compassion & choices

Care and Choice at the End of Life

Medical Aid-in-Dying Utilization Report

2025 Edition

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

January 2025

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

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

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

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

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

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

Sincerely,

Kevin Díaz
Interim President & CEO
Compassion & Choices

Context and Methods

Currently, nine of the 11 authorized jurisdictions have issued reports regarding the use of medical aid in dying laws: Oregon,[1] Washington,[2] Vermont,[3] California,[4] Colorado,[5] Hawai'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] Montana also does not issue utilization reports, so no data from Montana is included.

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

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

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

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[1] *Oregon Death with Dignity Act Annual Reports* (1998-2023) Available from: https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ar-index.aspx
[2] *Washington Death with Dignity Data* (2009-2022). Available from: https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct/DeathwithDignityData
[3] *Vermont Report Concerning Patient Choice at the End of Life.* (2018-2022) Available from: https://www.healthvermont.gov/systems/end-of-life-decisions/patient-choice-and-control-end-life.
[4] *California End of Life Option Act Annual Report* (2016-2023) Available from: https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act-.aspx
[5] *Colorado End-of-Life Options Act Annual Report* (2017-2023) Available from: https://www.colorado.gov/pacific/cdphe/medical-aid-dying
[6] *Hawai'i Our Care, Our Choice Act Annual Report* (2019-2023) Available from: https://health.hawaii.gov/opppd/ococ/
[7] *District of Columbia Death with Dignity Act Annual Report* (2017-2022) Available from: https://dchealth.dc.gov/publication/death-dignity-annual-reports
[8] *New Jersey Medical Aid in Dying for the Terminally Ill Act Data Summary* (2019-2023) Available from: https://nj.gov/health/advancedirective/maid/
[9] *Maine Death with Dignity Annual Report* (2019-2023) Available from: https://www.maine.gov/dhhs/data-reports/reports
[10] *Elizabeth Whitefield End-of-Life Options Act* Available from: https://www.nmhealth.org/about/erd/bvrhs/vrp/maid/

Medical Aid in Dying Jurisdiction Usage Reports

Based on reported data, the following is known:

- Cumulatively, for almost 30 years across all jurisdictions, 10,211 eligible people have used a prescription for medical aid in dying.
- Less than 1% of the people who die in each jurisdiction use the law each year.[11]
- Only 62% (just under two-thirds) of people with prescriptions ingest the medication and die. Up to 38% of people who go through the process and obtain the prescription may never take it. This group consists of people who die without using the medication, whether from illness, another cause of death, or an unreported reason. In any case, we hear from terminally ill people that they derive peace of mind simply from knowing they have the option if their suffering becomes too great.
- The majority of terminally ill people who utilize medical aid in dying (88%) are enrolled in hospice or palliative care services at the time of their deaths, according to annual reports for which hospice and palliative care data is available.
- There is nearly equal utilization of medical aid in dying among men and women. There is no data yet on the utilization of medical aid in dying by nonbinary or gender non-conforming people. However, New Jersey included a category for nonbinary people in its 2023 report.
- The rate at which Asian, Black, Hawaiian, Pacific Islander, Indigenous American, Alaskan Native, Latino/a/x, Hispanic, and multi-race people access medical aid in dying is consistently lower than white populations across all years and jurisdictions.[12]
- Year after year, reports indicate that the utilization of medical aid in dying is increasing among people of color. In 2022, California, New Jersey, and Washington, D.C. all reported more people of color accessing medical aid in dying than prior years. In 2023, Oregon, California, and Colorado reported more people of color accessing medical aid in dying than in prior years.
- Terminal cancer accounts for the vast majority of qualifying diagnoses (68.5%), with neurodegenerative diseases such as ALS or Huntington's disease following as the second-leading diagnosis. In recent years, some jurisdictions have seen growing numbers of patients with cardiovascular diseases seeking medical aid in dying.
- Over 77% of people who use medical aid in dying are able to die at home. According to various studies, that is the preference of most Americans.[13]

[11] According to the Center for Disease Control, in 2021 in jurisdictions that authorized medical aid in dying, 622,035 people died in total. In 2021, authorized jurisdictions report 1,216 people died after being provided with a prescription for medical aid in dying – less than 0.002% of total deaths in 2021. CDC has not released a newer *Deaths: Final Data for [Year]* report. Murphy, S., Kochanek, K., et al. (2024). (rep.). *Deaths: Final Data for 2021*. National Vital Statistics Report, 73(8). https://www.cdc.gov/nchs//data/nvsr/nvsr72/nvsr72-10.pdf.

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

[13] Kaiser Family Foundation, *Views and Experiences with End-of-Life Medical Care in the U.S.*, April 27, 2017. https://www.kff.org/report-section/views-and-experiences-with-end-of-life-medical-care-in-the-us-findings/.

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

Authorized Jurisdiction (a) (b)	Oregon	Washington	Vermont	California	Colorado	Washington, DC	Hawaii	New Jersey	Maine	Cumulative
Date Enacted	Oct 27, 1997	Mar 5, 2009	May 20, 2013	Jun 9, 2016	Dec 16, 2016	Feb 18, 2017	Jan 1, 2019	Aug 1, 2019	Jun 12, 2019	
Law	Death with Dignity Act	Death with Dignity Act	Patient Choice at the End of Life Act	End of Life Option Act	End-of-Life Options Act	Death With Dignity Act	Our Care, Our Choice Act	Medical Aid in Dying for the Terminally Ill Act	Death With Dignity Act	
Data Period	1997 - 2024	2009 - 2023	2013 - 2022	2016 - 2023	2017 - 2024	2017 - 2022	2019 - 2024	2019 - 2023	2019 - 2023	1997 - 2024
Total Years Effective as of 1/1/2025	27	15	11	8	8	7	6	5	5	27
Summary Data										
Individuals who received prescriptions (written or filled) (c)	4,881	3,704	200	6,449	1,995	31	361	315	252	18,188
Individuals who were dispensed medication (c)		3,704			1,458			315		5,477
Individuals who died after ingesting (a)	3,243	2,768	146	4,233		23	195	287	170	11,065
Individuals who died without having ingested or died from other causes	953	409	45	841		8	27	27	57	2,367
Individuals who ingested medication in a calendar year following their prescription's written date	303			232						535
Individuals whose ingestion status is unknown	741	361	9	1,112			24	8	11	2,266
Individuals who received prescriptions and for whom a death certificate was subsequently registered (d)		3,570	195		1,825		299		46	5,935
Unique providers who prescribed the medication (e)	168	207		341	288	4	21			1,029
Prescription rate per provider (f)	2.10	1.73		3.03	3.27	1.60	3.69			2.57
Unique pharmacists who dispensed the medication (e)		68			37					105
Characteristics/Demographics										
Gender (b)										
Female	1,522 46.93%	1,686 47.43%		1,960 49.23%	937 51.34%	13 54.17%	79 40.51%	132 45.99%	27 54.00%	6,356 48.30%
Male	1,721 53.07%	1,869 52.57%		2,013 50.57%	888 48.66%	11 45.83%	115 58.97%	155 54.01%	23 46.00%	6,795 51.63%
Other										
Unknown				8 0.20%			1 0.51%	0 0.00%		9 0.07%
Total	**3,243 100.0%**	**3,555 100.0%**		**3,981 100.0%**	**1,825 100.0%**	**24 100.0%**	**195 100.0%**	**287 100.0%**	**50 100.0%**	**13,160 100.0%**
Age Breakdown										
18-64	721 22.23%	809 22.72%			414 22.68%	9 36.00%	24 15.29%	69 24.04%	25 20.83%	2,071 22.47%
65-74	988 30.47%	1,122 31.52%			557 30.52%	6 24.00%	51 32.48%	57 19.86%	33 27.50%	2,814 30.53%
75-84	947 29.20%	956 26.85%			510 27.95%	6 24.00%	57 36.31%	90 31.36%	42 35.00%	2,608 28.30%
85+	587 18.10%	673 18.90%			344 18.85%	4 16.00%	25 15.92%	71 24.74%	20 16.67%	1,724 18.70%
Total	**3,243 100.0%**	**3,560 100.0%**			**1,825 100.0%**	**25 100.0%**	**157 100.0%**	**287 100.0%**	**120 100.0%**	**9,217 100.0%**
Age Breakdown (CA)										
Under 60				369 9.27%						369 9.27%
60-69				774 19.44%						774 19.44%
70-79				1,245 31.27%						1,245 31.27%
80-89				1,004 25.22%						1,004 25.22%
90+				589 14.80%						589 14.80%
Total				**3,981 100.0%**						**3,981 100.0%**

Authorized Jurisdiction (a) (b)	Oregon	Washington	Vermont	California	Colorado	Washington, DC	Hawaii	New Jersey	Maine	Cumulative
Age Median & Range										
Median	73			76	74			72		73
Range	21-102	20 - 101		23-107			44-101	32-100	31-98	20-107
Race/Ethnicity (i)										
Asian	57 1.76%	65 1.84%		243 6.08%			30 19.11%	14 4.88%		409 3.12%
Asian/Native American/Pacific Islander				20 0.50%	29 1.59%					49 0.37%
Black	5 0.15%			33 0.83%	9 0.49%	1 4.35%		3 1.05%		51 0.39%
Hawaiian, Pacific Islander	2 0.06%			4 0.10%			9 5.73%	0 0.00%		15 0.11%
Indigenous American, American Indian, Alaskan Native	11 0.34%			5 0.13%	3 0.16%			0 0.00%		19 0.14%
Latinx, Hispanic	48 1.48%			156 3.90%	55 3.01%	1 4.35%	5 3.18%	1 0.35%		266 2.03%
Multi-race (two or more races)	12 0.37%			23 0.58%			5 3.18%	0 0.00%		40 0.31%
Non-white, Hispanic and/or Non-white		20 0.57%								20 0.15%
Other, Unknown	17 0.52%	108 3.06%		22 0.55%	15 0.82%		5 3.18%	2 0.70%		169 1.29%
White	3,091 95.31%	3,338 94.53%		3,493 87.35%	1,714 93.92%	21 91.30%	103 65.61%	267 93.03%	49 100.0%	12,076 92.08%
Total	**3,243 100.0%**	**3,531 100.0%**		**3,999 100.0%**	**1,825 100.0%**	**23 100.0%**	**157 100.0%**	**287 100.0%**	**49 100.0%**	**13,114 100.0%**
Education (j) (k)										
High School Diploma, GED, or Less	884 27.26%	886 25.09%		908 22.81%	426 23.34%	0 0.00%	21 13.38%	82 28.57%	16 23.88%	3,223 24.57%
Some College	632 19.49%	1,609 45.57%		689 17.31%	250 13.70%	1 4.00%	11 7.01%	21 7.32%	9 13.43%	3,222 24.56%
Associate's, Bachelor's, Master's, Doctorate or Professional Degree	1,700 52.42%	1,007 28.52%		2,343 58.85%	1,138 62.36%	22 88.00%	67 42.68%	184 64.11%	43 64.18%	6,504 49.58%
Unknown	27 0.83%	29 0.82%		41 1.03%	11 0.60%	2 8.00%	58 36.94%	0 0.00%	0 0.00%	168 1.28%
Total	**3,243 100.0%**	**3,531 100.0%**		**3,981 100.0%**	**1,825 100.0%**	**25 100.0%**	**157 100.0%**	**287 100.0%**	**67 100.0%**	**13,117 100.0%**
Marital Status										
Married, Domestic Partner	1,459 44.99%	1,632 46.22%			837 45.86%			135 47.04%		4,063 45.72%
Widowed	693 21.37%	708 20.05%			375 20.55%			83 28.92%		1,859 20.92%
Divorced, Separated	818 25.22%	865 24.50%			463 25.37%			46 16.03%		2,192 24.67%
Never Married, Single, Other, Unknown	273 8.42%	326 9.23%			150 8.22%			23 8.01%		772 8.69%
Total	**3,243 100.0%**	**3,531 100.0%**			**1,825 100.0%**			**287 100.0%**		**8,886 100.0%**
End-of-Life Care										
Hospice and/or Palliative Care										
Enrolled	2,924 90.16%	1,010 83.13%		3,601 90.45%	1,535 84.11%		130 97.01%			9,200 88.48%
Not Enrolled	285 8.79%	151 12.43%		310 7.79%						746 7.17%
Unknown	34 1.05%	54 4.44%		70 1.76%	2 0.11%		4 2.99%			164 1.58%
Not under hospice care or unknown					288 15.78%					288 2.77%
Total	**3,243 100.0%**	**1,215 100.0%**		**3,981 100.0%**	**1,825 100.0%**		**134 100.0%**			**10,398 100.0%**

Authorized Jurisdiction (a)(b)	Oregon	Washington	Vermont	California	Colorado	Washington, DC	Hawaii	New Jersey	Maine	Cumulative
Insurance										
Private/Commerical	0.00%	296 8.70%		495 12.43%		12 48.00%	21 13.38%			824 7.62%
Medicare, Medicaid, and/or Other Governmental	0.00%	774 22.74%		365 9.17%		10 40.00%	48 30.57%			1,197 11.07%
Combination of Governmental and Private/Commercial		196 5.76%		2,079 52.22%			62 39.49%			2,337 21.62%
Insured (unspecified)	975 30.06%	1,416 41.61%		732 18.39%			10 6.37%			3,133 28.99%
None, Other, Unknown	2,268 69.94%	721 21.19%		310 7.79%		3 12.00%	16 10.19%			3,318 30.70%
Total	**3,243 100.0%**	**3,403 100.0%**		**3,981 100.0%**		**25 100.0%**	**157 100.0%**			**10,809 100.0%**
Underlying Illness (l)(m)										
Cancer, Malignant Neoplasms	2,244 69.20%	2,496 73.30%	150 75.00%	2,641 66.34%	1,195 59.90%	20 74.07%	152 70.37%	172 59.93%	127 67.20%	9,197 67.91%
Neurological Disease	370 11.41%	308 9.05%	26 13.00%	414 10.40%	302 15.14%	4 14.81%	23 10.65%	57 19.86%	24 12.70%	1,528 11.28%
Respiratory Disease	213 6.57%	227 6.67%	5 2.50%	271 6.81%	179 8.97%	1 3.70%	16 7.41%	19 6.62%	14 7.41%	945 6.98%
Cardiovascular, Circulatory Disease	249 7.68%	218 6.40%	2 1.00%	386 9.70%	183 9.17%	2 7.41%	17 7.87%	26 9.06%	12 6.35%	1,095 8.09%
Other illnesses	167 5.15%	156 4.58%	17 8.50%	269 6.76%	136 6.82%	0 0.00%	8 3.70%	13 4.53%	12 6.35%	778 5.74%
Total	**3,243 100.0%**	**3,405 100.0%**	**200 100.0%**	**3,981 100.0%**	**1,995 100.0%**	**27 100.0%**	**216 100.0%**	**287 100.0%**	**189 100.0%**	**13,543 100.0%**
MAID Process										
Place of Death/Where Medication Ingested										
Private Home, Residence	2,944 90.78%	1,069 40.85%		3,138 89.76%	1,494 81.86%			266 92.68%		8,911 77.70%
Hospice Facility	21 0.65%			47 1.34%	66 3.62%			12 4.18%		146 1.27%
Hospital, Acute Care Hospital	11 0.34%	1 0.04%		3 0.09%	23 1.26%					38 0.33%
Long Term Care, Assisted Living, Foster Care Facility	185 5.70%	99 3.78%		265 7.58%				3 1.05%		552 4.81%
Nursing Home	23 0.71%			24 0.69%	145 7.95%			5 1.74%		197 1.72%
Other, Unknown	59 1.82%	1,448 55.33%		19 0.54%	97 5.32%			1 0.35%		1,624 14.16%
Total	**3,243 100.0%**	**2,617 100.0%**		**3,496 100.0%**	**1,825 100.0%**			**287 100.0%**		**11,468 100.0%**
Patient Informed Family of Decision										
Yes	2,951 91.00%	1,353 42.83%		2,956 84.55%						7,260 73.35%
No, No Family to Inform	292 9.00%			280 8.01%						572 5.78%
Unknown		1,806 57.17%		260 7.44%						2,066 20.87%
Total	**3,243 100.0%**	**3,159 100.0%**		**3,496 100.0%**						**9,898 100.0%**

See endnotes on next page

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Endnotes

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

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

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

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

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

(f) Prescription Rate Per Provider: This number is our own calculation and is not reported by any 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) Underlying Illness: More than one illness may be reported, and some jurisdictions do not provide information for how illness is reported. Therefore, the number of total illness will vary from the total number of patients utilizing medical aid in dying.

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

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

Appendix: Medical Aid in Dying Original Authorization Information

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

Notes:

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

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