Commentary

Medical Aid in Dying: How Might U.S. Policy Prevent Suffering at the End of Life?

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Abstract

Medical aid in dying refers to policies that allow terminally ill patients to seek assistance from their medical providers to obtain medications to hasten death. In this paper, we used a 7-point policy analysis model to examine the diversity of medical aid in dying policies that exist in jurisdictions (states and territories) in the U.S. and the implications of these policies for suffering at end of life. As of this writing, these practices are available in 12 jurisdictions, including 11 states and the District of Columbia. Legalization has occurred via statutory approaches in 10 jurisdictions and permissive approaches in two jurisdictions. We discuss the structures of these laws, the requirements for participation, and the limitations created by having jurisdiction-specific policies on such broad, bioethical issues. Existing laws appear to relieve suffering in patients at end of life. Jurisdictional differences create barriers to comprehensive expansion but provide insights into practice in different contexts.

Keywords: aging, end-of-life care, health policy, policy analysis, medical aid in dying

Key Points:

- Medical aid in dying is growing in popularity as a legislative approach to relieving suffering at end-of-life.
- Medical aid in dying is not legal at the federal level in the U.S., and there are variations in the jurisdictional laws and policies that impact access.
- Restrictive policies have limited the amount of data available on how medical aid in dying is being used, and more research is needed to guide future policies.

Introduction

End of life (EOL) experiences have the potential to create immense suffering. Kahn and Steeves (1986) assert that *suffering* is "an individual's experience of threat to self and is a meaning given to events such as pain or loss" (p. 623). As such, suffering may be physical or existential in nature (Boston et al., 2011). The U.S. has historically relied on hospice and palliative care to relieve suffering in individuals with serious and progressive illness. Hospice care, in particular, is reserved for when illness is determined to be terminal. Serving roughly 1.5 million Americans and their families annually (National Hospice and Palliative Care Organization, 2021), hospice represents the dominant provider of EOL care (Wiener & Tilly, 2003). Still, EOL challenges are difficult to address, and suffering cannot always be adequately relieved (Boston et al., 2011), prompting interest in other methods to bring relief of suffering and autonomy to an individual's alleviation of suffering.

Medical aid in dying (MAID) is gaining traction across the U.S. in this regard. The use of MAID to relieve suffering is supported by research finding the primary drivers of MAID pursuit are concerns about decreased autonomy, quality of life, and dignity (Al Rabadi et al., 2019), all indicative of suffering. As of this writing, MAID is available in 12 U.S. jurisdictions, together representing 25% of the overall population (U.S. Census Bureau, 2021a). Although further expansion is anticipated (Pope, 2020), widespread legalization has been hindered by the ethically contentious nature of the practice, with supporters and opponents debating the appropriateness of legal protections for MAID as a method to palliate suffering.

The way that jurisdictional MAID statutes are written offers an opportunity to evaluate the collective body of U.S. MAID policies. Previous policy analyses have considered similarities and differences across statues, and key implications for patients (Pope, 2020). Lacking in the

literature, though, is an analysis of how these statutes converge on MAID's proposed objective of relieving suffering. As the number of people for whom MAID becomes an option increases with MAID's projected legal expansion, greater understanding of the ways policy aligns with its intended goal will provide crucial nuance to ongoing discussions on the development and revision of policy.

Accordingly, the purpose of this descriptive comparative analysis (Popple & Leightner, 2010) was to explore how MAID policy might relieve suffering. In so doing, we applied Wallace's (2015) policy analysis model. This model amalgamated previous work (Barusch, 2002; DiNitto, 2010; Dolgoff & Feldstein, 2012; Popple & Leighninger, 2010; Wharf & McKenzie, 2003) into seven evaluative criteria to facilitate a holistic depiction of a given policy These criteria include policy description, historical context, development of the policy, efficiency, alternative programs, effectiveness, and unintended consequences. Such analysis contributes timely policy considerations to a rapidly changing landscape of EOL care and concludes with a discussion of policy structure, requirements for participation, and limitations created by having jurisdiction-specific policies on such broad, bioethical issues.

Policy Description

In the U.S., "medical aid in dying," "death with dignity," "assisted death," and "assisted suicide," have been used interchangeably to describe the process through which a qualifying person seeks assistance from a medical provider to hasten their death. Such assistance includes information and a prescription for lethal medication that the patient must self-administer. This commentary uses "medical aid in dying," as this term is used widely in literature and legislation in North America, along with "death with dignity" (Mroz et al., 2021). In contrast, *euthanasia*, illegal throughout the U.S., is when a medical professional—not the patient—administers the

means to hasten death. Despite their widespread conflation, the difference in legal status between MAID and euthanasia renders their distinction especially germane to policy discussions.

Historical Context

Access to MAID in the U.S. has expanded through statutory and non-statutory means since Oregon passed the first MAID law in 1994. Implementation of Oregon's law was delayed by a court injunction, which was lifted in 1997. Oregon voters voted on the bill again in November 1997, and by failing to overturn it, paved the way for implementation (Death with Dignity Act History, n.d.). Subsequent laws passed in Washington (2008), Vermont (2013), California (2015/2016), the District of Columbia (2016/2017), Colorado (2016), Hawaii (2018/2019), Maine (2019), New Jersey (2019), and New Mexico (2021). Where two years are listed, the first is the year in which the law passed and the second is the year in which it went into effect. MAID is available in two other states via non-statutory proceedings: MAID is legal in North Carolina by way of standard of patient care (Tucker, 2019) and in Montana by way of a Montana Supreme Court case (*Baxter v. Montana*, 2009).

The right to refuse "unwanted life-sustaining and other treatments" (Institute of Medicine Committee on Care at the End of Life, 1997, p. 188) is widely accepted. Laws allow people to state EOL care preferences ex ante in case they lose decision-making or communication ability. Yet, actively hastening death remains divisive. In the U.S., many people associate MAID with Dr. Kevorkian, who advocated that terminally ill people be able to hasten death, and then was convicted of second-degree murder. Beyond euthanasia, some groups believe MAID is suicide, or—from the prescriber side—homicide, and thus is morally wrong (Hanson et al., 2018).

Since Oregon's Death with Dignity Act, U.S. courts have evaluated MAID. In *Vacco v. Quill* (1997) in New York and *Washington v. Glucksberg* (1997), defendants argued that by not

allowing MAID, states violated the due process and equal protection clauses of the 14th Amendment. Although the U.S. Supreme Court ruled against the defendants, the decision led to ongoing dialog of MAID by the courts. *Gonzalez v. Oregon* (formerly *Oregon v. Ashcroft*, 2006) bans federal prosecution of Oregon physicians for complying with the MAID law.

Development of Jurisdictional Policies

Because MAID is not legal at the U.S federal level, permissive MAID policies exist only at the jurisdictional level. Federal MAID efforts have generally reduced access (Kusmaul et al., 2021), such as the Assisted Suicide Funding Restriction Act (1997), which bans using federal dollars for MAID. Concurrently, the number of jurisdictions legalizing MAID has continued to increase. We outline Oregon's law, the first in the U.S. and then compare other jurisdictions' laws to Oregon's law. Results are summarized in Table 1.

Oregon

Oregon's MAID law has been in effect for 25 years, collects data annually, and has been recognized for working as intended. That is, clinical provision is generally in line with legislative intent (Emanuel et al., 2016). For these reasons, later MAID laws largely mirror Oregon's law.

Eligibility. There are three eligibility criteria that establish who is able to use MAID in Oregon. Patients must be: (a) be at least 18 years old, (b) have decision-making capacity, and (c) have a terminal illness with a prognosis of 6 months or less (Death with Dignity Act, 1997). Oregon dropped residency criteria (Compassion & Choices, n.d.) in 2022; other jurisdictions retained it.

A primary physician and a consulting physician must both substantiate a patient's eligibility for MAID. The consulting physician must attest, in writing, the patient's diagnosis, prognosis, and decision-making capacity (able to make informed medical decisions and is acting

voluntarily). If either physician doubts the patient's decision-making capacity, they must refer the patient for a third capacity evaluation, usually with a mental health specialist, who assesses for mental disorders that may compromise the patient's judgment.

Process. Oregon requires patients to make three requests for MAID to their physician: two oral and one written (Death with Dignity Act, 1997). The written request must be after the first oral request, but before or after the second oral request. The patient must sign and date the written request before two witnesses. At the second oral request, physicians must tell patients that they may withdraw their request any time (Death with Dignity Act, 1997). Patients are encouraged but not required to inform their next of kin of their MAID pursuit (Death with Dignity Act, 1997). Health care organizations and providers may refuse to participate.

Waiting Periods. Waiting periods exist to ensure patients are prepared to use MAID. Oregon requires two waiting periods. Patients must wait at least 15 days between the two oral requests. They may submit the written request between the oral requests. Physicians must wait at least 48 hours from the written request before prescribing medication to hasten death, providing it is also 15 days after the first oral request. A 2019 revision (S.B. 579, 2019) allows attending physicians to supersede waiting periods if they think the patient may die in the interim.

Subsequent Jurisdictions

Other laws resemble Oregon's law, but they are more like imitations than replications (Pope, 2020). The ways in which these laws vary—regarding eligibility criteria (e.g., residency, capacity assessment) and process requirements (e.g., waiting periods, sequence of events, medication disposal; Pope, 2020)—offer implications for clinical practice, as well as different ways to address access. This section describes those differences.

Legislative Variations in MAID Laws. Table 1 summarizes differences in the laws. Washington's Death with Dignity Act (2009) most closely resembles Oregon's law. There are large differences between laws in proving residency, both in number and type of proof required. Some jurisdictions require one form of proof. The District of Columbia recognizes 12 types of proof of residency; patients must submit at least two to use the Death with Dignity Act (2017). Patients may present one of 11 different items to verify residency as part of Maine's Death with Dignity Act (2019), such as received mail, a hunting/fishing license, receipt of any public benefit that has residence as a condition, and "any other objective facts tending to indicate place of residence."

In some ways, Hawaii's law is stricter than others, requiring every patient to have a capacity assessment by a psychiatrist, psychologist, or clinical social worker, in addition to the ones done by the attending and consulting physician. In contrast, Hawaii is considering expanding the scope of MAID professionals to broaden access. Senate Bill 839 (S. 839; 2021) proposed making advance-practice nurses eligible to participate in MAID and adding psychiatric mental health nurse practitioners and clinical nurse specialists to those eligible to conduct capacity evaluations.

Medication Disposal. Many laws explicate medication disposal processes to prevent misuse. A patient who does not to ingest a prescribed dose or anyone in possession of unused medication must legally dispose of it as determined by the federal Drug Enforcement Agency or state laws. Oregon does not have medication disposal requirements, yet there have been no reported misuses of MAID medications in Oregon (Emanuel et al., 2016; Pope, 2020).

Request Process. While the request process is similar across laws, California's End of Life Option Act (2016) has a distinct difference—attending physicians may discuss the request

only with the patient. No family or friends may participate in the consultation to support voluntary decision-making. The only exception is if the patient needs interpreters (End of Life Option Act, 2016).

Waiting Periods. The greatest variation in MAID laws is in waiting periods. Some states allow physicians to waive waiting periods when they feel the patient's death is imminent. Others do not allow waiving the waiting period (i.e., Maine). In Colorado, physicians cannot waive the waiting period between the oral requests, but there is no waiting period after the written request.

Documentation. Patients in California and Hawaii must complete a Final Attestation Form at least 48 hours prior to taking the medication. In this form, patients acknowledge their terminal diagnosis, prognosis, they are acting voluntarily and making an informed decision, and indicate whether they have informed any family members of their pursuit of MAID.

Failed Attempts at Legalization

The U.S.'s first recorded attempt to provide legal protections for medically assisted death was in Ohio in 1905 and 1906 (Appel, 2004). Despite consistent positive public support (Emanuel et al., 2016), Oregon did not legalize MAID until 90 years later. Thirty five jurisdictions attempted but did not pass MAID laws, six (Alabama, Idaho, South Carolina, South Dakota, Texas, and West Virginia) have never considered MAID legislation, and half of these (Alabama, Idaho, and South Carolina) have laws explicitly prohibiting the practice of MAID.

Arizona and New Mexico had cities and towns pass resolutions endorsing MAID: in Arizona, Bisbee (2015), Tucson (2015), and Sedona (2018; Arizona End-of-Life Options, 2015), and in New Mexico, Santa Fe (2018), Albuquerque (2018), and Las Cruces (2018; Wolff, 2020). Although rare, municipal resolutions indicate a grassroots push toward the right to die. This municipal grassroots push likely advanced the eventual statewide legalization in New Mexico.

Efficiency

Measuring MAID's efficiency is difficult. Some authors have argued efficiency is potential cost savings (Emanuel & Battin, 1998). Main points—(a) Medicare/other insurers spend much money on high-cost, high-technology EOL care and (b) allowing terminally ill people to choose MAID would save money—are valid, but even most MAID advocates are reticent to put a cost on human life. An analysis of MAID's fiscal efficiency must also consider what treatments someone would choose instead of MAID (Emanuel & Battin, 1998). One might postulate that patients who choose MAID would be more likely to choose palliative care or hospice than aggressive treatment, which also saves costs. Data does not exist to answer this question due to limitations on federal spending for MAID that preclude a comparison group.

Waiting Periods

Waiting periods can hinder efficiency. While all with a prognosis of 6 months or fewer are eligible for MAID, many people do not consider MAID until the very end of the illness course (Pope, 2020). Waiting periods may obstruct access (e.g. Supportive Testimony Regarding HB2451, 2020) due to potential for rapid decline at EOL. Nearly one quarter of patients die or become ineligible due to loss of decision making capacity during waiting periods (Health Canada, 2020; Nguyen et al., 2018, as cited by Pope, 2020), which suggests issues related to the efficiency of MAID legislation in applied situations (Burchbinder & Pope, 2018).

Telehealth

Practice changes since March 2020 have hastened the use of telehealth in sensitive practice situations, as many services once thought too sensitive to provide via telehealth moved to virtual platforms (Tretyakov, 2020; American Clinicians Academy on Medical Aid in Dying, 2020). No MAID law expressly prohibits telehealth (Pope, 2020). Hawaii (2019) uses telehealth

for third-party capacity assessments, increasing access, especially in remote parts of the archipelago. Originally, Vermont allowed telehealth in specific situations: when patients and physicians have pre-established relationships and no other way to meet (Patient Choice and Control at the End of Life Act, 2013). They expanded their law in 2022 allowing the use of telehealth for all requests (Act No. 97, 2022). Hawaii is considering telehealth more broadly to increase the efficiency of and access to MAID (S. 3047, 2020). Future laws should consider telehealth access to MAID, since patients at end of life may face barriers to accessing in-person consultancy services.

Alternative Programs

Palliative care offers "specialized medical care … focused on providing relief from the symptoms and stress of the illness … to improve quality of life" (Center to Advance Palliative Care, 2022), and relieve suffering in seriously and terminally ill patients (American Academy of Hospice and Palliative Medicine [AAHPM], 2016). Despite its growth across the U.S. (Center to Advance Palliative Care, 2022), the public remains unfamiliar with palliative care and its benefits (Taber et al., 2019). Palliative care groups are divided in their stance on MAID, partly due to current disparities in palliative care (Nelson et al., 2021). In contrast to AAHPM's (2016) position of studied neutrality, the National Hospice and Palliative Care Organization (2021) opposes MAID, calling instead for increased access to hospice and palliative care.

Oppositional framing between MAID and hospice/palliative care may be a false dichotomy; preliminary research suggests that most people (76%–95%) who utilize MAID are also enrolled in hospice or palliative programs (Emanuel et al., 2016; Oregon Health Authority, 2021). New Jersey's Aid in Dying for the Terminally Ill Act (2019) takes a both/and approach,

requiring physicians to discuss concurrent or adjunctive treatment alternatives or hospice care, and recommend their patients consult a physician about these options before using MAID.

Effectiveness

Central to weighing the effectiveness of a policy is consideration of its intended goal. If the goal is relieving suffering, jurisdictional reports of MAID utilization may provide valuable insight. For instance, patients in Oregon reported many reasons for seeking MAID: concern about losing autonomy and dignity, burdening family members, losing control of bodily functions, lacking adequate pain control, and leaving families with financial burdens (Public Health Division, 2020). By this measure, it would appear that those who died through MAID achieved relief from suffering. However, these data are only indirect indicators of suffering and are not uniformly collected, not even by California's Final Attestation form. Better metrics to capture this data, such as requiring it to be reported with cause of death, could assist in documenting the prevalence of MAID utilization. Without such data, it is difficult to confirm that MAID laws meet their intended goals, though patients continuing to seek it suggests that MAID addresses some EOL needs better than the alternatives.

Unintended Consequences

Unintended consequences of MAID form the basis for opponents' concerns. For example, the disability rights community has voiced concerns that abuses of MAID laws may promote the deaths of persons with disabilities. Many believe that supporting MAID suggests death is better than disability. Braswell (2018, 2019) calls for both sides to unite to address "the crisis of U.S. hospice care," which he describes as the failure of a system that requires family caregivers to fill gaps from what hospice is able to provide. He suggests combining these efforts would advance disability rights and improve EOL care for all (Braswell, 2018, 2019).

Potential unintended consequences of MAID laws concern access. It is unclear whether disparities in usage are an intended consequence resulting from poor policy design or unintended due to unclear articulation of policy goals and mechanisms (Oliver et al., 2019). Oregon has the most complete data on MAID usage, including diagnosis, age, race, and primary insurance, having collected it since 1998 (Pope, 2020). Most MAID users in Oregon in 2020 were White (97%; Public Health Division, 2021), while only 75% of Oregon's population is White (U.S. Census Bureau, 2021b). According to the U.S. Census Bureau (2021b), 62% of the U.S. population is White. This race disparity suggests unidentified barriers. The Assisted Suicide Funding Ban Act's exclusion of federal funding for MAID may also contribute to cost barriers for interested patients (Pope, 2020). The average cost of these medications is almost $3,000, inaccessible for some patients (Shankaran et al., 2017). Access barriers warrant further examination.

Finally, palliative care advocates are concerned (Meier, 2010) that the presence of MAID laws leads to declines in the quality of palliative care in a region, as the two are seen by some to be in direct opposition. Again, research is needed to determine if these concerns are founded.

Discussion

This commentary analyzed existing U.S. MAID laws with a special focus on how they might meet MAID's intended goal of relieving suffering. In the absence of direct evidence about suffering, we found that much of the development and revision of MAID policies suggests a push toward alleviating suffering. Our analysis also uncovered similarities and differences across statutes that may shape the experience of suffering for interested individuals. Components commonly observed across policies included (a) a mental health assessment, (b) similar

sequences of events, (c) waiting periods, and (d) additional components that reflect sociocultural trends (e.g., interpretation services and considerations for post-death disposal of medication).

Key differences are in details of the process. All U.S. MAID laws at baseline require three separate requests: Two oral and one written. In laws that specify, the first request is an oral request. From there, requirements vary. The District of Columbia requires patients submit the written request between the two oral requests. New Jersey allows patients to submit the written request with the first oral request. Oregon, Washington, California, Colorado, Vermont, and Hawaii encourage waiting to submit the written request until both physicians have submitted paperwork. There is no evidence to support one approach over another in ensuring patient safety. Although these varying processes do not seem to affect access or relief of suffering, such differences may create barriers to a national model.

Waiting periods introduce pauses to the process to ensure patients are making informed choices and vary between laws. Most laws require 15 days between oral requests; Hawaii (2019) requires 20 days. It is unclear why Hawaii chose the longer time, and legislators have tried to reduce it to 15 days (see S. 323). California has no waiting period between the written request and prescription. Oregon has waiting periods between oral requests and between the written request and prescription but allows physicians to eliminate both, a unique feature. Oregon does not report when physicians have used this feature, though the median length of time between the first oral request and death remains about 45 days (Public Health Division, Center for Health Statistics, 2021). Given this diversity, more scrutiny of waiting periods is needed.

Influence of Policy on Suffering

This analysis focused on whether MAID policies were able to alleviate suffering among those who are at the end of life, on which comments are rather limited due to a lack of research.

California's final attestation form, and Oregon's reporting of the reasons people choose MAID provide beginning understanding, but there is no collective policy approach to assess patient suffering nor what suffering MAID can relieve.

The larger policy debate has failed to consider openly the effects of such policies on the suffering of others in the population and others involved in the process. Newer MAID legislation has recognized the suffering caused in communities by the opioid epidemic by their inclusion of medication disposal requirements. MAID medications have typically been barbiturates (Pope, 2020) and MAID laws that address disposal attempt to address medication diversion. On the other hand, the opioid crisis has complicated access to controlled substances, possibly affecting the suffering of MAID seekers.

Other suffering that the policy debate fails to consider is the potential suffering of providers. Some provider groups such as the American College of Physicians (Sulmasy & Mueller, 2017) and the American Medical Association (2019) have come out against MAID but these policy statements often fail to provide guidance to providers in states where it is legal. Providers are able to refuse to participate in MAID due to their own beliefs, but patients are not required to report the numbers of providers they approached in their quest for MAID and the reasons for refusals. There is also no reporting from the perspective of the provider related to their feelings or ethical consideration about the topic. To this end, legislation considers only those providers who assess patients and prescribe medications, such as physicians or nurse practitioners, but does not address non-provider members of interprofessional health care teams, such as social workers whom patients may approach for information and referral on MAID.

Research and Policy Recommendations

Table 2 summarizes our recommendations for increasing access to MAID in states where it is legal, based on available information about access and barriers identified through this policy analysis. However, to advance research-informed policy recommendations, such as patients who do and do not access MAID, as well as the barriers that they experience in their attempts to access MAID additional data are needed. As such, we first recommend expanding data collection through funding for research on MAID and, more broadly, for research on suffering at EOL. One policy approach could include repealing the Assisted Suicide Funding Ban Act, and further, allowing use of federal funds for MAID research. Additionally, standardization in language across policies can assist in comparative analyses and discussion at the federal level.

Access. Cost is an important policy consideration as it relates to access and it is complicated, in part because of the Assisted Suicide Funding Ban Act's prohibition on the use of federal (e.g., Medicare) dollars for MAID. We lack information about people who are unable to access MAID due to cost. Insurance companies are not required to cover medical evaluation components of MAID, nor the medications. In addition, insurance coverage for MAID procedures could be a conflict of interest, as insurance companies would have a financial interest in promoting MAID in patients with costly illnesses. Including federal dollars as an option to cover MAID access, while following standardized eligibility policies, could expand utilization among vulnerable populations for whom cost is a barrier, and address the potential conflicts related to insurance coverage.

Recommendations 3-12 in Table 2 address ways to ensure and expand access to MAID based on factors identified from the policy analysis, such as reducing steps to MAID once eligibility in determined, broadening the types of identification cards allowable, increasing telehealth access, dropping the residency requirements in states where MAID is legal, and

waiving waiting periods when death is imminent. Thus, future MAID policies must consider access, such as which providers can participate, to what extent, and when. Many MAID laws exclude advance practice nurses, nurse practitioners, and physician assistants even for the consulting assessment. Medicare patients may choose their primary hospice provider but this option is limited for MAID recipients due to provider-based statutory restrictions. New Mexico is the first state to allow physician assistants and nurse practitioners to practice MAID in this capacity (Elizabeth Whitefield End-of-Life Options Act, 2021). Hawaii's S.B. 839 (2021) sought to add advance practice nurses, suggesting a larger move in this direction. Offering discussion of MAID alongside hospice and palliative care services in areas where MAID is legal should be normalized, rather than suggesting that these services are an either/or dichotomy. Support for disposing MAID medication when it is prescribed but not utilized should also be provided during ongoing discussions. Finally, future policies must include language for how utilization will be documented, tracked, and reviewed through evaluation.

Consent. Recommendation 13 in Table 2 recommends addressing the issue of consent. Current laws require current/active decision-making capacity; if one loses that ability, they lose the ability to access MAID. Current laws convey that MAID is available only for those with physical health diagnoses. As more people die from non-physical health diagnoses such as dementia-related illnesses, questions about advance directives for MAID will become a greater part of policy debate. Yet, policies must also address concerns about vulnerable populations, i.e. those with intellectual and developmental disabilities who have faced discrimination in healthcare and outright euthanasia at times. Additional research is warranted to explore and address these challenges.

Conclusion

The proliferation of jurisdictional legalization (Pope, 2020) and the rapid pace at which legalization is occurring behooves further analysis of how these policies affect the lives of those they touch. While suffering is at the center of support for MAID-focused policies, no prior analyses examine whether policies meet their intent to relieve suffering. By identifying common components across existing U.S. MAID policies, this analysis suggests that MAID could be effective and efficient at relieving suffering. However, because direct data on pertinent outcomes are sparse, more data are needed before concrete declarations on the relationship between MAID and suffering can be made. Ethical implications will continue to be debated, though policy implications (who uses MAID, the number of unique providers, the emergence of complications, those present during death, etc.) greatly impact available choices to limit suffering at end of life.

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Table 1. Comparison of Oregon's MAID Legislation to Additional Jurisdictions With MAID

Jurisdiction	Enacted	Eligibility/Differences	Process	Waiting Period	Medication Disposal
Oregon	1997	Individuals must: be ≥ 18 years old, have decision-making capacity, & have a terminal illness & a prognosis ≤ 6 months	Process requires three separate requests: an initial oral request, a written request, & a second oral request.	Patients must wait a minimum of 15 days between first oral request & second oral request. Written request can be submitted between the two oral requests.	None on record.
Washington	2009	Individuals must verify that they live in Washington.		Physicians may not waive waiting periods; a recent bill proposed to (a) decrease 15-day waiting period to 72 hours, & (b) allow physicians to bypass waiting period if they feel death is imminent (H.B. 1141, 2021).	Any unused medication must be disposed in a lawful manner.
Vermont	2013		Physicians may only write prescription after the last of: (a) written request; (b) second oral request; (c) physician offering patient an opportunity to rescind request (Pope, 2020).	Due to waiting periods built between requests, those pursuing MAID must wait a minimum of 17 days total prior to utilization.	Vermont Department of Health must outline rules for safely disposing of unused medications.
California	2016			Physicians may not waive 15-day waiting period between first & second oral request. No waiting period between written request & prescription writing. Patients must complete Final Attestation	

				Form within 48 hours prior to taking medication.	
Colorado	2016			Policy does not allow physicians to waive 15-day waiting period.	Whomever has unused medications after death must lawfully dispose of them.
District of Columbia	2017	Individuals must present two of 12 acceptable items to verify residency.			
Hawaii	2019	Every patient must receive a capacity assessment from a psychiatrist, psychologist, or clinical social worker, in addition to those completed by the attending and consulting physicians.		Waiting period of 20 days. A recent bill was proposed to (a) decrease the waiting period to 15 days and (b) allow physicians to bypass waiting period if they feel death is imminent (S. 839, 2021). Patients must complete the Final Attestation Form within 48 hours prior to taking medication.	Whomever has of unused medications after death must lawfully dispose of them.
Maine	2019	Individuals may present one of 11 different items to verify residency.		Maine currently does not allow physicians to waive 15-day waiting period or 48-hour waiting period.	
New Jersey	2019		Upon receipt of first oral request, attending physician must recommend patients participate in optional consultation about	Physicians cannot waive (a) the 15-day waiting period between first & second oral request, or (b) the 48-hour waiting period between second oral request &	Prior to ingestion, the patient must designate someone to lawfully

			alternative end-of-life care options (e.g., palliative or hospice care).	prescription writing. Patients can submit written request when making first oral request, allowing both waiting periods to be satisfied in the same 15-day window (Pope, 2020).	dispose of any unused medications following death.
New Mexico	2021	Not stipulated.		Waiting period of 48 hours between the writing of the prescription & filling of the prescription to ensure timely access for critically ill & suffering patients.	

Table 2. Recommendations to Increase Access to MAID in States Where It Is Legal

1. Allow federal funding to support MAID research and services (i.e., repeal the Assisted Suicide Funding Restriction Act)
2. Be deliberate about the language utilized in MAID legislation and practices (i.e., medical aid in dying vs. death with dignity)
3. Once a patient's eligibility to utilize MAID law is affirmed, streamline the steps needed to utilize MAID

4. Allow various forms of identification to confirm one's identity in the eligibility process
5. Increase telehealth access to MAID
6. Consider dropping residency requirements in states where MAID is legalized as Oregon did
7. Decrease or waive the waiting period for receiving medication, particularly when patient's death is imminent
8. Expand the scope of professionals eligible to conduct evaluations (i.e., capacity evaluations)
9. Offer support for MAID in tandem with hospice and palliative care services
10. Ease ability to dispose of MAID medication
11. Include language in laws for how MAID utilization will be documented and tracked
12. Consistently review MAID laws' utilization and practices through evaluation
13. Explore and address ethical challenges surrounding capacity to provide informed consent among vulnerable populations