

LISTEN



Stories

about

Medical Aid in Dying (MAID)

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Objectives

Use a case based format to:

- Describe the qualifications for Medical Aid in Dying
- Explore the Diversity of patient priorities and suffering at end of life
- Answer YOUR questions about MAID



Disclosures

I participate in legislative advocacy for access to MAID

I am occasionally reimbursed for providing
expert legislative testimony
by Compassion and Choices

I Will discuss off label use of FDA approved medications

Question.....I am?

1. Very familiar the clinical practice of MAID
2. Somewhat familiar with the clinical practice of MAID
3. Not very familiar with the clinical practice of MAID

John

- 90 yo proud WW II veteran
- Started and ran own business post war
- Proud, Resilient, Fiercely Independent
- Private
- Small family, no partner, no children

- Progressive Metastatic Prostate Cancer
 - Couple of years of “nuisance”, then different
 - Urinary incontinence/Foley
 - Pain well managed * with NSAIDS

John

- Accepted, adapted to
 - Limited mobility, Walker, SOME assistance
 - Hard Line: no SNF, no assistance with PADLs
 - Hospice, Incontinence/Foley

- Progressive decline
 - Homefast
 - PADLs

John

- Very clear and consistent
- No unfinished business
- Let me die as I have lived
- Discussed MAID with hospice team

John

- Completed process in <4 weeks
 - Written request signed by his one close friend and his friend
- Requested process be private
- Agreed to have hospice nurse and friend present
 - Friend assisted with mixing meds
 - MAID process smooth
 - Letter of gratitude and support for law given to me post death
 - “tremendous privilege” to honor my friend



What IS Medical Aid in Dying

A practice that legally allows a physician*
to prescribe a lethal dose of medication

for a *capable*
terminally ill adult

With a *<6 month* prognosis
to *voluntarily self-administer*

for the purpose of *hastening death*

* Some states allow APRN and PAs to prescribe



MAID Eligibility

- Be 18 or older
- Terminal Illness
- \leq 6 month Prognosis*
- Voluntarily make a request
- Capable of making an informed decision
- Able to self administer medication to hasten death



MAID Process in VT

Prescribing Physician First Verbal Request

- Assess Eligibility
- Provide Comprehensive Information

Prescribing Physician Second Request

- at least 15 days later

Consulting Physician Request

Patient Written Request

Contact Pharmacy with Prescription

File Vermont Department of Health Paperwork



Comprehensive Resources

- Patient Choices Vermont
 - <https://www.patientchoices.org/>

- Academy of Aid in Dying Medicine
 - <https://www.aadm.org>



Gail

- 72 yo Woman
- Married 47 years, no children,
- Artist, Museum Educator, Social with “Gift of Gab”
- Lived in several states
- Vermont 4 years
- Social network surrounded group meals

- Diagnosed with Aggressive Glioblastoma
 - speech affected
 - Deeply Feared loss of communication

Gail

- Active treatment, poor response, progressive disease
 - Hospice
- Clear and consistent desire to avoid incapacity
 - Expressive aphasia terrifying
 - Husband used creativity to assure effective communication
 - Socializing challenging given aphasia
- Unacceptable quality of life
 - Loss of ability to effectively Communicate
 - She and partner strong mutual avoidance of PADL assist

Gail

- Voiced interest in MAID
 - Joint, extended Visits
 - Hospice RN and SW,
 - PCP, Consultant
 - Palliative care MD, Prescriber
- Communication ability
 - Pauses
 - Creativity
 - Subtlety
- Assure Intent
 - accurate and consistent
 - compliance with law

Gail

- Rapid decline
- Discussions with Oncology no effective intervention
- Trail of Steroids ineffective
- Date was chosen based on QoL and to assure access
- MAID process
 - In own Bed,
 - Friends present
 - Asleep <5 minutes
 - Death < 1 hour



Death and Dying

Unique

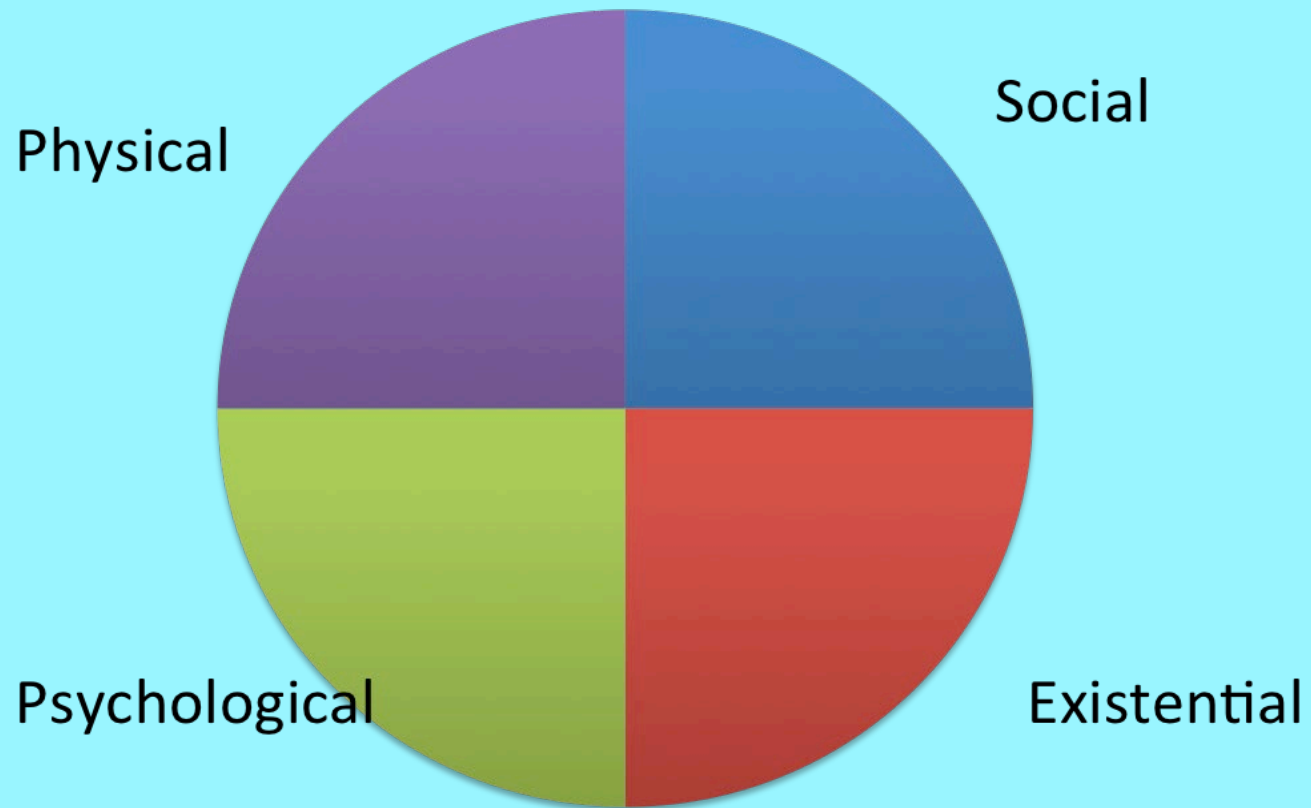
Deeply Personal

Enduring Impact



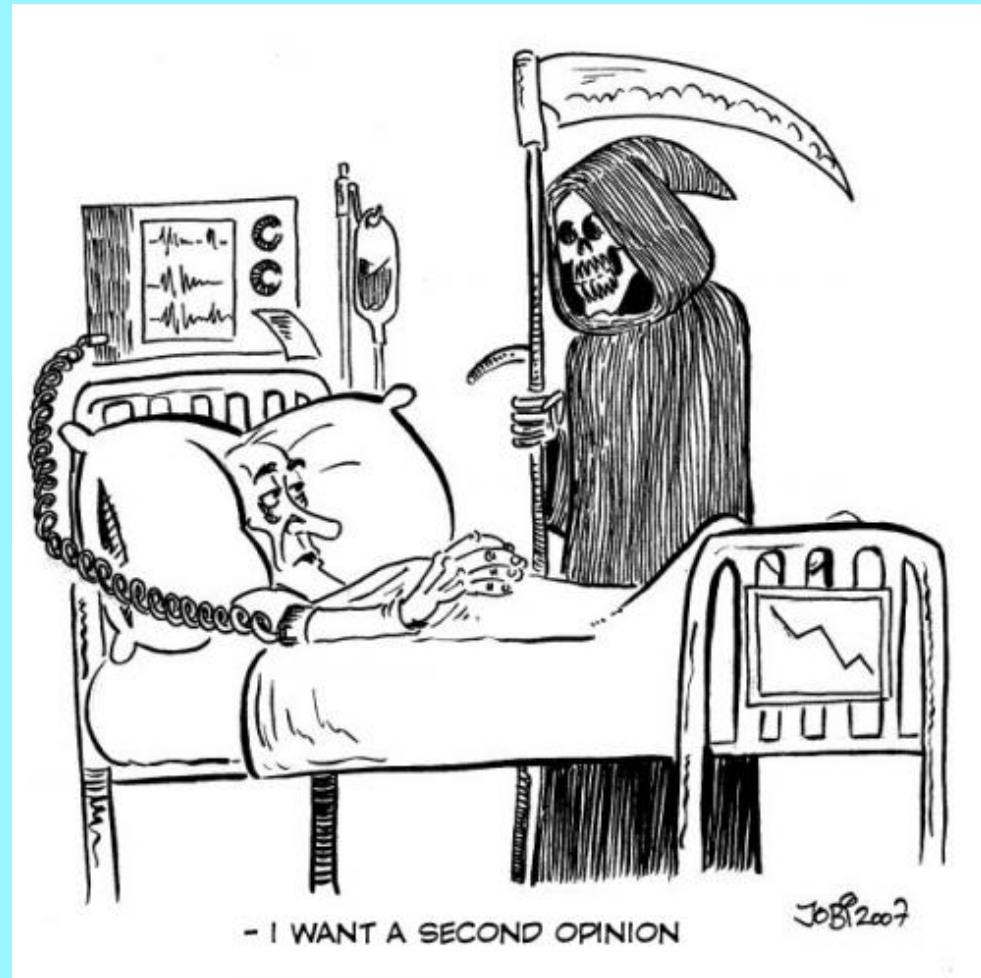
Total Suffering

adapted from
Dame Cicely Saunders



<http://www.csi.kcl.ac.uk/keypub.html>

We all Die

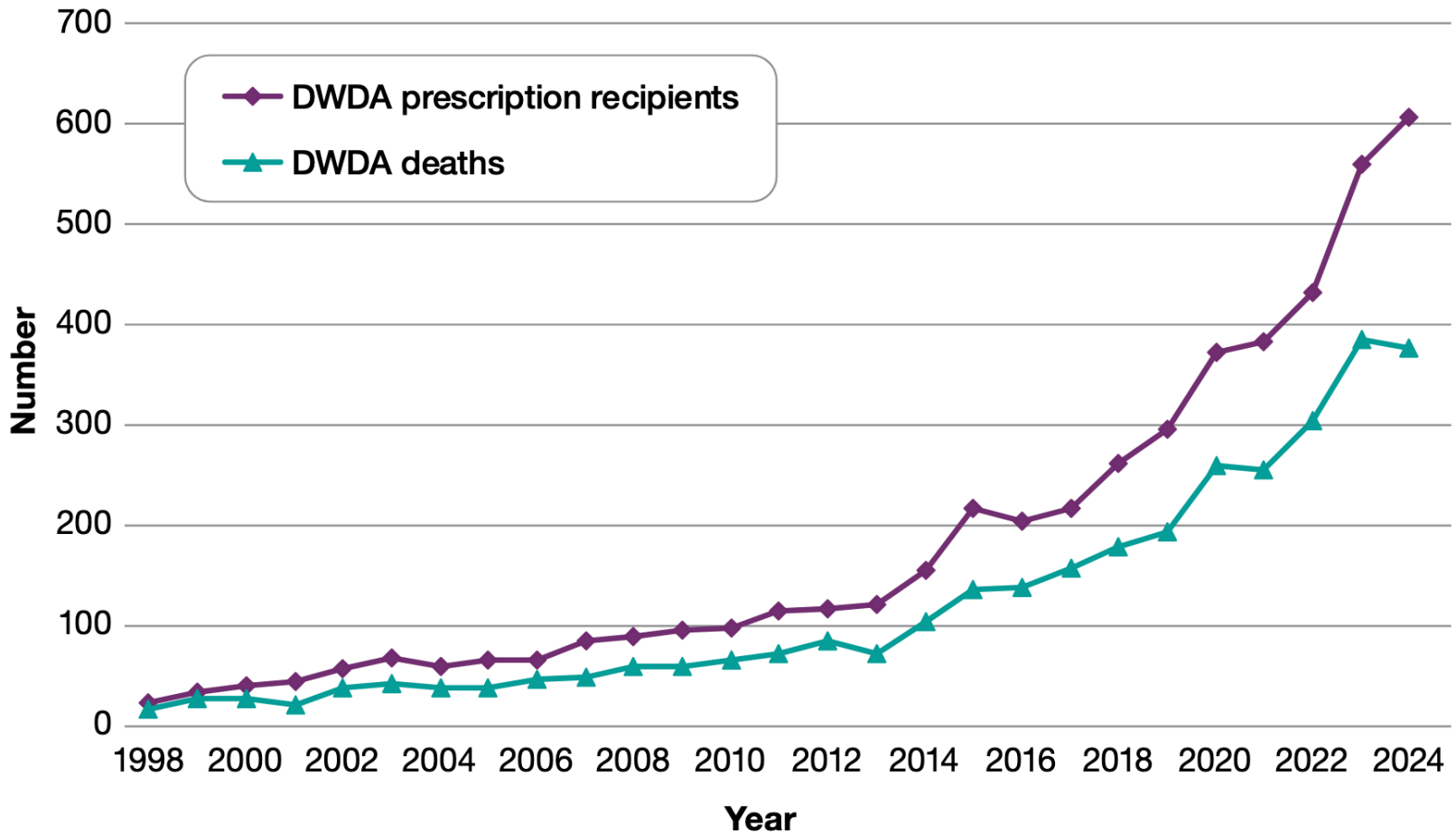


Oregon Data

Characteristics	2024		2023		1998–2022		Total	
	(N=376)		(N=386)		(N=2,481)		(N=3,243)	
Less able to engage in activities making life enjoyable	330	(87.8)	342	(88.6)	2,227	(89.8)	2,899	(89.4)
Loss of dignity ⁶	239	(63.6)	245	(63.5)	1,678	(71.3)	2,162	(69.4)
Losing control of bodily functions	176	(46.8)	181	(46.9)	1,087	(43.8)	1,444	(44.5)
Burden on family, friends/caregivers	158	(42.0)	170	(44.0)	1,183	(47.7)	1,511	(46.6)
Inadequate pain control, or concern about it	128	(34.0)	135	(35.0)	694	(28.0)	957	(29.5)
Financial implications of treatment	35	(9.3)	32	(8.3)	126	(5.1)	193	(6.0)
End-of-life care								
Hospice								
Enrolled	346	(92.0)	336	(87.0)	2,242	(91.6)	2,924	(91.1)
Not enrolled	30	(8.0)	50	(13.0)	205	(8.4)	285	(8.9)
<i>Unknown</i>	0		0		34		34	

Oregon Data

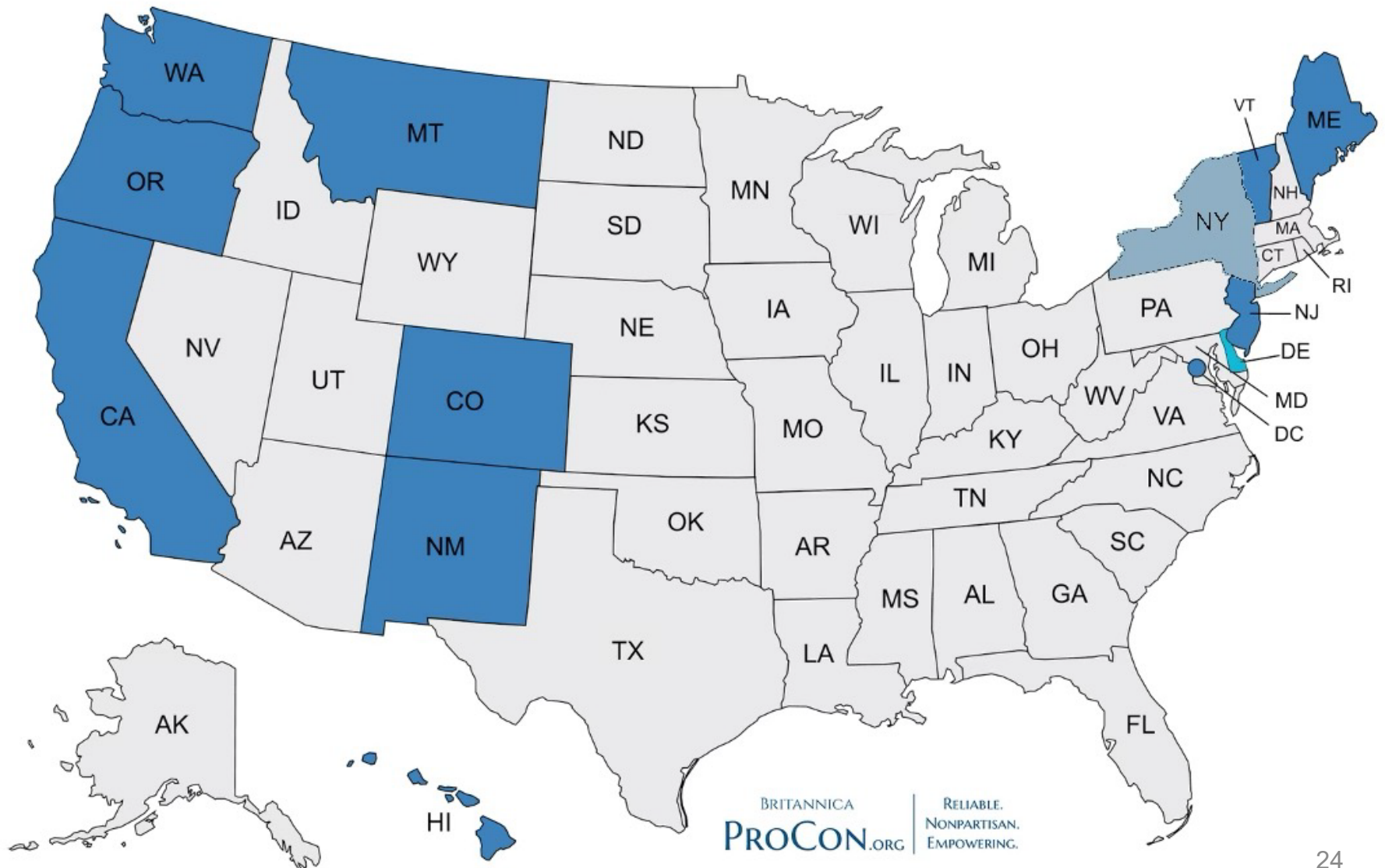
Figure 1: DWDA prescription recipients and deaths,* Oregon, 1998–2024



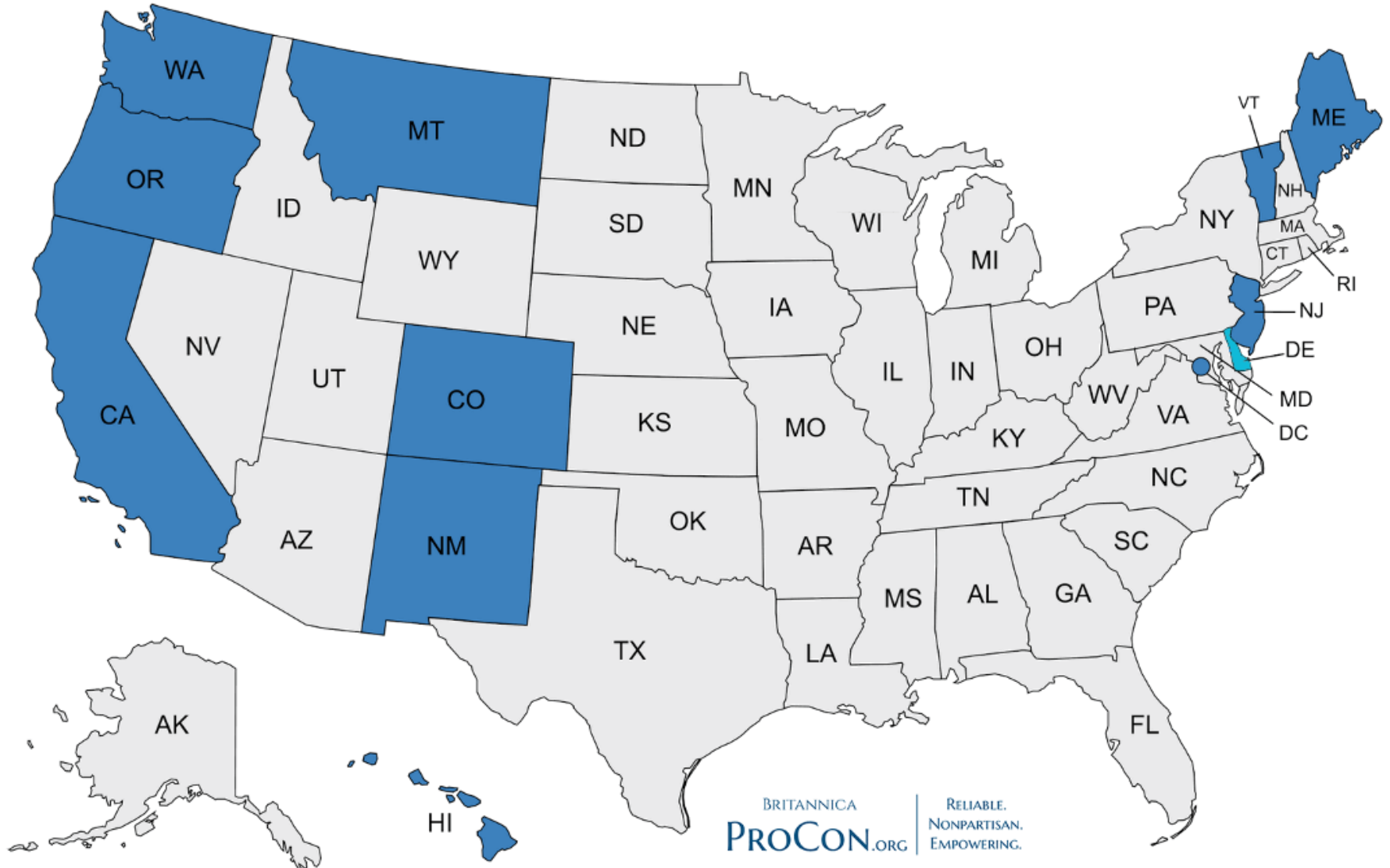
Sara

- 60 years old
- Married, two grown children
- Husband worked hard in Oil/Gas industry.
- Lived in many exotic places, exploration
- Retired early moved to upstate NY for family time
- Diagnosed with high grade locally advanced gyn cancer
- Physicality markedly, permanently diminished

Adapted from <https://www.britannica.com/procon>



Adapted from <https://www.britannica.com/procon>



Sara

- Specialty Cancer care at Sloan Kettering
- Chemo, short lived remission
- Second line chemo and XRT

- ”Technically adequate”
 - Oncology, palliative care

- Multiple complications
 - spinal mets, bowel obstruction, hydronephrosis, pain

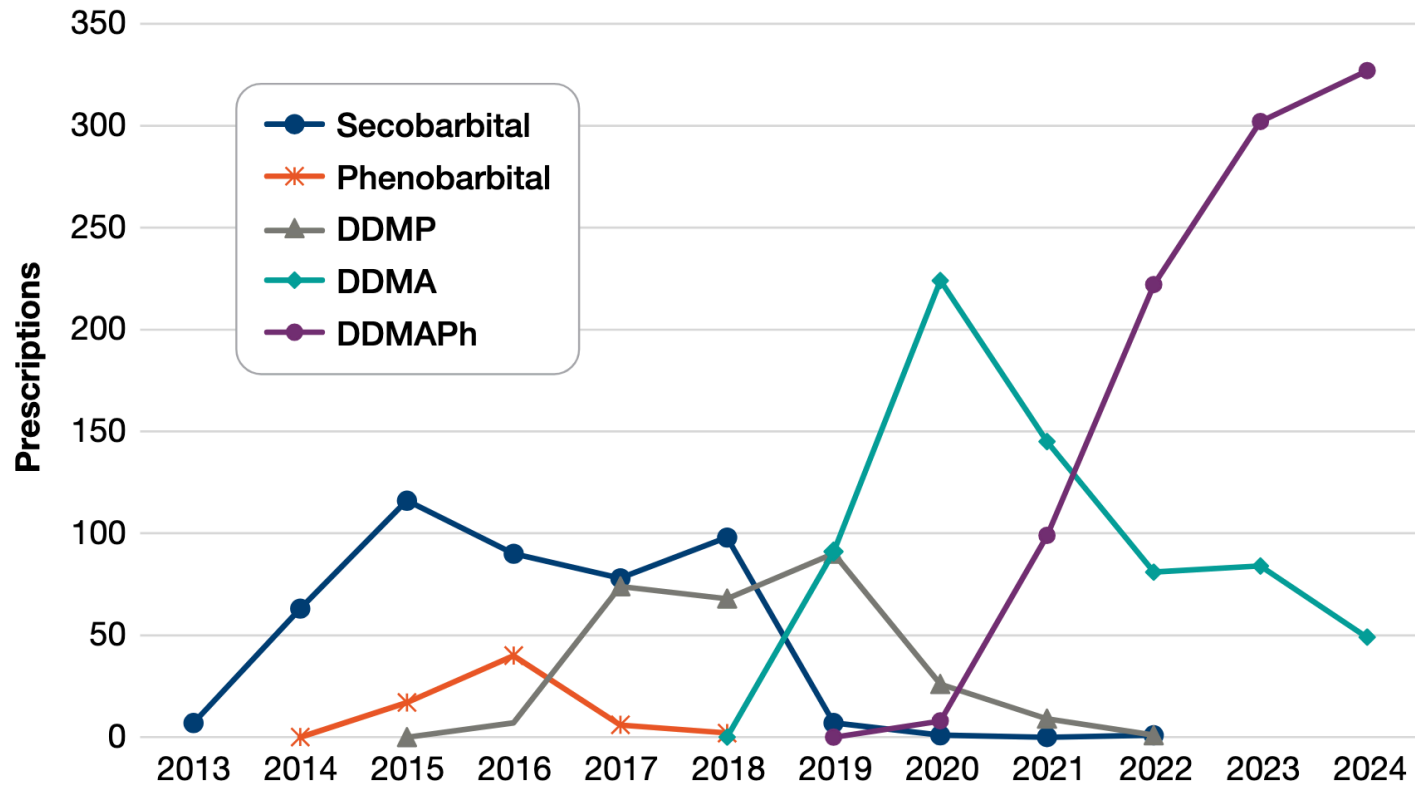
- Worries
 - Immobility
 - Physical dependence
 - Cognitive function

Sara

- Strong Vermont connection
- Wanted option to hasten death
- Very challenging pain, medication side effects
- Completed qualifications , hoped to wait
- Remote check ins
- Moved up date
- Planned week-long vacation
- Symptom crisis
- Moved up date.
- Asleep 8 minutes, died 50 min

Oregon Data

Figure 3: Medication used in DWDA ingestions, 2013-2024*



* See [Table 4](#) footnotes for definitions of the drug combination abbreviations.

MAID Pharmacology Data

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scan code to access this article
and other resources online.



The Pharmacology of Aid in Dying: From Database Analyses to Evidence-Based Best Practices

Patrick Macmillan, MD,¹ Susan Hughes, MS,² Angelique Loscar, MBA,³ and Lonny Shavelson, MD⁴

Traveling for Medical Care

Deborah

- 65 yo woman
- Married, Two Children
- Dual Masters in Physical Education, Counseling
- Robust physical activity part of daily life
- Work included developing Employee Wellness programs for large companies
- Started own business of Adventure travel in US, Europe, South America
- Multilingual (English, German, Italian, Spanish)
- Not a rule follower, Rocked the Boat

Deborah

- Became “clumsy” , frequent falls, slurred speech
- Symptoms led to stopping travel, tapering activity
- Eventually diagnosed with Multi System Atrophy
- “Life..... Was over”
- Neurologist “too many questions”
- Second opinion, then Mayo clinic evaluation
- No effective treatments; supportive care
- Openly discussed grief and desire to hasten death

Deborah

- Very well supported by PCP, therapists
- Concern about ?depression, ? Suicidal ideation
- Medication trials, therapy not felt to be successful

- Palliative Care Consultation
 - Clear, consistent, repeated requests for MAID
 - No clear <6 month prognosis
 - Referred for grief counseling
 - Explored legal options available to her
 - Palliative Support volunteer referral; two, weekly contact

Deborah

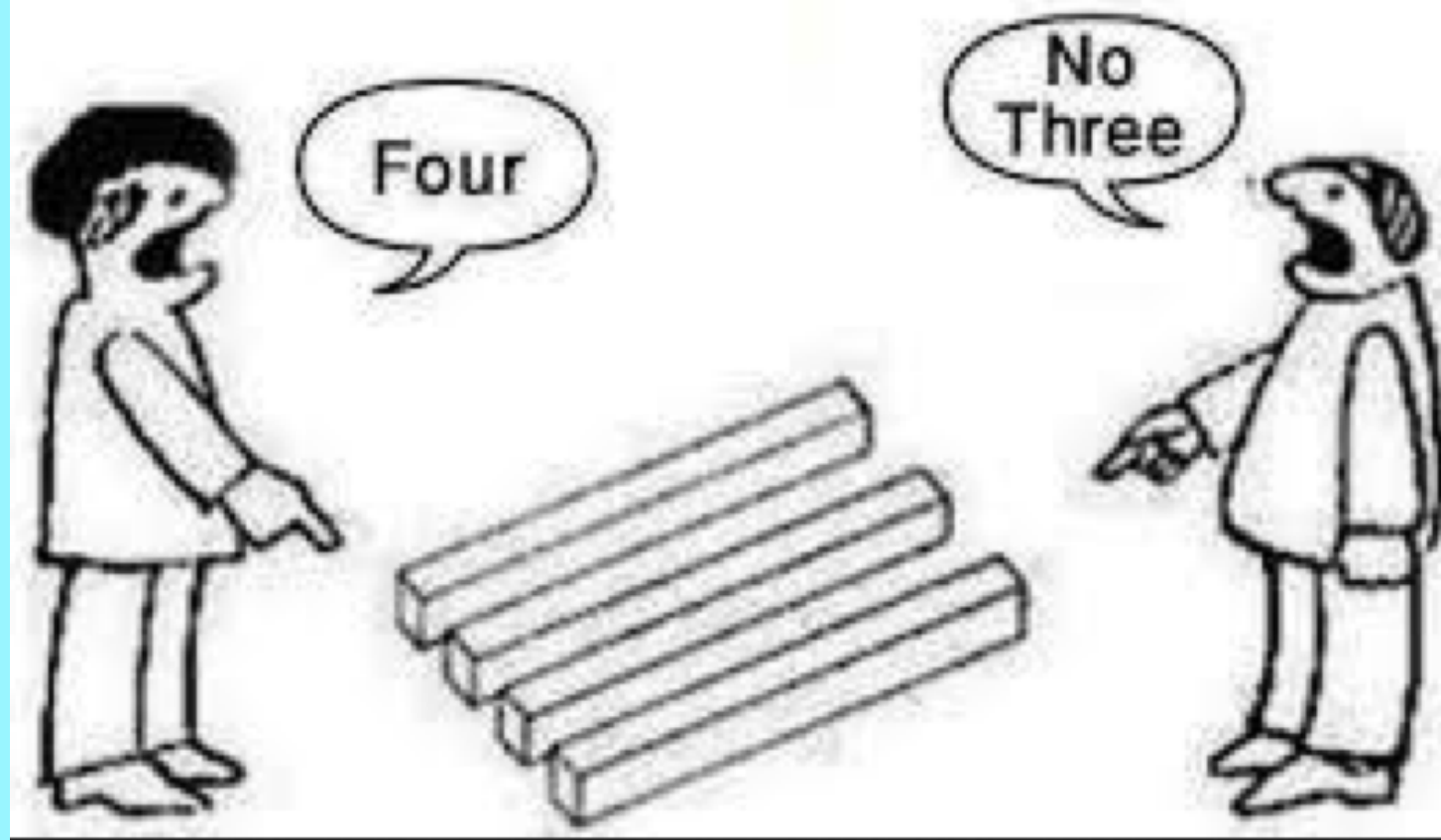
- Multiple visits
- Explore deep grief/suffering
- PCP, Grief counselor actively involved
- Neurology connections not therapeutic

- Terminal Illness confirmed
- Prognostically did not qualify
- Clear, frustrated
- Talk of hastening death on own repeatedly
- Crisis referral, safety measures

Deborah

- Openly discussed her frustration lack of MAID access
- Deep legacy work
- Ongoing counseling
- Moments of Joy, some activity
- No good days
- Hastened her own death

It is really confusing!!!





Limitations of MAID

- Access
- Prognosis and Terminal Illness
- Capacity throughout process
 - Rapidly progressive disease
 - Cognitive impairment/Dementia
- Physical Limitations
 - Self administer



The Future of MAID

- Increased access
- More Normalization of Patient Centered Dying
- Openly acknowledgment of Suffering
- Issues of DEI
 - Access to comprehensive EOL care
 - Physical disabilities
 - Financial challenges*

LISTEN



References/Information

Patient Choices Vermont

<https://www.patientchoices.org>

Academy of Aid in Dying Medicine

<https://www.aadm.org/>

Vermont Department of Health

<https://healthvermont.gov/systems/end-life-decisions/patient-choice-and-control-end-life>

Vermont Ethics Network

<https://vtethicsnetwork.org/palliative-and-end-of-life-care/medical-aid-in-dying-act-39>

Oregon Health Authority

[Oregon Health Authority : Oregon's Death with Dignity Act : Death with Dignity Act : State of Oregon](#)

Compassion and Choices

<https://www.compassionandchoices.org/research/doc2doc-program/>

References

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