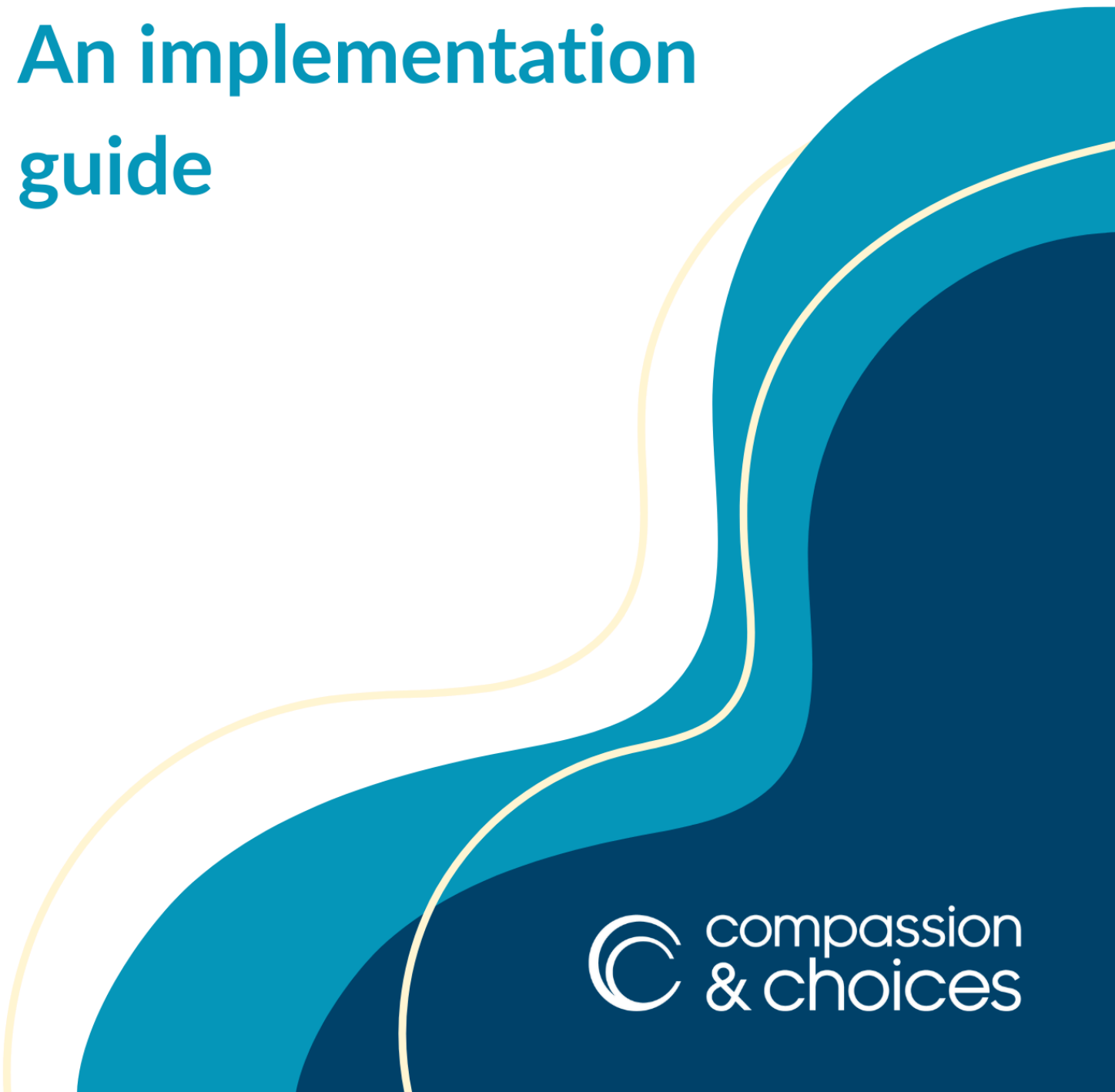
Integrating Medical Aid-in-Dying Care:

An implementation guide



compassion & choices

Table of contents

Compassion & Choices is the nation's oldest, largest, and most active nonprofit working to improve care and expand options for the end of life. For more than 40 years we have sought to change attitudes, practices, and policies so that everyone can access the information and care they need.

Integrating Medical Aid-in-Dying Care

Medical aid in dying (MAID) is a time-tested end-of-life option that provides peace of mind to people facing terminal illness. Based on insights gained in over 30 years of experience with MAID, this resource summarizes the process for integrating a new law into practice in four simple steps:

1. **Understand the law**
   Understand the practice of medical aid in dying and the requirements specific to your jurisdiction.

2. **Know the stakeholders**
   Familiarize yourself with the landscape in your jurisdiction - who are the key players?

3. **Support regulatory development**
   Know the regulatory process, why those regulations matter, and how to provide input.

4. **Public & professional education**
   Learn strategies and discover resources to improve understanding of MAID among professionals and the general public.

Step 1: Understand the law

Once aid-in-dying legislation has been authorized in a jurisdiction, the transition from legislative campaign to implementation poses unique challenges. First and foremost it is critical to understand what medical aid in dying is; then consider the core elements of the law and their implications for practice.

What is medical aid in dying?

Medical aid in dying, sometimes referred to as "MAID", is an 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-administer to end their life.

Eligibility

Existing laws authorizing medical aid in dying in the United States 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.[1] 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 into the gastrointestinal tract through an affirmative, conscious, voluntary act.
    - 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.

Self-administration

The self-administration requirement is a core safeguard to prevent involuntary administration. Jurisdictions where medical aid in dying is authorized all require medication to be self-administered into the gastrointestinal tract. A critical factor in

[1] 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/

ensuring that a person self-administers their medication according to the law is that they remain in control of the procedure from start to finish and take voluntary action to deliver the medication into their body via the gastrointestinal tract.

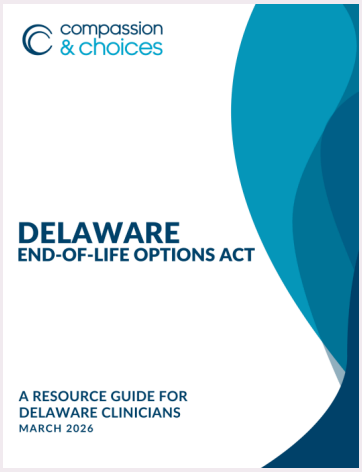
The process to access medical aid in dying

Patients must follow a multi-step process to access medical aid in dying. While some elements vary by jurisdiction, in general an individual must:

1. Make an initial verbal request to their "attending" clinician, which is the person who will write the prescription.
2. Undergo evaluation by a second "consulting" clinician to confirm eligibility.
3. Make a second verbal request to the attending clinician.
4. Submit a written request to the attending clinician using a standardized form.
    - Jurisdictions often provide a template written request form.
5. The attending clinician submits a prescription for medical aid-in-dying medications to a compounding pharmacy.
6. The patient self-administers the medications at a time of their choosing, if at all.
7. A member of the healthcare team will report the death as required by law.

Delaware End-of-Life Options Act: A Resource Guide for Delaware Clinicians provides healthcare professionals and public health officials with detailed information about the clinical practice of medical aid in dying. While this resource is Delaware-specific, it is an example of the kind of clinical resources Compassion & Choices can provide.

This resource contains need-to-know information about the clinician's role, including details about the process from the clinician's perspective. [It is available here](#).



Understanding the nuances

While all medical aid-in-dying laws in the United States to date share the same core eligibility criteria, protections, and process, there is some variability. Several points on which laws differ include:

- **Which clinicians may prescribe**. Across all jurisdictions, physicians (MD or DO) may serve as the attending or consulting clinician for medical aid in dying. In some jurisdictions, Advanced Practice Registered Nurses (APRNs) or Physicians' Associates (PAs) may also serve in these roles.
- **Waiting periods.** Mandatory waiting periods between requests vary across jurisdictions. In some, those waiting periods can be waived if the patient is not expected to live long enough to complete the process. Some jurisdictions mandate a waiting period between submission of the written request and when the prescription may be written.
- **Mental health evaluations.** Some jurisdictions mandate a psychological evaluation for all patients wishing to pursue MAID in order to verify decision-making capacity. Most jurisdictions require this evaluation only if the attending or consulting clinician has doubts about the patient's mental state.
- **Reporting.** Requirements for reporting (by attending and consulting provider and dispensing pharmacy) varies across jurisdictions, including which information must be reported and the required timelines for submitting reports.
- **Timeline for implementation.** Each piece of legislation determines when the option will become available to patients once the law passes. More information on timelines is available below.

Timeline

The text of the legislation will determine the timeline for how quickly the law goes into effect, and must be taken into account when planning support for implementation. In jurisdictions where there is a months-long implementation period between the law's signing and its effective date, that time can be used to build collaborative relationships and continue education efforts for the public and professionals.

In some cases, the timeline may not be explicitly stated or it may depend on external factors. This was the case in Delaware, where the Ron Silverio/Heather Block End-of-Life Option Act had an effective date of January 1, 2026, *or when the Department of Health and Social Services (DHSS) had published the regulations*, whichever was sooner. This made open communication with DHHS all the more important.

Step 2: Know the stakeholders

The next step is to understand the stakeholders that will be involved in the process of integrating the practice of MAID into medical practice. They include the jurisdiction's government agencies and officials responsible for crafting regulations and monitoring the formal implementation of the law. State and local groups are also important avenues to deliver information about MAID to professionals and the general public.

Working with state health departments

One of the most important things the law determines is which government agency is responsible for activities relating to implementing medical aid in dying. This will most frequently be the jurisdiction's Department of Health or equivalent. That agency will be responsible for establishing regulations, providing forms, and, if applicable, administrating the reporting process.

Department of Health resources

Each jurisdiction's Department of Health has latitude to decide what information and resources to provide, if any. Departments in many jurisdictions opt to provide a landing page where basic information about the law can be provided and where utilization statistics are published. If an online portal is used for reporting, that information will typically also be included. Examples include:

- The California Department of Public Health hosts a page on the End of Life Option Act which includes basic information about the law, as well as links to the statutory language, required forms, and the portal where forms should be submitted.
- Similarly, the Oregon Health Authority's page on the Death with Dignity Act includes information about the law, links to the statute, an FAQ, required forms, and the state's collection of annual reports.

When a relationship can be established with the relevant agency, Compassion & Choices and other stakeholders have the opportunity to offer insight and support for these processes, including education for stakeholders, the creation of resources, or consultation on content created by the agency.

Key questions to consider

- Will the state be developing regulatory language? If so:
  - What administrative agency is responsible for this process?
  - What does that process look like?
  - Will there be opportunities to assist in guideline development?
  - Will they issue temporary language and guidelines?
  - Will there be additional hearings or a comment period prior to the law going into effect?
- Who will be responsible for collecting and reporting data? This may be the same body that developed the regulations, but it may not.
  - Is there an opportunity to provide input on what should or should not be reported?
- Who will be responsible for compliance and monitoring?
- Will the state build a new webpage to host information about the law?
- What are their biggest concerns? Barriers? Needs?

Case study: Delaware

Following the passage of the Ron Silverio/Heather Block End-of-Life Option Act in 2025, Compassion & Choices staff worked closely with the Delaware Department of Health and Social Services (DHSS) to prepare for implementation.

Due to our expertise and hard work in Delaware over the previous decade, staff were invited to join a working group to provide feedback on the regulations. This working group consisted of stakeholders from state government and the healthcare community, which added a breadth of expertise to the regulatory process. Thanks to this relationship, Compassion & Choices staff from the Engagement, Policy, and Advocacy & Outreach teams were able to answer questions and highlight key issues prior to the regulations being drafted. Then, following the publication of the draft regulations in early 2026, staff were able to further analyze and provide formal feedback. Once the final regulations were published, staff from DHSS joined a webinar hosted by Compassion & Choices to speak about the regulations and answer questions from healthcare professionals.

Beyond the regulatory process, this collaboration with DHSS opened doors to further relationships with state officials and healthcare organizations, reinforcing Compassion & Choices' credibility in that space and improving our reach to provide information and resources.

Working with professional associations

Professionals working in a variety of fields may be affected by the implementation of medical aid in dying in their state, and outreach to these individuals typically requires a different approach than that used for the general public. Healthcare providers, faith leaders, legal professionals, and others frequently hold membership in professional groups, associations, and societies, which tend to serve as a key source of information for those members.

Organizations such as physicians', nurses', or bar associations often have a state branch or chapter; some of these groups may already have interacted with the legislative process in some way, such as advocating for or releasing a position statement on medical aid in dying. Other groups may not be aware of the law at all. In either case, it is important to have an understanding of the positioning of these groups and the professional landscape in the jurisdiction. For groups that may be supportive or neutral on the issue, offering information or resources to them or exploring opportunities to provide education, purchase advertisements, or place op-eds can be a great way to spread awareness among their membership.

It is important to understand that in the healthcare sphere, a professional *association* is distinct from a state *board*. While an association may provide networking support, informational resources, or even training opportunities, a board governs professionals' licensure for a given discipline. At a minimum, a jurisdiction will typically have a medical board (overseeing physicians), a board of nursing (overseeing nurses), and a board of pharmacy (overseeing pharmacists). A professional board may or may not opt to provide information directly about medical aid in dying. In many cases, the board's website may link to the relevant Department of Health page for more information.

Working with advocacy groups

Many jurisdictions have nonprofit organizations working in the end-of-life space. Some of these operate independently as statewide "End-of-Life Options" organizations, while some operate as state chapters of national organizations. In many cases, such groups predate the passage of laws or even the introduction of legislation related to medical aid in dying. Collaboration with these groups has several advantages, including:

- On-the-ground support and local-level expertise, especially in jurisdictions in which C&C has minimal staff presence to help inform strategy

- Familiarity with the legislation and history of the movement
- Patient and community support, such as:
    - *Volunteer programs* – Volunteers are key to providing local-level support. They can deliver education and bolster presence at local events, increasing public awareness and decreasing stigma around this option. In some jurisdictions, robust volunteer programs have made bedside support possible for patients choosing medical aid in dying.
    - *Helplines* – Direct lines of communication with the public, whether by phone or email, enable support to patients navigating the aid-in-dying process. This can be especially helpful for jurisdictions without residency requirements, where patients are navigating relocation, trying to connect with clinicians, or identifying a place to take the medications.
    - *Support funds* – The cost of aid-in-dying medications can be prohibitive for many patients and pose a barrier to access. Patient support funds can help cover the cost of medications or other unanticipated costs.

Case Study: Collaboration with End of Life Washington

Compassion & Choices and Compassion & Choices Action Network work collaboratively with End of Life Washington on end-of-life care policy and to educate community members about the importance of end-of-life planning.

Compassion & Choices provides technical expertise and a cross-jurisdictional perspective on end-of-life care policy, while End of Life Washington provides a local perspective on access to end-of-life care options rooted in their work directly supporting patients from planning to bedside. Collaborations in recent years have included successfully advancing legislation to improve patient access to the Washington Death with Dignity Act. We regularly communicate about regulations, laws, and policy related to end-of-life care and planning, and troubleshoot barriers to access as they arise.

Step 3: Developing regulatory language

Regulatory language helps establish expectations and processes for individuals and institutions acting in accordance with the law. These regulations, sometimes referred to as "rules," offer greater specificity than the legislation alone. While not all jurisdictions opt to publish regulations, those that do tend to focus on the following elements:

- Defining **roles and responsibilities** of involved parties (e.g., attending and consulting providers, patient, health care facility, government agency, etc.)
    - Responsibilities of healthcare providers include the provision of aid-in-dying care, documentation of care, referrals (in the event a provider is unable or opts not to participate), and mandated reporting.
- The **timeline to submit required documentation**
    - Required documents should be explicitly identified, including any sample forms and the process and mechanism for their submission.
    - Where required, this should also include documentation to be submitted related to the mental health evaluation of the patient. If this is required only at the discretion of the prescribing professional, those parameters should also be stipulated.
- Establishing the **mechanism to submit required documentation**
    - The creation of an online portal providers can use to submit data directly reduces administrative burden on both providers and government agencies.
    - If it is not possible to use or create an online portal, reports may be submitted via email, postal mail, or fax.
    - There are variations between jurisdictions in which administrative bodies will receive and process required forms.
- Statements relating to **confidentiality and liability** concerning the required collection of patient data
- Some jurisdictions include provisions for who may (or must) sign the **death certificate**
    - Death certificates can be a source of concern for healthcare providers, administrators, or coroners/medical examiners who may not be as familiar with the process of medical aid in dying. It is common to receive questions or even opposition from individuals or groups regarding how a death certificate should be filled out following the death of someone who utilized medical aid in dying as part of their end-of-life care.

- Details around **utilization reports**, including what information will be published and in what cadence

Examples of regulatory language

Each jurisdiction's regulatory language looks a little different, varying by the legislation and by the degree to which the regulatory agency chose to establish rules. Examples of published regulations include but are not limited to:

- The Oregon Administrative Rules, Code of Colorado Regulations, and the Code of Vermont Rules establish rules for reporting requirements, confidentiality, and annual data reports.

Several jurisdictions choose not to publish regulations beyond what is already in the legislation, but instead maintain a webpage with information about the law. Examples include:

- California's *End of Life Option Act*
- Hawai'i's *Our Care, Our Choice Act*
- The *D.C. Death with Dignity Act*

Utilization reports

The reporting requirements for prescribing providers and pharmacists present an opportunity for better understanding who is choosing to pursue medical aid in dying. As a result, most jurisdictions produce a report summarizing data submitted by providers. Because both the forms and reporting process are typically determined by the Department of Health during the regulatory process, it is helpful to be aware of experiences with reporting in other jurisdictions.

Key considerations

- Confidentiality
  - The confidentiality of those choosing to participate in medical aid in dying under the law — either as patients or as healthcare professionals — is of paramount importance. Individual-level data should never be published in reports.
  - Even compiled data can be identifying, particularly in cases where multiple variables are combined (e.g. ethnicity and underlying illness). It is good practice to implement minimum cell sizes, where a category will not be reported if a minimum number of individuals is not met.

- Consistency
    - One of the benefits of regular reporting is that it becomes possible to examine trends that emerge over time. This becomes difficult if variables are inconsistent from year to year. To the extent possible, reports should be kept consistent to allow for more robust analysis.
- Accuracy and revision
    - Depending on the required timelines for document submission, it is possible for new data to emerge for a given period even after the report has been released. It is good practice to issue updates after additional data has been received in order to maximize accuracy.
    - Oregon is a good example of a jurisdiction which revises its reports each year to account for data received after initial publication. This ensures that their reporting is as accurate as possible.

Important data points

- Demographics should be accurate, comprehensive, and respectful. Including information such as:
    - Gender
    - Age
    - Race/ethnicity
- Total number of individuals receiving prescriptions
- Total number of individuals who died after ingesting prescriptions
- Total number of individuals who died without having ingested the prescription
- Enrollment in hospice
- Enrollment in palliative care
- Underlying illness (as confidentiality allows)
- Place of death (e.g. home, hospital, long-term care facility)

Compassion & Choices' Medical Aid in Dying Utilization Report is a compilation of utilization data reported by jurisdictions where medical aid in dying is authorized. Although differences exist in how each jurisdiction collects and reports data, Compassion & Choices analyzes reported data to provide a picture of access to medical aid in dying in the United States. Read the most recent report here.

Clarifying existing regulations

In some cases, clarification may be issued in response to perceived ambiguities in published regulations. This could be done by the agency responsible for authoring the regulations, but it can also be done by other agencies whose area of jurisdiction is impacted by the legislation in question.

One such case occurred in California in 2023, and the clarification was issued by the Department of Social Services. While this agency was not responsible for drafting the regulations, it determined that the clarification was necessary due to the way that the legislation impacted facilities regulated by the agency.

Case study: California

On April 19, 2023, the California Health and Human Services Agency's Department of Social Services sent a statewide letter to all residential care facilities for the elderly (aka assisted living facilities). This letter clarified that a resident who is qualified for medical aid in dying has a right to ingest their aid-in-dying medications at the facility, whether or not the facility allows staff to participate under the End of Life Option Act.

Step 4: Support healthcare professionals, organizations, and the public

In the months leading up to and following the authorization of a new aid-in-dying law, both healthcare professionals and members of the public must be informed about the availability of this care option and supported as they seek to implement it within their systems and communities.

Outreach & education

Clinicians and healthcare administrators require access to reliable information and opportunities to educate themselves, their staff, and their patients.

Community members, many of whom will be entirely unfamiliar with medical aid in dying, will need to understand what it is and have opportunities to learn whether it may be an option for them or their loved ones.

Compassion & Choices offers interdisciplinary expertise and perspective gained from years of experience in all authorized jurisdictions to provide guidance and support both to healthcare professionals and the general public.

Strategies

- **Public education/awareness campaigns:** This effort includes virtual and in-person education events focusing on the basics of what medical aid in dying is, who it is for, and how it can be accessed.
- **Professional education:** Content focuses on what healthcare and community professionals need to know about medical aid in dying in order to support their patients or clients.
- **Technical assistance:** Individualized support is available to organizations seeking to implement medical aid in dying in their settings. This is most often offered to healthcare organizations and facilities seeking to build or implement an institutional policy and process for supporting patients at the end of life.

Compassion in Practice: The process of integrating medical aid in dying care into an existing clinical practice can vary based on a number of factors — including practice type, setting, and the patient population. Compassion in Practice is a series of short articles designed to highlight the wide variety of ways this care can be implemented. Learn more and view the highlighted programs here.

Developing organizational policy

While medical aid-in-dying laws outline the specific requirements for a patient to request and obtain the prescription, healthcare organizations are encouraged to develop internal policies that provide clear information to patients, clinicians, and staff that address how requests for medical aid in dying will be received and managed within an interdisciplinary care team.

Broadly speaking, policies should:

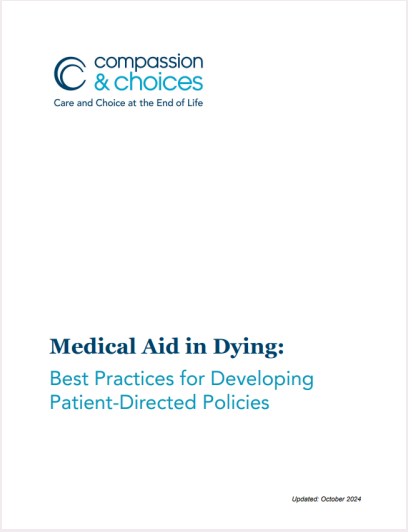
Align with existing palliative care standards. All goals-of-care conversations should center on patient priorities, whether or not those priorities include medical aid in dying. The practice of medical aid in dying should be integrated into the organization's existing interdisciplinary model of care.

Set clear standards for the organization's participation and serve as a reference for staff. The policy should be explicit about the ways the organization will support patient-directed care, including medical aid in dying, and establish processes to facilitate that care.

Support the interdisciplinary care team. The policy should establish roles and responsibilities for all staff or volunteers who may be involved in the process. Structures for training should be established, as well as mechanisms for managing and supporting conscientious objections and moral distress.

Medical Aid in Dying: Best Practices for Developing Patient-Directed Policies is designed to provide healthcare organizations with guidance and resources for:

- Developing policies and procedures to support patients who inquire about or choose medical aid in dying
- Developing policies and procedures to support clinicians and staff in providing patient-centered care to patients who inquire about or choose medical aid in dying



The goal of good end-of-life care is to provide patient-directed options that improve quality of life by anticipating, preventing, and treating suffering. Quality care in the final phases of terminal illness addresses physical, intellectual, emotional, social, and spiritual needs, and facilitates patient autonomy, access to information and choice in care. The resource is available here.