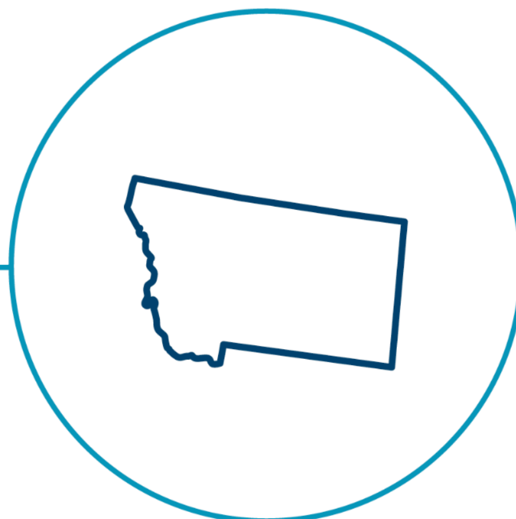
An Introduction to Medical Aid in Dying



MONTANA

CompassionAndChoices.org
info@compassionandchoices.org
800.247.7421

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Medical aid in dying in Montana

Medical aid in dying is the practice in which a terminally ill, mentally capable adult patient voluntarily requests and receives a prescription medication from a physician that they can self-administer to die peacefully. This allows patients to end their lives on their own terms. Medical aid in dying is authorized in 14 jurisdictions with regulations varying by jurisdiction to ensure that the process is carried out ethically and safely.

Montana authorized medical aid in dying through a Supreme Court case in 2009 (*Baxter v. Montana;* learn more at candc.org/case/baxter-v-montana), unlike other states where it has been established through legislation or ballot initiatives. As a result, the eligibility and request process is not established by law. We encourage you to work with your provider to understand the process they follow.

Most providers in Montana follow the procedural process that is used in Oregon, which you will see included throughout this packet, including below:

Eligibility

To be eligible to use the law, the individual 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

The patient must also be:

- Capable of self-ingesting the aid-in-dying medication
- Capable of making an informed decision and voluntary request

A person is not eligible for medical aid in dying solely because of age or disability.

Making a request

The patient must make at least one request to their attending physician. Because there is no statutory waiting period in Montana's *Baxter* ruling, providers generally adhere to the Oregon guidelines, which set out 15 days between oral requests for medication. **It is important to talk to your physician about their specific approach to making a request and waiting periods.** Only the patient can make these requests; they cannot be made through an advance directive or by a family member or friend. The requests must be made to a physician, not office staff. Please see the “Steps” section of this document for details.

Medication

The type and dosage of aid-in-dying medication doctors prescribe, including medications to prevent nausea and vomiting, varies with each individual. The medication cannot be injected. The patient must be able to ingest the medication without assistance. **The prescribing physician must send the prescription directly to the pharmacy. The pharmacy will NOT accept a prescription directly from a patient.** A designated family member or friend may pick up the medications.

If anyone, whether a patient, family member, or healthcare provider, has questions, they can contact Compassion & Choices' free and confidential Call Compassion line at 800.247.7421 for information and support.

The patient may ask their provider or pharmacy about the cost of these medications. Some insurance policies cover the cost of the medication and/or the physician visits. Please contact the insurance provider to find out what the policy covers.

Unused medication

There is no obligation to take the medication, even after the prescription has been filled. If the person who was prescribed the medication does not use it,it should be disposed of in accordance with state and federal law. **<u>Please note it is illegal to use another person’s medication.</u>**

To safely discard unused medication:

- Do NOT flush down the toilet, sink or other drain
- Remove all personal information on bottle labels and medicine packaging

- Use the following website to search for other authorized drug collection/disposal locations near you: https://www.fda.gov/drugs/disposal-unused-medicines-what-you-should-know/drug-disposal-drug-take-back-locations
- Contact the pharmacist who filled the prescription for more assistance.

Death certificates

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 on the death certificate, (for example, cancer, ALS).

Steps for accessing medical aid in dying in Montana

The first step is to speak with your doctor to discuss your interest in medical aid in dying. Be sure to be explicit in your discussion, and **ask if they will support this option by writing a prescription, and to identify their process for fulfilling your request.** Review the "Talking With Your Physician" section of this packet for prompts you can use to begin your discussion. Because much of the process in Montana is not established in law, good communication with your doctor is critical to ensure you understand the procedures they adhere to.

If you are considering medical aid in dying, it is also a good time to think about any additional planning that you may need to begin, including consideration of hospice enrollment.

Note: Hospice is a specialized service (covered by insurance and Medicare), providing individualized support to people at the end of their lives. Those eligible for medical aid in dying are also eligible to receive hospice services. **Many hospice organizations have a policy regarding medical aid in dying, so it is important to review and discuss that policy if enrolled in hospice and pursuing this option.** Visit candc.org/hospice-care for more information.

If your healthcare provider says "no" to supporting this option:

If your physician decides not to participate, or is unable to, you should ask for a referral to another clinician who has chosen to participate. If additional assistance is needed, some health systems offer the support of a care navigator or social worker to assist with resources and referrals. If your doctor does not provide a referral, or your health system does not allow medical aid in dying, you may consider establishing care with a system or facility that will support you in medical aid in dying.

Don't be afraid to advocate for the end-of-life experience you want. For more information and resources, visit **candc.link/personal-advocacy**.

Compassion & Choices' Call Compassion team is available to offer personalized support, resources, and general information at no cost. You can contact Call Compassion at 800.247.7421 , messages are typically returned within 1–2 business days. Language interpreter services are available.

If your healthcare provider says yes:

1. **Make a verbal request for the prescription for aid-in-dying medication directly to your attending doctor.** Ask your doctor to write the verbal request down in your medical record. Your first verbal request is when you state that you would like to pursue medical aid in dying, asking your doctor to write a prescription, or stating that you would like to begin the process of requesting medical aid in dying.

2. In all jurisdictions, you must make at least one oral request to your healthcare provider. In Montana, most providers follow the Oregon law which requires making two oral requests. The second time you ask has to be a minimum of 15 days after the first time you ask. So, make an appointment for a second consultation with your healthcare provider so you can ask a second time.

   Since Montana does not have a centralized written request form, patients should discuss with their physicians the appropriate way to ensure their request is made and documented.

   a. The best practice as established in the law of other authorized jurisdictions is that at least one witness cannot be a relative or someone who stands to benefit from the person's estate, be the person's attending healthcare provider, or be an owner, operator or employee of a healthcare facility in which the person is a resident or receiving medical care.

3. Your healthcare provider may prescribe you aid in dying medication. It usually takes several days to fill a prescription.

4. Pick up your prescription OR have a designated person pick it up for you.

5. Planning for the day of ingestion is also important to do during this time, and allows your healthcare team and loved ones to support you as you wish. This could include discussing

who you want to present, what kind of sounds or smells you would like to experience, managing symptoms prior to ingestion, and what you would like the day to feel like. This is also a good time to review or discuss final arrangements.

6. When the time has come, you can take the medication if you still feel it is necessary*.

***You can always decide not to take the medication.**

Talking with your healthcare provider

The process to access medical aid in dying can take weeks and sometimes months. We encourage people to start the discussion early. You don't have to wait until you're sick to ask your doctor if they would support you in accessing medical aid in dying if you should become eligible for it. Your provider may not be familiar with Montana's Aid-in-Dying judgement itself, and may have some questions; see information about our Call Compassion line at the end of this section for a resource you can share.

Some people feel anxious about discussing end-of-life issues with their physicians, but doing so will enable you to have an end-of-life care experience consistent with your values. If you are uncomfortable with talking to your doctor about this, you can bring a friend to help you or start the conversation in writing. It is important to make sure you are able to access the end of life option you want.

Both doctors and health systems are allowed to opt out of providing medical aid in dying, so it's important to make sure that you are able to access it.

No one but you can make this request. It is important to speak directly with the clinician; do not ask the office staff, nurse or physician's assistant, or leave a request on voicemail. Below are some examples of ways to ask your clinician about their ability to support you in a way that aligns with your values.

Discussing aid in dying with your healthcare provider

Language for someone who DOES NOT have a terminal illness:

> *Though I am not currently facing a terminal illness, access to the option of medical aid in dying, if I were to qualify, is important to me. I would like to know if you/this hospital system would support that decision to access the Montana Aid-in-Dying judgment.*

> *I want to live with as much quality as possible for as long as I can, and I've thought long and hard about what I want my end-of-life experience to look like. If I ever meet the legal requirements, I would like to have the option of using the Montana Aid-in-Dying judgment. Is that something you would be able to support me in seeking?*

> *I hope you will honor my decisions and respect my values, as I respect yours. Will you write a prescription for aid-in-dying medication in accordance with the Montana Aid-in-Dying judgment when I am eligible? If you are not able to honor that request, I would like to find out now.*

Language for someone who DOES have a terminal illness:

> *I have thought about this for quite some time, and am interested in accessing the Montana Aid-in-Dying judgment. Is this a decision that you would support me in?*

> *I want to die the way I've lived: on my own terms. That's why I'm interested in the Montana Aid-in-Dying judgment. Am I eligible? If yes, will you write a prescription for aid-in-dying medication in accordance with the Montana Aid-in-Dying judgment? If you will not write the prescription, will you record in my chart that I am eligible to use the law and refer me to a healthcare provider who is able and willing to honor my request? If you will write a prescription, what specific steps will you require me to take to request one?*

Whether your doctor elects to participate in your medical aid in dying process or not, it is important to ask that your request be recorded in your medical record.

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Glossary

Advance care planning

A continuous process of conversation and documentation to clarify and communicate a person's preferences for future medical care, values, and goals. Ideally, these conversations happen before a health crisis and are revisited as circumstances and needs change over time. Advance care planning can include completing documents such as a living will, health care proxy (or medical durable power of attorney), do not resuscitate order (DNR), portable medical orders, or a dementia directive, which vary by state. But the conversations themselves have value regardless of whether any forms are filled out.

Advance directive

A general term for any document that contains instructions pertaining to a person's wishes related to medical treatment if they cannot make care decisions on their own. An advance directive can include a living will, a health care proxy (or medical durable power of attorney), and other documents that vary by state. Note: in some states and among some professionals, "advance directive" and "living will" are used interchangeably. See also "living will" below.

Find state specific advance directives on Compassion & Choices' website at:
CompassionAndChoices.org/our-issues/advance-care-planning

Attending healthcare provider

A healthcare provider — typically a physician, advanced practice registered nurse, or physicians' associate — who has primary responsibility for a person's care and treatment. In the context of medical aid in dying, the attending healthcare provider is the clinician who writes the prescription for aid-in-dying medication. Some medical aid in dying laws use different terms, such as "prescribing provider" or "treating provider," and eligibility to serve in this role varies by state. Note that "attending" carries different meanings in other care settings, such as hospitals and hospice.

Decision-making capacity

The ability to make informed choices about one's own medical care. To have decision-making capacity, a person must be able to understand the information their medical team provides,

reason through their options, and communicate their choice. If a person loses decision-making capacity, their healthcare proxy can make decisions on their behalf based on what they would have wanted or documented in their advance care plan.

DNR

Stands for ”do not resuscitate,” a medical order instructing healthcare providers not to perform cardiopulmonary resuscitation (CPR) if a person stops breathing or their heart stops beating. A DNR is specific to CPR and does not limit other treatments, such as medication, surgery, or nutrition. Ideally, a DNR order is created before an emergency occurs, while the individual is mentally capable, or by their healthcare proxy if they are not.

Health care proxy

A person authorized to make health care decisions on another person's behalf if that person is unable to make their own. Also known as a representative, surrogate, agent, or medical durable power of attorney for health care, a health care proxy works closely with the health care team to ensure the patient's care and treatment preferences are followed. Choosing a health care proxy — and preparing them to advocate confidently for those wishes — is an important part of advance care planning. This role should be reviewed periodically as circumstances and relationships change.

Hospice

A program in which an interdisciplinary team of healthcare professionals provides comfort and support to people with a terminal illness who have chosen to focus on quality of life rather than curative treatment. Hospice can be provided wherever the person resides, most often at home, and is voluntary. It also involves and supports the individual's family and/or loved ones.

Life-sustaining treatment

Medical treatment intended to keep a person alive. Depending on the illness and the patient, life-sustaining treatment may include medication, surgically inserted assistive devices, respiratory support, and/or artificial nutrition and hydration.

Living will

A document that expresses a person's healthcare preferences if they become unable to speak for themselves. Note: in some states and among some professionals, "advance directive" and "living will" are used interchangeably. A living will can be one component of advance care planning (see "advance care planning " above).

Medical aid in dying

A safe, time tested, and trusted medical practice in which a terminally ill, mentally capable adult with a prognosis of six months or less to live may request from their healthcare provider a prescription for medication that they can choose to self-ingest to bring about a peaceful death. Where medical aid in dying is currently authorized, providers are required to confirm that a patient is fully informed and provide the patient with information about additional end-of-life options, including comfort care, hospice and pain control, before providing a prescription.

POLST/MOLST

Stands for Physician (or Medical) Orders for Life Sustaining Treatment. A medical order completed with a healthcare provider that provides detailed guidance about the wishes of a person with a serious illness for end-of-life care. Because it is a medical order (not simply a planning document) it carries immediate legal weight and is intended to guide care in an emergency. POLST is part of advance care planning. In many states, the form is printed on brightly colored paper so first responders can easily identify it in an emergency.

Palliative care

A form of medical support available to patients at any stage of illness or age, focused on comfort and quality of life. It can be provided alongside curative treatments or as the primary focus at end of life when a patient chooses to prioritize comfort over treatment. Rather than replacing other care, palliative care functions as an additional layer of support that helps patients and their families navigate complex medical situations.

Palliative sedation

Palliative sedation — also referred to as terminal sedation — is the continuous administration of intravenous or subcutaneous medication to relieve severe, intractable symptoms that

cannot be otherwise controlled with less invasive interventions. Must be managed carefully by a medical team, often within a hospital setting.

Paramedic

An emergency responder who provides advanced medical care in the field. The specific procedures a paramedic can perform depend on local and state protocols.

Prognosis

Prognosis refers to the likely path of a disease and may include an estimated time an individual has left to live. Medical aid-in-dying laws and hospice eligibility require a prognosis of six months or less.

Terminally ill

When a disease or illness cannot be cured and is likely to lead to death, it is considered a terminal illness.

Voluntarily stop eating and drinking (VSED)

A legal option for any seriously ill individual with decision-making capacity, who wishes to shorten their dying process, by abstaining from foods and fluids of any kind, including artificial nutrition and/or hydration.

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Tracking of end-of-life plans & documents

Individual Name: ___________________________________ Individual Birthdate: _____________

Choosing medical aid in dying is a process that requires conversation, planning and coordination. This document is designed to help organize essential information related to the process and share with others if you choose to do so.

Advance directive:

- Location of advance directive documents: ____
- Durable power of attorney for health care (name/relationship/phone):

  ____

Hospice (if enrolled):

- Name of organization: ____
- Contact Person: ____
- Contact Email or Phone: ____
- Is Hospice aware of and able to support end of life plans? Yes ____ No ____
- If no, what is the plan for making sure end of life plans are honored?

  ____

  ____
- Any special arrangements need to be made with Hospice to make sure end of life plans are supported? Yes ____ No ____
  - If so, what are they and who is in charge of getting those in place?

    ____

- Will you be requesting someone from the Hospice present? Yes ____ No ____
  - If so, who?: ____

Final arrangements:

- Have these arrangements been made? Yes ____ No ____
  - If yes, name of Mortuary/Funeral Home: ________________________________
  - If yes, what information/details should be shared: ______________________

    ____

    ____

    ____

    ____

Medical aid in dying:

- Attending physician: ____
  - Phone: ____
- Consulting physician: ____
  - Phone: ____
- Date of oral request: ____

  Healthcare provider Name: ____
- Date video request submitted: ____
- Date of mental capacity evaluation: ______________________________________

  Evaluator's Name: ____
- Date written request submitted: ____
- Date aid-in-dying medications prescribed: __________________________________

- Date aid-in-dying medications picked up/received: ________________________________
    - Medications: ____
- Name of pharmacy: ____
- Location or contact person for instructions on disposing of unused medication:

  ____

Plans for ingestion:

- Date of planned ingestion: ____
- Who knows about your plan: ____
- Who will be present during ingestion: ____
- Describe how you you want the day to go (environment, smells, sounds, activities):

  ____

  ____

  ____

- Plan for unexpected events (such as prolonged dying process, vomiting, waking up, etc.)
    - Date(s) discussed: ____
    - Plan details: ____

      ____

      ____

      ____

Additional notes: