

# Managing Requests for Medical Aid in Dying Within the Veterans Health Administration

Andrea Ruskin, MD<sup>a</sup>; Margaret Bauer, PhD<sup>a</sup>; Loay Alrojolah, MD<sup>b</sup>

**Background:** Managing requests for medical aid in dying (MAID) within the Veterans Health Administration (VHA) presents unique ethical, legal, and clinical challenges. MAID is a process in which a physician provides a terminally ill patient with the means to end their own life. It is explicitly prohibited under federal law, including within the VHA, regardless of its legality at the state level.

**Case Presentation:** This case report describes the management of a male veteran who requested MAID while exhibiting active suicidal ideation. The patient's distress stemmed from fears of impending loss of autonomy and functional decline, factors often linked to requests for MAID among patients with terminal illnesses. Addressing

the request for MAID necessitated balancing the veteran's autonomy and fears of functional decline with the duty to protect patients from self-harm and provide mental health care for suicidal ideation.

**Conclusions:** MAID requests are especially difficult for VHA palliative care clinicians who are trained to identify and honor preferences for care and alleviate physical and emotional distress. A veteran's request for MAID reflects a desire for autonomy and relief, but the federal prohibition on MAID prevents clinicians from honoring these specific preferences. This case highlights the importance of nuanced clinical approaches, ethical reflection, and interdisciplinary collaboration in navigating such complex scenarios.

Author affiliations can be found at the end of this article.

**Correspondence:**

Andrea Ruskin  
(andrea.ruskin@va.gov)

*Fed Pract.* 2026;43(7).  
Published online July 7.  
doi:10.12788/fp.0739

Requests for medical aid in dying (MAID) within the Veterans Health Administration (VHA) present unique ethical, legal, and clinical challenges. MAID is a process in which a physician provides a terminally ill patient with the means to end their own life. It is expressly prohibited by federal law, including within the US Department of Veterans Affairs (VA), regardless of its legality at the state level.<sup>1</sup> MAID is also prohibited within community care institutions funded by the VA. The American Medical Association, American Geriatrics Society, and American Academy of Hospice and Palliative Medicine have adopted neutral positions regarding MAID due to varying opinions among their respective members.<sup>2-4</sup> VHA palliative care clinicians are trained to identify and honor preferences for care and alleviate physical and emotional distress, which may complicate the management of MAID requests. Veterans can request MAID due to their desire for autonomy and pain relief, but the VHA prohibits clinicians from honoring these specific preferences. The inability to help veterans achieve their care preferences conflicts with the core mission of palliative care to reduce suffering and respect end-of-life wishes.

This case report describes the management of a veteran who requested MAID while also exhibiting active suicidal ideation. The patient's distress stemmed from fears of impending loss of autonomy and

functional decline, factors frequently linked to requests for MAID in terminally ill patients.<sup>5,6</sup> Addressing the veteran's request for MAID required balancing respect for patient autonomy and concerns about future suffering with the VA mission to protect veterans from self-harm and provide mental health care for suicidal ideation. This case highlights the importance of nuanced clinical approaches, ethical reflection, and interdisciplinary collaboration in navigating such complex scenarios. Informed consent was obtained from the patient's family and health care agent (HCA) to publish this report.

## CASE PRESENTATION

A 73-year-old male veteran, with Parkinson disease (PD), diagnosed at age 52 years, was referred to palliative care following diagnosis of a glioblastoma multiforme (GBM). The patient also had a history of major depressive disorder (MDD), suicidal ideation (SI), benign prostatic hypertrophy, and migraines. He was divorced, had no children, and his only sibling (sister) was deceased. His brother-in-law served as his HCA.

The patient had many close friends in the community, was an architect by training, and was active in the removal of barriers and increasing access for people with disabilities. Since 2010, about 7 years before his PD diagnosis, the patient used psychiatry and psychology resources to treat MDD, functional decline, and SI. He was hospitalized in 2016

after self-administration of heroin. During the hospitalization the patient received a high risk for suicide label. He articulated a firm and long-standing belief in his right to die and shared plans to end his life when he experienced a significant decline in his independence and quality of life (QoL).

When diagnosed with PD, the patient shared that his QoL was of utmost importance. He was aware that he would have significant physical decline as PD progressed and felt like there would be a point when his QoL would not be acceptable. When that happened, he wanted to end his life by available means. He was followed closely by his VHA care team for physical and emotional distress.

When diagnosed with a GBM in 2023, the patient declined treatment and was referred to palliative care, which had sporadically treated him for PD-related distress prior to 2023. During his previous palliative care visits, the patient had discussed a desire to engage in MAID when his functional status declined. After the GBM diagnosis, he reported no acute intent to harm himself with heroin, but planned to travel to Vermont for MAID when he felt he no longer had an adequate QoL based on functional capability.

Pharmacologic and nonpharmacologic approaches were used to treat the patient's pain. He reported significant benefit from biofeedback therapy provided by the VA Headache Center of Excellence. This work also reconnected him to meditation, which he used daily to relieve pain and distress. The patient managed head pain with non-pharmacologic and pharmacologic interventions for 6 months and reported satisfaction with his QoL.

After 6 months, imaging showed progression of the brain tumor, which was associated with more fatigue and memory decline. At that time, the patient was enrolled in home hospice and reported continued intent to pursue MAID in Vermont but had not taken steps toward carrying it out. The patient understood the VA could not assist him in pursuing MAID; however, his care team was able to assist him in sharing his preferences for care with his loved ones and health care power of attorney.

He experienced rapid functional and cognitive decline due to progression of the GBM and was admitted to the VA Connecticut

Healthcare System (VACHS) acute care unit where he exhibited confusion and screened positive for delirium using the Confusion Assessment Method.<sup>7</sup> His physical and cognitive deterioration was likely due to the progressive brain tumor, and the patient lacked the capacity to make complex medical decisions. Formal consent was obtained from his HCA to transfer him to inpatient hospice. Psychiatry followed the patient throughout.

After 4 weeks of hospice care, the patient had a witnessed suicide attempt while the nurse was assisting him in the bathroom. The patient attempted to use hospital pajamas to hang himself when he wrapped a hospital gown around his neck and stated he was trying to tie a knot. Due to his confusion and delirium, the patient was unable to express his reasoning for the suicide attempt. He was seen by the Psychiatry service, which determined that his suicide risk was low to intermediate. The Psychiatry service did not recommend a 1:1 safety sitter, but suggested medication changes. Levetiracetam was discontinued, and valproate 500 mg orally twice daily was initiated for seizure prevention.

The hospice team was informed of the suicide attempt and psychiatry recommendations. The suicide prevention team was also updated following this event and agreed with psychiatry recommendations. The patient continued to decline, was no longer able to get out of bed, and had minimal speech. The patient received comfort medications, including intravenous morphine 2 mg and lorazepam 0.5 mg as needed  $\leq 4$  times daily. He died 8 days later.

## DISCUSSION

Chronic medical illness has been associated with increased suicide risk.<sup>8-10</sup> The increased risk of suicide in chronically ill patients has been described as having as a bidirectional relationship with MDD, with depression not only increasing the risk of chronic medical illness but new-onset chronic medical illness being associated with new onset depression.<sup>11,12</sup> Chronic medical conditions are associated with numerous psychiatric disorders, and the presence of a comorbid psychiatric illness is associated with higher rates of hospitalization, emergency department visits, and increased health care costs.<sup>13</sup> Research has found that the association

between suicide risk and chronic medical illness remains even after accounting for comorbid mental health disorders.<sup>14</sup> This has been postulated to be due to a multitude of interpersonal, behavioral, cognitive, and affective factors (eg, perceived burdensomeness, loneliness, stress, pain catastrophizing, self-criticism).<sup>15</sup> Additionally, some researchers have questioned whether suicidality constitutes a distinct mental disorder.<sup>16</sup>

Patients with cancer are at increased risk for suicidal ideation (including passive death wishes) and suicide attempts.<sup>17,18</sup> Recent data indicate that compared with the general population, there is an 85% increased risk of suicide mortality in patients with cancer.<sup>19</sup> Studies show the incidence of suicide is greater for individuals with cancer compared with the general population, with standardized mortality ratios ranging from 1.4 to 5.7.<sup>20-22</sup>

Among patients with cancer, suicide risk is associated with several factors: worse prognosis, older age, male sex, living in a socioeconomically vulnerable environment, and increased communication about suicidal intent prior to death.<sup>23-25</sup> Just as the prevalence of suicidal ideation in people with cancer varies widely, reported rates of suicidality in caregivers of patients with cancer range from 2.7% to 71%.<sup>17,26</sup> A survey of health care workers indicated the following reasons patients with cancer may die by suicide or seek aid in assisted suicide: social isolation, pain, physical impairment, loss of autonomy and meaning, terminal illness, and psychic distress and desperation.<sup>27</sup>

As with cancer, patients with PD exhibit increased suicidal ideation compared with the general population.<sup>28,29</sup> Two studies found the suicide rate in individuals with PD is about twice as high as it is in the general population.<sup>30,31</sup> Among people with PD, male sex, younger age, initial onset of motor symptoms in the upper or both upper and lower extremities, history of depression or any psychiatric diagnosis, delusions, higher levodopa dosing, and urban residence have been clinically correlated with suicide. Jumping has been a frequent method of suicide.<sup>30,31</sup>

Some research has evaluated the perspectives of loved ones after a patient chooses MAID. A study in the Netherlands found that 92% of relatives surveyed believed that access to MAID improved QoL and reduced pain

at the end of life.<sup>32</sup> In another, family members of individuals who used MAID reported higher quality on items related to physical symptom control and preparedness for death, compared with individuals who did not pursue MAID or who requested but did not receive it. There were no differences on items assessing connectedness to their loved one, being unafraid of death, level of consciousness, or global quality of death items.<sup>33</sup> Another study found no significant differences in depression rates, grief, or use of mental health services among Oregon families whose loved ones died using MAID compared with those who did not.<sup>34</sup>

The higher suicide rate among terminally ill patients highlights the complex issue of MAID and the right to die. It is important to differentiate between euthanasia and medically-assisted dying. Euthanasia is an act whereby a person other than the patient acts to cause death. In MAID, the patient is provided with a medication that they self-administer. Recent Gallup polls found that > 70% of Americans believe physicians should be “allowed by law to end the patient’s life by some painless means if the patient and his or her family request it.”<sup>35</sup>

It is important to acknowledge MAID in the context of chronic suicidality, like in the case described in this article. It is imperative not to dismiss reports of suicidality in this population. Ignoring reports of suicidal ideation may lead to decreased access to pharmacologic and nonpharmacologic interventions. It is also important to maintain a timeline of symptom occurrence and to differentiate between chronic suicidality and the desire to die associated with having a terminal illness. A thorough assessment is necessary to assess whether the patient’s decision stems from a calculated decision with preserved capacity or from underlying mental health conditions. Other factors that may lead the patient to a hastened death (ie, pain, poor psychosocial support, delirium, cognitive impairment, incomplete understanding of treatment/prognosis) need to be addressed prior to finalizing choices. In this case, an assessment was performed by psychiatry, psychology, social work, and chaplains to ensure comprehensive evaluation.

The VHA offers resources to assist individuals experiencing suicidal ideation, including

suicide prevention coordinators who work directly with veterans and offer consultation to teams working with veterans at risk for suicide. Support for VHA clinicians who treat veterans considering MAID may help address any moral distress. In this case, the care team met early for overnight sign-out, had daily core hospice team meetings, as-needed safety huddles, and weekly care plan meetings to ensure maximal physical and emotional comfort for the patient. These meetings cultivate open, honest, and transparent discussions regarding any staff concerns or personal distress around the plan of care. The VACHS chief well-being officer was also available for all staff.

A systematic review of the impact of MAID on clinicians found that MAID legislation influenced emotional responses. For countries whose MAID legislation emphasized alleviation from pain in addition to terminal illness, clinicians reported more emotional reflection. Whereas, in countries where MAID legislation is stricter and can be applied solely for terminal illness, clinicians reported a stronger and more polarizing range of emotions.<sup>36</sup> This highlights the potential influence of the context in which clinicians work on their emotional experience with MAID. Given that MAID is not permitted in the VA, staff members may experience heightened emotional responses. In a survey of US adults, there was an interest in using MAID but there were knowledge deficits regarding the process and legality.<sup>37</sup>

Legal aspects come into play as well with regards to MAID. Eligibility requires the patient be aged  $\geq 18$  years, be terminally ill with a prognosis of  $\leq 6$  months, have the capacity to make their own health care decision, and be able to self-administer the medication. States also may have residency restrictions. Special care and adequate education are needed, as having anyone but the patient administer the medication may be considered criminal. Furthermore, since MAID is not allowed federally, this creates further distress in VHA clinicians entrusted to minimizing pain for patients.

Strategies to support veterans given prohibition of MAID include: conversations about the patient's values, clarifying reasons for request, assessing all domains of distress,

affirming concerns with compassion and nonjudgment, addressing any pain using pharmacologic and nonpharmacologic interventions, providing education on other permissible options for end-of-life care, and consulting other specialties.<sup>38</sup> End-of-life options permitted by the VA include withholding/withdrawing life-sustaining treatments, palliative sedation, and voluntary stopping of eating and drinking.<sup>39</sup> Given the complexities of MAID, the VHA should initiate discussions of MAID, educate clinicians on what they can and cannot do as federal employees, and establish committees to discuss approaches that could minimize pain for patients and clinician distress.

## CONCLUSIONS

Caring for veterans who request MAID requires clinicians to navigate a complex intersection of ethical obligations, legal constraints, and patient preferences. Within the VHA, where MAID is prohibited, clinicians must balance respect for patient autonomy with adherence to VA regulations. Comprehensive assessment to identify sources of distress, interdisciplinary collaboration, and recognition of permissible alternatives that align with patients' values are essential to provide effective end-of-life care at the VHA for individuals considering MAID. As requests for MAID continue to emerge in clinical practice, the VHA has an opportunity to strengthen clinician education, clarify institutional expectations, and promote supportive structures that reduce both patient suffering and clinician moral distress.

## Author affiliations

<sup>a</sup>Veterans Affairs Connecticut Healthcare System, West Haven

<sup>b</sup>Yale University, New Haven, Connecticut

## Author disclosures

The authors report no actual or potential conflicts of interest with regard to this article.

## Disclaimer

The opinions expressed herein are those of the authors and do not necessarily reflect those of *Federal Practitioner*, Frontline Medical Communications Inc., the US Government, or any of its agencies. This article may discuss unlabeled or investigational use of certain drugs. Please review the complete prescribing information for specific drugs or drug combinations—including indications, contraindications, warnings, and adverse effects—before administering pharmacologic therapy to patients.

## Ethics and consent

Informed consent was obtained from the patient's family and health care agent to publish this report.

## References

- Meisel A, Snyder L, Quill T; American College of Physicians--American Society of Internal Medicine End-of-Life Care Consensus Panel. Seven legal barriers to end-of-life care: myths, realities, and grains of truth. *JAMA*. 2000;284:2495-2501. doi:10.1001/jama.284.19.2495
- Physician-Assisted Suicide. American Medical Association Code of Medical Ethics. 2025. Accessed May 6, 2026. <https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-assisted-suicide>
- Youngner SJ, Thoman R. AGS survey actually supports engaged neutrality for physician-assisted death. *J Am Geriatr Soc*. 2020;68:2140-2141. doi:10.1111/jgs.16679
- Physician-Assisted Dying. American Academy of Hospice and Palliative Medicine. Updated 2007. Accessed May 6, 2026. <https://aaahpm.org/advocacy/where-we-stand/pad/>
- Ganzini L, Goy ER, Dobscha SK. Why Oregon patients request assisted death: family members' views. *J Gen Intern Med*. 2008;23:154-157. doi:10.1007/s11606-007-0476-x
- Pearlman RA, Hsu C, Starks H, et al. Motivations for physician-assisted suicide: patient and family voices. *J Gen Intern Med*. 2005;20:234-239. doi:10.1111/j.1525-1497.2005.40225.x
- Inouye SK, van Dyck CH, Alessi CA, et al. Clarifying confusion: the Confusion Assessment Method. A new method for detection of delirium. *Ann Intern Med*. 1990;113:941-948. doi:10.7326/0003-4819-113-12-941
- Fässberg MM, Cheung G, Canetto SS, et al. A systematic review of physical illness, functional disability, and suicidal behaviour among older adults. *Aging Ment Health*. 2016;20:166-194. doi:10.1080/13607863.2015.1083945
- Gürhan N, Beşer NG, Polat Ü, et al. Suicide risk and depression in individuals with chronic illness. *Community Ment Health J*. 2019;55:840-848. doi:10.1007/s10597-019-00388-7
- Kye SY, Park K. Suicidal ideation and suicidal attempts among adults with chronic diseases: a cross-sectional study. *Compr Psychiatry*. 2017;73:160-167. doi:10.1016/j.comppsy.2016.12.001
- Patten SB. Long-term medical conditions and major depression in a Canadian population study at waves 1 and 2. *J Affect Disord*. 2001;63:35-41. doi:10.1016/s0165-0327(00)00186-5
- Van der Kooy K, van Hout H, Marwijk H, et al. Depression and the risk for cardiovascular diseases: systematic review and meta analysis. *Int J Geriatr Psychiatry*. 2007;22:613-626. doi:10.1002/gps.1723
- Sporinova B, Manns B, Tonelli M, et al. Association of mental health disorders with health care utilization and costs among adults with chronic disease. *JAMA Netw Open*. 2019;2:e199910. doi:10.1001/jamanetworkopen.2019.9910
- Ahmedani BK, Peterson EL, Hu Y, et al. Major physical health conditions and risk of suicide. *Am J Prev Med*. 2017;53:308-315. doi:10.1016/j.amepre.2017.04.001
- Rogers ML, Joiner TE, Shahar G. Suicidality in chronic illness: an overview of cognitive-affective and interpersonal factors. *J Clin Psychol Med Settings*. 2021;28:137-148. doi:10.1007/s10880-020-09749-x
- Sisti D, Mann JJ, Oquendo MA. Toward a distinct mental disorder—suicidal behavior. *JAMA Psychiatry*. 2020;77:661-662. doi:10.1001/jamapsychiatry.2020.0111
- Kolva E, Hoffecker L, Cox-Martin E. Suicidal ideation in patients with cancer: a systematic review of prevalence, risk factors, intervention and assessment. *Palliat Support Care*. 2020;18:206-219. doi:10.1017/S1478951519000610
- Zaorsky NG, Zhang Y, Tuanquin L, et al. Suicide among cancer patients. *Nat Commun*. 2019;10:207. doi:10.1038/s41467-018-08170-1
- Heinrich M, Hofmann L, Baurecht H, et al. Suicide risk and mortality among patients with cancer. *Nat Med*. 2022;28:852-859. doi:10.1038/s41591-022-01745-y
- Yousaf U, Christensen ML, Engholm G, et al. Suicides among Danish cancer patients 1971-1999. *Br J Cancer*. 2005;92:995-1000. doi:10.1038/sj.bjc.6602424
- Misono S, Weiss NS, Fann JR, et al. Incidence of suicide in persons with cancer. *J Clin Oncol*. 2008;26:4731-4738. doi:10.1200/JCO.2007.13.8941
- Björkenstam C, Edberg A, Ayoubi S, et al. Are cancer patients at higher suicide risk than the general population?. *Scand J Public Health*. 2005;33:208-214. doi:10.1080/14034940410019226
- Kinslow CJ, Kumar P, Olfson M, et al. Prognosis and risk of suicide after cancer diagnosis. *Cancer*. 2024;130:588-596. doi:10.1002/cncr.35118
- Men VY, Emery CR, Yip PSF. Characteristics of cancer patients who died by suicide: a quantitative study of 15-year coronial records. *Psychooncology*. 2021;30:1051-1058. doi:10.1002/pon.5634
- Abdel-Rahman O. Socioeconomic predictors of suicide risk among cancer patients in the United States: a population-based study. *Cancer Epidemiol*. 2019;63:101601. doi:10.1016/j.canep.2019.101601
- O'Dwyer ST, Janssens A, Sansom A, et al. Suicidality in family caregivers of people with long-term illnesses and disabilities: a scoping review. *Compr Psychiatry*. 2021;110:152261. doi:10.1016/j.comppsy.2021.152261
- Senf B, Maiwurm P, Fettel J. Attitudes and opinions towards suicidality in professionals working with oncology patients: results from an online survey. *Support Care Cancer*. 2022;30:1775-1786. doi:10.1007/s00520-021-06590-2
- Berardelli I, Belvisi D, Nardella A, et al. Suicide in Parkinson's disease: a systematic review. *CNS Neurol Disord Drug Targets*. 2019;18:466-477. doi:10.2174/1871527318666190703093345
- Kessler RC, Borges G, Walters EE. Prevalence of and risk factors for lifetime suicide attempts in the National Comorbidity Survey. *Arch Gen Psychiatry*. 1999;56:617-626. doi:10.1001/archpsyc.56.7.617
- Chen YY, Yu S, Hu YH, et al. Risk of suicide among patients with Parkinson disease. *JAMA Psychiatry*. 2021;78:293-301. doi:10.1001/jamapsychiatry.2020.4001
- Lee T, Lee HB, Ahn MH, et al. Increased suicide risk and clinical correlates of suicide among patients with Parkinson's disease. *Parkinsonism Relat Disord*. 2016;32:102-107. doi:10.1016/j.parkreldis.2016.09.006
- Georges JJ, Onwuteaka-Philipsen BD, Muller MT, et al. Relatives' perspective on the terminally ill patients who died after euthanasia or physician-assisted suicide: a retrospective cross-sectional interview study in the Netherlands. *Death Stud*. 2007;31:1-15. doi:10.1080/07481180600985041
- Smith KA, Goy ER, Harvath TA, et al. Quality of death and dying in patients who request physician-assisted death. *J Palliat Med*. 2011;14:445-450. doi:10.1089/jpm.2010.0425
- Ganzini L, Goy ER, Dobscha SK, et al. Mental health outcomes of family members of Oregonians who request physician aid in dying. *J Pain Symptom Manage*. 2009;38:807-815. doi:10.1016/j.jpainsymman.2009.04.026
- Yi R. Most Americans favor legal euthanasia. Gallup. August 8, 2024. Accessed May 6, 2026. <https://news.gallup.com/poll/648215/americans-favor-legal-euthanasia.aspx>
- Dholakia SY, Bagheri A, Simpson A. Emotional impact on healthcare providers involved in medical assistance in dying (MAiD): a systematic review and qualitative meta-synthesis. *BMJ Open*. 2022;12:e058523. doi:10.1136/bmjopen-2021-058523
- Kozlov E, Luth EA, Nemeth S, et al. Knowledge of and preferences for medical aid in dying. *JAMA Netw Open*. 2025;8:e2461495. doi:10.1001/jamanetworkopen.2024.61495
- Geppert C; Veterans Administration National Center for Ethics in Health Care. Medical aid in dying in the VA. Presented at: VISN 1 Palliative Care Summit, September 2024.
- National Ethics Committee, Veterans Health Administration. The ethics of palliative sedation as a therapy of last resort. *Am J Hosp Palliat Care*. 2006;23:483-491. doi:10.1177/1049909106294883