Medical Aid in Dying and Healthcare Systems: Best Practices for Policy and Program Development

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Step 1: Convene an interdisciplinary panel of key stakeholders

Include health system leadership, medical ethicists, legal/risk management team members, palliative care clinicians, and at least one clinician experienced in aid-in-dying care (potentially from outside your system or state). If practical, include an administrator from a similar system with aid-in-dying policy experience.

Initial goals of the panel:

- Mission alignment: Align aid-in-dying policy with your system's mission, ethics, and end-of-life care philosophy.
- Clarify level of participation:
  - Fully participating (allowing providers to act as attending/prescribing physicians)
  - Consulting/second-opinion only
  - No active participation, with an affirmative non-abandonment policy (neutral, non-judgmental responses to inquiries, with referrals for information or participation)

Step 2: Create clear, patient- and clinician-centered policies

Clinical staff will receive inquiries about aid in dying and need clear, specific guidance on how to respond. Focus on providing care, address what clinicians can do, not only what they cannot do.

Develop policies that address:

- Sequence of responses to patient inquiries
- Responses at each level of care (primary, specialty, ect)
- How should staff who do not want to directly participate respond to patient inquiries?

- How should staff willing to fully engage respond?
- Clarify institutional limits on responses
- Establish clear referral pathways (e.g., centralized referral vs. department-based systems vs external)
- Ensure rapid referral processes for time-sensitive cases

Participation framework:

- Opt-out: Any staff member may opt out at any point, for any reason, without providing justification. Opt-out may include declining all involvement, participating in limited discussions, or providing referrals. Transfers of care should be timely, ideally with warm handoffs.
- Opt-in: Staff may participate at varying levels. Physicians may serve as attending/prescribing, consulting, or supportive clinicians. Non-physician staff may provide full or limited support, including counseling, care coordination, or presence at the aid-in-dying day.
- All staff must respond to patient inquiries in a non-judgmental manner. Policies should include clear, neutral handoff procedures and emphasize timely referrals to reduce stress for both patients and staff.

Step 3: Establish palliative care–based leadership and care

All patients considering aid in dying require high-quality palliative care, regardless of their decision. High-quality palliative care should present aid in dying as one option among many.

Designate a palliative care physician as program lead to oversee system-wide efforts, including workflow implementation, case review, education, and research. This leader should participate in relevant ethics and end-of-life committees and initially partner with an experienced aid-in-dying clinician.

Develop an interdisciplinary team (e.g., RN/APP, social worker, chaplain) to support protocol development, education, and consultation. This team may also serve as navigators to guide patients and clinicians and ensure efficient care coordination.

For participating institutions, the palliative care department should serve as the clinical home:

- Encourage referral of patients considering aid in dying
- Educate all palliative care clinicians on best practices, including mental health/capacity assessments and complex case management
- Promote early palliative care consultation, clearly identifying patients considering aid in dying
- Emphasize that evaluations for aid in dying include comprehensive goals-of-care discussions and symptom management—not solely aid-in-dying requests

Step 4: Provide education across the institution

Ensure that all clinicians caring for seriously ill adults receive training in end-of-life care, including how to discuss aid in dying during goals-of-care conversations. (oncology, cardiology, pulmonology, neurology, geriatrics, palliative care)

For participating institutions, provide additional education on longitudinal patient care, assertive symptom management, support for patient autonomy and normalizing shifting plans, if/when to dispense medication, complex medical or social case management, and safety considerations for the aid-in-dying day.

Incorporate aid-in-dying education into long-term training curricula for palliative care and other clinical trainees.

Summary: Aid in dying is not simply prescribing lethal medication—it is a comprehensive care process supporting patients as they consider their options.

Step 5: Standardize documentation, communication, and safety protocols

Create standardized EHR templates for aid-in-dying care that include patient motivations, eligibility assessments, consent, capacity evaluations, prescriptions, and post-death documentation.

Ensure compliance with legal requirements and best practices, and optimize workflows so documentation is accurate and submitted in a timely manner.

Step 6: Strengthen collaboration with community partners

Develop proactive relationships with community partners, including pharmacies, hospices, independent providers, end-of-life doulas, volunteer organizations, and mental health services.

Ensure alignment on quality standards before transferring patients outside your institution and offer ongoing education and consultation.

Establish clear communication processes between referring and receiving teams. For participating institutions, require warm handoffs and encourage continued communication through the end of life.

For non-participating but non-abandoning institutions, ensure timely and coordinated referrals to external providers.

Step 7: Develop a research strategy

Create a HIPAA-compliant, IRB-approved framework for aid-in-dying research.

Building institutional databases will support quality improvement and expand the evidence base for this evolving area of care.

Step 8: Finalize and disseminate policy

Provide a clear, accessible, and well-organized internal website for clinical staff.

Maintain up-to-date policies, protocols, and educational materials, along with a patient-facing website that clearly explains pathways for requesting aid-in-dying care and what to expect, whether within your institution or via referral.

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