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Perspective

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The Paradox of Medical Aid in Dying

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Legislative support for medical aid in dying (MAID) in the United States is growing. In the past year alone, three states — Delaware, Illinois, and New York — have legalized the practice, bringing the number of permissive jurisdictions up to 14 (13 states plus the District of Columbia). Nearly one third of the U.S. population now lives in a jurisdiction in which MAID is legal, permitting authorized clinicians to prescribe lethal medication for terminally ill patients, provided that certain regulatory requirements are met (e.g., the patient is an adult with a survival prognosis of 6 months or less, is mentally competent, can self-administer medication, and, in some jurisdictions, is a state resident and has waited for a prescribed period). And yet, despite this significant growth, there is a paradox at the heart of MAID: whatever reasons people may have for supporting it, its expansion hinges on its rarity.

One of the key ethical arguments driving MAID legalization in the United States rests on the assumption that it will remain a rare event. If it is working correctly, its proponents maintain, it will be used infrequently. In U.S. jurisdictions with the longest history of MAID, utilization rates are exceptionally low. In Oregon, which authorized MAID in 1997, a total of 400 deaths were recorded under the Oregon Death with Dignity Act (DWDA) in 2025, accounting for an estimated 1% of total deaths in Oregon that year.[1] Despite steady growth in utilization since 1997, the Oregon data have persuaded many lawmakers in other states that legalization will not lead to a "slippery slope" of abuse in which vulnerable patients are coerced to use MAID — a key concern of opponents.[2] The crux of MAID's utilization paradox lies in the fact that its popularity with legislators partially rests on its unpopularity in practice.

Given these low utilization rates, what can the drive toward expanded access to MAID tell us about cultural aspirations for death and dying in the United States today? A desire for greater control at the end of life is central to the pursuit of MAID. MAID allows terminally ill patients to control the timing and circumstances of their death, as well as the kinds of symptoms they are willing to live with and the types of suffering they hope to forgo. By enabling patients to plan the timing and place of their death and who will accompany them, it also invites control over the personal meanings of death.

From this perspective, death becomes an experience that one actively choreographs, rather than an event that one resists or endures.

MAID both reshapes the dying process and permits the dying person to pursue a good death — one that reflects certain personal, cultural, and aesthetic values. Typically such a death means being surrounded by loved ones and meaningful objects, in a preferred location (often at home), with ritual flourish (such as a final toast), before ingesting a lethal dose of medication. It often also means sanitizing death by curtailing the dying process, which minimizes the emission of unpleasant odors, sounds, and bodily fluids that otherwise accompany the slow decline of natural dying.

Planning for death provides a way to tame its inherent uncertainty, infusing it with a measure of personal control. The desire for such planning highlights the value of self-determination in American society. MAID laws carve out a pathway by which terminally ill people — who must lose so much of their agency — may reclaim autonomy over their last great life event. In some cases, the desire to avoid suffering at the end of life might also reflect the secularization of American society in the modern era and the erosion of cultural beliefs that cast suffering as grounded in religious purpose.[3] This potential of MAID to control uncertainty and limit suffering appeals to many Americans regardless of their eligibility for it; MAID may be even more attractive in the current historical moment, which is marked by the overwhelming uncertainty of war and political unrest, economic instability, climate change, and anxiety about artificial intelligence.

At the same time, the clinical implications of MAID stretch further than the utilization statistics might suggest. Many more patients request MAID from a physician than go on to use it[1]: some patients who request it are ineligible, and some merely want to have medication on hand for reassurance. Having the option of MAID is valuable in and of itself, even if the medication is not ultimately consumed. Last year in Oregon, 637 people received prescriptions under the DWDA, of whom 358 ingested the medication, 100 died from natural causes without ingesting it, and 179 had unknown ingestion status.[1]

Studies of clinician–patient interactions have also revealed that MAID is often a starting point for deeper conversations about end-of-life concerns.[4] Initiating a discussion of MAID may signal that a patient is ready to move on to a different stage of treatment, often shifting from curative to palliative intent. Or it may open a space for a patient to express existential distress and fears about dying. It can facilitate a search for alternative forms of control, such as pain or symptom management, or declining of certain treatments. In a society in which discussing death is still relatively taboo, legalizing MAID opens the door to a new outlook on end-of-life planning — one that may ultimately benefit many more U.S. patients than just those who are eligible for MAID. It provides a cultural warrant for a richer discussion of a deeply stigmatized topic, changing the kinds of conversations about death and dying that physicians and patients might have.

With more jurisdictions legalizing MAID, physicians who care for seriously ill patients must prepare for these conversations, regardless of whether they practice in a jurisdiction in which MAID is authorized or would agree to prescribe it if they could legally do so.[5] Though advocacy for MAID may be based partly on its infrequent use, its cultural legacy reaches beyond its legal authorization in specific jurisdictions or its use by specific patients. As a cultural phenomenon that has captured the public imagination, MAID invites creative thinking about what the demand for it reveals about how people die in America today. Its ascendance suggests that many Americans want more opportunities to plan for their deaths and to infuse them with personal meaning. The planning process, in turn, can restore some control over an uncertain, fear-inspiring — and, in some ways, fundamentally unknowable — process.

This cultural understanding can, and should, be channeled to improve end-of-life care for all patients. MAID's expansion shows that there is value in having an end-of-life option that people don't want, or need, to use. One unintended benefit of legalizing MAID is its capacity to help patients and physicians start new conversations about what matters most to patients in the final stages of serious illness and how they can live and die in ways that align with those values. It can provide an opening for patients to express their greatest hopes and fears. By reminding terminally ill patients that death may be a choice, it can interrupt the logic of simply accepting the next treatment until no options remain. This, then, is another facet of MAID's paradox: it holds the potential to touch far more lives than those that it ends.

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Medical Standards by Federal Fiat

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The constitutional structure of the United States gives the states broad regulatory authority over medical standards. This authority applies even — or perhaps especially — in contested areas of medicine, such as gender-affirming care for young people. Yet in recent executive actions, the U.S. government has moved to federalize medical standards, threatening to imperil the financial viability of hospitals and investigate physicians providing certain types of contested care if their actions are contrary to a politically appointed federal official's views about medicine. The federal government's legal theories could jeopardize the practice of medicine for all physicians and the health of all patients, not just those who provide or pursue gender-affirming care.

Historically, the federal–state division of authority over medical practice has been strict. This division is evident in health care financing and medical product regulation, for example. States license physicians and set standards for medical care, often incorporating standards established by the medical profession while allowing broad discretion for physician judgment.[1] The federal government reimburses clinicians and health care organizations for covered Medicare services and provides most Medicaid funding, depending on the state. It can condition receipt of federal dollars on compliance with specific requirements, so long as such provisions are not coercive. Similarly, the Federal Food, Drug, and Cosmetic Act (FDCA) of 1938 governs drugs that have been introduced into interstate commerce and requires manufacturers to provide instructions for each of their intended uses for their products.[2] Only rarely can the federal government regulate medical practice directly (e.g., in the case of prescribing of certain controlled substances).[3] The example of gender-affirming care for minors illustrates the resulting legal patchwork: some states have enacted laws intended to safeguard access to such care, adopting the standards of care set by leading professional associations,[4] whereas others have overridden those standards, many going so far as to criminalize these services.

The Trump administration has attempted to alter the balance of federal–state authority in the area of gender-affirming care in two important ways. First, in June 2025, the U.S. Department of Justice (DOJ) issued administrative subpoenas to more than 20 health systems and clinics providing gender-affirming care, demanding unusually broad information related to off-label prescribing of puberty blockers and hormones. Because the FDCA requires drug labels to include adequate directions for intended uses, federal investigations of off-label promotion typically focus on whether manufacturers or their agents have wrongfully marketed drugs for uses beyond their labeled indications. The U.S. Congress has not clearly signaled that it intends this policy to apply to physicians' ability to prescribe drugs off label. The DOJ's subpoenas, however, demanded information at the heart of physician judgment and the patient–doctor relationship, including physicians' case-specific clinical assessments justifying off-label prescriptions and information that could be used to identify patients, including children, by name.