

From Prognosis to Prescription: Six Simple Facts About Medical Aid in Dying



Under medical aid-in-dying laws, the doctor and/or qualified clinician (according to state requirements)

writing a prescription must be licensed and with primary responsibility for the care of an individual. Most frequently, that is a family-practice or palliative-care physician, a hospice medical director, or other specialist who is qualified to confirm a diagnosis and prognosis of terminal illness, and routinely addresses serious and terminal illnesses.



Two qualified clinicians need to confirm the terminal diagnosis, prognosis and patient's mental capability to make healthcare decisions.

A terminally ill adult may only receive a prescription for medical aid in dying if two qualified clinicians determine the person is suffering from a terminal illness, has less than six months to live and is mentally capable of making their own healthcare decisions.



Since the first law was enacted in 1997, there has been no evidence of anyone prescribing aid-in-dying medication inappropriately.

There has never been a documented instance of abuse. State medical boards are responsible for reviewing alleged failures to comply with the law; no board has found that a clinician has engaged in inappropriate conduct under any medical aid-in-dying law in the country. A clinician not legally qualified to fulfill the role who nonetheless provides a prescription is subject to discipline by the state medical board.



Qualified clinicians are experts at determining their patients' mental capability.

They are specially trained and required on a daily basis to assess whether patients have the mental capacity to make informed healthcare decisions — including life and death choices. If either the attending or consulting clinician is concerned about the patient's mental capacity, evaluation by a mental health specialist is required before a prescription for aid-in-dying medication can be written.



Doctors tend to overestimate how much time their patients have left, making fears that patients will

prematurely take aid-in-dying medications unfounded. To be referred to hospice a person must have a prognosis of six months or less to live, a time frame that has thus become a guide to end-of-life care decisions. As one study published in the November 2005 issue of Mayo Clinic Proceedings found, the vast majority of physicians overestimate how long a person has to live after being diagnosed with a terminal illness.



Studies indicate that the availability of medical aid in dying in authorized states is improving physician training in end-

of-life care. Studies in Oregon and Washington, along with a host of national surveys published in the New England Journal of Medicine, JAMA and other medical journals, link the availability of medical aid in dying as a palliative care option to a number of positive end-of-life care outcomes, including better physician training.