

Medical Aid-in-Dying Utilization Report

2025 Edition



NOTE: The data tables attached to the Utilization Report are continuously updated to include the most recent data as it becomes available. The Utilization Report itself, along with the analyses it contains, undergoes an annual update. As a result, there may be differences between the data presented in the tables and the narrative within the report, since the text reflects the data as it stood at the time of the January 2025 report's publication.

January 2025

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

Today, more than one in five people — 22% — live in a jurisdiction where medical aid in dying is authorized. This list includes 10 states: Oregon (1994), Washington (2008), Montana (2009), Vermont (2013), California (2015), Colorado (2016), Hawaii (2018), New Jersey (2019), Maine (2019), and New Mexico (2021), as well as the District of Columbia (2016).

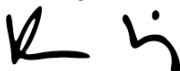
We no longer have to hypothesize about what will happen if this medical practice is authorized. We have almost 30 years of data since Oregon implemented its law and years of experience from other authorized jurisdictions, including annual statistical reports from nine jurisdictions. This report is a compilation of annual reports from all of the authorized jurisdictions that collected data in 2023.

Across the authorized jurisdictions that report data, 10,211 individuals to date have chosen to use medical aid in dying. While few people use the option, many gain peace of mind and comfort simply knowing it exists. Further, medical aid in dying creates a shift within our end-of-life care system to one that is resoundingly person-driven—leading to improvements in hospice care, palliative care, and pain and symptom management. We have reassuring data, strong public support, and evidence that medical aid in dying is a desirable and politically viable option.

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

If you have any questions about this report, please contact National Director of Policy Bernadette Nunley at policy@compassionandchoices.org for more information.

Sincerely,



Kevin Diaz
Interim President & CEO
Compassion & Choices

Context and Methods

Currently, nine of the 11 authorized jurisdictions have issued reports regarding the use of medical aid in dying laws: Oregon,¹ Washington,² Vermont,³ California,⁴ Colorado,⁵ Hawai‘i⁶, the District of Columbia⁷, New Jersey,⁸ and Maine.⁹ In all jurisdictions where medical aid in dying was authorized by legislation or ballot measure, there are statistical reporting requirements for administrative agencies, such as state health departments. However, the reported data is not standardized and the report formats can change from year to year. In addition, the New Mexico Department of Health has not issued an official report as of this writing, so data from New Mexico is not included.¹⁰ Montana also does not issue utilization reports, so no data from Montana is included.

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

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

This report aggregates utilization information available in 2024, which includes data from calendar year 2023. Although differences exist in how each jurisdiction collects and reports data about medical aid in dying, Compassion & Choices records all reported data from each jurisdiction in the aggregate to provide a picture of access to medical aid in dying in the United States. Key findings are below.

¹ Oregon Death with Dignity Act Annual Reports (1998-2023) Available from: <https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ar-index.aspx>

² Washington Death with Dignity Data (2009-2022). Available from: <https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData>

³ 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>.

⁴ 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>

⁵ Colorado End-of-Life Options Act Annual Report (2017-2023) Available from: <https://www.colorado.gov/pacific/cdphe/medical-aid-dying>

⁶ Hawai‘i Our Care, Our Choice Act Annual Report (2019-2023) Available from: <https://health.hawaii.gov/oppd/ococ/>

⁷ District of Columbia Death with Dignity Act Annual Report (2017-2022) Available from: <https://dchealth.dc.gov/publication/death-dignity-annual-reports>

⁸ New Jersey Medical Aid in Dying for the Terminally Ill Act Data Summary (2019-2023) Available from: <https://nj.gov/health/advancedirective/maid/>

⁹ Maine Death with Dignity Annual Report (2019-2023) Available from: <https://www.maine.gov/dhhs/data-reports/reports>

¹⁰Elizabeth Whitefield End-of-Life Options Act Available from: <https://www.nmhealth.org/about/erd/bvrhs/vrp/maid/>

Medical Aid in Dying Jurisdiction Usage Reports

Based on reported data, the following is known:

- > Cumulatively, for almost 30 years across all jurisdictions, 10,211 eligible people have used a prescription for medical aid in dying.
- > Less than 1% of the people who die in each jurisdiction use the law each year.¹¹
- > Only 62% (just under two-thirds) 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 without using the medication, whether from illness, another cause of death, or an unreported reason. In any case, we hear from terminally ill people that they derive peace of mind simply from knowing they have the option if their suffering becomes too great.
- > The majority of terminally ill people who utilize medical aid in dying (88%) are enrolled in hospice or palliative care services at the time of their deaths, according to annual reports for which hospice and palliative care data is available.
- > There is nearly equal utilization of medical aid in dying among men and women. There is no data yet on the utilization of medical aid in dying by nonbinary or gender non-conforming people. However, New Jersey included a category for nonbinary people in its 2023 report.
- > The rate at which Asian, Black, Hawaiian, Pacific Islander, Indigenous American, Alaskan Native, Latino/a/x, Hispanic, and multi-race people access medical aid in dying is consistently lower than white populations across all years and jurisdictions.¹²
- > Year after year, reports indicate that the utilization of medical aid in dying is increasing among people of color. In 2022, California, New Jersey, and Washington, D.C. all reported more people of color accessing medical aid in dying than prior years. In 2023, Oregon, California, and Colorado reported more people of color accessing medical aid in dying than in prior years.
- > 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 second-leading diagnosis. In recent years, some jurisdictions have seen growing numbers of patients with cardiovascular diseases seeking medical aid in dying.
- > Over 77% of people who use medical aid in dying are able to die at home. According to various studies, that is the preference of most Americans.¹³

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 2021. CDC has not released a newer *Deaths: Final Data for [Year]* report. 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>.

¹² In all jurisdictions and across all years, Asian populations have represented 3.44% of patients utilizing medical aid in dying and Latinx and Hispanic populations have comprised 2.05%. Patients from all other racial and ethnic groups accounted for less than 1%. Additionally, 1.26% of patients were classified as "other" or "unknown."

¹³ Kaiser Family Foundation, *Views and Experiences with End-of-Life Medical Care in the U.S.*, April 27, 2017.

<https://www.kff.org/report-section/views-and-experiences-with-end-of-life-medical-care-in-the-us-findings/>.

- > Differences in data collection and reporting among jurisdictions do not allow for thorough comparisons of the use of medical aid in dying across the United States.
- > Increased access to medical aid in dying is observed in jurisdictions that have improved their laws by removing residency requirements, adjusting waiting periods and waivers, and allowing advanced practice registered nurses (APRNs, including nurse practitioners) and other qualified healthcare providers to participate. This change is observed across years of increased access to medical aid in dying in California, Colorado, Hawaii, Oregon, and Washington, beginning in 2018 with the amendment to Oregon's law.

Authorized Jurisdiction (a)(b)	Oregon	Washington	Vermont	California	Colorado	Washington, DC	Hawaii	New Jersey	Maine	Cumulative										
Date Enacted	Oct 27, 1997	Mar 5, 2009	May 20, 2013	Jun 9, 2016	Dec 16, 2016	Feb 18, 2017	Jan 1, 2019	Aug 1, 2019	Jun 12, 2019											
Law	Death with Dignity Act	Death with Dignity Act	Patient Choice at the End of Life Act	End of Life Option Act	End-of-Life Options Act	Death With Dignity Act	Our Care, Our Choice Act	Medical Aid in Dying for the Terminally Ill Act	Death With Dignity Act											
Data Period	1997 - 2023	2009 - 2022	2013 - 2022	2016 - 2023	2017 - 2023	2017 - 2022	2019 - 2024	2019 - 2023	2019 - 2023	1997 - 2024										
Total Years Effective as of 1/1/2025	27	15	11	8	8	7	6	5	5	27										
Summary Data																				
Individuals who received prescriptions (written or filled) (c)	4,274	3,159	200	6,449	1,482	31	361	315	252	16,523										
Individuals who were dispensed medication (c)		3,159			1,123			315		4,597										
Individuals who died after ingesting (a)	2,847	2,341	146	4,233		23	195	287	170	10,242										
Individuals who died without having ingested or died from other causes	857	368	45	841		8	27	27	57	2,230										
Individuals who ingested medication in a calendar year following their prescription's written date	260			232						492										
Individuals whose ingestion status is unknown	606	284	9	1,112			24	8	11	2,054										
Individuals who received prescriptions and for whom a death certificate was subsequently registered (d)		2,639	195		1,297		299		46	4,476										
Unique providers who prescribed the medication (e)	146	207		341	248	4	21			967										
Prescription rate per provider (f)	2.00	1.70		3.03	2.70	1.60	3.69			2.45										
Unique pharmacists who dispensed the medication (e)		68			37					105										
Characteristics/Demographics																				
Gender (h)																				
Female	1,336	46.93%	1,432	47.25%		1,960	49.23%	745	51.66%	13	54.17%	79	40.51%	132	45.99%	27	54.00%	5,724	48.28%	
Male	1,511	53.07%	1,599	52.75%		2,013	50.57%	697	48.34%	11	45.83%	115	58.97%	155	54.01%	23	46.00%	6,124	51.65%	
Other																				
Unknown					8	0.20%					1	0.51%	0	0.00%					9	0.08%
Total	2,847	100.0%	3,031	100.0%		3,981	100.0%	1,442	100.0%	24	100.0%	195	100.0%	287	100.0%	50	100.0%	11,857	100.0%	
Age Breakdown																				
18-64	656	23.04%	719	23.68%		308	23.75%	9	36.00%	24	15.29%	69	24.04%	25	20.83%			1,810	23.30%	
65-74	871	30.59%	982	32.35%		399	30.76%	6	24.00%	51	32.48%	57	19.86%	33	27.50%			2,399	30.88%	
75-84	823	28.91%	781	25.72%		340	26.21%	6	24.00%	57	36.31%	90	31.36%	42	35.00%			2,139	27.53%	
85+	497	17.46%	554	18.25%		250	19.28%	4	16.00%	25	15.92%	71	24.74%	20	16.67%			1,421	18.29%	
Total	2,847	100.0%	3,036	100.0%		3,981	100.0%	1,442	100.0%	25	100.0%	157	100.0%	287	100.0%	120	100.0%	7,769	100.0%	
Age Breakdown (CA)																				
Under 60						369	9.27%											369	9.27%	
60-69						774	19.44%											774	19.44%	
70-79						1,245	31.27%											1,245	31.27%	
80-89						1,004	25.22%											1,004	25.22%	
90+						589	14.80%											589	14.80%	
Total						3,981	100.0%											3,981	100.0%	

Authorized Jurisdiction (a)(b)	Oregon	Washington	Vermont	California	Colorado	Washington, DC	Hawaii	New Jersey	Maine	Cumulative
Age Median & Range										
Median	73			76	72			72		73
Range	25-102	20 - 101		23-107			44-101	32-100	31-98	20-107
Race/Ethnicity (i)										
Asian	44 1.55%	52 1.73%		243 6.08%	18 1.39%		30 19.11%	14 4.88%		401 3.44%
Asian/Native American/Pacific Islander				20 0.50%	8 0.62%					28 0.24%
Black	4 0.14%			33 0.83%	6 0.46%	1 4.35%		3 1.05%		47 0.40%
Hawaiian, Pacific Islander	2 0.07%			4 0.10%			9 5.73%	0 0.00%		15 0.13%
Indigenous American, American Indian, Alaskan Native	8 0.28%			5 0.13%	2 0.15%			0 0.00%		15 0.13%
Latinx, Hispanic	38 1.33%			156 3.90%	38 2.93%	1 4.35%	5 3.18%	1 0.35%		239 2.05%
Multi-race (two or more races)	11 0.39%			23 0.58%			5 3.18%	0 0.00%		39 0.33%
Non-white, Hispanic and/or Non-white		20 0.67%								20 0.17%
Other, Unknown	13 0.46%	97 3.23%		22 0.55%	8 0.62%		5 3.18%	2 0.70%		147 1.26%
White	2,727 95.79%	2,838 94.38%		3,493 87.35%	1,217 93.83%	21 91.30%	103 65.61%	267 93.03%	49 100.0%	10,715 91.85%
Total	2,847 100.0%	3,007 100.0%		3,999 100.0%	1,297 100.0%	23 100.0%	157 100.0%	287 100.0%	49 100.0%	11,666 100.0%
Education (j) (k)										
High School Diploma, GED, or Less	761 26.73%	750 24.94%		908 22.81%	296 22.82%	0 0.00%	21 13.38%	82 28.57%	16 23.88%	2,834 24.29%
Some College	566 19.88%	1,515 50.38%		689 17.31%	171 13.18%	1 4.00%	11 7.01%	21 7.32%	9 13.43%	2,983 25.56%
Associate's, Bachelor's, Master's, Doctorate or Professional Degree	1,499 52.65%	713 23.71%		2,343 58.85%	823 63.45%	22 88.00%	67 42.68%	184 64.11%	43 64.18%	5,694 48.80%
Unknown	21 0.74%	29 0.96%		41 1.03%	7 0.54%	2 8.00%	58 36.94%	0 0.00%	0 0.00%	158 1.35%
Total	2,847 100.0%	3,007 100.0%		3,981 100.0%	1,297 100.0%	25 100.0%	157 100.0%	287 100.0%	67 100.0%	11,669 100.0%
Marital Status										
Married, Domestic Partner	1,305 45.84%	1,421 47.26%			584 45.03%			135 47.04%		3,445 46.32%
Widowed	602 21.15%	583 19.39%			271 20.89%			83 28.92%		1,539 20.69%
Divorced, Separated	702 24.66%	742 24.68%			335 25.83%			46 16.03%		1,825 24.54%
Never Married, Single, Other, Unknown	238 8.36%	261 8.68%			107 8.25%			23 8.01%		629 8.46%
Total	2,847 100.0%	3,007 100.0%			1,297 100.0%			287 100.0%		7,438 100.0%
End-of-Life Care										
Hospice and/or Palliative Care										
Enrolled	2,559 89.88%	1,010 83.13%		3,601 90.45%	1,084 83.58%		130 97.01%			8,384 88.49%
Not Enrolled	254 8.92%	151 12.43%		310 7.79%						715 7.55%
Unknown	34 1.19%	54 4.44%		70 1.76%	2 0.15%		4 2.99%			164 1.73%
Not under hospice care or unknown					211 16.27%					211 2.23%
Total	2,847 100.0%	1,215 100.0%		3,981 100.0%	1,297 100.0%		134 100.0%			9,474 100.0%

Authorized Jurisdiction (a)(b)	Oregon	Washington	Vermont	California	Colorado	Washington, DC	Hawaii	New Jersey	Maine	Cumulative
Insurance										
Private/Commercial	914 32.10%	296 10.19%		495 12.43%		12 48.00%	21 13.38%			1,738 17.53%
Medicare, Medicaid, and/or Other Governmental	1,477 51.88%	774 26.65%		365 9.17%		10 40.00%	48 30.57%			2,674 26.97%
Combination of Governmental and Private/Commercial		196 6.75%		2,079 52.22%			62 39.49%			2,337 23.57%
Insured (unspecified)		970 33.40%		732 18.39%			10 6.37%			1,712 17.27%
None, Other, Unknown	456 16.02%	668 23.00%		310 7.79%		3 12.00%	16 10.19%			1,453 14.66%
Total	2,847 100.0%	2,904 100.0%		3,981 100.0%		25 100.0%	157 100.0%			9,914 100.0%
Underlying Illness (l)(m)										
Cancer, Malignant Neoplasms	2,014 70.74%	2,149 74.13%	150 75.00%	2,641 66.34%	891 60.04%	20 74.07%	152 70.37%	172 59.93%	127 67.20%	8,316 68.56%
Neurological Disease	310 10.89%	263 9.07%	26 13.00%	414 10.40%	249 16.78%	4 14.81%	23 10.65%	57 19.86%	24 12.70%	1,370 11.29%
Respiratory Disease	183 6.43%	192 6.62%	5 2.50%	271 6.81%	122 8.22%	1 3.70%	16 7.41%	19 6.62%	14 7.41%	823 6.78%
Cardiovascular, Circulatory Disease	206 7.24%	171 5.90%	2 1.00%	386 9.70%	125 8.42%	2 7.41%	17 7.87%	26 9.06%	12 6.35%	947 7.81%
Other illnesses	134 4.71%	124 4.28%	17 8.50%	269 6.76%	97 6.54%	0 0.00%	8 3.70%	13 4.53%	12 6.35%	674 5.56%
Total	2,847 100.0%	2,899 100.0%	200 100.0%	3,981 100.0%	1,484 100.0%	27 100.0%	216 100.0%	287 100.0%	189 100.0%	12,130 100.0%
MAID Process										
Place of Death/Where Medication Ingested										
Private Home, Residence	2,614 91.82%	1,069 40.85%		3,138 89.76%	1,063 81.96%			266 92.68%		8,150 77.30%
Hospice Facility	11 0.39%			47 1.34%	53 4.09%			12 4.18%		123 1.17%
Hospital, Acute Care Hospital	8 0.28%	1 0.04%		3 0.09%	14 1.08%					26 0.25%
Long Term Care, Assisted Living, Foster Care Facility	146 5.13%	99 3.78%		265 7.58%				3 1.05%		513 4.87%
Nursing Home	22 0.77%			24 0.69%	105 8.10%			5 1.74%		156 1.48%
Other, Unknown	46 1.62%	1,448 55.33%		19 0.54%	62 4.78%			1 0.35%		1,576 14.95%
Total	2,847 100.0%	2,617 100.0%		3,496 100.0%	1,297 100.0%			287 100.0%		10,544 100.0%
Patient Informed Family of Decision										
Yes	2,593 91.08%	1,353 42.83%		2,956 84.55%						6,902 72.64%
No, No Family to Inform	254 8.92%			280 8.01%						534 5.62%
Unknown		1,806 57.17%		260 7.44%						2,066 21.74%
Total	2,847 100.0%	3,159 100.0%		3,496 100.0%						9,502 100.0%

See endnotes on next page

Rev. 2.27.2025

Endnotes

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

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

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

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

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

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

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

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

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

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

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

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

(n) The data tables attached to the Utilization Report are continuously updated to include the most recent data as it becomes available. The Utilization Report itself, along with the analyses it contains, undergoes an annual update. As a result, there may be differences between the data presented in the tables and the narrative within the report, since the text reflects the data as it stood at the time of the January 2024 report's publication.

Appendix: Medical Aid in Dying Original Authorization Information

Jurisdiction	Law / Court Case	Date Implemented	Authorization Mechanism	Data Period	Years Effective as of 1/1/2025
Oregon	Death with Dignity Act	Oct 27, 1997*	Ballot Initiative	1997 - 2023	27
Washington	Death with Dignity Act	Mar 5, 2009	Ballot Initiative	2009 - 2022	15
Montana	Baxter v. Montana	Dec 31, 2009	MT Supreme Court	n/a	15
Vermont	Patient Choice at the End of Life Act	May 20, 2013	Legislation	2013 - 2022	11
California	End of Life Option Act	June 9, 2016**	Legislation	2016 - 2023	8
Colorado	End-of-Life Options Act	Dec 16, 2016	Ballot Initiative	2017 - 2023	8
Washington, D.C.	Death With Dignity Act	Feb 18, 2017	Legislation	2017 - 2022	7
Hawaii	Our Care, Our Choice Act	Jan 1, 2019	Legislation	2019 - 2023	6
New Jersey	Medical Aid in Dying for the Terminally Ill Act	Aug 1, 2019	Legislation	2019 - 2023	5
Maine	Death With Dignity Act	June 12, 2019	Legislation	2019 - 2023	5
New Mexico	End-of-Life Options Act	June 18, 2021	Legislation	n/a	3

Notes:

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

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