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Convention 2026
Continuing Legal Education Series

Implementation of the New Medical Aid in Dying Law

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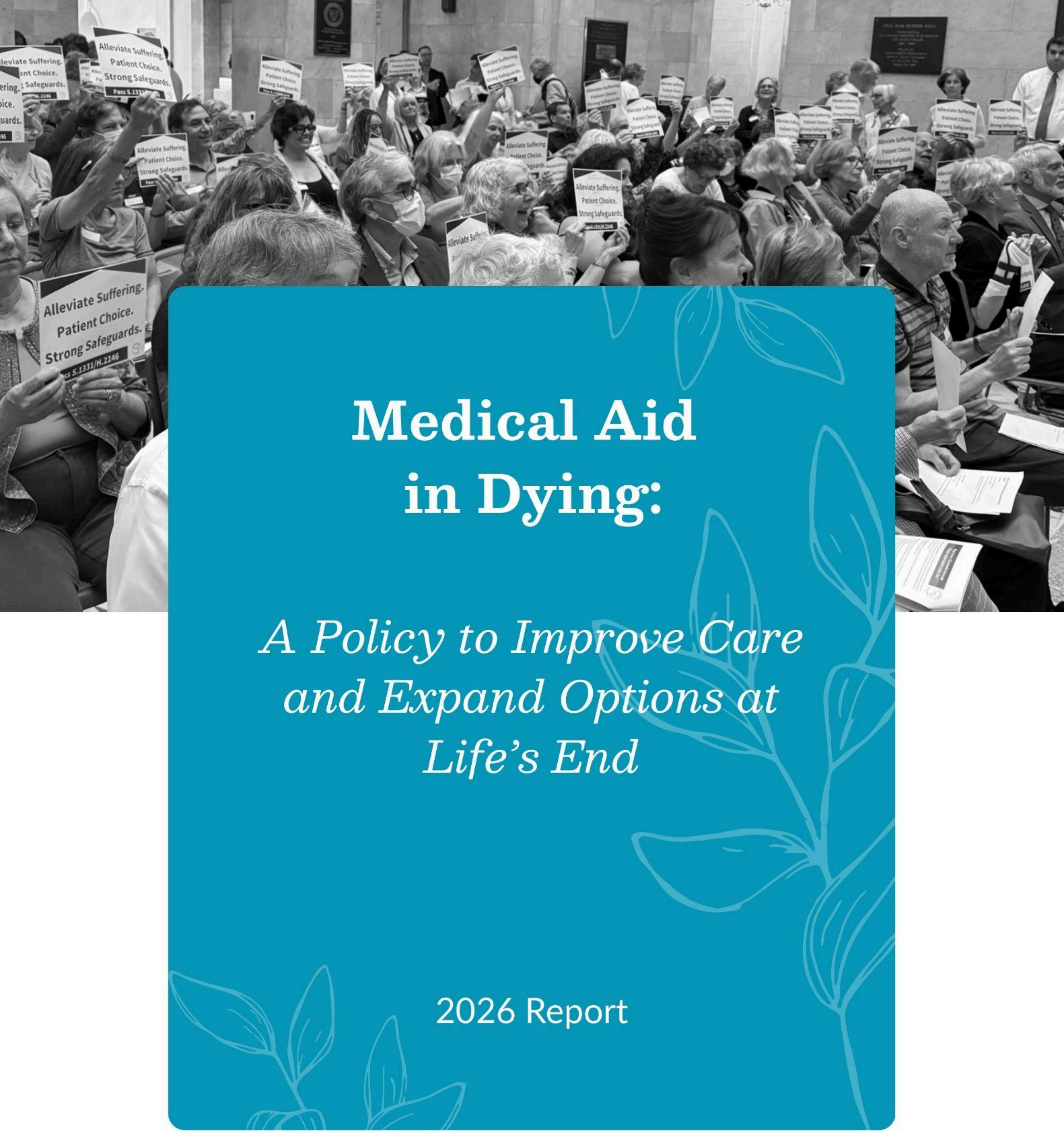
Presenters: Corinne Carey, JD
Hon. Rachel Kretser
David Leven, JD



Medical Aid in Dying:

A Policy to Improve Care and Expand Options at Life's End

2026 Report

compassion & choices

February 2026

Every person will face decisions at the end of life. Yet too often, our healthcare system and our broader culture avoid honest conversations about dying until choices are constrained, suffering is heightened, and patients lose control over care that should reflect their values, priorities, and dignity.

Medical aid in dying must be understood within this broader context. It is not a replacement for hospice, palliative care, pain management, or disease-directed treatment. Rather, it is one option within a full spectrum of end-of-life care, including comfort care, the refusal or withdrawal of life-sustaining treatment, and hospice care. Together, these options support patient-directed decision-making at the end of life. When people are empowered with accurate information and meaningful options, they are better able to engage in thoughtful conversations with their clinicians and loved ones and to make decisions aligned with what matters most to them.

Lawmakers today are not starting from theory. Nearly three decades of experience, beginning in Oregon and now spanning 13 states and Washington, D.C., provide a robust, evidence-based foundation for medical aid in dying policy. Research, patient experiences, and clinical data consistently demonstrate that medical aid in dying protects patients, upholds individual autonomy, and strengthens end-of-life care overall. Importantly, its availability has helped normalize earlier and more honest discussions about dying. These conversations improve hospice utilization, pain management, and alignment between care delivered and patient wishes, whether or not the option is ultimately used.

Medical aid in dying allows terminally ill, mentally capable adults with a prognosis of six months or less to request a prescription for medication they may choose to self-ingest to bring about a peaceful death. While most authorized states limit access to residents, three jurisdictions, Montana, Oregon and Vermont, allow non-residents to access medical aid in dying. As a result, all individuals technically have access to this option, but only if they are able to travel, temporarily relocate, or permanently change their state of residence near the end of life.

For many terminally ill people, this reality creates significant hardship. Relocating or interrupting continuity of care in the final months of life can mean leaving trusted clinicians, separating from loved ones, navigating unfamiliar healthcare systems, and bearing logistical, financial, and emotional burdens at an already vulnerable time. No one nearing the end of life should be forced to uproot themselves or die away from their community in order to access an option that reflects their values and priorities.

As experience has grown, lawmakers in authorized jurisdictions have refined these laws to remove unnecessary barriers while maintaining strong safeguards. During the 2024–2025 legislative session, Delaware and Illinois became the 12th and 13th jurisdictions to authorize medical aid in dying, and in February 2026, New York became the 14th. These actions reflect a shared understanding that end-of-life care policy should be responsive to clinical realities and grounded in compassion, evidence, and respect for patient autonomy.

States that have not authorized medical aid in dying effectively deny many terminally ill individuals meaningful access to this option, leaving them to endure suffering they may find unacceptable or to seek care far from home. Policymakers have the opportunity to address this inequity by adopting thoughtful, evidence-based legislation that ensures people can receive comprehensive end-of-life care within their own communities, supported by the clinicians and loved ones they trust.

This policy resource is offered in the spirit of partnership. It provides up-to-date, data-driven information; addresses common questions and concerns; and reflects lessons learned from decades of implementation. Our hope is that it supports lawmakers in advancing policies that not only authorize medical aid in dying, but also contributes to a broader cultural shift that encourages open dialogue about death and dying, affirms patient autonomy, and improves end-of-life care for everyone. Ensuring that medical aid in dying is available as an option, alongside hospice, palliative care, and other established practices, is part of the gold standard of patient-directed end-of-life care.

Thank you for your leadership on this deeply human issue, one that transcends partisanship and reflects compassion, dignity, and respect for individual choice. Compassion & Choices stands ready to support your efforts to expand access to comprehensive end-of-life care and to ensure that individuals can make decisions consistent with their values.

If you have questions or would like additional information, please contact Bernadette Nunley, Chief Legal Advocacy Officer, at policy@compassionandchoices.org. We look forward to working with you to advance patient-centered end-of-life policy.

Sincerely,

Kevin Díaz
President and CEO
Compassion & Choices

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Section I: *Introduction*

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

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

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

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[1] While both the United States and Canada use the acronym MAID, U.S. "medical aid-in-dying" laws differ fundamentally from Canadian laws. In Canada, the definition of "medical assistance in dying," the legal landscape, the Canadian healthcare system, and quality of care are not the same as in the U.S. Also, in Canada, euthanasia is allowed. In contrast, euthanasia is illegal in every U.S. state, and the core eligibility criteria for U.S. medical aid-in-dying laws have remained the same since Oregon implemented the nation's first medical aid-in-dying law in 1997. More information about differences between U.S. and Canadian laws and systems can be found in Section V: The Truth About Medical Aid in Dying.

Section II: *Legislative overview*

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

Eligibility criteria, core safeguards, and established process

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

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

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

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

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[2] D. Orentlicher, T.M. Pope, B.A. Rich. (2015). Clinical Criteria for Physician Aid in Dying. *Journal of Palliative Medicine*. https://doi.org/10.1089/jpm.2015.0092.

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

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

Additional statutory requirements

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

- The terminally ill adult must make at least one request to their attending healthcare provider.
- The written request must be witnessed by at least one person who cannot be a relative or someone who stands to benefit from the person's estate upon their death.
- At least one healthcare provider must confirm the terminal diagnosis, prognosis of six months or less to live, and the person's ability to make an informed healthcare decision prior to the attending healthcare provider writing a prescription.
- If a healthcare provider has concerns about an individual's capacity to make an informed healthcare decision, the individual is required to undergo an additional mental capacity evaluation with a mental health professional (such as a psychiatrist, psychologist, licensed clinical social worker, psychiatric nurse practitioner, or licensed clinical professional counselor). The request for aid-in-dying medication cannot proceed unless the mental health professional affirms that the individual is capable of making an informed decision.[3]

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[3] Hawai'i's Our Care, Our Choice Act mandates that a psychiatrist, psychologist, or social worker conduct a mental health evaluation for all terminally-patients seeking medical aid in dying. In New York, a psychologist, neurologist, or psychiatrist must conduct mental health evaluation for all terminally-ill patients seeking medical aid in dying. Additionally, New Mexico's Elizabeth Whitefield End-of-Life Options Act requires a mental health evaluation if the requesting individual has a recent history of a mental health disorder or an intellectual disability that could cause impaired judgment with regard to end-of-life medical decision making.

- Medical aid-in-dying laws are subject to all applicable state and federal laws and regulations, including those that require assistance to individuals who may require additional support to understand and navigate the process (e.g., language interpretation for patients who may not be able to read or speak English).

Voluntary participation

The laws balance a patient's need to receive the information they are requesting while also respecting and establishing clear boundaries for healthcare providers who are unwilling or unable to participate in the medical aid-in-dying process. Each law also explicitly states both healthcare provider and healthcare entity participation is voluntary and that no provider or entity is obligated to prescribe or dispense aid-in-dying medication. Further, federal law protects an individual's right to transfer their medical records to an alternate provider if their regular healthcare provider(s) opt out or cannot support them in the care option.[4] Generally, if the person requests that their healthcare provider transfer their medical records to an alternate healthcare provider, their healthcare provider is legally required to do so within a reasonable amount of time. Additionally, a healthcare provider must document the request for medical aid in dying in the patient's record.

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

Liability for violating the law

While those who comply with all aspects of the law and meet the standard of care are provided immunity from certain criminal prosecution (e.g., homicide, assisting suicide or elder abuse) or civil lawsuits (such as malpractice), the jurisdictions retain the ability to hold those who fail to adhere to these strict requirements and medical care standards

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[4] Health Insurance Portability and Accountability Act, 45 C.F.R. § 164.524 (2022). https://www.law.cornell.edu/cfr/text/45/164.524.

criminally and civilly liable. Moreover, most existing laws establish that any attempt to pressure or coerce someone to request or use medical aid in dying is a felony.

Authorized laws overview

Thirteen jurisdictions in the United States — 13 states and Washington, D.C. — have authorized medical aid in dying:

- Oregon's *Death with Dignity Act*[5]
- Washington's *Death with Dignity Act*[6]
- Montana – authorized by state supreme court decision *Baxter v. Montana*[7]
- Vermont's *Patient Choice at End of Life Act*[8]
- California's *End of Life Option Act*[9]
- Colorado's *End-of-Life Options Act*[10]
- Washington, D.C.'s *Death with Dignity Act*[11]
- Hawai'i's *Our Care, Our Choice Act*[12]
- New Jersey's *Medical Aid in Dying for the Terminally Ill Act*[13]
- Maine's *Death with Dignity Act*[14]
- New Mexico's *End-of-Life Options Act*[15]
- Delaware's *End of Life Options Act*[16]
- Illinois's *End of Life Options for Terminally Ill Patients Act*[17]
- New York's *Medical Aid in Dying Act*[18]

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[5] Death with Dignity Act, Or. Rev. Stat. §§ 127.800-127.995 (1994 & rev. 2023).
[6] Death with Dignity Act, Wash. Rev. Code § 70.245 (2009).
[7] *Baxter v. State*, 224 P.3d 1211, 1214 (Mont. 2009).
[8] Patient Choice at End of Life Act, Vt. Vt. Stat. Ann. tit. 18, § 5281 (2025).
[9] End of Life Option Act, Cal. Health & Safety Code § 443 (West 2025).
[10] End-of-Life Options Act, Colo. Rev. Stat. § 25-48-101 (2025).
[11] Death with Dignity Act, D.C. Code § 44-105.03 (2025).
[12] Our Care, Our Choice Act, Haw. Rev. Stat. § 327L (2024).
[13] Medical Aid in Dying for the Terminally Ill Act, N.J. Stat. Ann. § 26:16-1 (2025).
[14] Death with Dignity Act, Me. Rev. Stat. Ann. 22 § 2140 (2025).
[15] End-of-Life Options Act, N.M. Stat. Ann. § 24-7C (2025).
[16] End of Life Options Act, Del. Code Ann. tit. 16, § 2501C (2025).
[17] End-of-Life Options for Terminally Ill Patients Act, Public Act 104-0441 Ill. (2025).
[18] Medical Aid in Dying Act, S.B. 138, 2025 Leg., 238 Sess. (N.Y. 2026).

Section III: *A solid body of evidence*

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

A 2022 sample of Colorado physicians showed that many are willing and prepared to discuss medical aid in dying with patients and to provide referrals.[19] A 2022 survey of nurses in the U.S. showed that 49% would personally support the concept of medical aid in dying and 57% would support it professionally.[20] Furthermore, a 2023 national poll from Susquehanna Polling & Research showed that nearly 8 out of 10 of U.S. residents (79%) with a disability agree that medical aid in dying "should be legal for terminally ill, mentally capable adults who chose to self-ingest medication to die peacefully."[21]

Additionally, a 2024 study found that while providers may initially feel unsure about medical aid in dying, their experiences often change after participating in a medical aid-in-dying case. Specifically, after having written an aid-in-dying prescription, 96% of clinicians reported that they were "hardly" or "not at all" morally conflicted.[22] Another study found that among consulting and attending physicians caring for patients who requested medical aid in dying, 75.5% felt their most recent case was "emotionally fulfilling" and "professionally rewarding."[23]

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[19] Campbell E., et al. (2022). Physicians' Attitudes and Experiences with Medical Aid in Dying in Colorado: a "Hidden Population" Survey. *Journal of General Internal Medicine*, *37*(13). https://doi.org/10.1007/s11606-021-07300-8.

[20] Davidson, J., et al. (2022). Nurses' Values and Perspectives on Medical Aid in Dying: A Survey of Nurses in the United States. *Journal of Hospice and Palliative Nursing*, *24*(1). https://doi.org/10.1097/njh.0000000000000820.

[21] Susquehanna Polling & Research. (2023). *USA/National Public Opinion Survey of 1,004 respondents - Cross Tabulation Report, February 2023*. https://bit.ly/SPRNatDisabilityPoll2023.

[22] Pottash M., et al. (2023). A Survey of Clinicians Who Provide Aid in Dying. *American Journal of Hospice and Palliative Medicine*, *41*(9). https://doi.org/10.1177/10499091231205841.

[23] Campbell E., et al. (2022). Physicians' Attitudes and Experiences with Medical Aid in Dying in Colorado: a "Hidden Population" Survey. *Journal of General Internal Medicine*, *37*(13). https://doi.org/10.1007/s11606-021-07300-8.

Finally, another study looked at the impact of legalizing medical aid in dying on patient trust and found that legalizing medical aid in dying does not undermine patient trust in the medical profession.[24]

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

Medical aid in dying protects patients

A 2015 report from the Journal of the American Academy of Psychiatry and Law noted, "There appears to be no evidence to support the fear that [medical aid in dying] disproportionately affects vulnerable populations." Vulnerable populations include the elderly, women, the uninsured, people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnic minorities, compared with background populations.[25]

Few will utilize medical aid in dying, but many benefit from these laws

People who utilize medical aid in dying account for less than 1% of annual deaths.[26] That said, the laws benefit more than the small number of people who ultimately decide to self-ingest the medication. In the jurisdictions that have already authorized medical aid in dying, people report significant relief from worry about future physical and emotional pain just from knowing the option is there, regardless of whether or not they choose to pursue it.[27] A 2022 article showed that access to medical aid in dying helped terminally ill people

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[24] Anderson, J., et al. (2024). The Impact of Legalizing Medical Aid in Dying on Patient Trust: A Randomized Controlled Survey Study. *Journal of Palliative Medicine*, *27*(11). https://doi.org/10.1089/jpm.2023.0706.

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

[26] According to the Centers for Disease Control, in 2022 in jurisdictions that authorized medical aid in dying, 598,151 people died in total. In 2022, authorized jurisdictions report 1,904 people died after being provided with a prescription for medical aid in dying — less than 0.003% of total deaths in 2022. CDC has not released an updated *Deaths: Final Data* report since 2022. Xu, J.,Murphy, S.,, et al. (2025). (rep.). *Deaths: Final Data for 2022*. National Vital Statistics Report, 74(4). https://www.cdc.gov/nchs/data/nvsr/nvsr74/nvsr74-04.pdf.

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

prepare for death and provided a sense of autonomy for themselves. Being able to support an individual's wishes helped with the grieving process of their loved ones.[28]

Medical aid in dying improves end-of-life care

Oregon has long been at the forefront of end-of-life care, leading the nation in development of patient-directed practices, adherence to advance directives, and hospice utilization. In fact, Oregon boasts one of the highest rates of people who die in their own homes rather than in hospitals.[29] The experience and data demonstrate that the implementation and availability of medical aid in dying further promote these practices and improve other aspects of end-of-life care.[30]

- A 2001 survey of physicians about their efforts to improve end-of-life care following authorization of the Oregon Death With Dignity Act showed 30% of responding physicians had increased the number of referrals they provided for hospice care, and 76% made efforts to improve their knowledge of pain management.[31]
- A 2015 Journal of Palliative Medicine study found that Oregon was the only state both in the highest quartile of overall hospice use and the lowest quartile for potentially concerning patterns of hospice use.[32] "Concerning patterns of hospice use" is defined as very short enrollment, very long enrollment, or disenrollment. This same study suggested its medical aid-in-dying law may have contributed to more open conversations between doctors and patients about end-of-life care options, which led to the more appropriate hospice use.
- Hospice programs across Oregon, in fact, reported an increase in referrals following passage of the Oregon Death With Dignity Act.[33] Over 20 years later, according to a 2023 article in the journal Voices in Bioethics, more than 90% of

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[28] Singer, J., et al. (2023). An Examination and Proposed Theoretical Model of Risk and Protective Factors for Bereavement Outcomes for Family Members of Individuals Who Engaged in Medical Aid in Dying: A Systematic Review. *Palliative Medicine, 37*(7). https://doi.org/10.1177/02692163231172242.

[29] Tolle, S., Teno, J. (2017). Lessons from Oregon in Embracing Complexity in End-of-Life Care. *New England Journal of Medicine, 376*(11) . https://doi.org/10.1056/nejmsb1612511.

[30] Lee, M., Tolle, S. (1996). Oregon's Assisted Suicide Vote: The Silver Lining. *Annals of Internal Medicine, 124*(2). https://doi.org/10.7326/0003-4819-124-2-199601150-00014.

[31] Ganzini, L, et al. (2001). Oregon Physicians' Attitudes About and Experiences With End-of-Life Care Since Passage of the Oregon Death with Dignity Act. *JAMA, 285*(18). https://doi.org/10.1001/jama.285.18.2363.

[32] Wang, S., et al. (2015). Geographic Variation of Hospice Use Patterns at the End of Life. *Journal of Palliative Medicine, 18*(9). https://doi.org/10.1089/jpm.2014.0425.

[33] *Id.*

those who used medical aid in dying were receiving hospice services at the time of their death.[34]

- Additionally, research shows that most patients who request medical aid in dying actively pursue palliative care, enroll in hospice, and subsequently have good symptomatic relief.[35]

For some, comfort care, pain management are not enough to relieve suffering

Evidence from scientific studies confirms despite the wide availability of hospice and palliative medicine, many patients experience pain at the end of life. One study found that the prevalence of pain increases significantly at the end of life, jumping from 26% of patients experiencing pain in the last 24 months of life to 46% in the last four months of life.[36]

Additionally, breakthrough pain — severe pain that occurs even when a patient is already medicated — remains a nightmare experience for many. In the National Breakthrough Pain Study, among respondents who had cancer (at all stages), 83.3% reported breakthrough pain. For those cancer patients who experienced breakthrough pain, only 24.1% reported that using some form of pain management worked every time.[37]

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

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[34] 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.

[35] DeWolf, T., Cazeau, N. (2022). Medical Aid in Dying: An Overview of Care and Considerations for Patients With Cancer. *Clinical Journal of Oncology Nursing*, *26*(6). https://doi.org/10.1188/22.CJON.621-627.

[36] Smith, A., et al. (2010). The Epidemiology of Pain During the Last 2 Years of Life. *The Annals of Internal Medicine*, *153*(9). https://doi.org/10.7326/0003-4819-153-9-201011020-00005.

[37] Katz, N., et al. (2016). Impact of Breakthrough Pain on Community-Dwelling Cancer Patients: Results from the National Breakthrough Pain Study. *Postgraduate Medicine*, *129*(1). https://doi.org/10.1080/00325481.2017.1261606.

People decide to use medical aid in dying for many reasons

According to utilization reports, patients decide to request medical aid in dying for multiple reasons all at once: pain and other symptoms such as breathlessness and nausea, loss of autonomy, and loss of dignity.[38] It is not any one reason, but rather it is the totality of what happens to one's body at the very end of life. For some people, the side effects of treatments such as chemotherapy or pain medication (sedation, relentless nausea, crushing fatigue, obstructed bowels, to name a few) are in addition to the agonizing symptoms of the disease. Others want the option of medical aid in dying so they can try another treatment with the peace of mind of knowing that if it results in unbearable suffering, they have a way to peacefully control an inevitable death.

Each case is unique and depends on the person's clinical situation, available therapies, and their own values and goals. Newly discovered treatments or "cures" may work for people in early stages of an illness, but they typically do not rescue a person close to death. Medical teams monitor promising research and generally know when a therapy is likely available for prescribing, much like the groundbreaking HIV treatments that eventually transformed a terminal diagnosis into a manageable chronic condition. Yet, many treatments offered in the final stages of life have debilitating side effects that may reduce quality of life, rather than restore it. Brittany Maynard, for example, pursued all potential treatment options for her brain cancer, including experimental therapies, before deciding to request medical aid in dying to ensure she would have the option of a gentle death available to her.[39]

Our experience aligns with years of data in Oregon, Washington, and California, where doctors select from a pre-printed form the top reasons people decide to request aid-in-dying medication under the law. While the form is completed from the provider perspective, it shows that there is no one reason for requesting medical aid in dying. The most frequently reported end-of-life concerns for people in Oregon and Washington are loss of autonomy (87%), impaired quality of life (86%), and loss of dignity (69%).[40]

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[38] DeWolf, T., Cazeau, N. (2022). Medical Aid in Dying: An Overview of Care and Considerations for Patients With Cancer. *Clinical Journal of Oncology Nursing*, *26*(6). https://doi.org/10.1188/22.CJON.621-627.

[39] Compassion & Choices. (n.d.). *Brittany Maynard.* https://compassionandchoices.org/stories/brittany-maynard/.

[40] Al Rabadi, L., et al. (2019). Trends in Medical Aid in Dying in Oregon and Washington. *JAMA Network Open*, *2*(8). https://doi.org/10.1001/jamanetworkopen.2019.8648.

The collective reasons total nearly 400%, which demonstrates that doctors are not selecting just one reason, but they are selecting multiple reasons.[41] The Oregon annual report indicates that doctors believe 29.5% of patients from 1997 through 2024 requested this option because of concerns about inadequate pain control, whereas concerns about finances were only noted for 6% of patients.[42]

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

> "The last time I saw my partner, Jack, I could tell he was in so much pain despite the excellent hospice care he was receiving. I remember crying and Jack crying a little too. Jack was dying, imminently. There was no stopping that. But those final moments between us didn't have to be wracked with pain. Jack could have avoided days of suffering if medical aid in dying were an option available to him. Instead, Jack suffered during his last days on earth. For what? I know that if I were in Jack's shoes, with a terminal illness like cirrhosis of the liver, I would want the same option for myself. As someone living with a disability, I believe I should get to make my own decisions about what kind of medical care I receive when I reach the end of my life. No one else should get to make that decision."
>
> — **Verna O'Brien (1961-2022)**, Illinois advocate for medical aid in dying

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[41] *Id.*

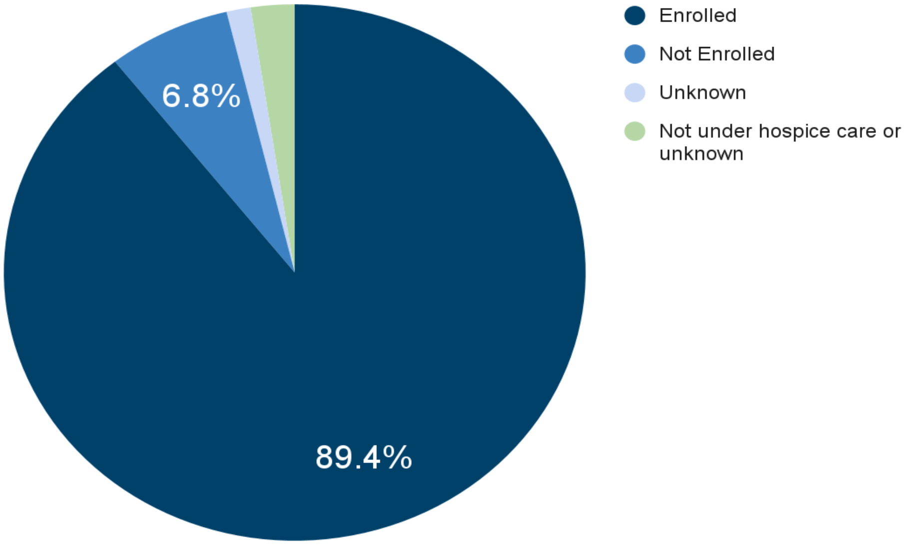
[42] Oregon Health Authority. (2024). *Oregon Death with Dignity Act Annual Report.* https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year27.

People want the option of medical aid in dying in addition to hospice and palliative care

Most people who request and obtain aid-in-dying medication are enrolled in hospice at the time of their death.[43] Additionally, research suggests that people who are not enrolled in hospice or palliative care are less likely to utilize medical aid in dying.[44]

Good hospice and palliative care do not eliminate the need for medical aid in dying.[45] They are not mutually exclusive, and Compassion & Choices supports quality hospice care regardless of whether or not people want to pursue medical aid in dying. Terminally ill people should have a full range of end-of-life options including disease-specific treatment, palliative care, refusal or administration of life-sustaining treatment, hospice care, or medical aid in dying. The option of medical aid in dying puts the decision-making power where it belongs: with the dying person.

Hospice and palliative care use among those who request medical aid in dying, 1997-2024*



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[43] DeWolf, T., Cazeau, N. (2022). Medical Aid in Dying: An Overview of Care and Considerations for Patients With Cancer. *Clinical Journal of Oncology Nursing, 26*(6). https://doi.org/10.1188/22.CJON.621-627.

[44] Grubbs, K., et al. (2024). MAiD in America: A Rapid Review of Medical Assistance in Dying in the United States and Its Implications for Practice for Health Care Professionals. *Journal of Hospice and Palliative Nursing, 26*(6). https://doi.org/10.1097/NJH.0000000000001070.

[45] Ganguly A., James M., Alici, Y. (2025). When Death is Desired: A Case of MAiD & the CL Psychiatrist. *Palliative and Supportive Care, 23*. https://doi.org/10.1017/s1478951524002037.

*This graph reflects data from all jurisdictions that report on hospice use. Currently, public health departments in nine authorized jurisdictions have issued reports regarding the use of medical aid-in-dying laws: Oregon,[46] Washington,[47] Vermont,[48] California,[49] Colorado,[50] Hawaiʻi,[51] the District of Columbia,[52] Maine,[53] and New Jersey.[54] More detailed reports can be provided upon request. Vermont, Washington, D.C., New Jersey, and Maine do not provide this data on hospice utilization in their reports on medical aid in dying.

Patients involve their loved ones in the decision

Although not a requirement under existing laws, the majority of eligible patients involve their family in their decision-making process,[55] and many share that they are able to spend their last moments surrounded by loved ones.

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[46] Oregon Health Authority. (1998-2024). *Oregon Death with Dignity Act Annual Reports.* https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ar-index.aspx.

[47] Washington State Department of Health. (2009-2023). *Washington Death with Dignity Data.* https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData.

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

[49] California Department of Public Health. (2016-2024). *California End of Life Option Act Annual Reports.* https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act-.aspx.

[50] Colorado Department of Public Health & Environment. (2017-2024). *Colorado End-of-Life Options Act Annual Statistical Reports.* https://www.colorado.gov/pacific/cdphe/medical-aid-dying.

[51] Hawaiʻi Department of Health. (2019-2024). *Hawaiʻi Our Care, Our Choice Act Legislative Reports.* https://health.hawaii.gov/opppd/ococ/legislative-reports/.

[52] DC Health. (2017-2022). *District of Columbia Death with Dignity Act Annual Reports.* https://dchealth.dc.gov/publication/death-dignity-annual-reports.

[53] Maine Department of Health and Human Services. (2019-2024). *Maine Death with Dignity Act Annual Reports.* https://www.maine.gov/dhhs/data-reports/reports.

[54] New Jersey Department of Health. (2019-2024). *New Jersey Medical Aid in Dying for the Terminally Ill Act Data Summary.* https://nj.gov/health/advancedirective/maid/.

[55] Singer, J., et al. (2023). An Examination and Proposed Theoretical Model of Risk and Protective Factors for Bereavement Outcomes for Family Members of Individuals Who Engaged in Medical Aid in Dying: A Systematic Review. *Palliative Medicine, 37*(7). https://doi.org/10.1177/02692163231172242.

Section IV: *Evidence-based approach to improve access*

The Oregon model, enacted in 1997, established the framework for all subsequent medical aid-in-dying laws. Its multistep process, however, can take several weeks or even months to complete. Too often, eligible individuals are unable to finish the process and obtain the prescription before the end of their lives.

What the data demonstrates

Empirical and anecdotal data from Oregon and the other authorized jurisdictions suggest that medical aid-in-dying laws in the United States have significant procedural barriers to access for otherwise qualified dying patients. A study by Kaiser Permanente Southern California showed that one-third of patients who requested the option of medical aid in dying were unable to complete the process and obtain a prescription before they died. It is worth noting that Kaiser is a health system supportive of medical aid in dying, with dedicated patient navigators to assist people through the process.[56]

At a National Academy of Sciences two-day assisted-death conference in 2018, many speakers — including physicians, ethicists, and scholars — concluded that the biggest problem with the law was not one of abuse or coercion; it was that the process is just too cumbersome for patients to get through.[57] Unfortunately, many people die while attempting to navigate an unnecessarily burdensome process. Several factors contribute to this reality:

> **Late prognosis.** Many dying patients do not receive their six-month prognosis until they have far less than six months to live. In addition, most patients given a prognosis of six months or less do not reach the six-month mark, let alone live past it. One study of clinicians treating patients with advanced cancer found that only 41% of clinicians' prognosis predictions were accurate, and of the inaccurate prognoses, 85% overestimated the length of time a patient would live.[58] Another

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[56] Nguyen, H., Gelman, E., Bush, T. (2018). Characterizing Kaiser Permanente Southern California's Experience With the California End of Life Option Act in the First Year of Implementation. *JAMA Internal Medicine*, *178*(3). https://doi.org/10.1001/jamainternmed.2017.7728.

[57] National Academies of Sciences, Engineering, and Medicine. (2018). Physician-Assisted Death. https://doi.org/10.17226/25131.

[58] Gramling, R., et al. (2019). Palliative Care Clinician Overestimation of Survival in Advanced Cancer: Disparities and Association with End-of-Life Care. *Journal of Pain and Symptom Management*, *58*(4). https://doi.org/10.1016/j.jpainsymman.2018.10.510.

study found that nursing home residents with a less than six-month prognosis who died had a median survival time of 1.84 months.[59]

- **Complicating prognosis.** Patients with certain diagnoses, like bulbar-onset ALS, may become physically incapable of self-administering the aid-in-dying medication by the time they receive a six-month prognosis.[60]
- **Locating supportive and knowledgeable providers.** Approximately 30 million people in the continental United States live in "healthcare deserts," or areas where they lack adequate access to key healthcare services, including those necessary for people at the end of life.[61] A 2021 survey of advanced practice professionals at Seattle's Fred Hutch Cancer Center, which includes physician assistants (PAs) and nurse practitioners, showed that only 27% of respondents were knowledgeable about medical aid in dying. The authors also found a positive association between knowledge or comfort regarding medical aid in dying and willingness to participate in the procedure.[62]
- **Oppositional providers.** Anecdotal evidence shows that sometimes patients believe their doctor will "support" them in pursuing medical aid in dying when they become eligible under the law, only to find out very late that supporting them means keeping them comfortable in hospice care or referring them to another doctor — not writing them the prescription.[63] Some doctors who personally object to the practice believe they should not have to transfer a patient's medical records or document requests, because they believe transferring records is "participation"

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[59] Vu, L., et al. (2024). Understanding the Utility of Less Than Six-Month Prognosis Using Administrative Data Among U.S. Nursing Home Residents With Cancer. *Palliative Medicine Reports*, *5*(1). https://doi.org/10.1089/pmr.2023.0047.

[60] Marie, D., et al. (2025). Navigating End-of-Life Decisions with Amyotrophic Lateral Sclerosis: A Patient-Centered Perspective on the Clinical and Legal Barriers to Medical Aid in Dying. *Cureus*, *17*(9). https://doi.org/10.7759/cureus.92254.

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

[62] Singer, J., et al. (2022). Assessment of Oncology Advanced Practice Professionals Willingness to Participate in Medical Aid in Dying. *JAMA Network Open*, *5*(10). https://doi.org/10.1001/jamanetworkopen.2022.39068.

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

under the act, as is argued in a New Jersey lawsuit.[64] Transferring records and documentation, however, is part of standard medical care.[65]

Improvements to laws in authorized jurisdictions

In response to nearly three decades of evidence, twelve of the 14 authorized jurisdictions have made key improvements to enhance access while maintaining strict eligibility criteria. These updates cover:

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

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

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

Reducing mandatory waiting periods

Authorized jurisdictions consistently recognize that long waiting periods result in unnecessary suffering for dying people. Reducing or removing the waiting period between oral requests or between receiving and filling a prescription for medical aid in dying, or allowing a waiver of waiting periods, does not reduce the law's core safeguards or change the strict eligibility criteria.

> Based on years of practice, in 2019, the **Oregon** Legislature passed an important amendment to its law to better balance safeguards intended to protect patients and access to medical aid in dying. As long as a written request is provided and the attending qualified clinician attests that the otherwise qualified patient is likely to

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

[65] Health Insurance Portability and Accountability Act, 45 C.F.R. § 164.524 (2022). https://www.law.cornell.edu/cfr/text/45/164.524.

die while waiting, the amendment allows doctors to waive the 15-day waiting period between the two required oral requests and the 48-hour waiting period.[66]

The amendment was a direct result of evidence and data that demonstrated the need for easier access for eligible terminally ill patients facing imminent death. The Oregon Health Authority's annual reports in the years after the amendment passed show that 20-29% of patients between 2020 and 2024 required a physician exemption in order to make it through the process.[67]

- **California** recognized that waiting periods were posing an unnecessary barrier to terminally ill patients. In 2021, the Legislature amended the California End of Life Option Act to decrease the waiting period between the two oral requests from 15 days to 48 hours.[68]
- **New Mexico** requires just one written request, so there is no waiting period for requests. However, the law requires a 48-hour waiting period between receiving and filling a prescription for medical aid in dying medication, but allows a qualified clinician to waive the waiting period if a person is going to imminently die.[69]
- In 2023, the **Washington** Legislature amended the state's Death with Dignity Act to reduce the waiting period between a patient's first and second oral requests for the medication from 15 days to 7 days.[70]
- Between 2019 and 2021, the **Hawai'i** Department of Health's annual reports to the Legislature repeatedly found that some of the well-intentioned regulatory requirements outlined in the state's Our Care, Our Choice Act created unintended barriers for terminally ill patients. The 2021 report detailed that the 49 patients who died while trying to access medical aid in dying endured an average waiting period of 41 days.[71] As part of all three annual reports, the Department

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[66] Oregon State Legislature. (2019). *Senate Bill 579.* https://olis.oregonlegislature.gov/liz/2019R1/Downloads/MeasureDocument/SB579.

[67] Oregon Health Authority. (2024). *Oregon Death with Dignity Act Annual Report.* https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year27.

[68] California Legislature. (2021). *SB-380.* https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB380.

[69] New Mexico Department of Health. (2021). *The Elizabeth Whitefield End-of-Life Options Act.* https://www.nmhealth.org/publication/view/general/8382.

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

[71] Hawaii Department of Health. (2022). *2021 Our Care Our Choice Annual Report.* https://health.hawaii.gov/opppd/files/2022/07/corrected-MAID-2021-Annual-Report.pdf.

recommended that the Legislature adopt an amendment allowing doctors to waive the mandatory waiting period for patients whose death is imminent.

Accordingly, in 2023, the **Hawai'i** Legislature amended the Our Choice, Our Care Act to reduce the mandatory waiting period between the two oral requests required for a qualified patient to obtain a prescription for medication from 20 days to five days. The law now also allows providers to waive the mandatory minimum waiting period for terminally ill qualified patients who are not expected to survive the five-day waiting period.[72]

- In 2024, the **Colorado** Legislature amended the Colorado End-of-Life Options Act to reduce the mandatory waiting period between two oral requests from 15 days to seven days. Providers may waive the waiting period if the terminally ill individual is likely to die from the irreversible and incurable disease prior to the end of the waiting period.[73]
- In 2025, the **Maine** legislature amended the Maine Death with Dignity Act to allow an attending provider to waive up to 10 days of the 15-day mandatory minimum waiting period if the patient is unlikely to survive it and meets all other qualifications.[74]
- **Illinois** requires a five-day waiting period between oral requests and allows the attending provider to waive the waiting period if the patient is unlikely to survive it and meets all other qualifications.[75]
- New York requires a five-day waiting period between writing and filling the aid-in-dying prescription and allows the attending provider to waive the waiting period if the patient is unlikely to survive it and meets all other qualifications. Additionally, New York only requires one oral request and one written request.

Including more qualified healthcare providers

Authorized jurisdictions have amended their laws to include more qualified healthcare providers who can serve as attending, consulting, or mental health providers, which improves access for eligible patients. Similar to physicians, other healthcare providers, such as APRNs and PAs, often work independently and have the authority to write

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[72] Hawai'i State Legislature. (2023). *House Bill 650.* https://www.capitol.hawaii.gov/session/measure_indiv.aspx?billtype=HB&billnumber=650&year=2023.

[73] Colorado General Assembly. (2024). *Colorado SB24-068.* https://leg.colorado.gov/bills/sb24-068.

[74] Maine State Legislature. (2025). *LD 613.* https://legislature.maine.gov/legis/bills/getPDF.asp?paper=HP0381&item=5&snum=132.

[75] End-of-Life Options for Terminally Ill Patients Act, Public Act 104-0441 Ill. (2025).

prescriptions and manage patients' care. Amending medical aid-in-dying laws to include these clinicians recognizes their scope of practice and that they serve an important role in improving access to end-of-life care, including the option of medical aid in dying. The scope of practice for qualified healthcare providers is confirmed in jurisdictions before the type of participating healthcare providers is adjusted.

- In 2023, **Hawai'i** authorized qualified APRNs to be attending healthcare providers, and authorized licensed APRNs and clinical nurse specialists with psychiatric or mental health training, as well as licensed marriage and family therapists, to participate as mental health providers.[76]
- In 2023, **Washington** authorized APRNs and PAs to act as either the attending or consulting medical provider for those who want to access the Death With Dignity Act. A physician would still have to be one of the other providers in either case. Additionally, Washington expanded the types of licensed professionals who can participate as a mental healthcare provider to include independent clinical social workers, advanced social workers, mental health counselors, and psychiatric advanced registered nurse practitioners.[77]
- In 2024, **Colorado** authorized qualified APRNs with prescriptive authority to act as attending and consulting providers.[78]
- **New Mexico** allows APRNs and PAs to act as either the prescribing or consulting healthcare provider, as long as a physician acts as the other provider. Additionally, New Mexico does not require confirmation of eligibility for medical aid in dying by a consulting provider if the person is enrolled in a Medicare-certified hospice program. Master social workers, psychiatric nurse practitioners, and professional clinical mental health counselors are also able to participate as mental health providers.[79]

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[76] Hawai'i State Legislature. (2023). *House Bill 650.* https://www.capitol.hawaii.gov/session/measure_indiv.aspx?billtype=HB&billnumber=650&year=2023.

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

[78] Colorado General Assembly. (2024). *Colorado SB24-068.* https://leg.colorado.gov/bills/sb24-068.

[79] New Mexico Department of Health. (2021). *The Elizabeth Whitefield End-of-Life Options Act.* https://www.nmhealth.org/publication/view/general/8382.

- In **Vermont**,[80] **New Jersey,**[81] **Maine,**[82] and **Illinois,**[83] clinical social workers are able to participate as mental health providers.
- **Delaware** allows APRNs to act as attending and consulting providers.[84]
- **Illinois** allows APRNs to participate as licensed mental health professionals.[85]

Removing residency restrictions

With the exception of Vermont and Oregon, every jurisdiction where medical aid in dying has been authorized by statute limits patient access to those who have established residency in that state.[86] Compassion & Choices believes residency restrictions are unconstitutional, and does not recommend including them in legislation. To date, the Oregon and Vermont attorneys general have settled court cases challenging the constitutionality of their residency requirements, and the legislatures in both states have removed the requirements from their laws.

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[80] Vermont General Assembly. (2023). *Vermont Patient Choice at End of Life, Chapter 113.* https://legislature.vermont.gov/statutes/chapter/18/113

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

[82] Maine Legislature. (2019). *Maine Death with Dignity Act, Public Law Chapter 271.* https://legislature.maine.gov/legis/bills/bills_129th/chapters/PUBLIC271.asp

[83] End-of-Life Options for Terminally Ill Patients Act, Public Act 104-0441 Ill. (2025).

[84] Delaware Legislature. (2025). *Ron Silverio/Heather Block End of Life Options Act.* https://legis.delaware.gov/json/BillDetail/GenerateHtmlDocument?legislationId=141725&legislationTypeId=1&docTypeId=2&legislationName=HB140

[85] End-of-Life Options for Terminally Ill Patients Act, Public Act 104-0441 Ill. (2025).

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

Section V: *Medical aid-in-dying reporting requirements and utilization data*

Compassion & Choices supports optional, rather than mandated, reporting of medical aid in dying utilization data. We strive to balance the priority of integrating medical aid in dying into medical practice as a whole (where, for end-of-life care, there largely are not state-mandated reporting requirements) and use the reported data to further our mission of improving access to end-of-life care.

Accurate data collection and reporting on medical aid in dying is useful to improve the medical practice, to identify opportunities for education, to improve access, to quell concerns about medical aid in dying, and to counter false narratives.

When data collection is mandated, it must be adequately funded to ensure precision, accuracy, and patient and provider privacy. Partners in public health departments across the country provide data that is used to assess the health of our communities. We appreciate their partnership in providing accurate information about who utilizes medical aid in dying while protecting the identity of patients and providers.

Currently, public health departments in nine authorized jurisdictions have issued reports regarding the use of medical aid-in-dying laws: Oregon,[87] Washington,[88] Vermont,[89]

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[87] Oregon Health Authority. (1998-2024). *Oregon Death with Dignity Act Annual Reports.* https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ar-index.aspx.

[88] Washington State Department of Health. (2009-2023). *Washington Death with Dignity Data.* https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData.

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

California,[90] Colorado,[91] Hawai'i,[92] the District of Columbia,[93] Maine,[94] and New Jersey.[95] Compassion & Choices has compiled the data from these authorized jurisdictions.[96] Researchers have investigated the concerns about potential overuse and abuse of medical aid in dying and found these claims to be unsubstantiated by the data.[97] Key utilization data highlights include:

- In the past nearly 30 years, starting with Oregon and across all jurisdictions that report data, 12,425 people have ingested a prescription to end their suffering.[98]
- While data is not collected on patients who only discuss medical aid in dying with their healthcare providers but do not begin the statutory process, nor on patients who begin the process but do not receive a prescription, these unreported events represent an important group. They are individuals who have engaged in meaningful conversations with their providers to better understand all of their end-of-life care options, and to make informed decisions that reflect their values, priorities, and desire for a peaceful death.
- Less than 1% of the annual deaths in each jurisdiction are attributed to the use of medical aid in dying.[99]
- 61% (or just under 2/3) of people with prescriptions ingest the medication and die. Up to 39% of people who go through the process and obtain the prescription may never take it. This group consists of people who die from their underlying illness,

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[90] California Department of Public Health. (2016-2024). *California End of Life Option Act Annual Reports.* https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act-.aspx.

[91] Colorado Department of Public Health & Environment. (2017-2024). *Colorado End-of-Life Options Act Annual Statistical Reports.* https://www.colorado.gov/pacific/cdphe/medical-aid-dying.

[92] Hawai'i Department of Health. (2019-2024). *Hawai'i Our Care, Our Choice Act Legislative Reports.* https://health.hawaii.gov/opppd/ococ/legislative-reports/.

[93] DC Health. (2017-2022). *District of Columbia Death with Dignity Act Annual Reports.* https://dchealth.dc.gov/publication/death-dignity-annual-reports.

[94] Maine Department of Health and Human Services. (2019-2024). *Maine Death with Dignity Act Annual Reports.* https://www.maine.gov/dhhs/data-reports/reports.

[95] New Jersey Department of Health. (2019-2024). *New Jersey Medical Aid in Dying for the Terminally Ill Act Data Summary.* https://nj.gov/health/advancedirective/maid/.

[96] Compassion & Choices. (2025). *Medical Aid-in-Dying Utilization Report: 2026.* https://compassionandchoices.org/resource/medical-aid-in-dying-utilization-report/.

[97] Kozlov, E., et al. (2025). Knowledge of and Preferences for Medical Aid in Dying. *JAMA Network Open, 8*(2). https://doi.org/10.1001/jamanetworkopen.2024.61495.

[98] *Id.*

[99] According to the Center for Disease Control, in 2022 in jurisdictions that authorized medical aid in dying, 598,151 people died in total. In 2022, authorized jurisdictions report 1,904 people died after being provided with a prescription for medical aid in dying — less than 0.003% of total deaths in 2022. Xu, J.,Murphy, S., et al. (2025). (rep.). *Deaths: Final Data for 2022*. National Vital Statistics Report, 74(4). https://www.cdc.gov/nchs/data/nvsr/nvsr74/nvsr74-04.pdf.

another cause of death, or an unreported cause of death. In any case, they derive peace of mind simply from knowing they have the option if their suffering becomes too great.[100]

> The majority of terminally ill people who use medical aid in dying (89%) were enrolled in hospice or palliative care at the time of their death, according to reports that include hospice data.[101]

> There is nearly equal use of medical aid in dying among men and women. There is currently no data on use of medical aid in dying by nonbinary or gender-nonconforming people. However, New Jersey began including a category for nonbinary people with its 2023 report.[102]

> Terminal cancer accounts for the vast majority of qualifying diagnoses (67.7%), with neurodegenerative diseases such as ALS or Huntington's disease following as the second-leading diagnosis (11.2%). In recent years, many jurisdictions have seen growing numbers of patients with cardiovascular diseases seeking medical aid in dying.[103]

> Over 79% of people who use medical aid in dying are able to die at home, which is where most Americans would prefer to die, according to various studies.[104]

> 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, Hawai‘i, Oregon, and Washington, beginning in 2018 with the amendment to Oregon’s law.

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[100] Compassion & Choices. (2025). *Medical Aid-in-Dying Utilization Report: 2026*. https://compassionandchoices.org/resource/medical-aid-in-dying-utilization-report/.

[101] *Id.*

[102] *Id.*

[103] *Id.*

[104] Riutta, S., Puig, N., & Wankowski, D. (2024). Documenting and Honoring Preferred Place of Death in Oncology Hospice Patients. *The Annals of Family Medicine*, *22*(1). https://doi.org/10.1370/afm.22.s1.6887; Pinto, S., et al. (2024). Patient and Family Preferences About Place of End-of-Life Care and Death: An Umbrella Review. *Journal of Pain and Symptom Management*, *67*(5). https://doi.org/10.1016/j.jpainsymman.2024.01.014.

- **California** observed a 47.16% increase in the number of prescriptions written from 2021 to 2022, after their law was amended to reduce the waiting period.[105]
- **Colorado** observed a 28.14% increase in the number of prescriptions written from 2023 to 2024, after their law was amended to reduce the waiting period and expand the number of qualified providers.[106]
- **Hawaiʻi** observed a 51.66% increase in the number of prescriptions written from 2022 to 2023, after their law was amended to expand the number of qualified providers.[107]
- **Oregon** observed a 24.58% increase in the number of prescriptions written from 2019 to 2020, after their law was amended to reduce the waiting period.[108]
- **Washington** observed a 20.58% increase in the number of prescriptions written, after their law was amended to reduce the waiting period and expand the number of qualified providers.[109]

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[105] California Department of Public Health. (2023). *California End of Life Option Act 2022 Data Report*. https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPH_End_of_Life%20_Option_Act_Report_2022_FINAL.pdf. ; California Department of Public Health. (2022). *California End of Life Option Act 2021 Data Report*. https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPH_End_of_Life%20_Option_Act_Report_2021_FINAL.pdf.

[106] Colorado Department of Public Health & Environment. (2025). *Colorado End-of-Life Options Act, 2024 Data Summary, with 2017-2024 Trends and Totals*. https://drive.google.com/file/d/1S3yC6qkS15rywRVUhV_J6CuD3202k2nZ/view.

[107] State of Hawaii, Department of Health. (2024). *2023 Our Care, Our Choice Act (OCOCA) Annual Report*. https://health.hawaii.gov/opppd/files/2024/07/2023-OCOCA-Annual-Report-1.pdf.

[108] Oregon Health Authority. (2021). *Oregon Death with Dignity Act 2020 Data Summary*. https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year23.pdf.

[109] Washington State Department of Health. (2024). *Report to the Legislature: 2023 Death with Dignity*. https://doh.wa.gov/sites/default/files/2025-01/422-109-DeathWithDignityAct2023.pdf. ; Washington State Department of Health. (2023). *Report to the Legislature: 2022 Death with Dignity*. https://doh.wa.gov/sites/default/files/2023-10/422-109-DeathWithDignityAct2022.pdf.

Utilization data

All authorized jurisdictions (1998 – 2024)	Cumulative	
Summary data		
People who received prescriptions (prescriptions written or filled)	20,175	
People who died after ingesting	12,425	
Characteristics		
Sex		
Female	7,123	48.38%
Male	7,600	51.62%
Unknown	1	0.01%
Total	14,724	100%
Race		
Asian	515	3.51%
Asian/Native American/Pacific Islander	29	0.20%
Black	64	0.44%
Hawaiian, Pacific Islander	19	0.13%
Indigenous American, American Indian, Alaskan Native	27	0.18%
Latinx, Hispanic	338	2.31%
Multi-race (two or more races)	50	0.34%
Non-white, Hispanic and/or non-white	20	0.14%
Other, unknown	166	1.13%
White	13,432	91.62%
Total	14,660	100%
Age breakdown		

18 – 64	2,102	22.51%
65 – 74	2,843	30.44%
75 – 84	2,656	28.44%
85+	1,738	18.61%
Total	9,339	100%
Age breakdown (California)		
Under 60	503	9.28%
60 – 69	1,032	19.03%
70 – 79	1689	31.15%
80 – 89	1,379	25.43%
90+	820	15.12%
Total	5,423	100%
Education		
High school diploma, GED, or less	3,610	24.59%
Some college	3,493	23.79%
Associate's, bachelor's, master's, doctorate, or professional degree	7,405	50.44%
Unknown	173	1.18%
Total	14,681	100%
Hospice and/or palliative care		
Enrolled	10,584	89.39%
Not enrolled	809	6.83%
Unknown	159	1.34%
Not under hospice care or unknown	288	2.43%
Total	11,840	100%
Insurance		

Private/commercial	1,013	8.27%
Medicare, Medicaid, and/or other governmental	982	8.02%
Combination of governmental and private/commercial	3,240	26.45%
Insured (unspecified)	3756	30.66%
None, other, unknown	3,260	26.61%
Total	12,251	100%
Underlying illness		
Cancer, malignant neoplasms	10,269	67.70%
Neurological disease	1,694	11.17%
Respiratory disease	1,045	6.89%
Cardiovascular, circulatory disease	1,275	8.41%
Other illnesses	885	5.83%
Total	15,168	100%
Place of death / where medication ingested		
Private home, residence	10,720	79.31%
Hospice facility	177	1.31%
Hospital, acute care hospital	43	0.32%
Long term care, assisted living, foster care facility	619	4.58%
Nursing home	288	2.13%
Other, unknown	1,670	12.35%
Total	13,517	100%

Section VI: *The truth about medical aid in dying*

When crafting medical aid-in-dying legislation, lawmakers can rely on the experience and knowledge from existing laws, research, patient perspectives, and healthcare provider insight. We now have almost 30 years of data since Oregon implemented its law in 1997 and years of experience from other authorized jurisdictions. None of the dire predictions that opponents raised have come to fruition. The evidence confirms that medical aid-in-dying laws protect patients while offering a much-needed option. Improved knowledge about all end-of-life care options, including medical aid in dying, is essential because decisions regarding end-of-life care often involve significant planning and discussions among patients, families, and health care professionals.[110] The following section addresses and answers the most common issues raised about medical aid in dying.

Medical aid in dying is not euthanasia

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

In contrast, euthanasia, sometimes called “mercy killing,” is an intentional act by which another person (not the dying person) acts to cause death. Euthanasia is illegal throughout the United States and all medical aid-in-dying laws expressly prohibit euthanasia. Compassion & Choices does not support authorizing euthanasia because it would allow someone else — not the dying person — to cause the death of another.[111] This issue has become more prominent as Canada’s medical assistance in dying program allows physician-administered medical assistance in dying. Physician-administered aid-in-dying medication is illegal and is NOT available in the United States.

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[110] Kozlov E., et al. (2025). Knowledge of and Preferences for Medical Aid in Dying. *JAMA Network Open*, *8(2)*. https://doi.org/10.1001/jamanetworkopen.2024.61495.

[111] Compassion & Choices and current U.S. medical aid-in-dying practice does not support or encompass euthanasia. Euthanasia, which requires a third party to administer medication, commonly via injection, is illegal throughout the United States.

Medical aid in dying is different from suicide

The conflation — intentional or accidental — of medical aid in dying with suicide perpetuates false, harmful, and stigmatizing information. Suicide is a public health and medical concern that requires collective efforts to address. Medical aid in dying is available only to terminally ill adults who are mentally capable with a prognosis of six months or less to live. In fact, healthcare groups have concluded that medical aid in dying is distinct from suicide.[112] Equating medical aid in dying with suicide is irresponsible and does a disservice both to dying people who want access to medical aid in dying, as well as those impacted by suicide.

Additionally, from a legal perspective, all currently authorized laws emphasize with the same or similar language that: "Actions taken in accordance with [the Act] shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law." Assisting a suicide remains a felony in jurisdictions where medical aid in dying is authorized. Using the term "assisted suicide" inaccurately characterizes a legally authorized, legitimate medical practice as criminal activity under the law.

Opponents use the term "assisted suicide" in an attempt to discredit the legitimate practice of medical aid in dying. The American College of Legal Medicine filed an amicus brief before the United States Supreme Court in 1996 rejecting the term and adopted a resolution in 2008 in which they "publicly advocated the elimination of the word 'suicide' from the lexicon created by a mentally competent, though terminally ill, person who wishes to be aided in dying."[113]

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[112] See Section VII: The growing movement – Medical ethical considerations.

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

> “(I will) go through any and all treatments in order to stay alive for as long as possible … (but) there is nothing wrong with wanting to have as peaceful a transition as possible. The dying process doesn’t have to be painful. It doesn’t have to be filled with suffering if that’s not what the person wants. Death, if you are able to, should be something that you have some say in — whatever that is.”
>
> — **Susan Rahn**, mother, breast cancer patient and medical aid-in-dying advocate

There is no evidence that medical aid in dying increases suicide rates. It is a vast mischaracterization of suicide as a public health issue to blame the increase in death by suicide in a jurisdiction to medical aid in dying when there is no data or formal study that proves this. A 2024 study that reviewed 927,929 suicide deaths in U.S. jurisdictions where medical aid in dying is authorized “failed to find evidence that suicide rates were positively associated with [medical aid in dying] legalization or [medical aid in dying] implementation, when controlling for geographic variation and multiple sociodemographic factors associated with suicide risk.”[114]

When medical aid in dying is authorized, it increases the likelihood that a terminally ill person will express their desire to end their life to a medical provider who has the training to evaluate them and connect them to appropriate care and support. Further, data shows that medical aid-in-dying laws improve end-of-life care in general and hospice and palliative care specifically. For example, Oregon’s medical aid-in-dying law has helped spur the state to increase hospice enrollment, according to a report published in the New England Journal of Medicine.[115] Additionally, according to Dr. Neil Wenger, director of the UCLA Health Ethics Center, the California medical aid-in-dying law “really has created a new standard for how we ought to be helping people at the end of life."[116]

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[114] Sutton, O., Kious, B. (2024). Associations Between the Legalization and Implementation of Medical Aid in Dying and Suicide Rates in the United States. *AJOB Empirical Bioethics*, *19*. https://doi.org/10.1080/23294515.2024.2433474.

[115] Tolle, S., Teno, J. (2017). Lessons from Oregon in Embracing Complexity in End-of-Life Care. *New England Journal of Medicine*, *376*(11) . https://doi.org/10.1056/nejmsb1612511.

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

Availability of medical aid in dying is not a factor used to deny treatment

Medical aid in dying is only available to terminally ill individuals with a prognosis of six months or less to live. A research article from the New England Journal of Medicine concludes insurers have no financial incentive to pressure patients to accelerate their deaths because there are no substantial cost savings.[117] Furthermore, the article was co-authored by an opponent of medical aid in dying more than 20 years ago, when use of hospice care was less frequent.

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

A 2018 study published in the Hastings Center Report noted, "Financial pressure is much more likely to influence a decision to pursue or reject aggressive life-extending care than it is to influence a request for physician assisted death."[118] Both research and experience confirm that worry about finances is not one of the key motivating factors that lead someone to request medical aid in dying.

Medical aid in dying laws protect against coercion

Medical aid-in-dying laws in California, Colorado, Delaware, Hawaiʻi, Illinois, Maine, New Jersey, Oregon, Washington, and the District of Columbia provide additional criminal liability if a person forces or coerces a patient into choosing medical aid in dying. Additionally, healthcare providers do not receive additional reimbursement for supporting or prescribing medical aid in dying for their eligible patients.

There have been no substantiated reports of family members coercing a terminally ill person to use medical aid in dying in the nearly 30 years that such laws have been in effect. When faced with the prospect of losing a loved one, family members and caregivers are far more likely to cling to patients in late-stage illness and demand that all measures be

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[117] Emanuel, E., Battin, M. (1998). What Are the Potential Cost Savings from Legalizing Physician-Assisted Suicide? *New England Journal of Medicine*, *339*(3). https://doi.org/10.1056/nejm199807163390306.

[118] Freeman, L., Rose, S., Younger, S. (2018). Poverty: Not a Justification for Banning Physician-Assisted Death. *Hastings Center Report*, *48*(6). https://doi.org/10.1002/hast.937.

taken to prolong life.[119] A large, comprehensive cancer hospital study in the United States that analyzed decision-making in lung cancer patients and caregivers found that 65% of caregivers experienced treatment disagreements. The same study revealed that families and caregivers were less likely to agree with patient choices regarding decisions to discontinue therapeutic treatments or do not attempt resuscitation (DNAR) status.[120] Another study found that five primary themes identified as protective factors for negative bereavement outcomes: preparedness for death, place of death, sense of control and autonomy, reduction in suffering/burden, and being able to support the patient's end-of-life wishes.[121] Medical aid in dying offers the opportunity for those protective factors to be part of the end-of-life experience.

Patients have options for ingesting the medication

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

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

Once the prescription has been filled, the terminally ill person can choose when to take the medication, which causes deep sleep usually within 3–10 minutes. Respiration slows over the course of an hour or two, then stops, and the person dies peacefully in their sleep. According to the Oregon Death with Dignity Act Annual Reports, the median time between ingestion and death is 37 minutes.[122] Injection or infusion via a vein or any other

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[119] Zhang A., Siminoff L. (2003). The Role of the Family in Treatment Decision Making by Patients with Cancer. *Oncology Nursing Forum*, *30*(6). https://doi.org/10.1188/03.onf.1022-1028.

[120] Zhang A., Siminoff L. (2003). The Role of the Family in Treatment Decision Making by Patients with Cancer. *Oncology Nursing Forum*, *30*(6). https://doi.org/10.1188/03.onf.1022-1028.

[121] Singer, J., et al. (2023). An Examination and Proposed Theoretical Model of Risk and Protective Factors for Bereavement Outcomes for Family Members of Individuals Who Engaged in Medical Aid in Dying: A Systematic Review. *Palliative Medicine*, *37*(7). https://doi.org/10.1177/02692163231172242.

[122] Oregon Health Authority. (1998-2024). *Oregon Death with Dignity Act Annual Reports.* https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ar-index.aspx.

parenteral route of aid-in-dying medication by any person, including the doctor, family member or patient themselves, is explicitly prohibited in each of the laws.

Medication must be self-administered

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

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

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

Terminally ill individuals must have a six-month prognosis

In order to be eligible for medical aid in dying, a mentally capable, terminally ill adult must have a six-month prognosis. All authorized jurisdictions require that the diagnosis and prognosis be medically confirmed before the individual can proceed. A determination of terminality relates to disease progression, not treatment options. Whether an individual has elected to pursue or forego disease-directed treatment does not impact whether the disease is terminal. Malnutrition or dehydration resulting from psychiatric illness or from voluntary cessation of eating and drinking are reversible, not "terminal," and do not qualify a person for medical aid in dying.

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

Aid-in-dying medication is safe

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

In instances when aid-in-dying medication is dispensed but remains unused when the person dies, medication is to be disposed of according to guidelines established by the Drug Enforcement Agency (DEA) and as required under state statute.[123] Information on how to dispose of medication can be found on the DEA website or on The National Association of Boards of Pharmacy website.[124]

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

The death certificate protocol for medical aid in dying is consistent with reporting standards

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

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[123] U.S. Department of Justice, Drug Enforcement Administration. (n.d.). *Drug Disposal Information*. https://www.deadiversion.usdoj.gov/drug_disposal/drug-disposal.html.
[124] U.S. Department of Justice, Drug Enforcement Administration. (n.d.). *Drug Disposal Locator Tool.* https://apps.deadiversion.usdoj.gov/pubdispsearch/spring/main?execution=e1s1.

dying, as the purpose of the death certificate is to track and understand trends in diseases and public health concerns.

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

In other words, data from death certificates is not used to track utilization of end-of-life healthcare options. According to the CDC's guidance on death certificates in its Physicians Handbook on Medical Certification of Death, "[t]he immediate cause does not mean the mechanism of death or terminal event (for example, cardiac arrest or respiratory arrest). The mechanism of death should not be reported as the immediate cause of death because it is a statement not specifically related to the disease process, and it only attests to the condition or fact of death."[125]

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

Medical aid in dying in the United States differs from medical assistance in dying in Canada

Medical aid-in-dying laws in the United States emphasize patient control, safeguards against coercion, and integration into comprehensive end-of-life care. In addition, medical aid in dying in the United States exists only in the context of terminal illness, with objective eligibility criteria and clear protections in place. These clear and restricted eligibility requirements and enforceable safeguards protect against ethical violations and

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

clinician overreach.[126] Because of these structural differences, what happens in Canada would not be possible under the U.S. system.

United States	Canada
SYSTEM TYPE: *State-based* Medical aid in dying is authorized in **13 states and Washington, D.C.** Each jurisdiction has its own statute, safeguards, and reporting requirements, but all of them have the same eligibility requirements including a terminal disease diagnosis.	**SYSTEM TYPE:** *Federal* Following the *Carter v. Canada* Supreme Court decision in 2015, medical assistance in dying became a nationally recognized right and is administered by provincial and territorial governments.
ELIGIBILITY: Adults diagnosed with a terminal illness who have **six months or less to live** who are **mentally capable** of making a healthcare decision.	**ELIGIBILITY**: Adults with a grievous and irremediable medical condition that causes intolerable suffering. Patients **do not** need a terminal prognosis.
ADMINISTRATION: Medication **must be self-administered** by ingestion. Euthanasia and clinician-administration are prohibited.	**ADMINISTRATION:** Medication may be **self-administered or clinician-administered**, often by IV.
CONFIRMATION: Two independent clinicians — physicians in all states, and in some states nurse practitioners or physician assistants — must confirm that the patient meets every legal requirement. If there is any concern about the patient's judgment or capacity, a psychological evaluation may be required.[127]	**CONFIRMATION:** Two independent physicians or nurse practitioners must confirm eligibility.
WAITING PERIODS: Vary by state, but most require an initial **15-day waiting period** after the first request	**WAITING PERIODS:**

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[126] Díaz, K., Nunley, B. (2025). A Patient-Directed Approach: How the U.S. Model of Medical Aid in Dying Balances Compassion with Safeguards. *The American Journal of Bioethics*, *25*(5). https://doi.org/10.1080/15265161.2025.2488271.

[127] In New Mexico, patients enrolled in hospice already have one clinical certification for hospice enrollment, so they need only one additional clinician's certification to qualify for medical aid in dying.

and a **48-hour waiting period** before medication can be prescribed.	➔ If death is **reasonably foreseeable**: medical assistance in dying can proceed after approval. ➔ If death is **not reasonably foreseeable**: a minimum 90-day assessment period applies.

Organ donation and medical aid in dying

Individuals who ingest aid-in-dying medication in U.S. jurisdictions do not qualify for organ donation. The medication must be self-administered into the gastrointestinal tract, which makes it difficult to maintain the integrity of vital organs. Additionally, most individuals who want to use medical aid in dying choose to die at home where it is not possible to be connected to mechanical support and receive the tightly controlled medical response required to facilitate donation and organ transplantation.

Section VII: *The growing movement*

In recent years, public support and demand for this end-of-life care option has grown. As a result, the medical community and lawmakers are recognizing the value and importance of expanding end-of-life options by dropping their opposition, adopting supportive policies, and passing laws to authorize the practice. During the 2025 legislative session, 375 multi-partisan sponsors or co-sponsors introduced 36 bills to authorize, improve, study, or protect medical aid in dying in 25 states.[128] These bills were proposed in every region of the country.

Public support for medical aid in dying as an end-of-life care option

Numerous public opinion polls from a variety of sources, both nationally and at the state level, demonstrate that Americans consistently support medical aid in dying, with majority support among nearly every demographic group.[129] A 2023 nationwide poll by Susquehanna Polling & Research reported that nearly eight out of 10 of U.S. residents (79%) who self-identify as having a disability agree that "medical aid in dying (MAID) should be legal for terminally ill, mentally capable adults who chose to self-ingest medication to die peacefully."[130] A 2021 nationwide poll by Susquehanna Polling & Research reported that 68% of voters support medical aid in dying as an end-of-life care option. Additionally, when respondents were asked if they want the option of medical aid in dying personally for themselves, 67% said yes.[131] Gallup's 2020 Values and Beliefs poll shows that a majority of respondents have consistently favored medical aid in dying since Gallup first asked about it in 1996.[132]

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[128] Compassion & Choices. (2025). *Annual Report 2025*. https://compassionandchoices.org/issue/annual-report-2025.

[129] Compassion & Choices. (2024). *Polling on Voter & Healthcare Provider Support for Medical Aid in Dying*. https://www.compassionandchoices.org/resource/polling-medical-aid-dying.

[130] Susquehanna Polling & Research. (2023). *USA/National Public Opinion Survey of 1,004 respondents - Cross Tabulation Report, February 2023*. https://bit.ly/SPRNatDisabilityPoll2023.

[131] Susquehanna Polling & Research. (2021). *USA Omnibus - Cross Tabulation Report, November 2021*. https://compassionandchoices.org/wp-content/uploads/2024/04/usa-omnibus-cross-tabulation-report-final-november-2021-2.pdf.

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

Majority support among diverse groups

In addition to the medical and other organizations that have endorsed medical aid in dying noted above, the Coalition for Liberty and Justice, the Older Women's League[133] and SAGE,[134] a national organization that provides services and advocacy for LGBTQ+ elders, have all endorsed medical aid in dying on a national level. Broad support spans nearly every demographic, from age to ethnic group and from religious to political affiliation.[135]

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

- Dolores Huerta Foundation[136]
- Hispanic Health Network[137]
- Latino Commission on AIDS[138]
- Latinos for Healthcare Equity[139]
- National Hispanic Council on Aging[140]

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

[134] *Id.*

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

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

[137] Chacón, G. (2018). *Catholic and Latino Perspective on End-of-Life Suffering.* El Diario NY. https://eldiariony.com/2018/02/11/perspectiva-catolica-y-latina-sobre-el-sufrimiento-de-fin-de-vida/.

[138] Torres, J. (2019). *Latinos Support Medical Aid in Dying.* El Diario NY. https://eldiariony.com/2019/01/29/los-latinos-apoyan-la-ayuda-medica-para-morir/.

[139] *Id.*

[140] Cruz, Y. (2017). *All Americans Should Have Access to All End-of-Life Care Options.* The Hill. https://thehill.com/opinion/healthcare/357575-all-americans-should-have-access-to-all-end-of-life-care-options.

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

Additionally, Samuel DeWitt Proctor Conference, Inc., whose mission is to nurture, sustain and mobilize the African American faith community in collaboration with civic, corporate and philanthropic leaders to address critical needs of human rights and social justice within local, national and global communities issued a statement of support for medical aid in dying.[141]

Furthermore, prominent leaders in the African American community are endorsing medical aid in dying. In 2016, medical aid in dying was authorized in Washington, D.C., with the support of all but one member of the predominantly Black city council and a Black mayor.[142] Supporters include the late Maryland Congressman Elijah Cummings,[143] the first African American to be named speaker pro tem in the Maryland House of Delegates; Maryland Congressman Anthony G. Brown,[144] formerly Maryland's lieutenant governor; and Wes Moore,[145] Maryland's first African American governor, and the third African American elected governor in any U.S. state. In addition, Dr. Benjamin F. Chavis,[146] president and CEO of the National Newspaper Publishers Association; and Dr. Jeff Gardere,[147] famed psychologist and ordained minister, publicly endorse and advocate for medical aid in dying.

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[141] Samuel DeWitt Proctor Conference. (n.d.). *Samuel DeWitt Conference and Compassion & Choices - Declaration and Covenant on End-of-Life Care: Ensuring a Purposeful Transition.* https://compassionandchoices.org/wp-content/uploads/2024/04/covenant-on-end-of-life.pdf.

[142] Davis, A., Nirappil, F. (2023). *D.C. Becomes Seventh Jurisdiction to Allow Terminally Ill to End Their Lives.* The Washington Post. https://www.washingtonpost.com/local/dc-politics/dc-becomes-seventh-jurisdiction-to-allow-terminally-ill-to-end-their-lives/2016/11/15/da497266-ab5b-11e6-977a-1030f822fc35_story.html

[143] Compassion & Choices. (2019). *Congressman Elijah Cummings Endorses Maryland End-of-Life Option Act.* https://compassionandchoices.org/news/congressman-elijah-cummings-endorses-maryland-end-of-life-option-act/.

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

[145] Compassion & Choices. (2022). *Maryland Gov.-Elect Wes Moore Endorses Medical Aid in Dying.* https://compassionandchoices.org/news/maryland-gov-elect-wes-moore-endorses-medical-aid-in-dying/.

[146] Chavis, B. (2020). *Black Life Journeys Matter.* https://compassionandchoices.org/news/black-life-journeys-matter.

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

"I have experienced the loss of far too many people … some of whom suffered for months knowing they were about to die," wrote Rep. Cummings in a letter.[148] "[T]here are those among us whose conscience can never accept that any person should have the right to choose the manner and timing of their passing [but] at the end of life, an individual's right to self-determination about one of the most personal decisions that anyone could make supersedes the moral sensibilities of others."

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

Medical ethical considerations

Among U.S. physicians, support for medical aid in dying is strong. A 2020 Medscape poll of 5,130 U.S. physicians from 30 specialties showed an increase from 46% of respondents supporting medical aid in dying in 2010, to 55% in 2020. [149] A 2021 Gynecologic Oncology survey showed 69% of respondents believed that medical aid in dying should be legalized, and in a 2020 Oncology Ethics report, 55% of oncologists surveyed said that medical aid in dying should be legalized.[150] A 2022 study of Colorado physicians noted "those who have participated in [medical aid in dying] largely report the experience to be emotionally fulfilling and professionally rewarding," despite barriers to offering the end-of-life care option.[151] Additionally, 55% of physicians surveyed endorse the idea of medical aid in

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[148] Compassion & Choices. (2019). *Congressman Elijah Cummings Endorses Maryland End-of-Life Option Act.* https://compassionandchoices.org/news/congressman-elijah-cummings-endorses-maryland-end-of-life-option-act/.

[149] Kane, L. (2020). Life, Death, and Painful Dilemmas: Ethics 2020. *Medscape.* https://compassionandchoices.org/wp-content/uploads/2024/04/medscape-ethics-report-2020-life-death-and-pain.pdf

[150] Compassion & Choices. (2024). *Polling on Voter & Healthcare Provider Support for Medical Aid in Dying.* https://www.compassionandchoices.org/resource/polling-medical-aid-dying.

[151] Campbell E., et al. (2022). Physicians' Attitudes and Experiences with Medical Aid in Dying in Colorado: a "Hidden Population" Survey. *Journal of General Internal Medicine, 37*(13). https://doi.org/10.1007/s11606-021-07300-8.

dying, agreeing that "[p]hysician assisted death should be allowed for terminally ill patients."[152]

An additional study found that after having written an aid-in-dying prescription, 96% of clinicians reported that they were "hardly" or "not at all" morally conflicted.[153] Another study found that among consulting and attending physicians caring for patients who requested medical aid in dying, 75.5% felt their most recent case was emotionally fulfilling and professionally rewarding.[154]

A 2022 survey of nurses demonstrated that 86% of nurses would care for a patient contemplating medical aid in dying and that 57% would support the concept of medical aid in dying professionally as a nurse.[155] A research study cites high support from advanced practice providers for participation in medical aid in dying: Of all APPs (Advance practice providers) surveyed, 90.9% either agreed or strongly agreed that medical aid in dying should be legal, and the majority agreed that APPs should be included as eligible providers.[156]

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

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

- American College of Legal Medicine[157]
- American Medical Student Association[158]

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[152] Kane, L. (2020). Life, Death, and Painful Dilemmas: Ethics 2020. *Medscape*. https://compassionandchoices.org/wp-content/uploads/2024/04/medscape-ethics-report-2020-life-death-and-pain.pdf.

[153] Pottash M, et al. (2024). A Survey of Clinicians Who Provide Aid in Dying. *American Journal of Hospice and Palliative Medicine*, *41*(9). https://doi.org/10.1177/10499091231205841.

[154] Campbell E., et al. (2022). Physicians' Attitudes and Experiences with Medical Aid in Dying in Colorado: a "Hidden Population" Survey. *Journal of General Internal Medicine, 37*(13). https://doi.org/10.1007/s11606-021-07300-8.

[155] Compassion & Choices. (2024). *Polling on Voter & Healthcare Provider Support for Medical Aid in Dying*. https://www.compassionandchoices.org/resource/polling-medical-aid-dying.

[156] Harrawood, K. (2023). Medical Aid in Dying: The Role of the Nurse Practitioner. *Journal of the American Association of Nurse Practitioners*, *36*(8). https://doi.org/10.1097/JXX.0000000000000990.

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

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

- American Medical Women's Association[159]
- American Public Health Association[160]
- GLMA: Healthcare Professionals Advancing LGBT Equality[161]
- National Student Nurses' Association[162]

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

- American Academy of Family Physicians[163]
- American Academy of Neurology[164]
- American Academy of Hospice and Palliative Medicine[165]
- American Nurses Association[166]
- American Pharmacists Association[167]

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

[160] American Public Health Association. (2014). *Patients' Rights to Self-Determination at the End of Life*. (2014). https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/29/13/28/patients-rights-to-self-determination-at-the-end-of-life.

[161] GLMA: Health Professionals Advancing LGBTQ+ Equality. (2015). *GLMA Letter of Support on AB X2-15*. https://compassionandchoices.org/wp-content/uploads/2024/04/20151002-glma-letter-in-support-of-ca-eoloa.pdf.

[162] National Student Nurses' Association. (2018). *In Support of Increasing Education and Political Awareness in Nursing Students about Physician-Assisted Dying*. In *Resolutions 2018*. https://www.dropbox.com/s/8xwq5f827leqriq/NSNA%20Resolutions%202018.pdf?dl=0.

[163] Crawford, C. (2020). COD Addresses Medical Aid in Dying, Institutional Racism. *American Academy of Family Physicians*. https://aahpm.org/advocacy/where-we-stand/pad/.

[164] Russell, J., et al. (2018). Lawful Physician-Hastened Death. *Neurology, 90*(9). https://doi.org/10.1212/wnl.0000000000005012.

[165] Physician-Assisted Dying. (2024). *American Academy of Hospice and Palliative Medicine*. https://aahpm.org/advocacy/where-we-stand/pad/.

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

[167] American Pharmacists Association. (2024). *Physician-Assisted Suicide*. In *APhA House of Delegates: Currently Adopted Policy Statements*. https://www.pharmacist.com/DNNGlobalStorageRedirector.ashx?egsfid=OSr7tqp9160%3d.

- American Psychological Association[168]
- American Society of Health-System Pharmacists[169]
- Hospice and Palliative Nurses Association[170]
- National Association of Social Workers[171]
- Oncology Nursing Society[172]

Medical associations in many of the authorized jurisdictions currently have neutral positions on medical aid in dying, including Oregon,[173] California,[174] Colorado,[175] District of

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[168] American Psychological Association. (2017). *Resolution on Assisted Dying and Justification*. https://www.apa.org/about/policy/assisted-dying-resolution.
[169] American Society of Health-System Pharmacists. (2016). *Board Report on the Joint Council Task Force on Pharmacist Participation in Medical Aid in Dying*. https://www.ashp.org/-/media/assets/house-delegates/docs/hod-board-report-on-task-force.ashx.
[170] Hospice & Palliative Nurses Association. (2024). *HPNA Position Statement: Medical Aid in Dying (MAID)*. https://www.advancingexpertcare.org/practice-research/statements-hpna/.
[171] National Association of Social Workers. (2023). *Standard 1. Ethics and Values*. In *Standards for Palliative & End of Life Care*. https://www.socialworkers.org/Practice/NASW-Practice-Standards-Guidelines/Standards-for-Palliative-and-End-of-Life-Care.
[172] Oncology Nursing Society. (2019). *The Nurse's Role When a Patient Requests Medical Aid in Dying [republished statement, originally by the American Nurses Association]*. https://www.ons.org/sites/default/files/2023-12/The%20Nurse%E2%80%99s%20Role%20When%20a%20Patient%20Requests%20Medical%20Aid%20in%20Dying_Dec5.pdf
[173] Oregon Medical Association. (2011). *Physician Assisted Suicide*. In *Where We Stand*. https://www.theoma.org/oma/OMA/About-Content/Where_We_Stand_content/Where_We_Stand_Policies/Hospice-End-of-Life-Care-Death-Dying-Physician-Assisted-Suicide-PAS.aspx.
[174] California Medical Association. (2015). *California Medical Association Removes Opposition to Physician Aid in Dying Bill*. https://www.cmadocs.org/newsroom/news/view/ArticleId/27210/California-Medical-Association-removes-opposition-to-physician-aid-in-dying-bill.
[175] Colorado Public Radio. (2019). *Debate: Coloradans Will Vote on Medically Assisted Death Proposal*. https://www.cpr.org/show-segment/debate-coloradans-will-vote-on-medically-assisted-death-proposal-transcript/

Columbia,[176] Delaware, [177] Vermont,[178] Hawai‘i,[179] Maine,[180] New York,[181] and New Mexico.[182] At least nine other state medical societies and a component society in non-authorized jurisdictions have neutral positions: Connecticut,[183] Georgia,[184] Illinois,[185] Maryland,[186] Massachusetts,[187] Minnesota,[188] Nevada,[189] and Virginia.[190]

Additionally, the American Medical Association (AMA) and the National Alliance for Care at Home (NACH) (previously the National Hospice and Palliative Care Organization) have

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[176] Eckholm, E. (2014). ‘Aid in Dying’ Movement Takes Hold in Some States. *The New York Times*. https://www.nytimes.com/2014/02/08/us/easing-terminal-patients-path-to-death-legally.html.

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

[178] Vermont Medical Society. (2017). *Vermont Medical Society Policy on End-of-Life Care*. http://www.vtmd.org/sites/default/files/2017End-of-Life-Care.pdf.

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

[180] Maine Medical Association. (2019). *Statement on Physician-Assisted Suicide*. https://mainephysicians.org/wp-content/uploads/2024/09/Statement_on_Physician-Assisted_Suicide_Final-4-25-19.pdf.

[181] Mumford, J. (2022). *Why Family Doctors Support Medical Aid in Dying*. New York State Academy of Family Physicians. https://empirereportnewyork.com/why-family-doctors-support-medical-aid-in-dying-s-6471-savino-a-4321-a-paulin/.

[182] New Mexico Medical Society. (2019). *Medical Aid in Dying - CR 2019-01-608*. In *Council Meeting Minutes*. https://d2zhgehghqjuwb.cloudfront.net/accounts/14766/original/2019_1_5_Council_Minutes_-_PENDING_APPROVAL.pdf?1547577653

[183] Connecticut State Medical Society. (2019). *Testimony for House Bill 5898 An Act Concerning Aid in Dying for Terminally Ill Patients*. https://www.cga.ct.gov/2019/PHdata/Tmy/2019HB-05898-R000318-Connecticut%20State%20Medical%20Society-TMY.PDF

[184] Medical Association of Georgia. (2023). *Medical Aid in Dying (MAID)*. In *Reference Committee A: 2023 Items of Business*. https://www.mag.org/blog/reference-committee-a-2023-items-of-business.

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

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

[187] Massachusetts Medical Society. (2017). *Evolving on Medical Aid in Dying*. In *2017 MMS Annual Report: Report from the Frontlines*. https://www.massmed.org/About/2017-Annual-Report/.

[188] Minnesota Medical Association. (2024). *Legislative Proposal on End-of-Life Options: The MMA’s Take*. https://www.mnmed.org/insights/legislative-proposal-end-life-options-mmas-take-february-2024#:~:text=The%20adopted%20MMA%20policy%20deliberately,aid%2Din%2Ddying%20proposals.

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

[190] Medical Society of Virginia. (2022). *2022-2023 Policy Compendium*. https://www.msv.org/wp-content/uploads/2022/11/2022-2023-Policy-Compendium.pdf.

amended their policies to state that it is ethical for a provider to provide medical aid in dying to qualified patients seeking it.[191] NACH even went so far as to replace the outdated and pejorative expression “assisted suicide” with the correct terminology “medical aid in dying.“[192] While the AMA and NACH do not yet have a fully supportive policy, these changes are a significant step forward and demonstrate that acceptance within the medical field is increasing.

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

Support from state organizations

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

- Bar Associations – California,[193] Connecticut,[194] New York[195]

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[191] American Medical Association. (2019). *Report 2 of the Council on Ethical and Judicial Affairs (2-A-19): Physician Assisted Suicide (Resolution 15-A-16 and Resolution 14-A-17).* https://www.ama-assn.org/system/files/2019-05/a19-ceja2.pdf.

[192] National Hospice and Palliative Care Organization. (2021). *Statement on Medical Aid in Dying.* https://candc.link/nhpco.

[193] Conference of California Bar Associations. (2015). *Testimony in Support of ABX2-15.* https://drive.google.com/file/d/1MN8pi9iznOnABSNEgTLNr_XD5VPYzvM4/view?usp=drive_link.

[194] Connecticut Bar Association. (2015). *Testimony in Support of HB 7015.* https://www.cga.ct.gov/2015/juddata/tmy/2015HB-07015-R000318-Collins,%20Barbara-TMY.PDF.

[195] Andrus, J. (2024). *The New State Bar Association Supports Passage of New York’s Medical Aid in Dying Bill.* New York State Bar Association. https://nysba.org/the-new-state-bar-association-supports-passage-of-new-yorks-medical-aid-in-dying-bill.

- American Civil Liberties Union Affiliates – Connecticut,[196] Illinois,[197] Massachusetts,[198]New Jersey,[199] New Mexico,[200] New York[201]
- Disability Rights Organizations – Disability Rights New Mexico,[202] The Arc New York,[203]
- LGBTQ+ organizations – Gay and Lesbian Activist Alliance – D.C.[204]
- League of Women Voters – Delaware,[205] Maryland,[206] New York,[207] Utah[208]

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[196] ACLU - Connecticut. (2018). *Written Testimony Supporting House Bill 6425, An Act Concerning Aid in Dying for Terminally Ill Patients.* https://www.acluct.org/sites/default/files/field_documents/acluct_2021_testimony_supporting_hb_6425_aid_in_dying.pdf.

[197] ACLU - Illinois. (2024). *SB 3499: End of Life Options for Terminally Ill Patients Act.* https://action.aclu.org/send-message/support-end-life-options-terminally-ill-patients.

[198] ACLU - Massachusetts. (2023). *Testimony in Support of Medical Aid in Dying Legislation.* In *Joint Committee on Public Health - 10-20-2023 Hearing.* https://malegislature.gov/Events/Hearings/Detail/4746.

[199] ACLU - New Jersey. (2019). *Following Years-Long Push from ACLU-NJ, Advocates, NJ Enacts Medical Aid in Dying for the Terminally Ill.* Civil Liberties Reporter. https://www.aclu-nj.org/en/publications/civil-liberties-reporter-summer-2019.

[200] ACLU - New Mexico. (2017). *Representative Deborah Armstrong Files HB 171 to Authorize Medical Aid in Dying in New Mexico.* https://www.aclu-nm.org/en/press-releases/representative-deborah-armstrong-files-hb-171-authorize-medical-aid-dying-new-mexico.

[201] ACLU - New York. (2020). *Give People Who Are Dying the Right to a Peaceful Death.* In *Leading the Way: The 2020 Civil Liberties Agenda for New York.* https://www.nyclu.org/sites/default/files/field_documents/202001_nyclu_2020_report.pdf.

[202] Disability Rights New Mexico. (2019). *Oral Testimony for End of Life Options Act HB 47, House Judiciary Committee Hearing.* https://bit.ly/3w99Ov9.

[203] The ARC of New York. (2017). *Medical Aid in Dying.* https://thearcny.org/position-statements/medical-aid-in-dying/.

[204] Gay and Lesbian Activists Alliance. (2015). *Testimony on Death with Dignity Act, Bill 21-38.* http://glaa.org/archive/2015/glaaondeathwithdignityact0710.pdf.

[205] League of Women Voters of Delaware. (2022). *Delaware House Will Vote on HB140 End of Life Options in March 2022.* https://my.lwv.org/delaware/article/delaware-house-will-vote-hb140-end-life-options-march-2022.

[206] League of Women Voters of Maryland. (2019). *Death with Dignity.* https://www.lwvmd.org/dwd.

[207] League of Women Voters of New York. (2018). *Health Care - Medical Aid in Dying.* https://lwvny.org/wp-content/uploads/2021/05/Health-Care-Medical-Aid-in-Dying.pdf.

[208] League of Women Voters of Utah. (2016). *Positions on Death with Dignity.* https://my.lwv.org/sites/default/files/leagues/wysiwyg/%5Bcurrent-user%3Aog-user-node%3A1%3Atitle%5D/lwvutah_position_aid-in-dying.pdf.

- National Association of Social Workers – California,[209] Massachusetts,[210] Minnesota,[211]New Jersey,[212] New Mexico[213]

Religious and faith support

Every religion has its own values, tenets, and rituals around death. A person's individual beliefs are an important factor in their understanding of and approach to dying. While some faiths counsel against end-of-life options like hastening death or medical aid in dying, others counsel just as strongly in favor of patients being able to choose the option most meaningful to them.

Studies have shown that support of medical aid in dying is prominent within various faiths. According to Lifeway Research, 59% of Christians — including 70% of Catholics and 53% of Protestants — and 70% of individuals from other religions support medical aid in dying.[214]

National religious groups have stated their support for medical aid in dying, including:

- United Church of Christ[215]
- Society for Humanistic Judaism[216]

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[209] National Association of Social Workers, California Chapter. (2015). *Registered Support*. In *Hearing on ABX2-15, End of Life.* http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_0001-0050/abx2_15_cfa_20150901_115418_asm_comm.html.

[210] National Association of Social Workers, Massachusetts Chapter. (2017). *End of Life Options Act.* https://www.naswma.org/news/364836/End-of-Life-Options-Act.html.

[211] National Association of Social Workers, Minnesota Chapter. (2024). *Position Statements.* https://naswmn.socialworkers.org/Advocacy/Legislative-Agenda.

[212] National Association of Social Workers, New Jersey Chapter. (2018). *Memorandum Re: AB1504/S1072.* https://naswnj.socialworkers.org/LinkClick.aspx?fileticket=BY5sdXt5QYM%3D&portalid=12.

[213] Kawam, E. (2018). *Letter in Support of the Medical Aid in Dying*. National Association of Social Workers, New Mexico Chapter. https://endoflifeoptionsnm.org/wp-content/uploads/2018/12/NM-End-of-Life-Options-CoalitionLetterofSupport-Natl-Assoc-of-Social-Wkrs-2018.pdf.

[214] LifeWay Research. (2016). *American Views on Assisted Suicide: Representative Survey of 1,000 Americans.* https://research.lifeway.com/wp-content/uploads/2016/12/Sept-2016-American-Views-Assisted-Suicide.pdf

[215] United Church of Christ. (2021). *Faithfully Facing Dying.* https://www.ucc.org/what-we-do/justice-local-church-ministries/justice/health-and-wholeness-advocacy-ministries/health-care-justice/faithfully_facing_dying/.

[216] Society for Humanistic Judaism. (2013). *SJH Supports Physician-Assisted Death.* https://shj.org/organize/social-justice-issues-and-resolutions/physician-assisted-death/.

- American Ethical Union[217]
- Secular Coalition for America[218]
- Unitarian Universalist Association[219]

Many state faith-based organizations have also voiced their support:

- Christian organizations – Progressive Christians Uniting,[220] California-Pacific Conference of the United Methodist Church,[221] Catholics Vote Common Good,[222] California Council of Churches,[223] New York State Council of Churches.[224]
- Sadhana - Coalition of Progressive Hindus.[225]
- Jewish organizations – National Council of Jewish Women California,[226] Jewish Reconstructionist Congregation.[227]
- Non-denominational and Humanist organizations – Northern Virginia Ethical Society,[228] Black Nonbelievers of NYC,[229] Buffalo Unitarian United Church.[230]

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[217] American Ethical Union. (2020). *2020 – Supporting 'Death with Dignity.'* https://aeu.org/resource/2020-supporting-death-with-dignity/.

[218] Secular Coalition for America. (n.d.). *Medical Aid-in-Dying*. https://secular.org/issue/medical-aid-in-dying/.

[219] Unitarian Universalist Association. (1988). *The Right to Die with Dignity: 1988 General Resolution*. https://www.uua.org/action/statements/right-die-dignity.

[220] Progressive Christians Uniting. (2015). *Registered Support*. In *Hearing on ABX2-15, End of Life.* http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_0001-0050/abx2_15_cfa_20150901_115418_asm_comm.html.

[221] California-Pacific Conference of the United Methodist Church. (2015). *On the Eve of All Saints' Day*. https://www.calpacumc.org/bishop-carcano/on-the-eve-of-all-saints-day/

[222] https://drive.google.com/file/d/1RpIgLsFg2fEgG7ER89OvTT4cHCT4h0ef/view?usp=drive_link

[223] California Council of Churches. *Registered Support*. In *Hearing on ABX2-15, End of Life.* http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_0001-0050/abx2_15_cfa_20150901_115418_asm_comm.html.

[224] New York State Council of Churches. (2024). *Memorandum of Support: New York Medical Aid in Dying Act (A.995c/S.2445c).* https://acrobat.adobe.com/id/urn:aaid:sc:VA6C2:57ce3281-66dc-40fe-a67f-a3eabc50cfb6.

[225] Sadhana: Coalition of Jewish Progressives. (2024). *Memorandum of Support: New York Medical Aid in Dying Act (A.995c/S.2445c).* https://acrobat.adobe.com/id/urn:aaid:sc:VA6C2:0e332ebc-84cf-45a1-9e78-27ed4f8caba1.

[226] National Council of Jewish Women California Chapter. (2015). *Letter in Support of ABX2-15.* http://candc.link/cancjw

[227] Jewish Reconstructionist Congregation. (2018). *Support of Illinois Medical Aid in Dying Legislation*. In *Board of Directors' Meeting Notes.* https://www.jrctogether.org/wp-content/uploads/2020/12/December-12-2018-Board-Meeting-Minutes.pdf.

[228] Northern Virginia Ethical Society. (2021). *Resolution on Medical Aid in Dying.* https://noves.org/Presidents-Blog/10753384.

[229] New York State Assembly. (2025). *Justification*. In *Bill Search and Legislative Information: A00136.* https://nyassembly.gov/leg/?default_fld=&leg_video=&bn=A00136&term=2025&Summary=Y&Actions=Y&Memo=Y.

[230] Compassion & Choices. (2024). *New York State Council of Churches: "Supports New York's Medical Aid in Dying Act and Urges the Legislature to Act Swiftly to Pass It."*

Finally, notable faith leaders have shared their support, including:

- Reverend Madison T. Shockley II[231]
- Reverend Charles W. McNeil, Jr.[232]
- Reverend Dr. Paul Smith[233]

Impact of public political support

As noted above, public opinion data demonstrates wide support for medical aid in dying, and voters are rewarding lawmakers who advance this compassionate end-of-life care option by reelecting them. More than seven out of 10 Americans support medical aid in dying with majority support across virtually every demographic group. In addition, voters are eight times "more likely" (51%) than "less likely" (6%) to vote for a candidate for the state legislature if they sponsor or support medical aid-in-dying legislation, according to a national survey conducted by Susquehanna Polling & Research in 2021.[234]

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https://compassionandchoices.org/news/new-york-state-council-of-churches-supports-new-yorks-medical-aid-in-dying-act/.

[231] Compassion & Choices. (2018). *Lobbyist, Pastor Who Helped Pass CA End of Life Option Act Join Compassion & Choices Board*. https://compassionandchoices.org/news/lobbyist-pastor-helped-pass-ca-end-life-option-act-join-compassion-choices-board/.

[232] Compassion & Choices. (2022). *Advocate Profile - Rev. Charles W. McNeill, Jr.* https://www.youtube.com/watch?v=zMojdjlNYwM.

[233] Compassion & Choices. (2022). *Advocate Profile - Rev. Paul Smith.* https://www.youtube.com/watch?v=ma3jhsoEVtE.

[234] Susquehanna Polling and Research. (2021). *Nationwide Poll Shows Strong Support for Advance Care-Dementia Planning, Medical Aid in Dying.* susquehannapolling.com/wp-content/uploads/2023/06/PollMemo-CandC-SPR-Nov-24-21.pdf.

Section VIII: *About Compassion & Choices*

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

In our last fiscal year, our C3 and C4 secured nearly $23.5 million in revenue, with an operating budget of $24.3 million. Our funding comes almost exclusively from the generosity of individuals and family foundations,[235] with 73,000 active donors.[236] We receive virtually no corporate support, with the exception of pro bono services provided by law firms that litigate court cases to advance our mission; last year, we secured nearly $1.7 million in pro-bono legal services. We are a grassroots movement, the progress of which is the result of people experiencing unnecessary suffering at life's end, demanding care and seeking policies that better reflect their values and priorities.

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[235] Compassion & Choices and Compassion & Choices Action Network. (2024). *Combined Financial Statements.* https://drive.google.com/file/d/1SO-GxDZpFD6LUDdnbtkTc7fm79RMYUPE/view.

[236] *Id.*

Section IX: Conclusion

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

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

Terminally ill people:

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

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

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

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

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

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

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Care and Choice at the End of Life

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STATE OF NEW YORK

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2025-2026 Regular Sessions

IN ASSEMBLY

(Prefiled)

January 8, 2025

Introduced by M. of A. PAULIN, ROSENTHAL, DINOWITZ, HEVESI, STECK, LUPARDO, RIVERA, EPSTEIN, SEAWRIGHT, WOERNER, REYES, CRUZ, SAYEGH, DAVILA, STERN, BURDICK, GALLAGHER, KELLES, GONZALEZ-ROJAS, MITAYNES, MAMDANI, CLARK, ANDERSON, JACKSON, SEPTIMO, GLICK, GIBBS, TAPIA, LUNSFORD, CUNNINGHAM, LEVENBERG, SIMONE, BORES, FORREST, SHRESTHA, SHIMSKY, RAGA, RAJKUMAR, KIM, HUNTER, STIRPE, CHANDLER-WATERMAN, LEE, TAYLOR, MEEKS, OTIS, ALVAREZ, LAVINE, DAIS, JACOBSON -- Multi-Sponsored by -- M. of A. BRAUNSTEIN, BRONSON, HYNDMAN, RAMOS, ZINERMAN -- read once and referred to the Committee on Health

AN ACT to amend the public health law, in relation to a terminally ill patient's request for and use of medication for medical aid in dying

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. This act shall be known and may be cited as the "medical aid in dying act".

§ 2. The public health law is amended by adding a new article 28-F to read as follows:

ARTICLE 28-F

MEDICAL AID IN DYING

EXPLANATION--Matter in *italics* (underscored) is new; matter in brackets [-] is old law to be omitted.

2899-q. Reporting.
2899-r. Penalties.
2899-s. Severability.

§ 2899-d. Definitions. As used in this article:

1. "Adult" means an individual who is eighteen years of age or older.

2. "Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal illness or condition.

3. "Decision-making capacity" means the ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed health care, including medical aid in dying, and to reach an informed decision.

4. "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding a person's terminal illness or condition.

5. "Health care facility" means a general hospital, nursing home, or residential health care facility as defined in section twenty-eight hundred one of this chapter, or a hospice as defined in section four thousand two of this chapter; provided that for the purposes of section twenty eight hundred ninety-nine-m of this article, "hospice" shall refer only to a facility providing in-patient hospice care or a hospice residence.

6. "Health care provider" means an individual licensed, certified, or authorized by law to administer health care or dispense medication in the ordinary course of business or practice of a profession.

7. "Informed decision" means a decision by a patient who is suffering from a terminal illness or condition to request and obtain a prescription for medication that the patient may self-administer to end the patient's life that is based on an understanding and acknowledgment of the relevant facts and that is made voluntarily, of the patient's own volition and without coercion, after being fully informed of:

(a) the patient's medical diagnosis and prognosis;

(b) the potential risks associated with taking the medication to be prescribed;

(c) the probable result of taking the medication to be prescribed;

(d) the possibility that the patient may choose not to obtain the medication, or may obtain the medication but may decide not to self-administer it; and

(e) the feasible alternatives and appropriate treatment options, including but not limited to palliative care and hospice care.

8. "Medical aid in dying" means the medical practice of a physician prescribing medication to a qualified individual that the individual may choose to self-administer to bring about death.

9. "Medically confirmed" means the medical opinion of the attending physician that a patient has a terminal illness or condition and has made an informed decision which has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.

10. "Medication" means medication prescribed by a physician under this article.

11. "Mental health professional" means a licensed physician, who is a diplomate or eligible to be certified by a national board of psychiatry, psychiatric nurse practitioner, or psychologist, licensed or certified under the education law acting within such mental health professional's scope of practice and who is qualified, by training and experience,

certification, or board certification or eligibility, to make a determination under section twenty-eight hundred ninety-nine-i of this article.

12. "Palliative care" means health care treatment, including interdisciplinary end-of-life care, and consultation with patients and family members, to prevent or relieve pain and suffering and to enhance the patient's quality of life, including hospice care under article forty of this chapter.

13. "Patient" means a person who is eighteen years of age or older under the care of a physician.

14. "Physician" means an individual licensed to practice medicine in New York state.

15. "Qualified individual" means a patient with a terminal illness or condition, who has decision-making capacity, has made an informed decision, and has satisfied the requirements of this article in order to obtain a prescription for medication.

16. "Self-administer" means a qualified individual's affirmative, conscious, and voluntary act to ingest medication under this article. Self-administration does not include lethal injection or lethal infusion.

17. "Terminal illness or condition" means an incurable and irreversible illness or condition that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.

18. "Third-party health care payer" has its ordinary meaning and includes, but is not limited to, an insurer, organization or corporation licensed or certified under article thirty-two, forty-three or forty-seven of the insurance law, or article forty-four of the public health law; or an entity such as a pharmacy benefits manager, fiscal administrator, or administrative services provider that participates in the administration of a third-party health care payer system.

§ 2899-e. Request process. 1. Oral and written request. A patient wishing to request medication under this article shall make an oral request and submit a written request to the patient's attending physician.

2. Making a written request. A patient may make a written request for and consent to self-administer medication for the purpose of ending such patient's life in accordance with this article if the patient:

(a) has been determined by the attending physician to have a terminal illness or condition and which has been medically confirmed by a consulting physician; and

(b) based on an informed decision, expresses voluntarily, of the patient's own volition and without coercion the request for medication to end such patient's life.

3. Written request signed and witnessed. (a) A written request for medication under this article shall be signed and dated by the patient and witnessed by at least two adults who, in the presence of the patient, attest that to the best of the persons knowledge and belief the patient has decision-making capacity, is acting voluntarily, is making the request for medication of the patient's own volition and is not being coerced to sign the request. The written request shall be in substantially the form described in section twenty-eight hundred ninety-nine-k of this article.

(b) Both witnesses shall be adults who are not:

(i) a relative of the patient by blood, marriage or adoption;

(ii) a person who at the time the request is signed would be entitled to any portion of the estate of the patient upon death under any will or by operation of law;

(iii) an owner, operator, employee or independent contractor of a health care facility where the patient is receiving treatment or is a resident;

(iv) a domestic partner of the patient, as defined in subdivision seven of section twenty-nine hundred ninety-four-a of this chapter;

(v) an agent under the patient's health care proxy as defined in subdivision five of section twenty-nine hundred eighty of this chapter; or

(vi) an agent acting under a power of attorney for the patient as defined in section 5-1501 of the general obligations law.

(c) The attending physician, consulting physician and, if applicable, the mental health professional who provides a decision-making capacity determination of the patient under this article shall not be a witness.

4. No person shall qualify for medical aid in dying under this article solely because of age or disability.

5. Requests for a medical aid-in-dying prescription must be made by the qualified individual and may not be made by any other individual, including the qualified individual's health care agent, or other agent or surrogate, or via advance healthcare directive.

§ 2899-f. Attending physician responsibilities. 1. The attending physician shall examine the patient and the patient's relevant medical records and:

(a) make a determination of whether a patient has a terminal illness or condition, has decision-making capacity, has made an informed decision and has made the request voluntarily of the patient's own volition and without coercion;

(b) inform the patient of the requirement under this article for confirmation by a consulting physician, and refer the patient to a consulting physician upon the patient's request;

(c) refer the patient to a mental health professional pursuant to section twenty-eight hundred ninety-nine-i of this article if the attending physician believes that the patient may lack decision-making capacity to make an informed decision;

(d) provide information and counseling under section twenty-nine hundred ninety-seven-c of this chapter;

(e) ensure that the patient is making an informed decision by discussing with the patient: (i) the patient's medical diagnosis and prognosis; (ii) the potential risks associated with taking the medication to be prescribed; (iii) the probable result of taking the medication to be prescribed; (iv) the possibility that the patient may choose to obtain the medication but not take it; (v) the feasible alternatives and appropriate treatment options, including but not limited to (1) information and counseling regarding palliative and hospice care and end-of-life options appropriate to the patient, including but not limited to: the range of options appropriate to the patient; the prognosis, risks and benefits of the various options; and the patient's legal rights to comprehensive pain and symptom management at the end of life; and (2) information regarding treatment options appropriate to the patient, including the prognosis, risks and benefits of the various treatment options;

(f) offer to refer the patient for other appropriate treatment options, including but not limited to palliative care and hospice care;

(g) provide health literate and culturally appropriate educational material regarding hospice and palliative care that has been prepared by the department in consultation with representatives of hospice and palliative care providers from all regions of New York state, and that is available on the department's website for access and download, provided, however, an otherwise eligible patient cannot be denied care under this article if these materials are not developed by the effective date of this article;

(h) discuss with the patient the importance of:

(i) having another person present when the patient takes the medication and the restriction that no person other than the patient may administer the medication;

(ii) not taking the medication in a public place; and

(iii) informing the patient's family of the patient's decision to request and take medication that will end the patient's life; a patient who declines or is unable to notify family shall not have such patient's request for medication denied for that reason;

(i) inform the patient that such patient may rescind the request for medication at any time and in any manner;

(j) fulfill the medical record documentation requirements of section twenty-eight hundred ninety-nine-j of this article; and

(k) ensure that all appropriate steps are carried out in accordance with this article before writing a prescription for medication.

2. Upon receiving confirmation from a consulting physician under section twenty-eight hundred ninety-nine-h of this article and subject to section twenty-eight hundred ninety-nine-i of this article, the attending physician who determines that the patient has a terminal illness or condition, has decision-making capacity and has made a voluntary request for medication as provided in this article, may personally, or by referral to another physician, prescribe or order appropriate medication in accordance with the patient's request under this article, and at the patient's request, facilitate the filling of the prescription and delivery of the medication to the patient.

3. In accordance with the direction of the prescribing or ordering physician and the consent of the patient, the patient may self-administer the medication to themselves. A health care professional or other person shall not administer the medication to the patient.

§ 2899-g. Right to rescind request; requirement to offer opportunity to rescind. 1. A patient may at any time rescind the request for medication under this article without regard to the patient's decision-making capacity.

2. A prescription for medication may not be written without the attending physician offering the qualified individual an opportunity to rescind the request.

§ 2899-h. Consulting physician responsibilities. Before a patient who is requesting medication may receive a prescription for medication under this article, a consulting physician must:

1. examine the patient and such patient's relevant medical records;

2. confirm, in writing, to the attending physician and the patient, whether: (a) the patient has a terminal illness or condition; (b) the patient is making an informed decision; (c) the patient has decision-making capacity, or provide documentation that the consulting physician has referred the patient for a determination under section twenty-eight hundred ninety-nine-i of this article; and (d) the patient is acting voluntarily, of the patient's own volition and without coercion.

§ 2899-i. Referral to mental health professional. 1. If the attending physician or the consulting physician determines that the patient may lack decision-making capacity to make an informed decision due to a condition, including, but not limited to, a psychiatric or psychological disorder, or other condition causing impaired judgement, the attending physician or consulting physician shall refer the patient to a mental health professional for a determination of whether the patient has decision-making capacity to make an informed decision. The referring physician shall advise the patient that the report of the mental health professional will be provided to the attending physician and the consulting physician.

2. A mental health professional who evaluates a patient under this section shall report, in writing, to the attending physician and the consulting physician, the mental health professional's independent conclusions about whether the patient has decision-making capacity to make an informed decision, provided that if, at the time of the report, the patient has not yet been referred to a consulting physician, then upon referral the attending physician shall provide the consulting physician with a copy of the mental health professional's report. If the mental health professional determines that the patient lacks decision-making capacity to make an informed decision, the patient shall not be deemed a qualified individual, and the attending physician shall not prescribe medication to the patient.

3. A determination made pursuant to this section that an adult patient lacks decision-making capacity shall not be construed as a finding that the patient lacks decision-making capacity for any other purpose.

§ 2899-j. Medical record documentation requirements. An attending physician shall document or file the following in the patient's medical record:

1. the dates of all oral requests by the patient for medication under this article;

2. the written request by the patient for medication under this article, including the declaration of witnesses and interpreter's declaration, if applicable;

3. the attending physician's diagnosis and prognosis, determination of decision-making capacity, and determination that the patient is acting voluntarily, of the patient's own volition and without coercion, and has made an informed decision;

4. if applicable, written confirmation of decision-making capacity under section twenty-eight hundred ninety-nine-i of this article; and

5. a note by the attending physician indicating that all requirements under this article have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed or ordered.

§ 2899-k. Form of written request and witness attestation. 1. A request for medication under this article shall be in substantially the following form:

REQUEST FOR MEDICATION TO END MY LIFE

I, ________________________________, am an adult who has decision-making capacity, which means I understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed health care, and to reach an informed decision and to communicate health care decisions to a physician.

I have been diagnosed with (insert diagnosis), which my attending physician has determined is a terminal illness or condition, which has been medically confirmed by a consulting physician.

I have been fully informed of my diagnosis and prognosis, the nature of the medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives and treatment options including but not limited to palliative care and hospice care.

I request that my attending physician prescribe medication that will end my life if I choose to take it, and I authorize my attending physician to contact another physician or any pharmacist about my request.

INITIAL ONE:

(   ) I have informed or intend to inform one or more members of my family of my decision.

( ) I have decided not to inform any member of my family of my decision.

( ) I have no family to inform of my decision.

I understand that I have the right to rescind this request or decline to use the medication at any time.

I understand the importance of this request, and I expect to die if I take the medication to be prescribed. I further understand that although most deaths occur within three hours, my death may take longer, and my attending physician has counseled me about this possibility.

I make this request voluntarily, of my own volition and without being coerced, and I accept full responsibility for my actions.

Signed: __________________________

Dated: ___________________________

DECLARATION OF WITNESSES

I declare that the person signing this "Request for Medication to End My Life":

(a) is personally known to me or has provided proof of identity;

(b) voluntarily signed the "Request for Medication to End My Life" in my presence or acknowledged to me that the person signed it; and

(c) to the best of my knowledge and belief, has decision-making capacity and is making the "Request for Medication to End My Life" voluntarily, of the person's own volition and is not being coerced to sign the "Request for Medication to End My Life".

I am not the attending physician or consulting physician of the person signing the "Request for Medication to End My Life" or, if applicable, the mental health professional who provides a decision-making capacity determination of the person signing the "Request for Medication to End My Life" at the time the "Request for Medication to End My Life" was signed.

I further declare under penalty of perjury that the statements made herein are true and correct and false statements made herein are punishable.

I further declare that I am not (i) related to the above-named patient by blood, marriage or adoption, (ii) entitled at the time the patient signed the "Request for Medication to End My Life" to any portion of the estate of the patient upon such patient's death under any will or by operation of law, or (iii) an owner, operator, employee or independent contractor of a health care facility where the patient is receiving treatment or is a resident.

Witness 1, Date:

(Printed name)

(Address)

(Telephone number)

Witness 2, Date:

(Printed name)

(Address)

(Telephone number)

2. (a) The "Request for Medication to End My Life" shall be written in the same language as any conversations, consultations, or interpreted conversations or consultations between a patient and at least one of the patient's attending or consulting physicians.

(b) Notwithstanding paragraph (a) of this subdivision, the written "Request for Medication to End My Life" may be prepared in English even when the conversations or consultations or interpreted conversations or consultations were conducted in a language other than English or with auxiliary aids or hearing, speech or visual aids, if the English language form includes an attached declaration by the interpreter of the conversation or consultation, which shall be in substantially the following form:

INTERPRETER'S DECLARATION

I, (insert name of interpreter), (mark as applicable):

( ) for a patient whose conversations or consultations or interpreted conversations or consultations were conducted in a language other than English and the "Request for Medication to End My Life" is in English: I declare that I am fluent in English and (insert target language). I have the requisite language and interpreter skills to be able to interpret effectively, accurately and impartially information shared and communications between the attending or consulting physician and (name of patient).

I certify that on (insert date), at approximately (insert time), I interpreted the communications and information conveyed between the physician and (name of patient) as accurately and completely to the best of my knowledge and ability and read the "Request for Medication to End My Life" to (name of patient) in (insert target language).

(Name of patient) affirmed to me such patient's desire to sign the "Request for Medication to End My Life" voluntarily, of (name of patient)'s own volition and without coercion.

( ) for a patient with a speech, hearing or vision disability: I declare that I have the requisite language, reading and/or interpreter skills to communicate with the patient and to be able to read and/or interpret effectively, accurately and impartially information shared and communications that occurred on (insert date) between the attending or consulting physician and (name of patient).

I certify that on (insert date), at approximately (insert time), I read and/or interpreted the communications and information conveyed between the physician and (name of patient) impartially and as accurately and completely to the best of my knowledge and ability and, where needed for effective communication, read or interpreted the "Request for Medication to End my Life" to (name of patient).

(Name of patient) affirmed to me such patient's desire to sign the "Request for Medication to End My Life" voluntarily, of (name of patient)'s own volition and without coercion.

I further declare under penalty of perjury that (i) the foregoing is true and correct; (ii) I am not (A) related to (name of patient) by blood, marriage or adoption, (B) entitled at the time (name of patient) signed the "Request for Medication to End My Life" to any portion of the estate of (name of patient) upon such patient's death under any will or by operation of law, or (C) an owner, operator, employee or independent contractor of a health care facility where (name of patient) is receiving treatment or is a resident, except that if I am an employee or independent contractor at such health care facility, providing interpreter services is part of my job description at such health care facility or I have been trained to provide interpreter services and (name of patient) requested that I provide interpreter services to such patient for the purposes stated in this Declaration; and (iii) false statements made herein are punishable.

Executed at (insert city, county and state) on this (insert day of month) of (insert month), (insert year).

(Signature of Interpreter)

(Printed name of Interpreter)

(ID # or Agency Name)

(Address of Interpreter)

(Language Spoken by Interpreter)

(c) An interpreter whose services are provided under paragraph (b) of this subdivision shall not (i) be related to the patient who signs the "Request for Medication to End My Life" by blood, marriage or adoption, (ii) be entitled at the time the "Request for Medication to End My Life" is signed by the patient to any portion of the estate of the patient upon death under any will or by operation of law, or (iii) be an owner, operator, employee or independent contractor of a health care facility where the patient is receiving treatment or is a resident; provided that an employee or independent contractor whose job description at the health care facility includes interpreter services or who is trained to provide interpreter services and who has been requested by the patient to serve as an interpreter under this article shall not be prohibited from serving as an interpreter under this article.

§ 2899-l. Protection and immunities. 1. A physician, pharmacist, other health care provider or other person shall not be subject to civil, administrative, or criminal liability or penalty or professional disciplinary action by any government entity for taking any reasonable good-faith action or refusing to act under this article, including, but not limited to: (a) engaging in discussions with a patient relating to the risks and benefits of end-of-life options in the circumstances described in this article, (b) providing a patient, upon request, with a referral to another health care provider, (c) being present when a qualified individual self-administers medication, (d) refraining from acting to prevent the qualified individual from self-administering such medication, or (e) refraining from acting to resuscitate the qualified individual after the qualified individual self-administers such medication.

2. A health care provider or other person shall not be subject to employment, credentialing, or contractual liability or penalty for any reasonable good-faith action or refusing to act under this article, including, but not limited to:

(a) engaging in discussions with a patient relating to the risks and benefits of end-of-life options in the circumstances described in this article;

(b) providing a patient, upon request, with a referral to another health care provider;

(c) being present when a qualified individual self-administers medication;

(d) refraining from acting to prevent the qualified individual from self-administering such medication; or

(e) refraining from acting to resuscitate the qualified individual after the qualified individual self-administers such medication. However, this subdivision does not bar a health care facility from acting under paragraph (c) of subdivision two of section twenty-eight hundred ninety-nine-m of this article.

3. Nothing in this section shall limit civil, administrative, or criminal liability or penalty or any professional disciplinary action, or employment, credentialing, or contractual liability or penalty for negligence, recklessness or intentional misconduct.

§ 2899-m. Permissible refusals and prohibitions. 1. (a) A physician, nurse, pharmacist, other health care provider or other person shall not be under any duty, by law or contract, to participate in the provision of medication to a patient under this article.

(b) If a health care provider is unable or unwilling to participate in the provision of medication to a patient under this article and the patient transfers care to a new health care provider, the prior health care provider shall transfer or arrange for the transfer, upon request, of a copy of the patient's relevant medical records to the new health care provider.

2. (a) A private health care facility may prohibit the prescribing, dispensing, ordering or self-administering of medication under this article while the patient is being treated in or while the patient is residing in the health care facility if:

(i) the prescribing, dispensing, ordering or self-administering is contrary to a formally adopted policy of the facility that is expressly based on sincerely held religious beliefs or moral convictions central to the facility's operating principles; and

(ii) the facility has informed the patient of such policy prior to admission or as soon as reasonably possible.

(b) Where a facility has adopted a prohibition under this subdivision, if a patient who wishes to use medication under this article requests, the patient shall be transferred promptly to another health care facility that is reasonably accessible under the circumstances and willing to permit the prescribing, dispensing, ordering and self-administering of medication under this article with respect to the patient.

(c) Where a health care facility has adopted a prohibition under this subdivision, any health care provider or employee or independent contractor of the facility who violates the prohibition may be subject to sanctions otherwise available to the facility, provided the facility has previously notified the health care provider, employee or independent contractor of the prohibition in writing.

§ 2899-n. Relation to other laws and contracts. 1. (a) A patient who requests medication under this article shall not, because of that request, be considered to be a person who is suicidal, and self-administering medication under this article shall not be deemed to be suicide, for any purpose.

(b) Action taken in accordance with this article shall not be construed for any purpose to constitute suicide, assisted suicide, attempted suicide, promoting a suicide attempt, euthanasia, mercy killing, or homicide under the law, including as an accomplice or accessory or otherwise.

2. (a) No provision in a contract, other agreement or testamentary instrument, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication or take any other action under this article, shall be valid.

(b) No obligation owing under any contract, other agreement or testamentary instrument shall be conditioned or affected by the making or rescinding of a request by a person for medication or taking any other action under this article.

3. (a) A person and such person's beneficiaries shall not be denied benefits under a life insurance policy for actions taken in accordance with this article.

(b) The sale, procurement or issuance of a life insurance or annuity policy or third-party health care payer policy or coverage, or the rate charged for a policy or coverage, shall not be conditioned upon or affected by a patient making or rescinding a request for medication under this article.

(c) This article shall not limit the effect of a life insurance policy provision concerning incontestability pursuant to article thirty-two of the insurance law or any rights or obligations concerning a material misrepresentation in accordance with article thirty-one of the insurance law.

(d) No third-party health care payer may deny coverage for any service or item that would otherwise be covered by the policy because the patient has or has not chosen to request or use medication under this article.

4. An insurer or third-party health care payer shall not provide any information in communications made to a patient about the availability of medication under this article absent a request by the patient or by such patient's attending physician upon the request of such patient. Any communication shall not include both the denial of coverage for treatment and information as to the availability of medication under this article. This subdivision does not bar the inclusion of information as to the coverage of medication and professional services under this article in information generally stating what is covered by a third-party health care payer or provided in response to a request by the patient or by such patient's attending physician upon the request of the patient.

5. The sale, procurement, or issue of any professional malpractice insurance policy or the rate charged for the policy shall not be conditioned upon or affected by whether the insured does or does not take or participate in any action under this article.

§ 2899-o. Safe disposal of unused medications. A person who has custody or control of any unused medication prescribed under this article after the death of the qualified individual shall personally deliver the unused medication for disposal to the nearest qualified facility that properly disposes of controlled substances or shall dispose of it by lawful means in accordance with regulations made by the commissioner, regulations made by or guidelines of the commissioner of education, or guidelines of a federal drug enforcement administration approved take-back program. A qualified facility that properly disposes of controlled substances shall accept and dispose of any medication delivered to it as provided hereunder regardless of whether such medication is a controlled substance. The commissioner may make regulations as may be appropriate for the safe disposal of unused medications prescribed, dispensed or ordered under this article as provided in this section.

§ 2899-p. Death certificate. 1. If otherwise authorized by law, the attending physician may sign the qualified individual's death certificate.

2. The cause of death listed on a qualified individual's death certificate who dies after self-administering medication under this article will be the underlying terminal illness or condition.

§ 2899-q. Reporting. 1. The commissioner shall annually review a sample of the records maintained under sections twenty-eight hundred ninety-nine-j and twenty-eight hundred ninety-nine-p of this article. The commissioner shall adopt regulations establishing reporting requirements for physicians taking action under this article to determine utilization and compliance with this article. The information collected under this subdivision shall not constitute a public record available for public inspection and shall be confidential and collected and maintained in a manner that protects the privacy of the patient, the patient's family, and any health care provider acting in connection with such patient under this article, except that such information may be disclosed to a governmental agency as authorized or required by law relating to professional discipline, protection of public health or law enforcement.

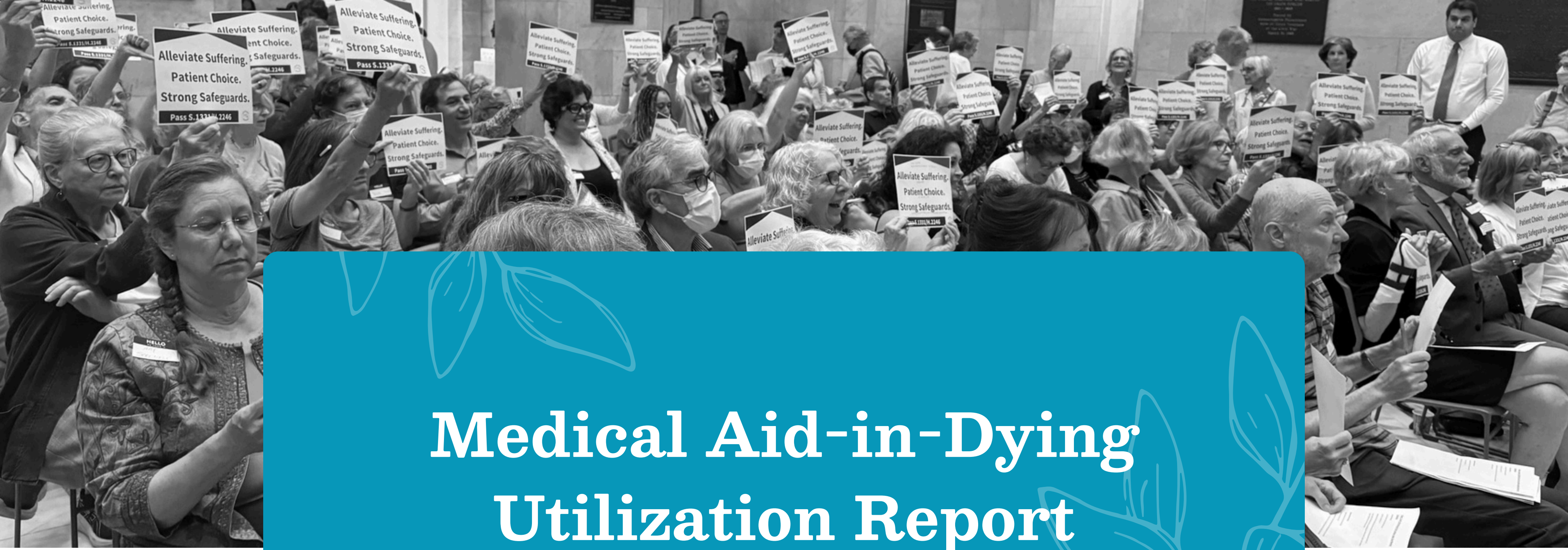
2. The commissioner shall prepare a report annually containing relevant data regarding utilization and compliance with this article and shall send such report to the legislature, and post such report on the department's website.

§ 2899-r. Penalties. 1. Nothing in this article shall be construed to limit professional discipline or civil liability resulting from conduct in violation of this article, negligent conduct, or intentional misconduct by any person.

2. Conduct in violation of this article shall be subject to applicable criminal liability under state law, including, where appropriate and without limitation, offenses constituting homicide, forgery, coercion, and related offenses, or federal law.

§ 2899-s. Severability. If any provision of this article or any application of any provision of this article, is held to be invalid, or to violate or be inconsistent with any federal law or regulation, that shall not affect the validity or effectiveness of any other provision of this article, or of any other application of any provision of this article, which can be given effect without that provision or application; and to that end, the provisions and applications of this article are severable.

§ 3. This act shall take effect immediately.



Medical Aid-in-Dying Utilization Report

2026

compassion & choices

February 2026

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 one in three people — 32.80% — live in a jurisdiction where medical aid in dying is authorized. This list includes 13 states: Oregon (1994), Washington (2008), Montana (2009), Vermont (2013), California (2015), Colorado (2016), Hawaii (2018), New Jersey (2019), Maine (2019), New Mexico (2021), Delaware (2025), Illinois (2025), New York (2026), as well as the District of Columbia (2016). Finally, Oregon, Vermont, and Montana do not have a residency requirement, meaning an adult residing in another jurisdiction and who meets the eligibility criteria, if they are able to travel, may access medical aid in dying in these jurisdictions.

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 in 1997 and years of experience from other authorized jurisdictions, including statistical reports from nine jurisdictions. This report is a compilation of data reports from the authorized jurisdictions that issue reports as of February 12, 2026. While this report only reflects the data published as of that date, the attached data tables are updated periodically as new data is published.

Across the authorized jurisdictions that report data, 12,425 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 Chief Legal Advocacy Officer Bernadette Nunley at policy@compassionandchoices.org for more information.

Sincerely,

Kevin Díaz
President & CEO
Compassion & Choices

Context and methods

Currently, nine of the 14 authorized jurisdictions' Departments of Health have issued reports regarding the use of medical aid in dying laws: Oregon,[1] Washington,[2] Vermont,[3] California,[4] Colorado,[5] Hawai‘i[6], the District of Columbia[7], 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, 11] 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 diseases and diagnoses for individuals who request medical aid in dying.

This report aggregates utilization data published on or before February 12, 2026, which includes data from calendar year 2024. 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.

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[1] Oregon Health Authority. (1998-2024). *Oregon Death with Dignity Act Annual Reports.* https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ar-index.aspx.

[2] Washington State Department of Health. (2009-2023). *Washington Death with Dignity Data.* https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData.

[3] Vermont Department of Health. (2018-2022). *Patient Choice & Control at End of Life.* (2018-2022). https://www.healthvermont.gov/systems/end-of-life-decisions/patient-choice-and-control-end-life.

[4] California Department of Public Health. (2016-2024). *California End of Life Option Act Annual Reports.* https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act-.aspx.

[5] Colorado Department of Public Health & Environment. (2017-2024). *Colorado End-of-Life Options Act Annual Statistical Reports.* https://www.colorado.gov/pacific/cdphe/medical-aid-dying.

[6] Hawai’i Department of Health. (2019-2024). *Hawai’i Our Care, Our Choice Act Legislative Reports.* https://health.hawaii.gov/opppd/ococ/legislative-reports/.

[7] DC Health. (2017-2022). *District of Columbia Death with Dignity Act Annual Reports.* https://dchealth.dc.gov/publication/death-dignity-annual-reports.

[8] New Jersey Department of Health. (2019-2024). *New Jersey Medical Aid in Dying for the Terminally Ill Act Data Summary.* https://nj.gov/health/advancedirective/maid/.

[9] Maine Department of Health and Human Services. (2019-2024). *Maine Death with Dignity Act Annual Reports.* https://www.maine.gov/dhhs/data-reports/reports.

[10] New Mexico Department of Health. (2021). *Elizabeth Whitefield End-of-Life Options Act.* https://www.nmhealth.org/about/erd/bvrhs/vrp/maid/.

[11] Although the New Mexico Department of Health has not yet released a report, End of Life Options New Mexico publishes utilization data on its website: https://endoflifeoptionsnm.org/.

Medical aid in dying jurisdiction usage reports

Based on reported data, the following is known:

- Over the past nearly three decades, across all jurisdictions, more than 20,000 eligible individuals have received prescriptions for medical aid in dying, with 12,425 going on to ingest them.
- While data is not collected on patients who only discuss medical aid in dying with their healthcare providers but do not begin the statutory process, nor on patients who begin the process but do not receive a prescription, these unreported events represent an important group. They are individuals who have engaged in meaningful conversations with their providers to better understand all of their end-of-life care options and to make informed decisions that reflect their values, priorities, and desire for a peaceful death.
- Less than 1% of the adults who die in each jurisdiction choose medical aid in dying each year.[12]
- Only 61% (just under two-thirds) of people with prescriptions ingest the medication and die. Up to 39% 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 adults that they derive peace of mind simply from knowing they have the option if their suffering becomes too great.
- The majority of terminally ill adults who utilize medical aid in dying (89%) are enrolled in hospice or palliative care services at the time of their deaths.
- 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 began including a category for nonbinary people with 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.[13]
- Year after year, reports indicate that the utilization of medical aid in dying is increasing among people of color. Since 2022, many jurisdictions have reported increases in the percentage of people of color utilizing medical aid in dying.

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[12] According to the Center for Disease Control, in 2022 in jurisdictions that authorized medical aid in dying, 598,151 people died in total. In 2022, authorized jurisdictions report 1,904 people died after being provided with a prescription for medical aid in dying – less than 0.3% of total deaths in 2022. CDC has not released an updated *Deaths: Final Data* report since 2022. Xu, J., Murphy, S., et al. (2025). (rep.). *Deaths: Final Data for 2022*. National Vital Statistics Report, 74(4). https://www.cdc.gov/nchs/data/nvsr/nvsr74/nvsr74-04.pdf.

[13] In all jurisdictions and across all years, Asian populations have represented 3.51% of patients utilizing medical aid in dying and Latinx and Hispanic populations have comprised 2.31%. Patients from all other racial and ethnic groups accounted for less than 1%. Additionally, 1.13% of patients were classified as “other” or “unknown.”

- Terminal cancer accounts for the vast majority of qualifying diagnoses (67.7%), with neurodegenerative diseases such as ALS or Huntington's disease following as the second-leading diagnosis (11.2%). In recent years, many jurisdictions have seen growing numbers of patients with cardiovascular diseases seeking medical aid in dying.
- Over 79% 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.[14]
- 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.

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[14] Riutta, S., Puig, N., & Wankowski, D. (2024). Documenting and Honoring Preferred Place of Death in Oncology Hospice Patients. *The Annals of Family Medicine*, *22*(1), 6887. https://doi.org/10.1370/afm.22.s1.6887; Pinto, S., et al. (2024). Patient and Family Preferences About Place of End-of-Life Care and Death: An Umbrella Review. *Journal of Pain and Symptom Management*, *67*(5). https://doi.org/10.1016/j.jpainsymman.2024.01.014.

Authorized Jurisdiction (a)(b)	Oregon	Washington	Vermont	California	Colorado	Washington, DC	Hawaii	New Jersey	Maine	Cumulative
Date Effective	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 - 2024	2009 - 2023	2013 - 2025	2016 - 2024	2017 - 2024	2017 - 2022	2019 - 2024	2019 - 2024	2019 - 2024	1997 - 2024
Total Years Effective as of 1/1/2026	28	16	12	9	9	8	7	6	6	28

Summary Data

	Oregon	Washington	Vermont	California	Colorado	Washington, DC	Hawaii	New Jersey	Maine	Cumulative
Individuals who received prescriptions (written or filled) (c)	4,881	3,704	390	8,242	1,995	31	361	443	318	20,365
Individuals who were dispensed medication (c)		3,704			1,458			443		5,605
Individuals who died after ingesting (a)	3,243	2,768	294	5,423		23	195	409	218	12,573
Individuals who died without having ingested or died from other causes	953	409	80	1,062		8	27	33	70	2,642
Individuals who ingested medication in a calendar year following their prescription's written date	303			282						585
Individuals whose ingestion status is unknown	741	361	16	1,450			24	11	16	2,619
Individuals who received prescriptions and for whom a death certificate was subsequently registered (d)		3,570	378		1,825		299		288	6,360
Unique providers who prescribed the medication (e)	168	207		341	288	4	21			1,029
Prescription rate per provider (f)	2.10	1.73		3.20	3.27	1.60	3.69			2.60
Unique pharmacists who dispensed the medication (e)		68			37					105

Characteristics/Demographics

	Oregon		Washington		Vermont		California		Colorado		Washington, DC		Hawaii		New Jersey		Maine		Cumulative	
Gender (h)																				
Female	1,522	46.93%	1,686	47.43%			2,661	49.07%	937	51.34%	13	54.17%	79	40.51%	198	48.41%	27	54.00%	7,123	48.38%
Male	1,721	53.07%	1,869	52.57%			2,762	50.93%	888	48.66%	11	45.83%	115	58.97%	211	51.59%	23	46.00%	7,600	51.62%
Other																				
Unknown													1	0.51%	0	0.00%			1	0.01%
Total	**3,243**	**100.0%**	**3,555**	**100.0%**			**5,423**	**100.0%**	**1,825**	**100.0%**	**24**	**100.0%**	**195**	**100.0%**	**409**	**100.0%**	**50**	**100.0%**	**14,724**	**100.0%**
Age Breakdown																				
18-64	721	22.23%	809	22.72%					414	22.68%	9	36.00%	24	15.29%	100	24.45%	25	20.83%	2,102	22.51%
65-74	988	30.47%	1,122	31.52%					557	30.52%	6	24.00%	51	32.48%	86	21.03%	33	27.50%	2,843	30.44%
75-84	947	29.20%	956	26.85%					510	27.95%	6	24.00%	57	36.31%	138	33.74%	42	35.00%	2,656	28.44%
85+	587	18.10%	673	18.90%					344	18.85%	4	16.00%	25	15.92%	85	20.78%	20	16.67%	1,738	18.61%
Total	**3,243**	**100.0%**	**3,560**	**100.0%**					**1,825**	**100.0%**	**25**	**100.0%**	**157**	**100.0%**	**409**	**100.0%**	**120**	**100.0%**	**9,339**	**100.0%**
Age Breakdown (CA)																				
Under 60							503	9.28%											503	9.28%
60-69							1,032	19.03%											1,032	19.03%
70-79							1,689	31.15%											1,689	31.15%
80-89							1,379	25.43%											1,379	25.43%
90+							820	15.12%											820	15.12%
Total							**5,423**	**100.0%**											**5,423**	**100.0%**

Authorized Jurisdiction (a)(b)	Oregon		Washington		Vermont		California		Colorado		Washington, DC		Hawaii		New Jersey		Maine		Cumulative	
Age Median & Range																				
Median	73						77		74						72				73	
Range	21-102		20 - 101				23-107						44-101		19-100		31-101		19-107	
Race/Ethnicity (i)																				
Asian	57	1.76%	65	1.84%			344	6.34%					30	19.11%	19	4.65%			515	3.51%
Asian/Native American/Pacific Islander								0.00%	29	1.59%									29	0.20%
Black	5	0.15%					46	0.85%	9	0.49%	1	4.35%			3	0.73%			64	0.44%
Hawaiian, Pacific Islander	2	0.06%					8	0.15%					9	5.73%	0	0.00%			19	0.13%
Indigenous American, American Indian, Alaskan Native	11	0.34%					13	0.24%	3	0.16%					0	0.00%			27	0.18%
Latinx, Hispanic	48	1.48%					222	4.09%	55	3.01%	1	4.35%	5	3.18%	7	1.71%			338	2.31%
Multi-race (two or more races)	12	0.37%					33	0.61%					5	3.18%	0	0.00%			50	0.34%
Non-white, Hispanic and/or Non-white			20	0.57%															20	0.14%
Other, Unknown	17	0.52%	108	3.06%			19	0.35%	15	0.82%			5	3.18%	2	0.49%			166	1.13%
White	3,091	95.31%	3,338	94.53%			4,738	87.37%	1,714	93.92%	21	91.30%	103	65.61%	378	92.42%	49	100.0%	13,432	91.62%
Total	**3,243**	**100.0%**	**3,531**	**100.0%**			**5,423**	**100.0%**	**1,825**	**100.0%**	**23**	**100.0%**	**157**	**100.0%**	**409**	**100.0%**	**49**	**100.0%**	**14,660**	**100.0%**
Education (j) (k)																				
High School Diploma, GED, or Less	884	27.26%	886	25.09%			1,254	23.12%	426	23.34%	0	0.00%	21	13.38%	123	30.07%	16	23.88%	3,610	24.59%
Some College	632	19.49%	1,609	45.57%			951	17.54%	250	13.70%	1	4.00%	11	7.01%	30	7.33%	9	13.43%	3,493	23.79%
Associate's, Bachelor's, Master's, Doctorate or Professional Degree	1,700	52.42%	1,007	28.52%			3,172	58.49%	1,138	62.36%	22	88.00%	67	42.68%	256	62.59%	43	64.18%	7,405	50.44%
Unknown	27	0.83%	29	0.82%			46	0.85%	11	0.60%	2	8.00%	58	36.94%	0	0.00%	0	0.00%	173	1.18%
Total	**3,243**	**100.0%**	**3,531**	**100.0%**			**5,423**	**100.0%**	**1,825**	**100.0%**	**25**	**100.0%**	**157**	**100.0%**	**409**	**100.0%**	**67**	**100.0%**	**14,681**	**100.0%**
Marital Status																				
Married, Domestic Partner	1,459	44.99%	1,632	46.22%					837	45.86%					202	49.39%			4,130	45.85%
Widowed	693	21.37%	708	20.05%					375	20.55%					107	26.16%			1,883	20.90%
Divorced, Separated	818	25.22%	865	24.50%					463	25.37%					66	16.14%			2,212	24.56%
Never Married, Single, Other, Unknown	273	8.42%	326	9.23%					150	8.22%					34	8.31%			783	8.69%
Total	**3,243**	**100.0%**	**3,531**	**100.0%**					**1,825**	**100.0%**					**409**	**100.0%**			**9,008**	**100.0%**
End-of-Life Care																				
Hospice and/or Palliative Care																				
Enrolled	2,924	90.16%	1,010	83.13%			4,985	91.92%	1,535	84.11%			130	97.01%					10,584	89.39%
Not Enrolled	285	8.79%	151	12.43%			373	6.88%											809	6.83%
Unknown	34	1.05%	54	4.44%			65	1.20%	2	0.11%			4	2.99%					159	1.34%
Not under hospice care or unknown									288	15.78%									288	2.43%
Total	**3,243**	**100.0%**	**1,215**	**100.0%**			**5,423**	**100.0%**	**1,825**	**100.0%**			**134**	**100.0%**					**11,840**	**100.0%**

Authorized Jurisdiction (a)(b)	Oregon		Washington		Vermont		California		Colorado		Washington, DC		Hawaii		New Jersey		Maine		Cumulative	
Insurance (l)																				
Private/Commerical		0.00%	296	8.70%			684	12.61%			12	48.00%	21	13.38%					1,013	8.27%
Medicare, Medicaid, and/or Other Governmental		0.00%	774	22.74%			150	2.77%			10	40.00%	48	30.57%					982	8.02%
Combination of Governmental and Private/Commercial			196	5.76%			2,982	54.99%					62	39.49%					3,240	26.45%
Insured (unspecified)	975	30.06%	1,416	41.61%			1,355	24.99%					10	6.37%					3,756	30.66%
None, Other, Unknown	2,268	69.94%	721	21.19%			252	4.65%			3	12.00%	16	10.19%					3,260	26.61%
Total	**3,243**	**100.0%**	**3,403**	**100.0%**			**5,423**	**100.0%**			**25**	**100.0%**	**157**	**100.0%**					**12,251**	**100.0%**
Underlying Illness (m)(n)																				
Cancer, Malignant Neoplasms	2,244	69.20%	2,496	73.30%	275	70.51%	3,590	66.20%	1,195	59.90%	20	74.07%	152	70.37%	256	62.59%	166	66.40%	10,394	67.68%
Neurological Disease	370	11.41%	308	9.05%	48	12.31%	546	10.07%	302	15.14%	4	14.81%	23	10.65%	81	19.80%	34	13.60%	1,716	11.17%
Respiratory Disease	213	6.57%	227	6.67%	15	3.85%	363	6.69%	179	8.97%	1	3.70%	16	7.41%	23	5.62%	18	7.20%	1,055	6.87%
Cardiovascular, Circulatory Disease	249	7.68%	218	6.40%	8	2.05%	552	10.18%	183	9.17%	2	7.41%	17	7.87%	34	8.31%	18	7.20%	1,281	8.34%
Other illnesses	167	5.15%	156	4.58%	44	11.28%	372	6.86%	136	6.82%	0	0.00%	8	3.70%	15	3.67%	14	5.60%	912	5.94%
Total	**3,243**	**100.0%**	**3,405**	**100.0%**	**390**	**100.0%**	**5,423**	**100.0%**	**1,995**	**100.0%**	**27**	**100.0%**	**216**	**100.0%**	**409**	**100.0%**	**250**	**100.0%**	**15,358**	**100.0%**
MAID Process																				
Place of Death/Where Medication Ingested																				
Private Home, Residence	2,944	90.78%	1,069	40.85%			4,832	89.10%	1,494	81.86%					381	93.15%			10,720	79.31%
Hospice Facility	21	0.65%					73	1.35%	66	3.62%					17	4.16%			177	1.31%
Hospital, Acute Care Hospital	11	0.34%	1	0.04%			8	0.15%	23	1.26%									43	0.32%
Long Term Care, Assisted Living, Foster Care Facility	185	5.70%	99	3.78%			335	6.18%								0.00%			619	4.58%
Nursing Home	23	0.71%					110	2.03%	145	7.95%					10	2.44%			288	2.13%
Other, Unknown	59	1.82%	1,448	55.33%			65	1.20%	97	5.32%					1	0.24%			1,670	12.35%
Total	**3,243**	**100.0%**	**2,617**	**100.0%**			**5,423**	**100.0%**	**1,825**	**100.0%**					**409**	**100.0%**			**13,517**	**100.0%**
Patient Informed Family of Decision																				
Yes	2,951	91.00%	1,353	42.83%			4,589	84.62%											8,893	75.21%
No, No Family to Inform	292	9.00%					182	3.36%											474	4.01%
Unknown			1,806	57.17%			652	12.02%											2,458	20.79%
Total	**3,243**	**100.0%**	**3,159**	**100.0%**			**5,423**	**100.0%**											**11,825**	**100.0%**

See endnotes on next page

Rev. 2.18.26

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 data 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 report an aggregate total number of unique providers across all years are Oregon and 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 jursidiction: 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-comformative 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) **Insurance:** While jurisdictions report whether or not a patient had insurance, no data is collected on whether insurance actually covered or reimbursed for medical aid in dying.

(m) **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.

(n) **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.

Appendix: Medical Aid in Dying Authorization Information

Jurisdiction	Law / Court Case	Authorization Date	Authorization Mechanism	Effective Date	Data Period	Years Effective as of 1/1/2026
Oregon	Death with Dignity Act	Nov 8, 1994	Ballot Initiative	Oct 27, 1997*	1997 - 2024	28
Washington	Death with Dignity Act	Nov 4, 2008	Ballot Initiative	Mar 5, 2009	2009 - 2023	16
Montana	*Baxter v. Montana*	Dec 31, 2009	MT Supreme Court	Dec 31, 2009	n/a	16
Vermont	Patient Choice at the End of Life Act	May 20, 2013	Legislation	May 20, 2013	2013 - 2022	12
California	End of Life Option Act	Oct 5, 2015	Legislation	June 9, 2016**	2016 - 2024	9
Colorado	End-of-Life Options Act	Nov 8, 2016	Ballot Initiative	Dec 16, 2016	2017 - 2024	9
Washington, D.C.	Death With Dignity Act	Dec 20, 2016	Legislation	Feb 18, 2017	2017 - 2022	8
Hawaii	Our Care, Our Choice Act	Apr 5, 2018	Legislation	Jan 1, 2019	2019 - 2024	7
New Jersey	Medical Aid in Dying for the Terminally Ill Act	Apr 12, 2019	Legislation	Aug 1, 2019	2019 - 2024	6
Maine	Death With Dignity Act	Jun 12, 2019	Legislation	Jun 12, 2019	2019 - 2024	6
New Mexico	End-of-Life Options Act	Jun 18, 2021	Legislation	Jun 18, 2021	n/a	4
Delaware	End of Life Option Act	May 20, 2025	Legislation	Jan 1, 2026	n/a	0
Illinois	End-of-Life Options for Terminally Ill Patients Act	Dec 12, 2025	Legislation	Sept 2026	n/a	0
New York	Medical Aid in Dying Act	Feb 6, 2026***	Legislation	Aug 5, 2026	n/a	0

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.

*** New York Senate Bill 138 / Assembly Bill 136 was passed by the legislature on June 9, 2025. In December 2025, the Governor announced her intention to sign with chapter amendments. On February 6, 2026, the Governor signed the law with amendments.

APPROVAL MEMORANDUM - No. 89 Chapter 714

MEMORANDUM filed with Assembly Bill Number 136, entitled:

"AN ACT to amend the public health law, in relation to a terminally ill patient's request for and use of medication for medical aid in dying"

APPROVED

New York has long been a beacon of freedom. This bill seeks to extend that freedom to terminally ill New Yorkers who want the right to die comfortably and on their own terms. My mother died of ALS, and I am all too familiar with the pain of seeing someone you love suffer and being powerless to stop it. Therefore, after careful reflection and deliberation with this bill's sponsors, advocacy organizations, and, most importantly, New Yorkers with personal experiences to share, I have decided to sign this bill, which makes medical aid in dying available to terminally ill New Yorkers with less than six months to live.

The bill, as passed by the Legislature, features a number of protections to ensure that no patient is coerced into utilizing and that no health care professional or religiously affiliated health facility is forced to offer medical aid in dying. It was important to me to add important guardrails to ensure the integrity of the patient's decision and the preparedness of medical institutions to appropriately administer medical aid in dying, including:

A mandatory waiting period of 5 days between when a prescription is written and filled.

An oral request by the patient for medical aid in dying must be recorded by video or audio.

A mandatory mental health evaluation of the patient seeking medical aid in dying by a psychologist or psychiatrist.

A prohibition against anyone who may benefit financially from the death of a patient from being eligible to serve as a witness to the oral request or an interpreter for the patient.

Limiting the availability of medical aid in dying to New York residents.

Requiring that the initial evaluation of a patient by a physician be in person.

Allowing religiously affiliated home hospice providers to opt out of offering medical aid in dying.

Ensuring that a violation of the law is defined as professional misconduct under the Education Law.

Extending the effective date of the bill to six months after signing to allow the Department of Health to put into place regulations required to implement the law while also ensuring that health care facilities can properly prepare and train staff for compliance.

I have reached an agreement with the Legislature to enact these changes. On the basis of this agreement, I am pleased to sign this bill into law.

This bill is approved. (signed) KATHY HOCHUL

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Communicating About Medical Aid in Dying in New York

David C. Leven, JD

Introduction

Hastening death by medical aid in dying is more ethically similar than it is different to other legal means of hastening death, including the withholding or withdrawal of life sustaining treatment, voluntarily stopping eating and drinking, or palliative sedation to unconsciousness. Each of these options will result in death, and each requires some form of physician participation. Health care professionals are arguably more actively involved in the resulting deaths of their patients when withdrawing life sustaining treatment such as a ventilator than by providing a potentially lethal medication that a patient can take at a time of his or her own choosing. If a clinician took someone off a life support without the permission of the patient or her surrogate decision maker and the patient died, the clinician would potentially be subject to murder charges. Similarly, providing palliative sedation to unconsciousness while not simultaneously providing life sustaining treatment without permission from the patient or his surrogate decision maker would be both unethical and illegal. The intent and consent of terminally ill patients matter much more than the intent and willingness of health care professionals.

Before there was experience with medical aid in dying (MAID), many arguments were made opposing it and various concerns were also raised, some understandable at the time. Unfortunately, many of these same arguments and concerns are still being expressed even though evidence shows that they no longer have validity, if ever they did. In fact, medical aid in dying laws have worked as intended and none of the problems expected by opponents have emerged. As a result, efforts to repeal MAID laws have failed. And many organizations, including medical organizations have eventually taken either a supportive or neutral position. I am unaware of any organization that was either supportive of neutral that has since become an opponent. There is continued strong opposition from some, primarily religions groups, most notably the Catholic Church hierarchy and some disability rights groups. Politically, virtually all Republican legislators have been opposed, despite polling, for example in NY, that consistently shows Republican voter support. And, there is generally support across demographic groups; political party, age, race region of the state.

Responding to 9 Opposition Arguments

Despite wide spread support for MAID, based in part on evidence from states that authorize the practice, arguments are still being made in opposition which can be refuted. Below are some arguments against MAID and responses to them.

Palliative or hospice care is enough to relieve the suffering of dying patients.

There is no question that the provision of good palliative or hospice care effectively relieves the suffering of the vast majority of dying patients. That is the reason that the Medical Aid in Dying Act requires that the attending physician must “discuss with the patient “feasible alternatives or additional treatment options including hospice and palliative care.” Those who die by MAID are far more likely to receive hospice care than others — about 90% on average in compared to a national average of about 50%. This means that even hospice care is unable to sufficiently relieve the suffering of some dying patients. As stated by Ann Jackson, the former CEO of the Oregon Hospice Association, who after indicating her initial opposition to MAID, said “However, I came to realize that it was arrogant of me to believe that hospice and palliative care professionals could meet all the needs of the dying. Oregon is consistently rated among the best states for providing hospice and palliative care. Yet, even with the best care, some patients still suffer intolerably and want the option to take prescription medication to die painlessly, peacefully and quickly in their sleep.” (“Hospice care isn’t enough for all the dying”, Sacramento Bee, December 9, 2015).

Certainly, patients should not die prematurely by a hastened death, whether by MAID or by other means, if there are things which could be done to improve their quality of life which they are willing to try. However, once desired treatment and care run their course, it should be up to the patient to decide how life will end. And, consider that the overarching goal of hospice and those who support the option of MAID is to ensure that patients have the best deaths possible. So those of us who work with dying patients want to ensure that this is what happens, that patients receive palliative care or hospice, as most MAID patients do, but again with the understanding that decisions about MAID, as with other hastening death options should be left to the patient in consultation with doctors and loved ones.

We should not allow MAID until all patients have adequate access to quality palliative care and hospice care.

Limited access to quality and palliative care is a valid concern, especially for low-income individuals, people of color, those with disabilities, and rural residents. However, there is no evidence that patients who use MAID have been deprived quality end of life care. So, there is no good reason to prevent patients from dying by MAID just because there are other patients, not these, who do not have access to quality care. And, as mentioned above, most patients are enrolled in hospice when they die by MAID, receiving the gold standard of end-of-life care. We must continue to strive for better end of life care and to ensure access to quality palliative care and hospice for all, but at the same time we must not deprive those who are suffering at the end of life the option of medical aid in dying.

Most people who end their lives by MAID do not do so primarily because of uncontrollable pain or other symptoms.

This is true but the argument is not valid. People suffer in diverse ways at the end of their lives. All who are dying and have decision-making capacity should be able to decide if and when their suffering has become intolerable, whether because of pain, other uncontrollable symptoms, other reasons that cause suffering or a combination of some or all of the above. What matters is that the patient has decided that life can no longer be continued because of suffering; however that suffering is determined by the patient. Mentally competent patients are currently permitted to reject any life-sustaining treatments or to stop them at any time, with the understanding that death will ensue. Decisions are routinely made to withdraw a feeding tube, stop dialysis, or turn off a pace maker. And, they are made regardless of the nature or extent of physical or other suffering. That being the case, denying terminally ill patients the right to access MAID cannot be justified simply because in some cases the suffering is not due to intolerable physical symptoms.

Prognostications by physicians are not always accurate so patients might end their lives prematurely by MAID.

While doctors far more often predict that patients will live longer than they actually do, even more importantly, patients who choose the option of MAID almost always wait until they are in fact quite close to death. So, the issue of inaccurate prognostication is not relevant in the context of MAID. Consider too that the process usually takes some seven weeks from the time the first request is made until the drugs are taken, if ever (about one third of patients never take them). Clearly, patients should be able to make end-of-life decisions and MAID in particular, based on the prognostications of two doctors, just as they can make decisions to hasten their deaths by stopping or never starting life-sustaining treatments, even if the prognostication is inaccurate.

Patients might be coerced into dying by MAID.

This would be an understandable concern if there was not over 50 years of combined experience with legal MAID, without any substantiated court or administrative findings of coercion or any other abuses. Even if coercion is theoretically possible, and will probably happen occasionally, that is not a sufficient reason to withhold access to MAID. Patients might also potentially be coerced to stop or never start life sustaining treatments, yet we allow patients to make decisions in this regard and there is actually more opportunity, generally, for coercion in those cases than with MAID due to the strict safeguards concerning MAID and the requirement of self administration.

There will be a slippery slope to allow patients who are not terminally ill to access Medical Aid in Dying or to allow euthanasia.

This is pure speculation. There is simply no evidence in the US to support this assertion, after over 20 years of states authorizing MAID in the US. It is highly unlikely, certainly for the foreseeable future, that MAID laws will be expanded to cover those who are not terminally ill. This is so despite the fact that although some patients who are not dying may be suffering as much if not more, due to the nature of their disease, than those who will soon die. Nor is it likely that laws will be expanded to allow doctors to euthanize patients (although we do allow them to do so with our suffering pets), with one possible exception. In order for there to be any expansion of MAID either laws would have to be enacted or courts would have to render decisions in cases seeking to establish expanded eligibility for MAID. And, all higher court decisions have ruled against those who have sought to establish MAID only for the terminally ill, as either a federal or state constitutional right.

The right to die by MAID, in accordance with one's values, may become, instead, a duty to die.

This is an absurd argument. At least since 1990, patients have had the right to die by stopping or never starting treatment. Any adult patient with decision making capacity can reject life sustaining treatment although death will result, whether by refusing to accept treatment when first offered or by having the treatment discontinued. This right even extends to those who are not terminally ill. However, very few patients reject life sustaining treatment, unless they are close to death. Nor is there any evidence that those who have LST withdrawn feel that they have a “duty to die”. So, understandably, in the context of LST the argument has not been made that those patients will feel a “duty to die”.

Life is precious. And so, despite having the right to die, the vast majority of patients choose to live, at least until suffering becomes or is becoming unbearable, usually when death draws near. There is simply no evidence, over almost three decades, that patients are in any way feeling a duty to die.

People who ultimately choose MAID would prefer to live but are now dying. They only want to control the manner and timing of their deaths, just as do patients who hasten their deaths by withholding or withdrawing life sustaining treatments or who die by voluntarily stopping eating and drinking.

There is now cumulative evidence over 50 years on the experience of MAID. Patients who choose this option are clearly not rushing to end their lives because of a perceived duty to do so. To the contrary, the facts conclusively show that very few people die by MAID, only about three of every 1,000. And, even among those patients who obtain the medication, about a third never take it, further evidence that patients are not feeling an obligation to end their lives. And, the MAID process usually takes about seven weeks from the time that a prescription is first requested, indicating that patients are acting in a thoughtful manner, almost always with the support of their families.

The fear mongering about a potential "duty to die" has no basis. And, one wonders if some opponents may think that there is a duty to live, even when suffering is intolerable at the end of life.

Doctors should not be involved in intentionally causing the death of their patients.

We actually do not know what the intent is of any doctor who prescribes the medications for a patient who chooses MAID. The doctor may not want the patient to die but is acting to support and respect the wishes of the patient when prescribing the drugs. Similarly, we do not know what the intent of a doctor is when a ventilator is withdrawn. The doctor may actually want the patient to die or not. We do know that in both situations the patient will die regardless of the doctor's intent. But the intent of the doctor is not really the point. The intent of the patient is what clearly matters.

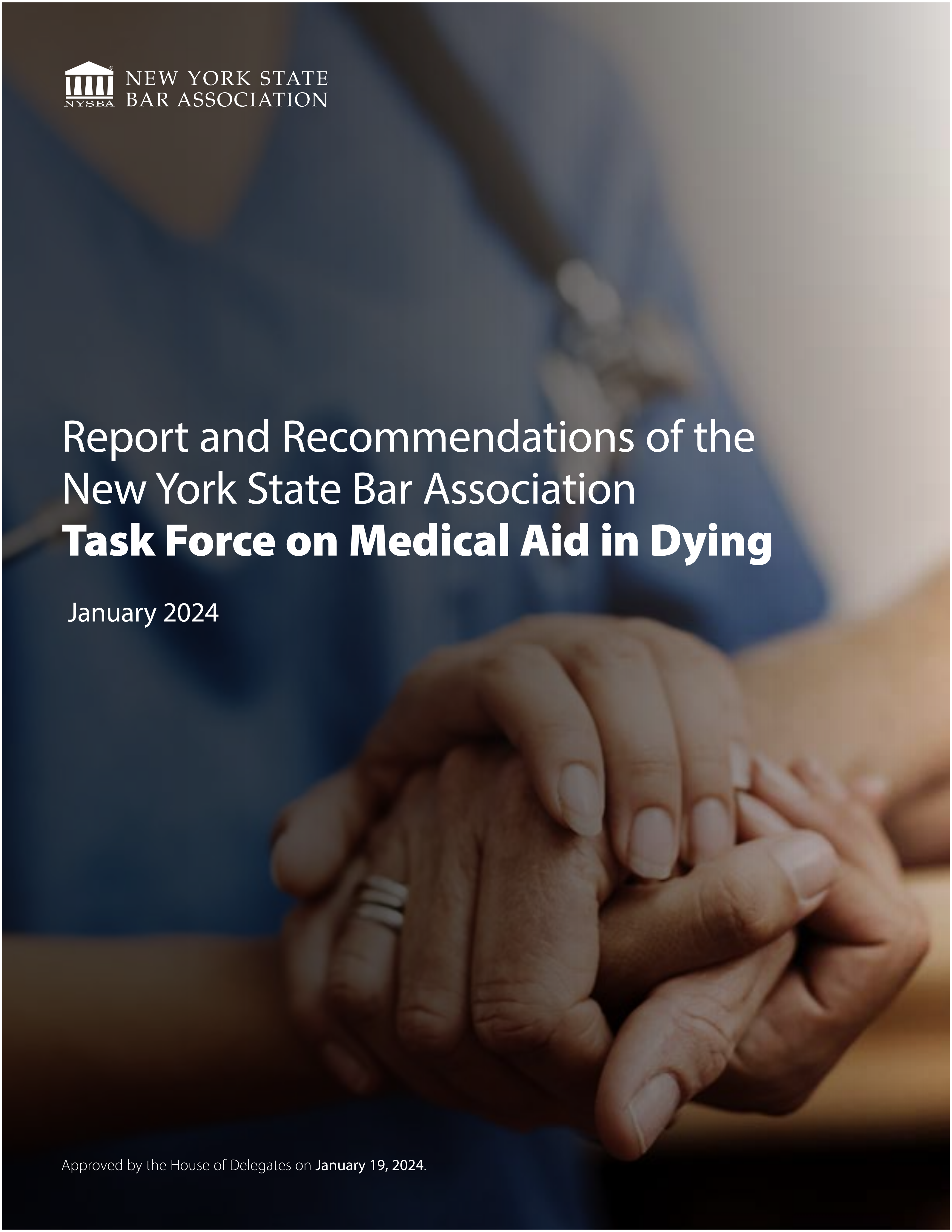
MAID is fundamentally incompatible with the doctor's role as healer.

When a patient is terminally ill, healing the illness itself is no longer possible. The relief of suffering and not abandoning the patient at a time of great need, might be considered another form of healing, compatible with a doctor's role. And it is, of course, or should be extremely important to the doctor that the patient has the best possible quality of life, usually with the provision of palliative or hospice care, as the patient is in the last chapter of life. When suffering becomes intolerable, the relief of that suffering may include a hastened death if that is what the patient decides. Doctors must have the ability to act in accordance with the wishes of their patients, whether it is to withdraw life sustaining treatment(s) or to prescribe life-ending medications to eligible patients. If doctors feel that they cannot do so because of their own ethical or religious values, none of the laws authorizing medical aid in dying, including the Medical Aid in Dying Act, require doctors to directly participate in the process.

Conclusion

With decades of data, it is clear that there are no longer any compelling arguments in opposition to MAID. There are no justifiable reasons why this medical option should not be available to adult, mentally capable, terminally ill patients, especially when there is overwhelming evidence that medical aid in dying laws have worked as intended.

David C. Leven is the Executive Director Emeritus and Senior Consultant to End of Life Choices New York. From 2002 to 2016 he was the Executive Director. An advocate for patients and an expert on advance care planning, patient rights, palliative care and end-of-life issues, including medical aid in dying, Mr. Leven has played a leadership role in having legislation introduced and enacted in New York to improve pain, palliative and end-of-life care and to increase the use of health care proxies.



NYSBA NEW YORK STATE BAR ASSOCIATION

Report and Recommendations of the New York State Bar Association **Task Force on Medical Aid in Dying**

January 2024

Approved by the House of Delegates on **January 19, 2024**.

Report and Recommendations of the New York State Bar Association Task Force on Medical Aid in Dying

January 2024

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I. EXECUTIVE SUMMARY

The New York State Bar Association Task Force on Medical Aid in Dying (MAID) was formed in June 2023 by President Richard Lewis. President Lewis framed the Task Force mission and charge to the Task Force as follows:

> The Task Force on Medical Aid in Dying shall review the legal, ethical, health and public health, and broader policy considerations concerning medical aid in dying, including legislative proposals in New York and issues that may be related to the design as well as implementation of any such proposals if enacted by the NYS Legislature. The focus of the Task Force review shall include available research evidence and public health data; risks and benefits; financing; potential inequities and disparities; and the impacts of any such proposal or law if enacted upon families and caregivers; providers and residential and correctional care facilities; professional and informal workforces; and structural vulnerability and social determinants of health across diverse communities. The Task Force may evaluate laws of other states, jurisdictions, and countries, including Canada, as may be relevant to the Task Force inquiry. Through a consultative process with its members and other sections, the Task Force will develop recommendations for submission to the NYSBA Executive Committee and House of Delegates.

The members of the Task Force are leaders in many NYSBA sections and committees with relevant expert knowledge in multiple areas, including disabilities rights; elder law; health and public health law; insurance law; palliative care, hospice, and end-of-life care. President Lewis appointed Mary Beth Morrissey Esq., PhD, MPH, who is chair elect of NYSBA's Health Law Section and an active member of the Committee on Rights of Persons with Disabilities and the Elder Law Section, as Task Force Chair. Dr. Morrissey had chaired NYSBA's Health Law Section Task Force on COVID-19 in 2020,[1] and NYSBA's Emergency Task Force on Mandatory Vaccination and Safeguarding the Public's Health in 2021.[2] She served on NYSBA's Nursing Homes and Long-Term Care Task Force in 2021,[3] chaired by Hermes Fernandez. Dr. Morrissey is a well-known public policy researcher in gerontological health, public health, and social work, and palliative and end-of-life care, and has a strong record of scholarship and policy advocacy in New York, as well as nationally and in the United Nations global health and aging communities. Judith Grimaldi chaired the Task Force's Working Group on Hospice, Palliative, and End-of-Life Care (End-of-Life Working Group), and Hon. Rachel Kretser chaired the Task Force's Legislative Working Group.

The Task Force heard from diverse parties, including individuals, organizations, attorneys, physicians, social workers, and other professionals with relevant expertise. Those who presented testimony included individuals and organizations who support the MAID bill, as well as those who

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[1] https://nysba.org/app/uploads/2021/01/health-Law-Resolutions-and-report-with-cover-approved-November-2020.pdf.

[2] https://nysba.org/app/uploads/2021/08/EC-Approved-Final-Report-on-Emergency-Task-Force-on-Mandatory-Vaccination-and-Safeguarding-the-Publics-Health..-with-appendix-a.pdf.

[3] https://nysba.org/app/uploads/2021/03/Task-Force-on-Nursing-Home-and-Long-Term-Care-Report-FINAL-approved-6.12.2021.pdf.

voice serious concerns about it or oppose it. In addition, the Task Force held a five-hour Open Forum on November 17 to afford people outside the legal community an opportunity to offer their ideas and insights.

This report summarizes the comprehensive and methodical review carried out by the Task Force since June 2023.

Section II explains that MAID cannot be created judicially under current controlling authority and reviews the history of certain New York laws relevant to the Task Force's focus of inquiry.

In Section III, the New York MAID bill is framed in the end-of-life spectrum of care options, alongside hospice and palliative care. The need for more information and counseling at the end of life is also addressed.

The MAID laws and the history of their implementation in 10 other U.S. jurisdictions are mapped out in Section IV to provide further context for consideration of the bill currently before the New York State Legislature, which would amend the Public Health Law to provide that certain terminally ill patients could request and use medication for aid in dying.[4]

Sections V and VI of this Report set forth additional comments and recommendations for consideration once MAID is authorized in New York State. The State ought then to draw on its past legislation and regulatory and payment models, and on approaches created in other states, to ensure citizens have equal access to comprehensive end-of-life care including MAID. Comments and recommendations address structural inequities and disparities in health and end-of-life care at the intersectionality of race, ethnicity, gender, disability, age, immigration status, and social determinants of health; additional safeguards for certain special populations; funding for MAID; and development and provision of MAID training.

The Appendices provide summaries of testimony by individuals and organizations who appeared during the Public Forum and before the Legislative Working Group, affiliations of the Task Force Members, and charts comparing MAID laws and reports nationwide.

In order to ensure that all eligible New Yorkers have equitable access to high-quality medical aid in dying as part of a continuum of compassionate end-of-life care options in New York**,** and further, based on the methodical review conducted by the Task Force pursuant to the charge from New York State Bar Association President Lewis and after serious deliberations:

The Task Force on Medical Aid in Dying recommends the New York State Bar Association adopt a position in support of the pending MAID bill (A995a/S2445); and additional comments and recommendations, and to support similar bills that accomplish this purpose.[5]

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[4] The NY Medical Aid in Dying Act, A995A/S2445A, available at https://nyassembly.gov/leg/?default_fld=&leg_video=&bn=A00995&term=&Summary=Y&Text=Y.

[5] This report reflects the consensus opinion of the New York State Bar Association Task Force members and does not reflect, unless otherwise stated, the views held by any individual member or the member's clients or employers. Participation in the Task Force by any one member should not be interpreted as an expression of support for the Task Force, this report, or Medical Aid in Dying by the member or the member's client or employer.