Medical Aid in Dying

Understanding the Law, Process, and Comparison with Other States

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What is “Aid in Dying”?

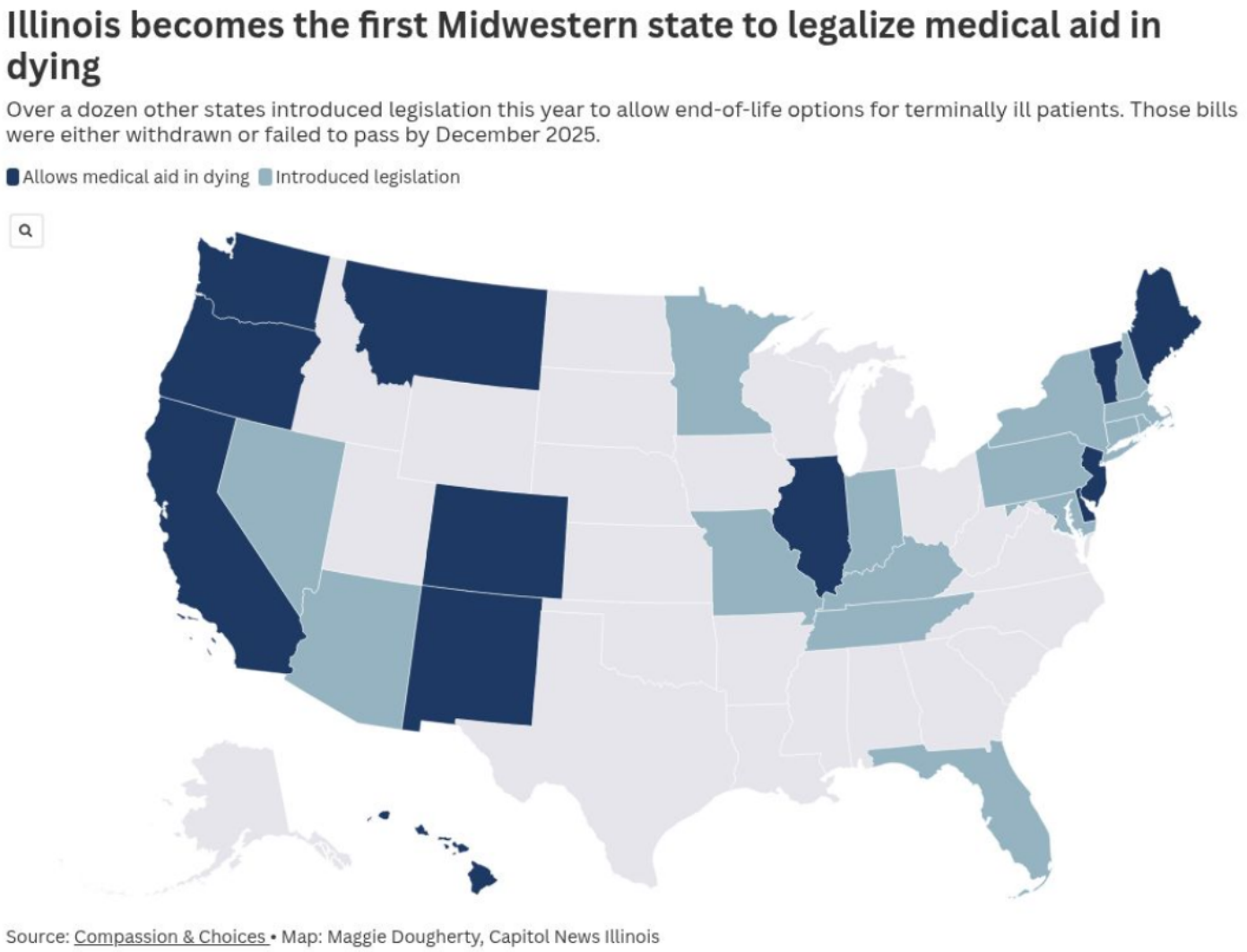
- A medical practice where terminally ill, mentally capable adults may request prescription medicine to end their lives
- Different from euthanasia: the patient must self-administer the medication
- Often called *Medical Aid in Dying* or *Death with Dignity*



Background & National Context



- Increasing emphasis on patient autonomy and end-of-life choice
- Laws adopted in multiple states with detailed safeguards
- Designed to balance choice with protection of vulnerable patients
- Continues to raise ethical, legal, and medical questions



Other jurisdictions with aid in dying laws:

- California
- Colorado
- Hawaii
- Maine
- Montana
- New Jersey
- New Mexico
- Oregon
- Vermont
- Washington
- Delaware
- Washington DC

- New York set to join in 2026
- Laws vary by state but share core safeguards
- Reflects a broader national trend in end-of-life care

Recent Addition-Illinois Law Overview (“Deb’s Law”)

- Formally titled “End-of-Life Options for Terminally Ill Patients Act” (SB 1950)
- Signed December 12, 2025
- Effective September 12, 2026
- Illinois becomes the 13th jurisdiction to authorize medical aid in dying
- Named after Deb Robinson, an Illinois resident living with a terminal illness



Statutory Structure of Illinois Act

- Establishes eligibility, request procedures, and safeguards
- Defines responsibilities of:
  - Attending physicians
  - Consulting physicians
  - Healthcare providers and facilities
- Includes opt-out protections and immunity provisions



SB 1950

Section 5. Findings and intent.
(a) The General Assembly finds that:
(1) Medical aid in dying is part of general medical care and complements other end-of-life options, such as comfort care, pain control, palliative care, and hospice care, for individuals to have an end-of-life experience aligned with their beliefs and values.
(2) The availability of medical aid in dying provides an additional end-of-life care option for terminally ill individuals who seek to retain their autonomy and some level of control over the progression of the disease as they near the end of life or to ease unnecessary pain and suffering.
(3) Illinoisans facing a terminal diagnosis have been at the forefront of statewide efforts to provide the full range of end-of-life care options available in 10 states and the District of Columbia, to qualified mentally capable terminal adults residing in Illinois through the addition of medical aid-in-dying care as an end-of-life option in their home state. Advocates include:
(A) Deb Robertson, a lifelong Illinois resident who has been living with a rare form of her terminal illness, who wants to live but knows that she is going to die, and who has been actively engaged in advocacy to change Illinois law because she doesn't want to move to another state in order to access the end-of-life medical care that would bring her comfort and reduce her fear related to the pain of dying.

Patient Eligibility Requirements



- Must be 18 years or older
- Illinois Resident
- Diagnosed with a terminal illness
- Life expectancy of six months or less
- Must have mental capacity to make medical decisions

What is a Qualifying Illness?

- A terminal illness with a prognosis of six months or less to live
- Determination must be made by attending physician
- Must be confirmed by consulting physician
- Prognosis is based on a reasonable medical judgment
  - Examples: end-stage organ failure with no curative options, advanced metastatic cancer
  - Does not qualify: chronic illness alone, disability, age, or mental illness alone



Who is an Attending and Consulting Physician?

- Attending: The physician who has the primary responsibility for the care of the patient and treatment of the patient's terminal disease
- Consulting: a physician who is qualified by specialty of experience to make a professional diagnosis and prognosis regarding the patient's disease
- Both have to be physicians and not APPs

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Residency Requirement

- Requests can only be made by Illinois residents:
  - Driver's license or state ID
  - Voter registration
  - Evidence that person owns, rents, or leases property in IL
  - Location of any dwelling occupied by the person
  - Place where motor vehicle is registered
  - Address on tax return filed for preceding year
  - Address where mail is received
  - Residence address on driver's license
  - Receipt of any public health benefit conditioned on residency
  - Any other objective facts tending to indicate a person's place of residence is IL

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Patient Request Process

- Patient must initiate the request personally
- Two oral requests to the attending physician
- Oral requests must be at least five days apart
- One written request required
- Requests cannot be made through advance directives or surrogates

Patient Request Process

- Patient must have:
  - Decision-making ability
  - Ability to self-administer medication



Written Request & Witness Requirements

- ✓ Written request must be signed by the patient
- ✓ Two adult witnesses required
- ✓ Witnesses attest that the patient:
  - Appears mentally capable
  - Is acting voluntarily
  - Is not being coerced
- ✓ At least one witness must be independent
- ✓ Second witness may be a family member



Written Request Form

"Request for Medication to End My Life in a Peaceful Manner

I, ... (NAME OF PATIENT), am an adult of sound mind, and a resident of Illinois. I have been diagnosed with ..... (NAME OF CONDITION) and given a terminal disease prognosis of 6 months or less to live by my attending physician.

I affirm that my terminal disease diagnosis was given or confirmed during at least one in-person visit to a health care professional.

I have been fully informed of the feasible alternatives and concurrent or additional treatment opportunities for my terminal disease, including, but not limited to, comfort care, palliative care, hospice care, or pain control, as well as the potential risks and benefits of each. I have been offered, have received, or have been offered and received resources or referrals to pursue these alternatives and concurrent or additional treatment opportunities for my terminal disease.

I have been fully informed of the nature of the medication to be prescribed, including the risks and benefits, and I understand that the likely outcome of self-administering the medication is death.

I understand that I can rescind this request at any time, that I am under no obligation to fill the prescription once written, and that I have no duty to self-administer the medication if I obtain it.

I request that my attending physician furnish a prescription for medication that will end my life if I choose to self-administer it, and I authorize my attending physician to transmit the prescription to a pharmacist to dispense the medication at a time of my choosing.

I make this request voluntarily, free from coercion or undue influence.

Dated: .....

Signed.....

Independent Witness: Statutory Restrictions

The independent witness may not be:

- A relative of the patient
- Someone entitled to the patient's estate
- The attending physician
- An owner, employee, or resident of the healthcare facility
- A translator assisting the patient



Provider Opt-Out

- No provider is required to participate
- Applies to:
  - Individual physicians
  - Advanced practice providers
  - Entire facilities or systems





Provider Responsibilities Under the Act

Healthcare providers involved in the process must:

- Receive and document patient requests
- Confirm eligibility and terminal diagnosis
- Ensure compliance with timing and procedural requirements
- Refer the patient to a consulting physician
- Arrange mental health evaluation if capacity is questioned
- Maintain required records and reports



Providers Who Participate

Providers who choose to participate:

- May prescribe aid-in-dying medication once all requirements are met
- Must follow documentation, reporting, and compliance obligations
- Receive legal immunity for good-faith compliance
- May not delegate decision-making responsibilities

Attending Physician Responsibilities

For those who participate, key responsibilities include:

- Confirm patient meets eligibility requirements
- Determine patient has decision-making capacity
- Ensure requests are voluntary and informed (aka “informed Decision)
- Discuss:
  - Diagnosis and prognosis
  - Feasible alternatives (palliative care, hospice)
- Document compliance with statutory steps



Informed Decision

- A decision made after being fully informed by attending MD and consulting MD of the following:
  - Diagnosis and prognosis
  - Potential risks and benefits associated with taking the medication
  - Probable result of taking the medication (i.e., death)
  - Feasible end-of-life options for the terminal illness (comfort care, palliative care, hospice care, and pain control)
  - The right to withdraw request
  - Right not to obtain the drug if it is prescribed, or the right not to take the drug if it is prescribed

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Consulting Physician Responsibilities

- Independently confirm:
  - Terminal diagnosis
  - Prognosis of six months or less
  - Patient capacity
- Must review medical records
- Must provide written confirmation



Providers Who Do Not Participate

- Participation is entirely voluntary
- Physicians may decline based on conscience or belief
- Healthcare facilities may opt out entirely
- Facilities must provide written notice of non-participation to staff and patients
- Providers may not be disciplined or penalized for opting out





Mental Capacity Assessment

- Triggered only if capacity is questioned
- Referral to “licensed mental health professional”
  - Psychiatrist
  - Psychologist
  - Clinical social worker
  - Advanced practice registered nurse who is certified as a psychiatric mental health practitioner
- Process pauses until capacity is confirmed



After Prescription is Approved

- Prescription is written by attending physician
- Medication is typically dispensed by a participating pharmacy
- Patient decides if and when to ingest medication
- Self-administration required
- May rescind request at any time, even after medication dispensed

“Self Administration”

- Medication has to be self-administered. The Act defines “self-administer” as:

“an affirmative, conscious, voluntary action, performed by a qualified patient, to ingest medication prescribed pursuant to this Act to bring about the patient's peaceful death. Self-administration does not include administration by parenteral injection or infusion.”

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Additional Legal Protections

Medical aid in dying is not classified as suicide

Cause of death listed as underlying terminal illness

Life insurance and annuity benefits remain valid



Additional Legal Protections

Providers acting in good faith compliance are immune from:

- Civil liability
- Criminal liability
- Professional liability

Acts not protected:

- Failure to follow statutory requirements
- Coercion or undue influence
- Forgery or falsification of documents
- Administration of medication by anyone other than the patient

Can Medical Aid in Dying (MAID) be added to POLST form?

- Guidance from the POLST IL Committee Leaders:
- MAID should NOT be incorporated into a POLST or advance directive because of how the MAID law is structured.
  - The patient must be decisional
  - There must be 2 requests
  - MAID must be initiated directly by the patient, not by a surrogate, family member, or prior written expression.

- Because of these statutory requirements, documenting MAID on a POLST or any advance directive:
  - Creates expectations that cannot legally be honored.
  - May cause distress for families, who cannot act on the patient's written statements if the patient has lost capacity.
  - Does not practically guide clinical care, since MAID cannot be enacted based on prior wishes, unlike other POLST elements.

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Reporting Requirements

- 2 items providers are obligated to report:

1. Within 30 days of providing a prescription for medication used for aid in dying, attending MD has to report to IDPH:

- the name of the patient
- the patient's diagnosis and prognosis
- notice that requirements under the Act have been met; and
- notice that medication has been prescribed pursuant to act

Reporting Requirements

2. Within 60 days after notification of a qualified patient's death from self-administration of medication, attending MD shall submit to IDPH the "Attending Physician Follow-Up Form" with the following info:

    - patient's name and DOB

    - date of patient's death

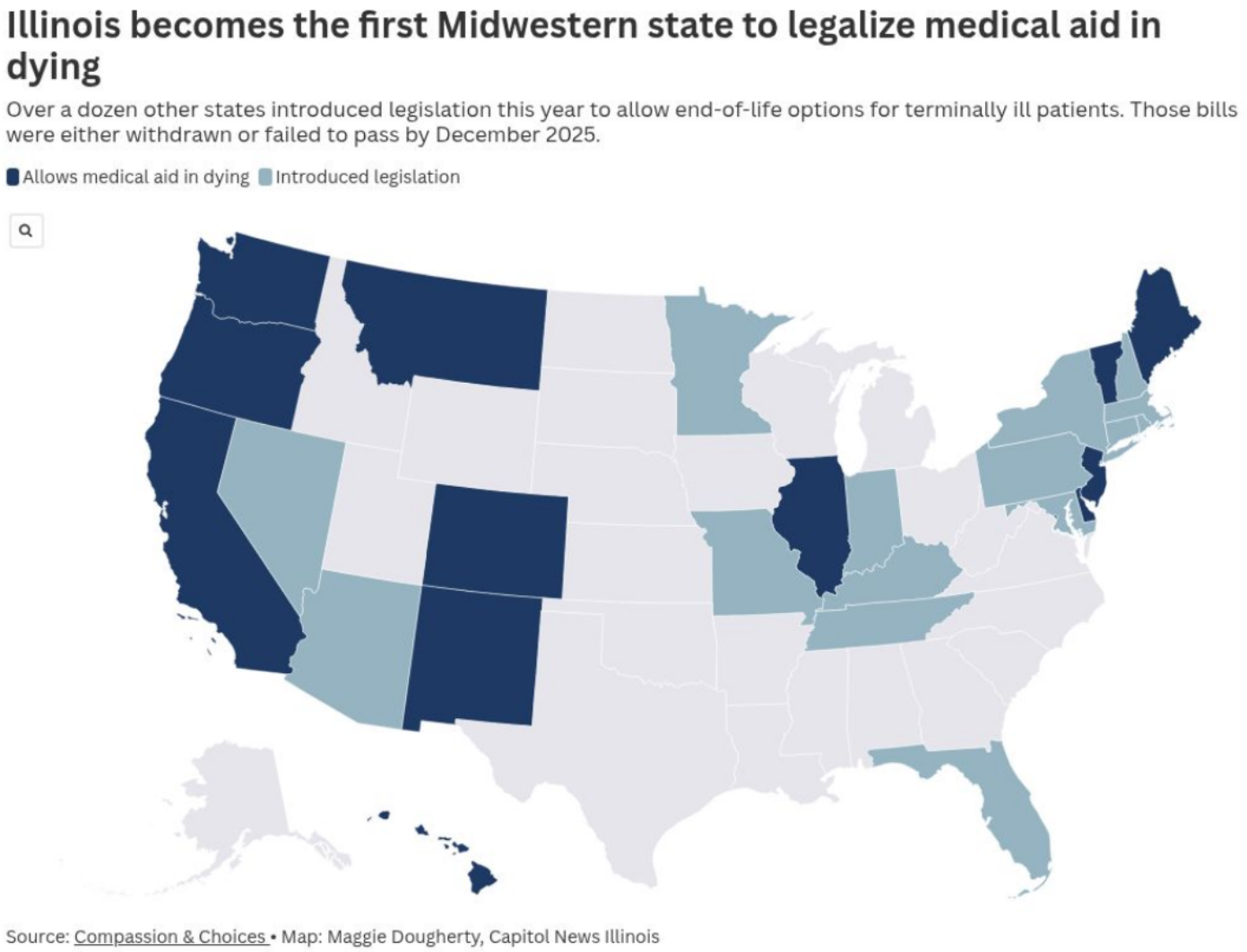
    - a notation of whether the patient was enrolled in hospice services at the time of the qualified patient's death.

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Safe Disposal of Unused Medication

- Anyone who has custody or control of medication prescribed pursuant to Deb's Law shall deliver it to the "nearest qualified facility" that disposes of controlled substances, or, if none is available, disposing it by lawful means in accordance with applicable State and federal guidelines.

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Key Policy Comparisons

Feature	Illinois	Typical Other Jurisdictions	New York
Status	Law effective September 12, 2026	Already in effect in many jurisdictions	6 months after signing
Residency Requirement	Must be Illinois resident	Most require residency (exceptions vary)	Applies to New York residents
Waiting Period	5 days between oral requests	Varies by state (e.g. 2-15 days)	5 days required
Witness Requirement	2 witnesses (at least 1 independent; 1 may be related)	Many require 2 independent witnesses	2 independent witnesses
Physician Evaluation	Attending + consulting physician with psychologist/psychiatrist if mental capacity questioned	Attending + consulting physician with psychologist/psychiatrist if mental capacity questioned	Attending + consulting physician with psychologist/psychiatrist if mental capacity questioned
Provider Participation	Voluntary	Voluntary	Voluntary

Benefits and Concerns

Commonly cited benefits

- Promotes patient autonomy and dignity at end of life
- Provides an option to reduce prolonged suffering
- Allows patients greater control over timing and circumstances of death
- Includes procedural safeguards to ensure voluntary decision-making



Commonly raised concerns

- Risk of coercion or pressure, particularly for vulnerable patients
- Ethical and moral objections
- Fear of expansion beyond terminal illness
- Potential impact on patient-provider relationship



Aid in Dying Statistics

- 2022: 5,329 Americans had used an aid-in-dying process to legally end their lives
  - Median age: 74
- 2025: About 10,211 Americans used aid-in-dying
  - 77% of those deaths occurred in a private home
  - 5% took place in nursing homes, assisted living, or foster care settings
    - 1.4% specifically attributed to “nursing home”
  - About 38% of people who obtain aid-in-dying prescription never take them

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Payne v. Pritzker; 1:26-cv-06886

- Filed June 11, 2026, in Federal Court, by Individuals and Disability Rights Organizations a
- Alleges violations of:
  - Americans with Disabilities Act (ADA), 42 U.S.C. § 12132;
  - Section 1557 of the Affordable Care Act, 42 U.S.C. § 18001; and
  - Section 504 of the Rehabilitation Act, 29 U.S.C. § 794
  - Procedural Due Process and Equal Protection
  - Interference of Liberty Interest of Physicians Protected by 14th Amendment

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Payne v. Pritzker; 1:26-cv-06886

Concerns with the Law:

- Ends physician ethical obligation of do no harm;
- Insufficient safeguards with no judicial hearing or prior review; and
- Pressure from Insurers, Hospitals and Physicians to end life early.

“By singling out only these individuals for assisted suicide, with no protections, EOLA devalues their lives and stigmatizes and discriminates against Plaintiffs because they have life-threatening disabilities and should be placed in a lower tier of care.”

Current Status of Case: Litigating Plaintiff’s Motion for a Preliminary Injunction

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Questions?