.hawaii.gov/opppd/files/2022/07/corrected-MAID-2021-Annual-Report.pdf

[40] *Physician-Assisted Death: Scanning the Landscape:Proceedings of a Workshop.* National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Sciences Policy, R.A. English, C.T. Liverman, C.M. Cilio, J. Alper, Rapporteurs (2018). Available from: https://www.nap.edu/catalog/25131/physician-assisted-death-scanning-the-landscape-proceedings-of-a-workshop

overestimated the length of time a patient would live.[41] Another study found that nursing home residents with a less than six-month prognosis who died had a median survival time of 1.84 months.[42]

- **Locating supportive and knowledgeable providers.** Approximately 30 million people in the continental United States live in "healthcare deserts," or areas where they lack adequate access to key healthcare services including those necessary for people at the end of life.[43] A 2021 survey of advanced practice professionals at Seattle's Fred Hutch Cancer Center, a collective term that includes physician assistants (PAs) and nurse practitioners, showed that only 27% of respondents stated that they were knowledgeable about medical aid in dying. The authors found a positive association between knowledge or comfort regarding medical aid in dying and willingness to participate in the procedure.[44] An additional study found that after having written an aid-in-dying prescription, 96% of clinicians reported that they were "hardly" or "not at all" morally conflicted.[45] Another study found that among consulting and attending physicians caring for patients who requested medical aid in dying, 75.5% felt their most recent case was emotionally fulfilling and professionally rewarding.[46]
- **Oppositional providers.** In addition, anecdotal evidence shows that sometimes patients are led to believe their doctor will "support" them when they become eligible under the law, only to find out very late that supporting them means keeping them comfortable in hospice care or referring them to another doctor without sufficient time to navigate the process — not writing them the prescription.[47] Some doctors who personally object to the practice believe they should not have to transfer a patient's medical records or document requests, because they believe transferring records is

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[41] Palliative Care Clinician *Overestimation of Survival in Advanced Cancer: Disparities and Association with End-of-Life Care*. Gramling, Robert, Gajary-Coots, Elizabeth, Cimino, Jenica, et. al. Journal of Pain and Symptom Management, 2019: 58(4), e19-e20. Available from: https://www.sciencedirect.com/science/article/abs/pii/S0885392418310571

[42] Vu, L., Koroukian, S. M., Douglas, S. L., Fein, H. L., Warner, D. F., Schiltz, N. K., Cullen, J., Owusu, C., Sajatovic, M., Rose, J., & Martin, R. (2024). *Understanding the Utility of Less Than Six-Month Prognosis Using Administrative Data Among U.S. Nursing Home Residents With Cancer.* Palliative Medicine Reports, 5(1), 127–135. https://doi.org/10.1089/pmr.2023.0047

[43] Nguyen, A. (2021, September 9). *Mapping Healthcare Deserts: 80% of the Country Lacks Adequate Access to Healthcare*. GoodRx. https://www.goodrx.com/healthcare-access/research/healthcare-deserts-80-percent-of-country-lacks-adequate-healthcare-access

[44] From Fred Hutchinson Cancer Center: Assessment of willingness to provide medical aid in dying. From the Loggers and Shen labs, Clinical Research Division: https://www.fredhutch.org/content/www/en/news/spotlight/2022/12/crd-singer-jamaopen.html

[45] Pottash M, Saikaly K, Stevenson M, Krohmal B. *A Survey of Clinicians Who Provide Aid in Dying.* American Journal of Hospice and Palliative Medicine®. 2024;41(9):1045-1050. https://doi.org/10.1177/10499091231205841

[46] Campbell EG, Kini V, Ressalam J, et al. *Physicians' attitudes and experiences with medical aid in dying in Colorado: a "hidden population" survey.* J Gen Intern Med. 2022;37(13):3310-3317. https://doi.org/10.1007/s11606-021-07300-8.

[47] *Andrea "Mimi" Ankerholz. Compassion & Choices.* (2021). https://www.compassionandchoices.org/stories/andrea-mimi-ankerholz; Jesse Ankerholz. Compassion & Choices (2022). https://www.compassionandchoices.org/stories/jesse-ankerholz

"participation" under the act, as is argued in a New Jersey lawsuit.[48] Transferring records and documentation, however, is part of standard medical care.[49]

Improvements to Laws in Authorized Jurisdictions

In response to the evidence compiled across the authorized jurisdictions, several have taken action to reduce barriers while maintaining the same strict eligibility criteria:

Waiting Periods. The authorized jurisdictions are consistently recognizing that long waiting periods result in unnecessary suffering for dying people. Reducing or removing the waiting period between oral requests or between receiving and filling a prescription for medical aid in dying, or allowing a waiver of waiting periods does not reduce the core safeguards or change the strict eligibility criteria.

- Based on years of practice, in 2019 the Oregon Legislature passed an important amendment to its law to better balance safeguards intended to protect patients and access to medical aid in dying. As long as a written request is provided and the attending qualified clinician attests that the otherwise qualified patient is likely to die while waiting, the amendment allows doctors to waive the 15-day waiting period between the two required oral requests and the 48-hour waiting period if they determine and attest that the patient is likely to die while waiting.[50] The amendment was a direct result of evidence and data that clearly demonstrated the need for easier access for eligible terminally ill patients facing imminent death. The Oregon Health Authority annual reports in the years after the amendment show that 20-28% of patients between 2020 and 2023 required a physician exemption in order to make it through the process.[51]
- California recognized that waiting periods were posing an unnecessary barrier to terminally ill patients. In 2021, the Legislature amended the California End of Life Option Act to decrease the waiting period between the two oral requests from 15 days to 48 hours.[52]
- New Mexico requires just one written request, so there is no waiting period related to requests. However, the law requires a 48-hour waiting period between receiving and filling a prescription for medical aid in dying medication, but allows a qualified clinician to waive the waiting period if a person is going to imminently die.[53]

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[48] Fourth Amended Complaint at 4, Petro v. Grewal (Super. Ct. N.J. 2020) (No. Mer-C-53-19). Available from: https://drive.google.com/file/d/1EgSCh_zkx9DWGaD6gGPgJ3bMeXL6TDlM/view?usp=sharing

[49] *Health Insurance Portability and Accountability Act, Access of individuals to protected health information, 45 CFR § 164.524* (2022) Available from: https://www.govinfo.gov/content/pkg/CFR-2011-title45-vol1/pdf/CFR-2011-title45-vol1-sec164-524.pdf

[50] *Senate Bill 579, 80th Oregon Legislative Assembly—2019 Regular Session*. Available from: https://olis.oregonlegislature.gov/liz/2019R1/Downloads/MeasureDocument/SB579

[51] *Oregon Death with Dignity Act Annual Reports* (2020-2023) Available from: https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ar-index.aspx

[52] *California SB 380 End of Life Option Act. Enacted October 2021.* Available from https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB380

[53] *The Elizabeth Whitefield End-of-Life Options Act* (2021), available at https://www.nmhealth.org/publication/view/general/8382

- In 2023, the Washington Legislature amended the state's Death with Dignity Act to reduce the waiting period between a patient's first and second oral request for the medication from 15 days to 7 days.[54]
- In 2023, the Hawaii Legislature amended the Our Choice, Our Care Act to reduce the mandatory waiting period between the two oral requests required for a qualified patient to obtain a prescription for medication from 20 days to five days. It also allows providers to waive the mandatory minimum waiting period for terminally ill qualified patients who are not expected to survive the five-day waiting period.[55]
- In 2024, the Colorado Legislature amended the Colorado End-of-Life Options Act to reduce the mandatory waiting period between two oral requests from 15 days to seven days. Providers may waive the waiting period if the terminally ill individual is likely to die from the irreversible and incurable disease prior to the end of the waiting period.[56]

Residency Restrictions. With the exception of Vermont and Oregon, every jurisdiction where medical aid in dying has been authorized by statute limits patient access to those who have established residency in that state.[57] Compassion & Choices believes that residency restrictions are unconstitutional, and we recommend that jurisdictions do not include residency requirements in their bills or laws. To date, the Oregon and Vermont attorneys general settled court cases challenging the constitutionality of their residency requirements, and the legislatures in both states have removed the requirements from their laws.[58]

Qualified Healthcare Providers. Authorized jurisdictions have expanded the types of healthcare providers who can serve as attending, consulting or mental health providers, which improves access for eligible patients. Similar to physicians, other healthcare providers, such as APRNs and PAs, often work independently and have authority to write prescriptions and manage patients' care. Amending medical aid-in-dying laws to include these clinicians recognizes they play an important role in improving access to end of life care, including the option of medical aid in dying. The scope of practice for healthcare providers is confirmed in jurisdictions before the types of healthcare providers who can participate is expanded.

- In 2023, Hawaii authorized qualified APRNs to be attending healthcare providers and authorized licensed APRNs and clinical nurse specialists with psychiatric or mental health training and licensed marriage and family therapists to participate as mental health providers.[59]
- In 2023, Washington authorized APRNs and PAs to act as either the attending or consulting medical provider for those who want to access the Death With Dignity Act. A physician would still have to be one of the other providers in either case. Additionally,

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[54] *Washington State Legislature, Engrossed Substitute Senate Bill 5179* (April 6, 2023), available at https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5179-S.SL.pdf?q=20230510092955

[55] *Hawai'i House Bill 650* (signed June 1, 2023), available at https://www.capitol.hawaii.gov/session/measure_indiv.aspx?billtype=HB&billnumber=650&year=2023

[56] *Colorado SB24-068* (signed June 5, 2024), available at https://leg.colorado.gov/bills/sb24-068

[57] Montana was authorized by court decision, and most providers follow the Oregon model.

[58] As of December 2024, there is ongoing litigation to remove the residency requirement from the New Jersey law.

[59] *Hawai'i House Bill 650* (signed June 1, 2023), available at https://www.capitol.hawaii.gov/session/measure_indiv.aspx?billtype=HB&billnumber=650&year=2023

Washington expanded the types of licensed mental health professionals who can participate as a mental healthcare provider to include independent clinical social workers, advanced social workers, mental health counselors and psychiatric advanced registered nurse practitioners.[60]

- In 2024, Colorado authorized qualified APRNs with prescriptive authority to act as attending and consulting providers.[61]
- New Mexico allows APRNs and PAs to act as either the prescribing or consulting healthcare provider so long as a physician acts as the other provider. Additionally, New Mexico does not require confirmation of eligibility for medical aid in dying by a consulting provider if the person is enrolled in a medicare-certified hospice program. Master social workers, psychiatric nurse practitioners and professional clinical mental health counselors are also able to participate as mental health providers.[62]
- In Vermont,[63] New Jersey,[64] and Maine[65] clinical social workers are able to participate as mental health providers.

Some jurisdictions considering legislation are also weighing more streamlined approaches to reduce the burden on providers and terminally ill patients like ensuring greater clarity and transparency from healthcare providers and facilities.

Section IV: Medical Aid-in-Dying Utilization Report

Currently, public health departments in nine authorized jurisdictions have issued reports regarding the use of medical aid-in-dying laws: Oregon,[66] Washington,[67] Vermont,[68] California,

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[60] *Washington State Legislature, Engrossed Substitute Senate Bill 5179* (April 6, 2023), available at https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5179-S.SL.pdf?q=20230510092955

[61] *Colorado SB24-068* (signed June 5, 2024), available at https://leg.colorado.gov/bills/sb24-068

[62] *The Elizabeth Whitefield End-of-Life Options Act* (2021), available at https://www.nmhealth.org/publication/view/general/8382

[63] *Vermont Patient Choice at End of Life, Chapter 113*, available at https://legislature.vermont.gov/statutes/chapter/18/113

[64] *New Jersey Medical Aid in Dying for the Terminally Ill Act, Chapter 59* (April 12, 2019), available at https://pub.njleg.gov/bills/2018/PL19/59_.HTM

[65] *Maine Death with Dignity Act, Public Law Chapter 271*, available at https://legislature.maine.gov/legis/bills/bills_129th/chapters/PUBLIC271.asp

[66] *Oregon Death with Dignity Act Annual Reports* (1998-2023) Available from: https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ar-index.aspx

[67] *Washington Death with Dignity Data* (2009-2022). Available from: https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData

[68] *Vermont Report Concerning Patient Choice at the End of Life.* (2018-2022) Available from: https://www.healthvermont.gov/systems/end-of-life-decisions/patient-choice-and-control-end-life.

[69] Colorado,[70] Hawai‘i,[71] the District of Columbia,[72] Maine[73] and New Jersey.[74] Compassion & Choices has compiled annual report data from the authorized jurisdictions that collect data.[75] Key highlights include:

- In the past almost 30 years, starting with Oregon and across all jurisdictions that report data, just 10,211 people have ingested a prescription to end their suffering.[76]
- Less than 1% of the people who die in each jurisdiction use the law each year.[77]
- Only 62% (or just under 2/3) of people with prescriptions ingest the medication and die. Up to 38% of people who go through the process and obtain the prescription may never take it. This group consists of people who die from their underlying illness, another cause of death or an unreported cause of death. In any case, they derive peace of mind simply from knowing they have the option if their suffering becomes too great. [78]
- The majority of terminally ill people who use medical aid in dying (88%) were enrolled in hospice or palliative care at the time of their death, according to annual reports for which hospice data is available.[79]
- There is nearly equal use of medical aid in dying among men and women. There is currently no data on use of medical aid in dying by nonbinary or gender-nonconforming people. However, New Jersey included a category for nonbinary people in its 2023 report.[80]
- Terminal cancer accounts for the vast majority of qualifying diagnoses (68.5%), with neurodegenerative diseases such as ALS or Huntington's disease following as the

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[69] *California End of Life Option Act Annual Report* (2016-2023) Available from: https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act-.aspx

[70] *Colorado End of Life Options Act Annual Report* (2017-2023) Available from: https://www.colorado.gov/pacific/cdphe/medical-aid-dying

[71] *Hawai'i Our Care, Our Choice Act Annual Report* (2019-2023) Available from: https://health.hawaii.gov/opppd/ococ/

[72] *District of Columbia Death with Dignity Act Annual Report. (*2017-2022) Available from: https://dchealth.dc.gov/publication/death-dignity-annual-reports

[73] *Maine Patient Directed Care at End Of Life Annual Report.* (2019-2023) Available from: https://www.maine.gov/dhhs/data-reports/reports

[74] *New Jersey Medical Aid in Dying for the Terminally Ill Act Data Summary* (2019-2023) Available from: https://nj.gov/health/advancedirective/maid/

[75] *Medical Aid-in-Dying Data Across Authorized States, 2025*. Compassion & Choices. Available from: https://compassionandchoices.org/resource/medical-aid-in-dying-utilization-report/.

[76] *Id.*

[77] According to the Center for Disease Control, in 2021 in jurisdictions that authorized medical aid in dying, 622,035 people died in total. In 2021, authorized jurisdictions report 1,216 people died after being provided with a prescription for medical aid in dying – less than 0.002% of total deaths in 2021. Murphy, S., Kochanek, K., et al. (2024). (rep.). *Deaths: Final Data for 2021*. National Vital Statistics Report, 73(8). https://www.cdc.gov/nchs//data/nvsr/nvsr72/nvsr72-10.pdf.

[78] *Medical Aid-in-Dying Data Across Authorized States, 2025. Compassion & Choices. Available from: https://compassionandchoices.org/resource/medical-aid-in-dying-utilization-report/*

[79] *Id.*

[80] *Id.*

second-leading diagnosis. In recent years, some jurisdictions are seeing growing numbers of patients with cardiovascular diseases seeking medical aid in dying.[81]

- Over 77% of people who use medical aid in dying are able to die at home,[82] which is where most Americans would prefer to die, according to various studies.[83]

All Authorized Jurisdictions (1998 – 2023)	Cumulative	
Summary Data		
People who received prescriptions (prescriptions written or filled)	16,450	
People who died after ingesting	10,211	
Characteristics		
Sex		
Female	5,704	48.26%
Male	6,106	51.66%
Unknown	9	0.08%
Total	11,819	100%
Race		
Asian	401	3.44%
Asian/Native American/Pacific Islander	20	0.17%
Black	47	0.40%
Hawaiian, Pacific Islander	15	0.13%
Indigenous American, American Indian, Alaskan Native	15	0.13%
Latinx, Hispanic	239	2.05%
Multi-race (two or more racers)	39	0.33%
Non-white, Hispanic and/or Non-white	20	0.17%
Other, Unknown	147	1.26%
White	10,715	91.91%

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[81] *Id.*

[82] *Id.*

[83] *Views and Experiences with End-of-Life Medical Care in the U.S.* (2017). Hamel, Wu, and Brodie. Kaiser Family Foundation. Available from: https://www.kff.org/report-section/views-and-experiences-with-end-of-life-medical-care-in-the-us-findings

Total	11,658	100%
Age Breakdown		
18 − 64	1,810	23.30%
65 − 74	2,399	30.88%
75 − 84	2,139	27.53%
85+	1,421	18.29%
Total	7,769	100%
Age Breakdown (California)		
Under 60	369	9.27%
60 – 69	774	19.44%
70 – 79	1,245	31.27%
80 – 89	1,004	25.22%
90+	589	14.80%
Total	3,981	100%
Education		
High School Diploma, GED, or Less	2,834	24.29%
Some College	2,983	25.56%
Associate's, Bachelor's, Master's, Doctorate or Professional Degree	5,694	48.80%
Unknown	158	1.35%
Total	11,669	100%
Hospice and/or Palliative Care		
Enrolled	8,346	88.45%
Not Enrolled	715	7.58%
Unknown	164	1.74%
Not under hospice care or unknown	211	2.24%
Total	9,436	100%
Insurance		

Private/Commercial	1,738	17.46%
Medicare, Medicaid, and/or Other Governmental	2,674	26.87%
Combination of Governmental and Private/Commercial	2,337	23.48%
Insured (unspecified)	1,750	17.58%
None, Other, Unknown	1,453	14.60%
Total	9,952	100%
Underlying Illness		
Cancer, Malignant Neoplasms	8,272	68.52%
Neurological Disease	1,369	11.34%
Respiratory Disease	818	6.78%
Cardiovascular, Circulatory Disease	941	7.79%
Other Illnesses	673	5.57%
Total	12,073	100%
Place of Death / Where Medication Ingested		
Private Home, Residence	8,150	77.32%
Hospice Facility	123	1.17%
Hospital, Acute Care Hospital	26	0.25%
Long Term Care, Assisted Living, Foster Care Facility	510	4.84%
Nursing Home	156	1.48%
Other, Unknown	1,575	14.94%
Total	10,540	100%

Section V: The Truth About Medical Aid in Dying

When crafting medical aid-in-dying legislation, lawmakers can rely on the experience and knowledge from existing laws, research, patient perspectives and healthcare provider insight. We now have almost 30 years of data since Oregon implemented its law in 1997 and years of experience from other authorized jurisdictions. None of the dire predictions that opponents raised have come to fruition. In fact, there has never been a single substantiated case of misuse or abuse of the laws. The evidence confirms that medical aid-in-dying laws protect patients while offering a much-needed option. The following section addresses the most common inaccurate claims about medical aid in dying and sets the record straight.

Medical Aid in Dying Is Not Euthanasia

Medical aid in dying is fundamentally different from euthanasia. Medical aid in dying is a practice by which a terminally ill, mentally capable person with a prognosis of six months or less chooses to request, obtain and take medication that brings about a peaceful death. In all authorized United States jurisdictions, only the dying person can request an aid-in-dying prescription under the law, and if and when they decide to ingest the medication, they must self-administer it. Therefore, control stays with the patient from beginning to end.

In contrast, euthanasia, sometimes called "mercy killing," is an intentional act by which another person (not the dying person) acts to cause death. Euthanasia is illegal throughout the United States, and all medical aid-in-dying laws expressly prohibit euthanasia. Compassion & Choices does not support authorizing euthanasia because it would allow someone else — not the dying person — to cause the death of another.[84]

Medical Aid in Dying Is Different From Suicide

The conflation — intentional or accidental — of medical aid in dying with suicide perpetuates false, harmful and stigmatizing information. Suicide is a public health and medical concern that requires collective efforts to address. Medical aid in dying is available only to terminally ill people who are mentally capable with a prognosis of six months or less to live. In fact, healthcare groups have concluded that medical aid in dying is distinct from suicide.[85] Equating

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[84] In Canada, euthanasia is allowed by law. Compassion & Choices and current U.S. medical aid in dying practice do not support or encompass euthanasia. Euthanasia, which requires a third party to administer medication, commonly via injection, is illegal throughout the United States.

[85] UpToDate. (n.d.). UpToDate. https://www.uptodate.com/contents/medical-aid-in-dying-clinical-considerations/print (American Academy of Hospice and Palliative Medicine, the American Public Health Association, the American Psychiatric Association, the American Medical Women's Association and the American Academy of Family Physicians

medical aid in dying with suicide is irresponsible and does a disservice both to dying people who want the option, as well as those impacted by suicide.

Additionally, from a legal perspective the Oregon, Washington, Vermont, California, Colorado, Hawaii, New Jersey, Maine, New Mexico and District of Columbia laws emphasize with the same or similar language that: "Actions taken in accordance with [the Act] shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law." Assisting a suicide remains a felony in jurisdictions where medical aid in dying is authorized. Saying "assisted suicide" inaccurately characterizes a legally authorized, legitimate medical practice as criminal activity under the law.

Opponents use the term "assisted suicide" in an attempt to discredit the legitimate practice of medical aid in dying. The American College of Legal Medicine filed an amicus brief before the United States Supreme Court in 1996 rejecting the term and adopted a resolution in 2008 in which they "publicly advocated the elimination of the word 'suicide' from the lexicon created by a mentally competent, though terminally ill, person who wishes to be aided in dying."[86]

> "(I will) go through any and all treatments in order to stay alive for as long as possible ... (but) there is nothing wrong with wanting to have as peaceful a transition as possible. The dying process doesn't have to be painful. It doesn't have to be filled with suffering if that's not what the person wants. Death, if you are able to, should be something that you have some say in — whatever that is."
>
> – Susan Rahn, Mother, Breast Cancer Patient and Medical Aid-in-Dying Advocate

Medical Aid-in-Dying Laws Do Not Promote Suicide

There is no evidence that medical aid in dying impacts suicide rates, and it is a vast mischaracterization of suicide as a public health issue to blame the increase in death by suicide in a jurisdiction to medical aid in dying when there is no data or formal study that proves this. A 2024 study that reviewed 927,929 suicide deaths in US jurisdictions where medical aid in dying is authorized "failed to find evidence that suicide rates were positively associated with [medical

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[86] *American College of Legal Medicine, Policy on Aid in Dying.* (2008). Available from: https://compassionandchoices.org/docs/default-source/policy/american-college-of-legal-medicine-position-statement.pdf

aid in dying] legalization or [medical aid in dying] implementation, when controlling for geographic variation and multiple sociodemographic factors associated with suicide risk."[87]

There is no substantiated correlation between medical aid in dying and suicide. When medical aid in dying is authorized, it increases the likelihood that a terminally ill person will express their desire to end their life to a medical provider who has the training to evaluate them and connect them to appropriate care and support. Further, data shows that medical aid-in-dying laws improve end-of-life care in general and hospice and palliative care specifically. For example, Oregon's medical aid-in-dying law has helped spur the state to lead the nation in hospice enrollment, according to a report published in the New England Journal of Medicine.[88] Additionally, according to Dr. Neil Wenger, director of the UCLA Health Ethics Center, the California medical aid-in-dying law "really has created a new standard for how we ought to be helping people at the end of life."[89]

Availability of Medical Aid in Dying Is Not a Factor Used to Deny Treatment

Medical aid in dying is only available to terminally ill individuals with a prognosis of six months.. A research article from the New England Journal of Medicine concludes insurers have no financial incentive to pressure patients to accelerate their deaths because there are no substantial cost savings.[90] The article was co-authored by an opponent of medical aid in dying more than 20 years ago, when use of hospice care was less frequent.

Furthermore, with the exception of New Mexico and Vermont, each of the laws in authorized jurisdictions explicitly state that the obligations created by wills, contracts, insurance and annuity policies cannot be affected by a terminally ill person's decision to request or use medical aid in dying. In other words, people are entitled to their existing benefits regardless of whether they use medical aid in dying.

A 2018 study published in the Hastings Center Report noted, "Financial pressure is much more likely to influence a decision to pursue or reject aggressive life-extending care than it is to influence a request for physician assisted death."[91] No one wants to leave their family destitute

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[87] Sutton, O. P., & Kious, B. M. (2024). *Associations between the legalization and implementation of medical aid in dying and suicide rates in the United States.* AJOB Empirical Bioethics, 1–9. https://doi.org/10.1080/23294515.2024.2433474

[88] *Lessons from Oregon in Embracing Complexity in End-of-Life Care*. New England Journal of Medicine, S.W. Tolle, MD, J.M. Teno, MD, (2017). Available from: https://jimdo-storage.global.ssl.fastly.net/file/a8cc42d8-c90f-49c1-b357-1932af60b8c5/EoLLessonsOregon.TolleSWTenoJM-NEJM-03-2017.pdf

[89] *There's an Unforeseen Benefit to California's Physician-Assisted Death Law.* Los Angeles Times, (2017). Available from: https://www.latimes.com/health/la-me-end-of-life-care-20170821-htmlstory.html

[90] *Emanuel EZ, Battin MP. 1998. What Are the Potential Cost Savings from Legalizing Physician-Assisted Suicide? NEJM 339:167-172. Available from: https://www.nejm.org/doi/10.1056/NEJM199807163390306*

[91] *Poverty: Not a Justification for Banning Physician-Assisted Death.* Hastings Center Report, L.M. Freeman, S.L. Rose, S.J. Youngner (2018). Available from: https://doi.org/10.1002/hast.937

trying to extend an inevitable and irreversible dying process, but both research and experience confirm that worry about finances is not one of the key motivating factors that lead someone to request medical aid in dying.

Medical Aid in Dying Laws Protect Against Coercion

All medical aid in dying laws make it a felony to coerce someone to request medical aid in dying. Additionally, healthcare providers do not receive additional reimbursement for supporting or prescribing medical aid in dying for their eligible patients.

There have been no substantiated reports of family members coercing a terminally ill person to use medical aid in dying in the over 25 years that such laws have been in effect. In addition, a person who uses medical aid in dying is already expected to die within six months. Furthermore, when faced with the prospect of losing a loved one, family members and caregivers are far more likely to cling to patients in late-stage illness and demand that all measures be taken to prolong life.[92] A large U.S. comprehensive cancer hospital study analyzing decision-making in lung cancer patients and caregivers reported that 65% of caregivers experienced treatment disagreements. The same study revealed that families and caregivers were less likely to agree with patient choices regarding decisions to discontinue therapeutic treatments or do not attempt resuscitation (DNAR) status.[93] Another study found that five primary themes identified as protective factors for negative bereavement outcomes. The five factors included preparedness for death, place of death, sense of control and autonomy, reduction in suffering/burden, and being able to support the patient's end-of-life wishes.[94] Medical aid in dying offers the opportunity for those protective factors to be part of the end-of-life experience.

Patients Have Various Options for Ingesting the Medication

The type and dosage of aid-in-dying medication the qualified prescriber or healthcare provider prescribes can vary. Just like there is not just one blood pressure medicine, there is not just one medication for aid in dying. Historically, prescriptions for aid in dying involved three separate medications: two to speed absorption and prevent nausea followed by a short-acting barbiturate. However, as science and technology continue to advance, and due to market-driven variations in the cost and availability of drugs over time, several medications and

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[92] *Compromised Autonomy: When Families Pressure Patients to Change Their Wishes*. Journal of Hospice and Palliative Nursing, L. Blackler, LCSW-R, MBE, (2016). Available from: https://alliedhealth.ceconnection.com/files/CompromisedAutonomyWhenFamiliesPressurePatientstoChangeTheirWishes-1490189149086.pdf

[93] Zhang AY, Siminoff LA. *The role of the family in treatment decision making by patients with cancer.* Oncol Nurs Forum. 2003;30(6):1022-1028. Available from: https://doi.org/10.1188/03.onf.1022-1028

[94] Singer, J., Daum, C., Evans, A., Schneider, S., Vugrin, M., & Loggers, E. (2023). *An examination and proposed theoretical model of risk and protective factors for bereavement outcomes for family members of individuals who engaged in medical aid in dying: A systematic review*. Palliative medicine, 37(7), 947–958. https://doi.org/10.1177/02692163231172242

combinations of medications have been developed and are now successfully used in aid-in-dying prescriptions.

In practice, the medication is provided as a powder and mixed together with approximately 2-4 ounces of liquid and ingested by the terminally ill person.

Once the prescription has been filled, the terminally ill person can choose when to take the medication, which causes deep sleep usually within 3-10 minutes. Respiration slows over the course of an hour or two, then stops, and the person dies peacefully in their sleep. According to the Oregon Death with Dignity Act Annual Reports, the average time between ingestion and death is 35 minutes.[95] Injection or infusion via a vein or any other parenteral route of aid-in-dying medication by any person, including the doctor, family member or patient themselves, is explicitly prohibited in each of the laws.

Medication Must Be Self-Administered

As stated above, to be eligible for medical aid in dying, a person must be able to self-administer the medication through an affirmative, conscious, voluntary act to ingest it. Self-administration does not include injection or infusion via a vein or any other parenteral route by any person, including a healthcare provider, family member or patient themselves.

The self-administration requirement is one of the core patient safeguards to prevent coercion, and the jurisdictions where medical aid in dying is currently authorized all require that medication be self-ingested. The critical factor in determining whether a person is self-administering their medication is whether the person remains in control of the procedure themselves and takes a voluntary action to deliver the medication to the body through the gastrointestinal tract.

Assistance can be provided in aspects of preparation, holding, and bringing the medication close, but the individual must complete the ingestion. A person can request an accommodation to access medical aid in dying, just as they may do so to access other medical services, in accordance with the Americans with Disabilities Act. Someone other than the terminally ill individual can prepare and mix the aid-in-dying medications and bring them to the patient – as long as the terminally ill individual is not assisted in actually ingesting the medications. The terminally ill individual must be in control of and complete the ingestion from start to finish.

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[95] *Oregon Death with Dignity Act Annual Reports* (1998-2023) Available from: https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ar-index.aspx

Terminally Ill Individuals Must Have a Six Month Prognosis

In order to be eligible for medical aid in dying, a mentally capable, terminally ill adult must have a six month prognosis. All authorized jurisdictions require that the diagnosis and prognosis be medically confirmed before the individual can proceed. A determination of terminality relates to disease progression, not treatment options. Whether an individual has elected to pursue or forego disease-directed treatment does not impact whether the disease is terminal.

A six month prognosis is a time frame that is already integral to the medical standard of care and is often used as a guide for many end-of-life treatment decisions, including hospice eligibility. This is crucial to ensure that medical aid-in-dying is only available to individuals who are at the end of life.

Medical Aid-in-Dying Medication Is Safe

There is little chance of an accidental overdose attributable to aid-in-dying medication — far less of a chance than many over the counter medications. The medication requires a high dosage to work and is bitter to the point of near intolerance (particularly without the preparatory medication). One is far more likely to overdose on common over-the-counter medications like cough syrup or the many potentially lethal medications one is often prescribed at the end of life, such as morphine.

In instances when aid-in-dying medication is dispensed but remains unused when the person dies, medication is to be disposed of according to guidelines established by the Drug Enforcement Agency and as required under state statute.[96] Information on how to dispose of medication can be found on the DEA website or on The National Association of Boards of Pharmacy website.[97]

If hospice is involved, they can dispose of it just as they do with all unused sedatives and pain medications, many of which are also potent and hazardous controlled substances. If hospice is not involved, pharmacists often ask that unused opioids and sedatives be returned to them or a state-approved prescription drug take-back program for disposal.

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[96] *Drug Disposal Information*, U.S. Department of Justice, Drug Enforcement Administration. Available from: https://www.deadiversion.usdoj.gov/drug_disposal/drug-disposal.html.
[97] *Drug Disposal Locator Tool.* Available from: https://apps.deadiversion.usdoj.gov/pubdispsearch/spring/main?execution=e1s1.

The Death Certificate Protocol for Medical Aid in Dying Is Consistent With Reporting Standards

Death certificates for medical aid in dying comply with guidelines provided by the Centers for Disease Control and Prevention (CDC). When a terminally ill person dies using medical aid in dying, the underlying terminal disease is listed as the cause of death (for example, cancer, ALS). It is critical to list the disease that caused the death and not medical aid in dying, as the purpose of the death certificate is to track and understand trends in diseases and public health concerns.

To illustrate, if a person has a stroke and is put on a ventilator that is subsequently removed, the doctor lists "stroke" as the cause of death, not "disconnecting the ventilator" or "suffocation." When palliative sedation is administered by a qualified healthcare provider, such as in cases where a hospice patient with terminal cancer has unremitting pain and symptoms, the cause of death is listed as cancer and does not refer to impacts the medications.

In other words, data from death certificates is not used to track utilization of end-of-life healthcare options. According to the CDC's Guidance on Death Certificates, "The immediate cause does not mean the mechanism of death or terminal event (for example, cardiac arrest or respiratory arrest). The mechanism of death should not be reported as the immediate cause of death because it is a statement not specifically related to the disease process, and it only attests to the condition or fact of death.[98]

It is essential that doctors list the underlying terminal disease because public health officials use death certificates to compile data on various statistics, including leading causes of death, and report that data to the National Center for Health Statistics based upon the International Classification of Diseases (ICD). In jurisdictions with authorizing statutes and reporting requirements, providers confidentially submit medical aid in dying-related data to the departments of health for tracking and analysis. Departments of health experts cross check required medical aid in dying reporting with death certificates. Adding information about medical aid in dying on a death certificate does not improve data surveillance and is a duplication of information already collected through the law.

Section VI: The Growing Movement

In recent years, public support and demand for this end-of-life care option has grown. As a result, the medical community and lawmakers are recognizing the value and importance of expanding end-of-life options by dropping their opposition, adopting supportive policies and passing laws to authorize the practice. During the 2024 legislative session, 428 multi-partisan

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[98] *Physicians Handbook on Medical Certification of Death*. Centers for Disease Control and Prevention. (2023). Available from: https://www.cdc.gov/nchs/data/nvss/handbook/2023-physicians-mcod-handbook.pdf

sponsors or co-sponsors introduced 37 bills to authorize or improve medical aid in dying in 19 states. These bills were proposed in every region of the country.

Public Support for Medical Aid in Dying as an End-of-Life Care Option

Numerous public opinion polls from a variety of sources, both nationally and at the state level, demonstrate that Americans consistently support medical aid in dying, with majority support among nearly every demographic group.[99] A 2023 nationwide poll by Susquehanna Polling & Research reported that nearly eight out of 10 of U.S. residents (79%) who self-identify as having a disability agree that "medical aid in dying (MAID) should be legal for terminally ill, mentally capable adults who chose to self-ingest medication to die peacefully.[100] A 2021 nationwide poll by Susquehanna Polling & Research reported that 68% of voters support medical aid in dying as an end-of-life care option. Additionally, when respondents are asked if they want the option of medical aid in dying personally for themselves, 67% said yes.[101] Gallup's 2020 Values and Beliefs poll shows that a majority of respondents have consistently favored medical aid in dying since Gallup first asked about it in 1996.[102]

Majority Support Among Diverse Groups

In addition to the medical and other organizations that have endorsed medical aid in dying noted above, the Coalition for Liberty and Justice, the Older Women's League[103] and SAGE,[104] a national organization that provides services and advocacy for LGBT elders, have all endorsed medical aid in dying on a national level. Broad support spans nearly every demographic, from age to ethnic group and from religious to political affiliation.[105]

Six national Latino/a/x organizations have adopted supportive policies on medical aid in dying:

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[99] *Polling on Voter & Healthcare Provider Support for Medical Aid in Dying*, Compassion & Choices. Updated February 2023. Available from: https://www.compassionandchoices.org/resource/polling-medical-aid-dying.

[100] *USA/National Public Opinion Survey of 1,004 respondents - Cross Tabulation Report*, February 2023. Accessed at: https://bit.ly/SPRNatDisabilityPoll2023

[101] *Nationwide Poll Shows Strong Support for Advance Care-Dementia Planning, Medical Aid in Dying*, Susquehanna Polling & Research, Omnibus Survey (2021). Available from: https://compassionandchoices.org/wp-content/uploads/2024/04/usa-omnibus-cross-tabulation-report-final-november-2021-2.pdf

[102] *Prevalence of Living Wills in U.S. Up Slightly*. Jones, Jeffrey (2020) Gallup. Available from: https://news.gallup.com/poll/312209/prevalence-living-wills-slightly.aspx

[103] *Nation's Largest LGBT Elders Group Endorses Medical Aid-in-Dying Laws* (2019). Available from: https://compassionandchoices.org/news/nations-largest-lgbt-elders-group-endorses-medical-aid-in-dying-laws?_ga=2.55396968.238481543.1668781176-1514433183.1665591539

[104] *Id.*

[105] Prevalence of Living Wills in U.S. Up Slightly. Jones, Jeffrey (2020) Gallup. Available from: https://news.gallup.com/poll/312209/prevalence-living-wills-slightly.aspx; American Views on Assisted Suicide. LifeWay Research (2016). Available from: https://research.lifeway.com/wp-content/uploads/2016/12/Sept-2016-American-Views-Assisted-Suicide.pdf; USA/National Public Opinion Survey of 1,004 respondents - Cross Tabulation Report, February 2023. Accessed at: https://bit.ly/SPRNatDisabilityPoll2023

- Dolores Huerta Foundation[106]
- Hispanic Health Network[107]
- Latino Commission on AIDS[108]
- Latinos for Healthcare Equity[109]
- National Hispanic Council on Aging[110]

These endorsements have all come in the past four years and represent a growing recognition that Latino/a/x (Hispanic) constituents support this option and that the laws, as written, protect vulnerable patients.

Additionally, Samuel DeWitt Proctor Conference, Inc., whose mission is to nurture, sustain and mobilize the African American faith community in collaboration with civic, corporate and philanthropic leaders to address critical needs of human rights and social justice within local, national and global communities issued a statement of support for medical aid in dying.[111] Furthermore, prominent leaders in the African American community are endorsing medical aid in dying. In 2016, medical aid in dying was authorized in Washington, D.C., with the support of all but one member of the predominantly Black city council and a Black mayor.[112] Supporters include the late Maryland Congressman Elijah Cummings,[113] the first African American to be named speaker pro tem in the Maryland House of Delegates; and Maryland Congressman Anthony G. Brown,[114] formerly Maryland's lieutenant governor. In addition, Dr. Benjamin F.

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[106] *Civil Rights Icon Dolores Huerta Partners with End-of-Life Care Advocacy Group to Launch Multi-State Bilingual Education Campaign*. Available from: https://compassionandchoices.org/news/civil-rights-icon-dolores-huerta-partners-with-end-of-life-care-advocacy-group-to-launch-multi-state-bilingual-education-campaign-2/; *Let's Stand for Aid-in-Dying Law.* Albuquerque Journal, D. Huerta, Guest Column Op-Ed, (2019). Available from: https://endoflifeoptionsnm.org/dolores-huerta/.

[107] *Catholic and Latino Perspectives on End-of-Life Suffering; Hispanic Health Network,* El Dario, G. Chacón, Guest Column Op-Ed (2018). Available from: https://eldiariony.com/2018/02/11/perspectiva-catolica-y-latina-sobre-el-sufrimiento-de-fin-de-vida/

[108] *Latinos Support Medical Aid in Dying; Latino Commission on AIDS.* El Dario, Dr. J. Torres, Guest Column Op-Ed, El Dario, (2019). Available from: https://eldiariony.com/2019/01/29/los-latinos-apoyan-la-ayuda-medica-para-morir/

[109] *Id.*

[110] *All Americans should have access to all end-of-life care options.* National Hispanic Council on Aging, Yanira Cruz, Guest Column Op-Ed, The Hill, October 28, 2017. Available from: https://thehill.com/opinion/healthcare/357575-all-americans-should-have-access-to-all-end-of-life-care-options

[111] *Samuel DeWitt Conference, Inc. Statement of Support for Medical Aid in Dying.* Available from: https://compassionandchoices.org/wp-content/uploads/2024/04/covenant-on-end-of-life.pdf

[112] *D.C. Becomes Seventh Jurisdiction to Allow Terminally Ill to End Their Lives.* The Washington Post, A.C. Davis and F. Nirappil (2016). Available from: https://www.washingtonpost.com/local/dc-politics/dc-becomes-seventh-jurisdiction-to-allow-terminally-ill-to-end-their-lives/2016/11/15/da497266-ab5b-11e6-977a-1030f822fc35_story.html?utm_term=.1500305615e9

[113] *Statement of Support Regarding End-of-Life Options,* Representative Elijah Cummings, (2019). Available from: https://compassionandchoices.org/news/congressman-elijah-cummings-endorses-maryland-end-of-life-option-act/

[114] *Former Maryland Lt. Governor Anthony Brown Endorses State's End-of-Life Option Act.* (2019). Available from: https://compassionandchoices.org/news/former-maryland-lt-gov-anthony-brown-endorses-states-end-of-life-option-act

Chavis,[115] president and CEO of the National Newspaper Publishers Association; and Dr. Jeff Gardere,[116] famed psychologist and ordained minister, publicly endorse and advocate for medical aid in dying.

"I have experienced the loss of far too many people … some of whom suffered for months knowing they were about to die," wrote Rep. Cummings in a letter.[117] "[T]here are those among us whose conscience can never accept that any person should have the right to choose the manner and timing of their passing [but] at the end of life, an individual's right to self-determination about one of the most personal decisions that anyone could make supersedes the moral sensibilities of others."

> "Dying is part of life ... And since dying is part of life, talking about it shouldn't be taboo. People should die a decent death. For me that means having had the conversations with those I have crossed in life and being at peace. It means being able to say goodbye to loved ones — if possible, at home."
>
> – Archbishop Desmond Tutu

Medical Ethical Considerations

Among U.S. physicians, support for medical aid in dying is strong. A 2020 Medscape poll of 5,130 U.S. physicians from 30 specialties demonstrated a significant increase in support for medical aid in dying from 2010. [118] A 2021 Gynecologic Oncology survey showed 69% of respondents believed that medical aid in dying should be legalized, and in a 2020 Oncology Ethics report, 55% of oncologists surveyed said that medical aid in dying should be legalized. [119] A 2022 study of Colorado physicians noted "those who have participated in [medical aid in dying] largely report the experience to be emotionally fulfilling and professionally rewarding,"

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[115] *Black Life Journeys Matter*. Chavis, Ben. Feb 13, 2020. Available from: https://compassionandchoices.org/news/black-life-journeys-matter

[116] *Dr. Jeff Gardere and Jennifer Milch: "Stop Needless Suffering. Pass the Medical Aid in Dying Act."* (2021). Available from: https://www.youtube.com/watch?v=SJBV_6n5WLQ&ab_channel=CompassionChoices

[117] *Statement of Support Regarding End-of-Life Options,* Representative Elijah Cummings, (2019). Available from: https://compassionandchoices.org/news/congressman-elijah-cummings-endorses-maryland-end-of-life-option-act

[118] *Medscape Ethics Report 2020: Life, Death, and Pain,* (2020). Available from: https://compassionandchoices.org/wp-content/uploads/2024/04/medscape-ethics-report-2020-life-death-and-pain.pdf

[119] *Polling on Medical Aid in Dying* (2022). Available from: https://compassionandchoices.org/resource/polling-medical-aid-dying

despite barriers to offering the end-of-life care option.[120] Additionally, 55% of physicians surveyed endorse the idea of medical aid in dying, agreeing that "[p]hysician assisted death should be allowed for terminally ill patients."[121]

A 2022 survey of nurses demonstrated that 86% of nurses would care for a patient contemplating medical aid in dying and that 57% would support the concept of medical aid in dying professionally as a nurse.[122] A research study cites high support from advanced practice providers for participation in medical aid in dying: Of all APPs [Advance practice providers] surveyed, 90.9% either agreed or strongly agreed that medical aid in dying should be legal, and the majority agreed that APPs should be included as eligible providers.[123]

Over the past six years, dozens of national and state medical and professional associations have endorsed or dropped their opposition to medical aid in dying in response to growing support for this option among qualified clinicians and the public.

Six national health organizations have taken positions supporting medical aid in dying:

> American College of Legal Medicine[124]
> American Medical Student Association[125]
> American Medical Women's Association[126]
> American Public Health Association[127]
> GLMA: Healthcare Professionals Advancing LGBT Equality[128]

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[120] Campbell EG, Kini V, Ressalam J, Mosley BS, Bolcic-Jankovic D, Lum HD, Kessler ER, DeCamp M. *Physicians' Attitudes and Experiences with Medical Aid in Dying in Colorado: a "Hidden Population" Survey.* J Gen Intern Med. 2022 Oct;37(13):3310-3317. doi: 10.1007/s11606-021-07300-8. Epub 2022 Jan 11. PMID: 35018562; PMCID: PMC8751472.

[121] *Medscape Ethics Report 2020: Life, Death, and Pain*, (2020). Available from: https://compassionandchoices.org/wp-content/uploads/2024/04/medscape-ethics-report-2020-life-death-and-pain.pdf

[122] *Polling on Medical Aid in Dying* (2022). Available from: https://compassionandchoices.org/resource/polling-medical-aid-dying

[123] Harrawood, K. A. (2023). *Medical aid in dying: The role of the nurse practitioner.* Journal of the American Association of Nurse Practitioners, 10.1097/JXX.0000000000000990. https://doi.org/10.1097/JXX.0000000000000990

[124] *American College of Legal Medicine,* Position on Medical Aid in Dying, (2008). Available from: https://compassionandchoices.org/wp-content/uploads/2024/04/american-college-of-legal-medicine-position-statement.pdf

[125] *American Medical Student Association*, Excerpted from: Preambles, Purposes, Principles: Principles Regarding Physician Aid in Dying. (2008). Available from: http://www.amsa.org/wp-content/uploads/2015/03/PPP-2015.pdf

[126] *American Medical Women's Association,* Excerpted from: Position Paper on Aid in Dying (2013/2018). Available from https://www.amwa-doc.org/wp-content/uploads/2018/09/Medical-Aid-in-Dying-Position-Paper.pdf

[127] *American Public Health Association,* Excerpted from: Patient's Rights to Self-Determination at the End. Policy # 20086. (2008). Available from: 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

[128] *GLMA Letter of Support on AB X2-15*, (2015). Available from: https://compassionandchoices.org/wp-content/uploads/2024/04/20151002-glma-letter-in-support-of-ca-eoloa.pdf.

- National Student Nurses' Association[129]

Because provider participation is critical to access medical aid in dying, lawmakers look to healthcare associations for input. Neutral positions, including engaged neutrality, recognize differences of opinion among providers and establish that those who participate in medical aid in dying are adhering to their professional ethical obligations, as are those who decline to participate. Ten national healthcare organizations have adopted neutral positions:

- American Academy of Family Physicians[130]
- American Academy of Neurology[131]
- American Academy of Hospice and Palliative Medicine[132]
- American Nurses Association[133]
- American Pharmacists Association[134]
- American Psychological Association[135]
- American Society of Health-System Pharmacists[136]
- Hospice and Palliative Nurses Association[137]
- National Association of Social Workers[138]
- Oncology Nursing Society[139]

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[129] *National Student Nurses' Association,* NSNA Resolutions (2018). Available from: https://www.dropbox.com/s/8xwq5f827leqriq/NSNA%20Resolutions%202018.pdf?dl=0

[130] *American Academy of Family Physicians COD Addresses Medical Aid in Dying, Institutional Racism*. (2018). Available from: https://www.aafp.org/news/2018-congress-fmx/20181010cod-hops.html

[131] *American Academy of Neurology position statement on Lawful Physician-Hastened Death.* (2018). Available from: http://n.neurology.org/content/90/9/420

[132] *American Academy of Hospice & Palliative Medicine.* Excerpted from: Statement on Physician-Assisted Death (2007). Available from: https://aahpm.org/advocacy/where-we-stand/pad/

[133] *American Nurses Association, The Nurse's Role When a Patient Requests Medical Aid in Dying* (2019). Revised Position Statement. Available from: https://ojin.nursingworld.org/table-of-contents/volume-24-2019/number-3-september-2019/nurses-role-medical-aid-in-dying/

[134] *American Pharmacists Association, Actions of the 2015 APhA House of Delegates*, Available from: https://docksci.com/report-of-the-2015-apha-house-of-delegates_5a35bf67d64ab2ddfc6de3a7.html

[135] American Psychological Association. (2017, August). *Resolution on Assisted Dying and Justification*. https://www.apa.org/about/policy/assisted-dying-resolution#:~:text=The%20APA%20Resolution%20on%20Assisted,to%20considerations%20of%20assisted%20dying.

[136] *American Society of Health-System Pharmacists, Board Report on the Joint Council Task Force on Pharmacist Participation in Medical Aid in Dying,* (2016). Available from: https://www.ashp.org/-/media/assets/house-delegates/docs/hod-board-report-on-task-force.ashx

[137] *Hospice and Palliative Nurses Association Value and Position Statements*, Available from: https://bit.ly/4es6th3

[138] *National Association of Social Workers, NASW Standards for Palliative and End of Life Care*, Available from: https://www.socialworkers.org/LinkClick.aspx?fileticket=xBMd58VwEhk%3D&portalid=0.

[139] Oncology Nursing Society. (2019). *The Nurse's Role When a Patient Requests Medical Aid in Dying.* https://www.ons.org/sites/default/files/2023-12/The%20Nurse%E2%80%99s%20Role%20When%20a%20Patient%20Requests%20Medical%20Aid%20in%20Dying_Dec5.pdf

Medical associations in many of the authorized jurisdictions currently have neutral positions on medical aid in dying, including Oregon,[140] California,[141] Colorado,[142] District of Columbia,[143] Vermont,[144] Hawaii,[145] Maine,[146] and New Mexico.[147] At least nine other state medical societies and a component society in non-authorized jurisdictions have neutral positions: Connecticut,[148] Delaware, [149]Georgia,[150] Illinois,[151] Maryland,[152] Massachusetts,[153] Minnesota,[154] Nevada,[155] New York,[156] and Virginia[157].

Additionally, the American Medical Association (AMA) and the National Alliance for Care at Home (NACH) (previously the National Hospice and Palliative Care Organization) have amended their policies to state that it is ethical for a provider to provide medical aid in dying to

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[140] *Oregon Medical Association,* Excerpted from: October 27 Board of Trustees Report. Available from: http://bit.ly/2CYT6Dx

[141] *California Medical Association Position on Medical Aid in Dying*, (2015) Available from: https://www.cmadocs.org/newsroom/news/view/ArticleId/27210/California-Medical-Association-removes-opposition-to-physician-aid-in-dying-bill

[142] Colorado Public Radio. (2019). *Debate: Coloradans Will Vote on Medically Assisted Death Proposal (Transcript)* https://www.cpr.org/show-segment/debate-coloradans-will-vote-on-medically-assisted-death-proposal-transcript/

[143] *Medical Society of the District of Columbia, Position on Medical Aid in Dying, (*2014). Available from: https://www.nytimes.com/2014/02/08/us/easing-terminal-patients-path-to-death-legally.html?unlocked_article_code=1.H00.pxQ5.qLe8whNONk-h&smid=url-share

[144] *Vermont Medical Society, Position on Medical Aid in Dying,* (2017). Available from: http://www.vtmd.org/sites/default/files/2017End-of-Life-Care.pdf

[145] *Hawaiʻi Society of Clinical Oncology, Hawaii Our Care, Our Choice Act Resources* (2018). Available from: https://www.accc-cancer.org/state-societies/Hawaii/resources/medical-aid-in-dying

[146] *Maine Medical Association Statement on Medical Aid in Dying,* (2019). Available from: https://mainephysicians.org/wp-content/uploads/2024/09/Statement_on_Physician-Assisted_Suicide_Final-4-25-19.pdf

[147] *New Mexico Medical Society Position on Medical Aid in Dying* (2019). Available from: https://d2zhgehghqjuwb.cloudfront.net/accounts/14766/original/2019_1_5_Council_Minutes_-_PENDING_APPROVAL.pdf?1547577653

[148] *Connecticut State Medical Society Position on Medical Aid in Dying.* (2019). Available from: https://www.cga.ct.gov/2019/PHdata/Tmy/2019HB-05898-R000318-Connecticut%20State%20Medical%20Society-TMY.PDF

[149] *MSD Support of Engaged Neutrality for Medical Aid in Dying* (2022). Available from: https://files.constantcontact.com/01c210be101/c65122d3-bb72-4b9c-a2f6-8563b3304710.pdf?rdr=true

[150] *Medical Associate of Georgia* (2023): Available from: https://www.mag.org/blog/reference-committee-a-2023-items-of-business

[151] *Illinois State Medical Society, Neutral Stance on Medical Aid in Dying.* (2023) Available from https://www.isms.org/ISMS.org/media/ISMSMediaLibrary/Resolutions/2023/12-2022-36.pdf

[152] *MEDCHI, The Maryland State Medical Society House of Delegates Position on Medical Aid in Dying.* (2016) Available from http://www.medchi.org/Portals/18/files/Events/Resolution%2016-16.pdf?ver=2016-08-26-140448-047

[153] *Massachusetts Medical Society Position on Medical Aid in Dying* (2017). Available from: https://www.massmed.org/About/2017-Annual-Report/

[154] *Minnesota Medical Association Position on Medical Aid in Dying* (2024) Available from: https://www.mnmed.org/insights/legislative-proposal-end-life-options-mmas-take-february-2024#:~:text=The%20adopted%20MMA%20policy%20deliberately,aid%2Din%2Ddying%20proposals.

[155] *Death With Dignity. (2023). Resolution #2023-21.* Nevada State Medical Association. Available from: https://nvdoctors.org/wp-content/uploads/2024/06/2023-2024-Compendium-updated-4.30.24.pdf

[156] *Why Family Doctors Support Medical Aid in Dying (S.6471 Savino / A.4321-A Paulin),* (2017). Available from: https://empirereportnewyork.com/why-family-doctors-support-medical-aid-in-dying-s-6471-savino-a-4321-a-paulin/

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qualified patients seeking it.[158] The NACHO even went so far as to replace the outdated and pejorative expression "assisted suicide" with the correct terminology "medical aid in dying."[159] While the AMA and NACH do not yet have a fully supportive policy, these changes are a significant step forward and demonstrate that acceptance within the medical field is increasing.

There is growing recognition within the healthcare field that patients want, need and deserve access to medical aid in dying. As more jurisdictions authorize medical aid in dying, the healthcare community is coming together, and providers are sharing their experiences and fine-tuning their collaborative efforts to better serve dying patients.

Support From State Organizations

Because this issue is primarily being advanced at the state level, often it is state — not national — organizations that take a position. At the state level, we enjoy support or engaged neutrality from hundreds of organizations. When organizations have a position of engaged neutrality, they have decided to not oppose medical aid in dying. Rather, their membership base has chosen to continue considering and developing their position on the matter for the time being. This support varies significantly by jurisdiction and grows weekly but includes:

- Bar Associations – California,[160] Connecticut,[161] New York[162]
- American Civil Liberties Union Affiliates – Connecticut,[163] Illinois,[164] Massachusetts,[165] New Jersey,[166] New Mexico,[167] New York[168]

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- Disability Rights Organizations – Disability Rights New Mexico,[169] The Arc New York,[170]
- LGBTQ+ organizations – Gay and Lesbian Activist Alliance – D.C.[171]
- League of Women Voters – Delaware,[172] Maryland,[173] New York,[174] Utah[175]
- National Association of Social Workers – California,[176] Massachusetts,[177] Minnesota,[178] New Jersey,[179] New Mexico[180]
- Faith Groups – United Church of Christ / Central Atlantic Conference (D.C., Delaware, New Jersey, Maryland),[181] United Methodist Church / California-Pacific,[182] Unitarian Universalist Association,[183] Unitarian Universalist Church / Maryland,[184] Society for Humanistic Judaism[185]

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Impact of Public Political Support

As noted above, public opinion data demonstrates wide support for medical aid in dying, and voters are rewarding lawmakers who advance this compassionate end-of-life care option by reelecting them. More than seven out of 10 Americans support medical aid in dying with majority support across virtually every demographic group. In addition, voters are eight times "more likely" (51%) than "less likely" (6%) to vote for a candidate for the state legislature if they sponsor or support medical aid-in-dying legislation, according to a national survey conducted by Susquehanna Polling & Research in 2021.[186]

Section VII: About Compassion & Choices

Compassion & Choices is the oldest and largest national nonprofit organization committed to improving care, expanding options and empowering everyone to chart their end-of-life journey. We have more than a half a million supporters and 6,100 volunteers nationwide.

In our last fiscal year, our C34 and C4 secured nearly $22.5 million dollars in revenue, with an operating budget of about the same size. Our funding comes almost exclusively from the generosity of individuals and family foundations,[187] with 73,000 active donors.[188] We receive virtually no corporate support, with the exception of pro bono services provided by law firms that litigate court cases to advance our mission. We are a grassroots movement, the progress of which is the result of people experiencing unnecessary suffering at life's end, demanding care and seeking policies that better reflect their values and priorities.

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Section VIII: Conclusion

Authorizing the full range of end-of-life options, including medical aid in dying, allows people to engage in open conversations with their healthcare providers, their loved ones and their faith leaders about their physical and spiritual needs at the end of life. Without the authorization of medical aid in dying, people nearing the end of life are unable to access this compassionate practice without traveling to another jurisdiction.

We now have almost 30 years of experience since the first such law was enacted in Oregon, demonstrating that medical aid-in-dying laws provide an additional end-of-life option for many constituents, while also protecting providers. Allowing this legislation to become law brings peace of mind to terminally ill people at or near the end of their lives and their community. Furthermore, the cost of inaction is high.

Terminally ill people:

- Need the peace of mind that having access to the full range of end of life options, including medical aid in dying, provides.
- Could experience needless agony when they die, while families and healthcare providers remain powerless with no legal way to respond to pleas for help.

Furthermore, society also fails to gain from the benefits that occur with medical aid in dying implementation including:

- Better conversations between providers and patients.
- Better palliative care training.
- Better hospice usage.
- More open conversations and essential planning for the end of life.

Your jurisdiction can realize these benefits for terminally ill people and their families right now by joining the growing number of jurisdictions that authorize this end-of-life option.

The debate quite simply comes down to who decides and who is in a better position to determine the care a patient receives at the end of life: the terminally ill patient in consultation with their provider and loved ones, or the government?

We urge you to review the evidence, experience, data and strong public support for this end-of-life care option to guide your policymaking.

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