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NATIONAL END-OF-LIFE DOULA ALLIANCE

Medical aid in dying:

An informational guide for end-of-life doulas

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Compassion & Choices is the nation's oldest, largest, and most active nonprofit working to improve care and expand options for care at the end of life. We envision a society that affirms life and accepts the inevitability of death, embraces options for compassionate dying and empowers everyone to choose end-of-life care that reflects their values, priorities, and beliefs.

The National End of Life Doula Alliance (NEDA) is a national alliance of end-of-life advocates working to ensure compassionate, inclusive, and dignified care for all. Through connection, education, and collective action, we support those who guide others through life's final journey.

Introduction

Medical aid in dying, often abbreviated as "MAiD," is a widely supported practice in end-of-life care that provides dying people with peace of mind and comfort during a difficult time. In the U.S. jurisdictions where this option is authorized, medical aid in dying allows a terminally ill, mentally competent adult to die peacefully on their own terms.

In November 1994, Oregon passed the nation's first law giving terminally ill adults access to medical aid in dying. Today more than one in four people live in a jurisdiction where medical aid in dying is authorized.

Evidence from nearly 30 years of practice demonstrates that the option of medical aid in dying increases utilization of hospice and encourages conversations about values and priorities while improving end-of-life care overall[1]. More importantly, the multistep process ensures patients are fully informed about care options, protected from coercion, and empowered to choose their own end-of-life journey.

A CONTINUED PUSH

Since Oregon's 1994 authorization, hundreds of bills have been introduced across the country.

As of August 2026, there are 14 bills to introduce medical aid in dying across the country, and two to improve existing laws. You can head to https://cand.org/state-advocacy/ for the most up to date numbers.

If you are reading this guide, we hope it is because you recognize the importance of patient-directed care at the end of life and are eager to learn about the practice of medical aid in dying. This content was developed through a partnership between Compassion & Choices and the National End of Life Doula Alliance. It has been curated by clinical, legal, and policy experts alongside end-of-life doulas with experience in medical aid in dying. Our goal is to provide accurate information and practical resources to doulas across the country, as they support their community. Thank you for all that you do!

Medical aid in dying

Facing the end of life can be one of the most profound and vulnerable times in a person's journey. Care during the terminal phase of an illness encompasses a range of interventions intended to relieve pain and discomfort, provide emotional and spiritual support, address practical needs, and

[1] Hoffman, D., 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

maintain quality of life. Alongside hospice, palliative care, and comprehensive symptom management, one option for care at the end of life is medical aid in dying.

Medical aid in dying is a clinical practice that provides eligible adults living with a terminal disease the choice to control their end-of-life experience. It is a clearly defined process available only in U.S. jurisdictions where it has been authorized by legislation, ballot measure, or court decision. While few people use this care option — less than 1% of adults who die in each jurisdiction[2] — many gain peace of mind and comfort by simply knowing it exists.

Eligibility

Laws authorizing medical aid in dying in the U.S. have slight variances, but each establishes strict eligibility criteria and practice requirements to ensure the highest standard of care. Eligibility for aid in dying, in most jurisdictions, requires an individual to be :

- An adult (18 years or older) resident of the state
  - *(VT, MT, and OR have exceptions for residency)*
- Diagnosed with an terminal (incurable and irreversible) illness
- Determined to have a prognosis of six months or less
- Able to make their own healthcare decisions
- Able to complete the multistep request process
- Able to self-administer medications to be absorbed by the gastrointestinal (GI) tract

An individual does not qualify for medical aid in dying solely based on age, disability or quality of life. A mental health condition is not a qualifying condition because it does not meet the definition of a terminal illness. Nor is it a disqualifier from access. This is a commonly misunderstood element, and an important thing for doulas to clarify when discussing the option.

Request process: an overview

Each piece of legislation outlines a clear multi-step process that outlines practice requirements while ensuring patients are fully-informed and empowered to choose the end of life experience right for them.

[2] *Medical Aid-in-Dying Utilization Report, 2026. Compassion & Choices.* https://compassionandchoices.org/resource/medical-aid-in-dying-utilization-report/

As an end-of-life doula, you will not be facilitating this process, but you will need to understand it, so that you can best support those you serve through clear and accurate information. Every jurisdiction has slight differences (most commonly related to eligible providers and required wait times between requests), so you will often see reference to that in this guide. For the most updated information on any jurisdiction's language, please visit https://candc.org/in-your-state/ and choose the state you are seeking information about.

In all jurisdictions, an attending healthcare provider and a consulting healthcare provider must both independently verify the patient's eligibility for medical aid in dying. Eligible healthcare providers vary by jurisdiction and include physicians, advanced practice registered nurses (APRNs), and physician assistants (PAs). The attending and consulting healthcare providers must also confirm the patient understands their options and is requesting life-ending medications of their own volition, without any undue influence.

If the attending or consulting healthcare provider is unclear about the patient's capacity to make their own healthcare decisions or has concerns about impaired judgment, a third evaluation by a licensed mental health professional (such as a psychiatrist, psychologist, or clinical social worker) is required. Each jurisdiction has outlined which licensed professionals they determine eligible for this. In Hawai'i and New York, this third evaluation is required as part of all requests. This is not a mental health evaluation, but a review of decision-making capacity.

Generally, a patient must **make three voluntary requests** for aid in dying directly to their attending healthcare provider: two oral requests with a waiting period in between and one written request signed by two adult witnesses.

Waiting periods vary by jurisdiction. To learn the unique timelines and/or exceptions to this process in your jurisdiction, please head to https://candc.org/state-advocacy/ for the specifics of the legislation your client will be following.

It is important to note that a request **cannot be made through an advance directive or by a healthcare proxy**, power of attorney, family member, or other individual acting on behalf of the patient. Requests must also be made **directly to the healthcare provider**, not through another member of the healthcare team or provider's staff.

If at any time the patient changes their mind and wishes to withdraw their request, they have the right to do so. Years of practice indicate this is not an uncommon or unexpected scenario. Utilization data from authorized jurisdictions that provide reports, approximately 38% of patients who go through the process and obtain a prescription may never take it[3]. If this occurs, no formal notification or withdrawal process is required.

[3] Medical Aid-in-Dying Utilization Report, 2026. Compassion & Choices. https://compassionandchoices.org/resource/medical-aid-in-dying-utilization-report/

Role of the attending provider

Important note: **The title for this role changes by jurisdiction, as do the credentials connected**. In some places this person can be a physician, PA, or APRN; in other places they must only be an MD or DO. They may also be called a "prescribing physician" instead of an attending provider. You can confirm the language and credentialing required in your jurisdiction by visiting: https://candc.org/in-your-state/

The patient's first oral request will expire if no medication is prescribed. If necessary and as long as they remain eligible, a patient can make a new oral request and begin the process again.

The professional in this role has primary responsibility for the patient's terminal illness and coordinating all of the steps associated with medical aid in dying including coordination with the consulting provider determining the best route of self-administration, and writing the prescription for aid-in-dying medication once the patient has completed the request process. The attending healthcare provider may or may not be the same as the attending for hospice, primary, or specialty care.

Following the receipt of a patient's request for medical aid in dying, the attending provider must confirm the patient meets all eligibility criteria and is making an independent and fully-informed decision regarding their end-of-life care. This requires meeting with the patient privately to confirm they are making the request of their own free will without any coercion or pressure. An interpreter can, and should, be present if necessary to ensure the patient is able to communicate in the language they are most comfortable.

Each jurisdiction's law also requires the attending provider to engage in open and ongoing conversation with the patient to:

- Review their diagnosis and prognosis
- Discuss the risks and expected result of taking the aid-in-dying medication
- Explain alternative, concurrent, or additional treatment options (i.e., hospice, comfort care, pain control)
- Ensure they understand they may rescind their request or halt the process at any time
- Determine the best and most appropriate method of self-administration
- Instruct on safekeeping and proper disposal of unused medication in accordance with state law
- Advise against taking the medication in a public place

- Discuss whether the patient wishes to notify anyone of their request, considering the benefit of having another person present for support at the time of self-administration
- Explore the patient's interest in discussing their plan for their chosen day of administration; consider what expectations the patient might have of the healthcare provider and if/how they are able to support

Documentation required of the attending provider

In most jurisdictions, once the attending provider writes the aid-in-dying prescription, the attending provider must submit the required documentation to their jurisdiction's Health Department. The forms and timelines for submission vary, but relevant documents generally include:

- A copy of the patient's completed written request for medication, usually called the "Written Request for Medication to End My Life in a Humane and Dignified Manner"
- The Attending Healthcare Provider Compliance Form
- The Consulting Healthcare Provider Compliance Form
- The Mental Health Professional Compliance Form, if an evaluation was performed

These forms, along with regulatory guidance and instructions for submitting can be found on the relevant jurisdiction's public health website.

In most jurisdictions, when the attending provider learns of a patient's ingestion of aid-in-dying medications or death from any other cause, whichever comes first, the attending provider completes a follow-up form.

Role of the consulting provider

The consulting provider role similarly differs by jurisdiction and may be a licensed physician, PA, or APRN. who is qualified by specialty or experience to make a diagnosis and prognosis regarding a terminal illness. They are not required to have primary responsibility for the patient's health care.

The consulting provider is required to evaluate the patient and their relevant medical records to confirm that the patient meets all required eligibility criteria for medical aid in dying, is acting voluntarily, making an informed decision, and understands the expected result of taking the medication.

The consulting provider must confirm, in writing, to the attending provider that the patient meets all eligibility criteria by completing a compliance form, available through their state health

department, and send it to the attending provider for them to submit within the required deadline.

Written request

In addition to the oral requests, the patient must also complete a written request, usually called a *Request for Medication to End My Life in a Humane and Dignified Manner* form, available through the jurisdiction's health department.

This form must be signed and dated by the patient and attending provider as well as two adult witnesses who attest the patient is acting voluntarily, is not coerced in any way, and signed in their presence. In nearly all jurisdictions, only one witness may be related to the patient by blood, marriage, or adoption; entitled to any portion of the patient's estate upon death; or an owner, operator, or employee of an institution where the patient resides or is receiving care. Visit our FAQ for more information on doulas offering their signature as a witness.

In some jurisdictions, there is a waiting period between the time the aid-in-dying medication is prescribed and when the patient can pick up the prescription. In some jurisdictions, this timing may be reduced if the patient is not likely to survive that waiting period.

Confirming decision-making capacity

If the attending or consulting provider questions the patients' decision-making capacity, they will refer the patient to a licensed mental health professional for an additional evaluation. The focus of this additional evaluation, which is not commonly needed[4] but is required in two jurisdictions (NY, HI), is to determine whether the patient is capable of making a healthcare decision; it is ***not*** to determine an individual's mental health or screen for a mental health condition. If decision-making capacity is lost during the request process, the patient is no longer eligible for medical aid in dying, as they must retain capacity up to the point of self-administration. It is important for doulas to be aware of the process, and to support conversations around it while ensuring their client is aware of the possibility.

Voluntary involvement

Just as clients can change their mind at any time in the process, healthcare professionals' involvement is also optional. Healthcare systems may choose to restrict their professionals from participating in the law as an attending provider, consulting provider, or mental health professional while performing duties for the healthcare system or entity. Healthcare facilities

[4] Andoh, E. *Medical aid in dying brings a compassionate close to life.* American Psychological Association, Vol 56, No 5. July 1, 2025. apa.org/monitor

establish their own policy around medical aid in dying and may not allow a patient to ingest on their property or may not allow staff to be present.

These are the kinds of things doulas do not want to find out by surprise. Assisting your clients with identifying the policy of clinicians, healthcare systems, and care facilities can avoid unexpected surprises. It also highlights the ways in which doulas can offer unique support.

Aid-in-dying medications

Through the process of evaluating someone's eligibility for medical aid in dying, the attending provider will determine the appropriate medication regimen based on the patient's condition and planned method of self-administration.

As a doula, your role is to understand the medications well enough that you can explain what they do, and confirm your client's elective participation along the way.

The pharmacology of medical aid in dying has evolved over time as drug availability has changed and understanding of the patient experience grows. Currently the most common aid-in-dying medication is a mixture of digoxin, diazepam, morphine, amitriptyline, and phenobarbital, abbreviated as DDMAPh[5].

DDMAPh must be prepared by a compounding pharmacy within a nonsterile environment. It is typically dispensed in a powder form which is mixed with a small amount of liquid, typically 2–4 ounces of apple juice at the time of ingestion. In compliance with compounding law, pharmacists must put a six-month expiration date on medications prepared in this manner. This should be a consideration when speaking with the patient about when they wish to receive the medications. If medications are obtained and then expire, the attending physician will need to issue a new prescription.

Clinicians experienced in this type of care often prescribe a dose of anti-nausea medication(s) approximately 30–60 minutes prior to not only reduce the risk of vomiting but to activate gastroparesis and assist in the delivery of medications to the gastrointestinal tract where they can be absorbed. These premedications are often in pill form and are usually taken one hour before the medical aid-in-dying medication. Other routes of self-administration may also require forms of pre-medication or preparation prior to self-administration. Again, your role as a doula is to understand the potential routes for ingestion and plans related.

[5] Hoffman, Strand. *Clinical practice and pharmacology decisions of medical aid in dying providers in the United States.* BMJ Supportive & Palliative Care. Dec 2025.

Methods of self-administration

To be eligible for medical aid in dying, a patient must be able to self-administer the medication through a conscious and voluntary act of ingestion or absorption through the gastrointestinal (GI) tract.

Healthcare professional presence at the bedside will vary depending on their institution's policy, their personal comfort, and most importantly their patient's choice. However, there are some options for self-administration for which a healthcare provider may be required.

Your role as a doula is to understand the process, and options for self-administration that may arise, so that you can set up your client for the best experience possible. Planning ahead for self-administration can make it easier to navigate changes.

Options for self-administration will be determined by the attending provider in consultation with the patient and may include[6]:

- **Oral ingestion** is the most common method and involves swallowing the entire mixture within a few minutes.
- **Feeding tube** administration uses an existing gastrostomy (G-tube) or jejunostomy tube (J-tube) to introduce the medication into the GI tract. A syringe attached to the tube allows the patient to push the plunger to introduce the medications, similar to the way they do for feedings. Although rare, a nasogastric tube (NG) may also be used. These tubes are placed, in advance, by a healthcare professional.
- **Rectal** administration allows the patient to introduce the medication into the GI tract via a syringe attached to a rectal catheter that is inserted **with the assistance of a clinician**.
- **Ostomy** administration allows the patient to introduce the medication by pushing the plunger of a syringe inserted into their stoma.

A patient may request an accommodation for options to self-administer medical aid-in-dying medications, just as they may for other medical services in accordance with the Americans with Disabilities Act.

Appropriate assistance you can provide as a doula includes picking up medications from the pharmacy, preparing and mixing the medication, bringing it to the patient, holding a cup and straw steady up to their mouth, and attaching it to a feeding tube or catheter. Even with assistance, the patient must control the process and take a voluntary action — such as swallowing or pushing a plunger — to introduce the entire dose of medication into their GI tract.

[6] Shavelson, Battin, Pope. *Medical aid in dying: Clinical Considerations.* UpToDate, updated 9/18/25.

The time between ingestion and death can vary depending on individual health factors, but years of data from Oregon offers us insight. Their reports show that on average, patients are asleep five to seven minutes after ingestion, and death occurs at around 134 minutes after ingestion (2 hours 14 minutes). Times between ingestion and death range from 1 minute to 137 hours[7]. Though these outliers are rare occurrences, the possibility of a prolonged experience should be considered during planning.

Administration of medications by injection, infusion, intrathecal, or other parenteral route is not permitted under any circumstance. Similarly, administration of the medication by anyone other than the patient, including a provider, clinician, doula or family member, is not permitted. This is generally considered euthanasia, which is not legal in the United States.

Medical aid in dying legislation also outlines that ingestion must not take place in a public location. Not only is this considered inappropriate, it could result in fines and incurred costs for family members and loved ones.

Coordinating with the pharmacist

Pharmacists play an important role in working collaboratively with the attending provider to prepare the prescribed medications, support the patient, and confirm all steps in the request process have been met. Pharmacists often counsel the patient regarding the medications that have been prepared for them, ensuring they understand preparation instructions as well as proper safekeeping and disposal of the medications.

They may also flag any concerns they have as a clinician, which could lead to a decision-making capacity review (like mentioned above). It is important for doulas to prepare their clients for this possibility.

Some jurisdictions allow prescriptions to be delivered personally, by mail, or through an authorized electronic transmission (such as an electronic health record) to a licensed pharmacist. The pharmacist will dispense the medication in person or with a signature upon delivery if sent by mail or delivery service.

Generally, medication may be dispensed to the patient, attending provider, or an individual expressly designated by the patient (such as a family member or doula). Doulas should check the law in their jurisdiction to ensure the law allows for an “expressly designated” individual to pick up the medications on the patient’s behalf. According to feedback from pharmacists familiar with preparing medical aid-in-dying medications, it may take several days to fill the customized prescription.

[7] Oregon Health Authority. (2025). Public Health Division Center for Health Statistics. Oregon Death With Dignity Data 2025 Data Summary.

Summary of the request process

1. The patient makes an initial verbal/oral request for medical aid in dying to a provider* who includes it in the patient's notes.
2. After statutorily defined waiting period*, the patient makes a second verbal/oral request, at which time the attending provider must offer the patient an opportunity to rescind their request.
3. A consulting provider meets with the patient to confirm eligibility.
4. The attending or consulting provider may refer to a psychologist or psychiatrist if there is question about the patient's decision-making capacity
5. The patient completes a written request for medical aid in dying, signed by two qualifying witnesses.
6. The attending provider may write the prescription (an additional waiting period may apply)
7. The attending provider submits a prescription to a compound pharmacy. It may take up to 48 hours for a pharmacy to compound this medication.
8. All of the above is clearly documented in the patient's medical record
9. Submit required forms to the jurisdiction's Health Department or equivalent.

*Remember that qualified providers and waiting periods vary by jurisdiction.

Protection for professionals and loved ones

Similar to other features of medical aid-in-dying laws, authorized jurisdictions offer differing levels of immunity and protections. Medical aid in dying laws in all but one jurisdiction (Maine) limits risk for healthcare providers by providing explicit immunity for those providers 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. For example, Illinois' law states, "A health care professional or health care entity shall not be subject to civil or criminal liability, licensing sanctions, or other professional disciplinary action

for actions taken in good faith compliance with this Act."[8] Because end-of-life doulas are explicitly non-medical, these protections are not qualifying.

No authorized jurisdiction explicitly mentions doulas as having immunities and protections. However, in most medical aid-in-dying laws, immunities and protections explicitly extend to all individuals who may be a part of the patient's care team by using broad language. For example, Colorado's law states, "A **person** is not subject to civil or criminal liability or professional disciplinary action for acting in good faith under this article…"[9] Certainly, end-of-life doulas can be considered protected under this broad language. Make sure to review the law in your jurisdiction to help inform the level of protection.

It is important to note that professional liability insurance (PLI) for end-of-life doulas does exist, and can be an added layer of support and ease of mind for those offering support.

Special planning considerations

Every end-of-life doula has their own style when it comes to planning with a client, and that individualized experience and energy you offer is no different for someone accessing medical aid in dying. However, there may be some unique things to prepare for with clients accessing medical aid in dying depending on their support system, their healthcare team's involvement, their location, and their needs.

Healthcare system, or care facility policy: Each institution has its own policy regarding its physical space and its staff. This may impact your client's ability to ingest the medication on their property, or the availability for staff to be involved at any level. If you are working with someone early in their journey, exploring these policies with them is a very valuable process.

Healthcare team involvement level: As mentioned above, staff may be restricted from participating as a qualified healthcare provider while performing duties for the prohibiting entity. It is important to also remember that professionals may choose to not be involved due to personal beliefs, regardless of their workplace policy. Similarly, reviewing these policies with a client can be a very helpful experience.

[8] Illinois General Assembly. (2026). Illinois Compiled Statutes. End-of-Life Options for Terminally Ill Patients Act, 410 ILCS 22. https://ilga.gov/Legislation/ILCS/Articles?ActID=4646&ChapterID=35&Chapter=PUBLIC%20HEALTH&MajorTopic=HEALTH%20AND%20SAFETY&Print=True

[9] Colorado General Assembly. (2026). Colorado Revised Statutes. End-of-Life Options Act, C.R.S. 25-48-116.

Time & support: The time between ingestion and death varies greatly by person, and there are additional logistics to prepare for. If the healthcare team and loved ones are all involved, thoughtful scheduling to allow for caregiver breaks and rest is needed. If family or healthcare teams are not involved and you are the primary support, partnering with another doula is helpful to ensure the smoothest experience for all.

Location: As mentioned in the voluntary involvement section, it is very important to plan for the location of ingestion. Though many patients accessing medical aid in dying are ingesting medication in a known environment, some have to plan for an alternative location.

Scenarios you may run into:

- Your client lives in a hospice or healthcare facility and finds out *after* they have the prescription written that their facility will not allow them to ingest.
- Your client's family is supportive of their choice, but are not comfortable with the ingestion taking place in their home.
- Your client is unhoused or housing insecure.

We know of patients that have planned to ingest their medication at hotels, in AirB&Bs, in a friend's home, or at other private locations that have agreed to host or may even specialize in doing so. Each of these locations should be provided with information that the person renting the space is seriously ill and may die on their property. Any of these places has the right to say no when asked — so planning ahead for this is critical to avoid surprises or last-minute changes. Identifying available locations ahead of time can be especially useful for end-of-life doulas who are beginning to offer this kind of support.

Declaring time of death: Of course, this is a healthcare professionals role, and should not be something doulas are responsible for. However, if you are supporting a client who is not ingesting in a healthcare setting or will not have a professional on-site, it is important to discuss a plan with the attending physician so you know who to call after ingestion.

Transportation: Another important discussion is about your client's vessel after they have died. Where will they go next and who will make the phone call? This conversation should happen with their care team and loved ones, to ensure all options are considered. For most, the call will be to the coroner or a funeral home that is aware the ingestion is taking place. However, there may be unique circumstances due to location or available resources. It is important to note that calling a local non-emergency number could still result in an attempted resuscitation, so making a plan and having your client's POLST and/or DNR on hand will help navigate emergency responses.

Your documentation

In order to clearly establish their role, and the role of others present, many doulas choose to create agreements with their clients. These agreements clarify the role of the doula and help ensure compliance with medical aid in dying laws, since this can be a unique emotional experience for everyone involved.

This documentation might outline information about when and where your client will ingest their medication, plans for the environment, who may be present (including healthcare team), what is expected on the day of ingestion, the liquid your client wants to mix their medication with (juice, sorbet, etc.), your role/tasks as a doula, and the loved ones' involvement in supporting the process. It could also outline the phone calls and tasks to be completed after ingestion, and should include the signatures of those present. In states where there are no explicit immunities for care providers, this can be a critical step.

Developing your personal policy

While medical aid-in-dying laws outline the specific requirements for a patient to request and obtain the prescription, end-of-life doulas are encouraged to develop their own policy or practice around medical aid in dying that provides clear information to the people you care for, and their healthcare team.

Based on your comfort level and desire to support medical aid in dying, you will decide how you manage requests for support and what resources or networks you want to create. Broadly speaking, the policy should also align with NEDA's Scope of Practice (https://nedalliance.org/for-doulas/scope-of-practice/) for doulas to ensure you are working within established guidelines.

Compassion & Choices' "Medical Aid in Dying: A Guide to Creating Patient-Centered Policies" (https://compassionandchoices.org/resource/medical-aid-in-dying-best-practices-for-developing-patient-directed-policies/) is designed for healthcare organizations who must go through the same process. It provides in-depth guidance regarding the development of policies that support patients as well as staff and volunteers. Of course, this is far beyond what you may need as an end-of-life doula, but can offer you insights and questions to consider. This can also be shared with healthcare teams you collaborate with, who may be interested in developing their own policy.

Your personal policy could answer questions like:

- How will I navigate requests for supporting medical aid in dying?

- What local colleagues can I call on or collaborate with?
- How will I communicate with healthcare teams about the wishes of my client?
- How will I support family and loved ones through this process?
- How will I support someone at the bedside?
- What boundaries will I set in my work?

Navigating opposition or misinformation

Medical aid in dying remains one of the most widely discussed and, at times, misunderstood end-of-life options. As professionals, and advocates, an end-of-life doula's role is not to persuade or debate, but to provide accurate information, support informed decision-making, and honor the values and goals of the individual you are supporting. Public conversations and interdisciplinary care teams often include a wide range of ethical, religious, cultural, and professional perspectives.

Approaching these discussions with curiosity, respect, and factual information helps create space for meaningful dialogue while keeping the focus where it belongs: on patient autonomy, compassionate care, and alleviating suffering within the framework of applicable laws and established clinical safeguards. Regardless of personal beliefs, every individual deserves access to accurate information, freedom from misinformation, and the opportunity to make informed healthcare decisions consistent with their own values.

Here are five practical, patient-centered approaches that help doulas, advocates, and healthcare professionals navigate misinformation and opposition to medical aid in dying while maintaining professionalism and compassion.

1. **Lead with curiosity before information** - When someone expresses concern or opposition, begin by understanding where it comes from.

2. **Share facts while honoring opinions** - Acknowledge that people hold deeply held ethical, religious, and cultural beliefs while distinguishing those beliefs from legal and clinical realities.

3. **Keep the focus on the patient** - Medical aid in dying is a fully patient-directed process, so if discussions become polarized doulas can make an impact by gently redirecting attention to the individual receiving care.

4. **Correct misinformation calmly and respectfully** - Avoid arguing or trying to "win" the conversation. Instead, offer evidence-based clarification.

5. **Confidently fill your role** - End-of-life doulas are not trying to convince anyone to pursue, or reject, medical aid in dying. A doula's role is to educate, accompany, support communication, and advocate for informed choice while respecting the client's decisions and collaborating professionally with the healthcare team.

Frequently asked questions

Is medical aid in dying listed on the death certificate?

No. In all authorized jurisdictions, and in alignment with Centers for Disease Control and Prevention (CDC) guidance and established clinical practice in other situations where the cause, manner, or timing of death may have been influenced by other factors (such as ventilator withdrawal or discontinuation of dialysis), state death certificates must list the underlying terminal illness as the cause of death.

This guidance adheres to CDC Instructions for Completing the Cause of Death Section of the Death Certificate, which directs to "always enter the underlying cause of death" and states: "The immediate cause does not mean the mechanism of death or terminal event (for example, cardiac arrest). The mechanism of death should not be reported as the immediate cause of death." In addition, clinical and evidence-based guidance for death certificates and death investigations in the United States specifically instructs providers to "list the underlying terminal condition as the cause of death and the manner of death as natural."

It is standard practice in all authorized jurisdictions that the death certificate list the underlying terminal illness as the cause of death. Any variation in this practice threatens the privacy of the patient, the confidentiality of their decision for medical aid in dying, as well as the integrity of tracking trends in disease and public health concerns.

Is organ donation an option after medical aid in dying?

Generally, no. The majority of individuals who choose medical aid in dying do not qualify for tissue, organ, or body donation due to their illness and the high-dose medications ingested. In addition, organ donation requires viable organs to be retrieved quickly, often in a hospital setting — which may not align with your client's wishes. **However, it is not impossible.** If organ donation is deeply important to your client, we recommend speaking with your local tissue bank or organ procurement agency to review the individual situation.

Where required, how does someone show proof of residency?

Oregon and Vermont are the only authorized jurisdictions in which the qualified patient is not required to be a resident of the state to request medical aid in dying. In Montana, the option is available through Supreme Court Decision and does not explicitly mention residency. However, some providers may be less comfortable with a non-resident's request.

To qualify for medical aid in dying in all other authorized jurisdictions, the individual must show proof they are a resident of that jurisdiction. Generally, the ability to demonstrate residency can be satisfied by providing documents such as a driver's license or state-issued identification card; a voter registration card or other documentation showing the individual is registered to vote in the jurisdiction; evidence that the individual owns or leases property in the jurisdiction; or an income tax return for the most recent tax year. Remember to review the law in your jurisdiction to know exactly how individuals can demonstrate residency.

How can end-of-life doulas support someone through medical aid in dying?

Doulas first and foremost serve as a trusted support through the consideration of all end-of-life healthcare options available — including medical aid in dying. Offering your knowledge and support during advance care planning discussions, facilitating family communication, gathering information at healthcare visits, and providing other logistical support can be especially helpful for those following this process, which can feel overwhelming.

At the bedside, doulas can offer emotional and practical care as you would with any other client and their loved ones. In this unique situation, clients can also request accommodations just as they may for health-related services in accordance with the Americans with Disabilities Act. You could accommodate their request by preparing and mixing the medication, bringing it to the patient, holding a cup and straw steady up to their mouth, and attaching it to a feeding tube or catheter that has been placed by a healthcare professional.

It is critical to remember that even with assistance, the client must control the process and take a voluntary action — such as swallowing or pushing a plunger — to introduce the entire dose of medication into their GI tract.

Can an end-of-life doula serve as a witness on the written request?

Currently, all authorized jurisdictions require a qualified patient to complete a written request, which requires the signature of two witnesses. The laws also prohibit certain interested parties from acting as a witness; many jurisdictions have restrictions on who can serve as one of the witnesses, including those with certain relationships with the individual or who would benefit from a person's death. The specifics of each state's witness requirements can be found in the legislation.

In some cases, an end-of-life doula is a client's only support person, and they may feel the desire to offer support by serving as a witness. An end-of-life doula's signature on the form is generally considered legally defensible, but we certainly recommend planning for this in advance to avoid surprises or last-minute pressure.

Does medical aid in dying impact insurance or other benefits?

Patients who choose medical aid in dying remain entitled to existing benefits. In most jurisdictions, the law specifically states that a person's request for or use of medical aid in dying cannot affect their will, insurance, annuity policy, or other benefits.

Does insurance assist with aid in dying medications?

Prices of these medications vary widely across the country ($400–$800 is a commonly seen range) and this cost is often a huge barrier. Although most plans include benefits for end-of-life planning, coverage for medications associated with medical aid in dying is quite rare. This is largely due to The Assisted Suicide Funding Restriction Act of 1997, which prohibits the use of federal funds to assist in the death of an individual; many compounding pharmacies operate on a cash-only basis; and the prescription is a mixture of medications, and therefore, not part of any formulary. Since benefits and coverage can vary greatly, patients are encouraged to contact their insurance provider with questions.

Some jurisdictions have determined that state Medicaid funds may be used to cover care associated with medical aid dying — **California, New Mexico, Oregon, and Hawai'i.** Unfortunately, this is through reimbursement, which can be an additional barrier to folks in those states. Our team continues to look for opportunities to improve policy in this area.

There are many wonderful regional and state-based end-of-life options groups that may offer funding support for these medications, so we encourage doulas to research and identify any local opportunities to support access.

Is medical aid in dying the same as euthanasia?

No. Medical aid in dying is a patient-directed clinical practice that honors patient autonomy at the end of life, whereas euthanasia is an intentional act by another person to cause a patient's death, which is illegal throughout the United States.

Is medical aid in dying in the United States the same as Canada?

No. Just as the overall delivery of healthcare differs, the eligibility criteria, clinical practice and laws defining medical aid in dying within authorized U.S. jurisdictions are fundamentally different from the Canadian "medical assistance in dying" law. A detailed breakdown is provided by Compassion & Choices at candc.org/key-differences.

Can medical aid in dying be requested through an advance health care directive?

No. A request for medical aid in dying must come directly from the terminally ill individual, who must have decision-making capacity and meet eligibility criteria at the time of their request. No one can make a request for medical aid in dying before they are eligible, or on another person's behalf. Therefore, requests through an advance directive, conservator, or other agent or surrogate are not permitted. If eligibility is denied, or a prognosis changes, patients can begin the process again when they do become eligible.

It is still critical to include the interest in or desire for access to medical aid in dying within advance care planning documents, including formal paperwork or recorded interviews. Doulas can support folks documenting these wishes, even if that alone will not guarantee their access to medical aid in dying.

I have more questions, where can I go for help?

If you or the client you're serving have additional questions, please reach out by phone (800.247-7421) or by email at info@compassionandchoices.org. Leave us with your contact information, and the question(s) you're navigating. One of our team members will get back to you as soon as possible.

call compassion

800.247.7421

Compassion & Choices and NEDA wish to thank the passionate advocates who have worked for decades to ensure compassionate end-of-life care in their communities.

To the dedicated end-of-life doulas and professionals who carry the knowledge forward, we thank you for the tremendous compassion and skill that goes into supporting individuals facing the end of their life.

We send additional thanks and appreciation to the professionals who offered their expertise, experience, and knowledge to this document.