compassion & choices

ILLINOIS

END-OF-LIFE OPTIONS FOR TERMINALLY ILL PATIENTS ACT

A RESOURCE GUIDE FOR ILLINOIS CLINICIANS

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Compassion & Choices is the nation's oldest, largest, and most active nonprofit working to improve care and expand options for care at the end of life. We envision a society that affirms life and accepts the inevitability of death, embraces options for compassionate dying and empowers everyone to choose end-of-life care that reflects their values, priorities, and beliefs.

Introduction

Medical aid in dying, often abbreviated as "MAID," is a widely supported practice in end-of-life care that provides dying people with peace of mind and comfort during a difficult time. In the 14 U.S. jurisdictions where this option is currently authorized, medical aid in dying allows a terminally ill, mentally competent adult to die peacefully on their own terms.

In November 1994, Oregon passed the nation's first law giving terminally ill adults access to medical aid in dying. Today, more than one in three people live in a jurisdiction where medical aid in dying is authorized.

Evidence from nearly 30 years of practice demonstrates that the option of medical aid in dying increases the utilization of hospice care, encourages conversations about values and priorities, and improves end-of-life care overall[1]. More importantly, the multistep process ensures patients are fully informed about care options, protected from coercion, and empowered to choose their own end-of-life journey.

The End-of-Life Options for Terminally Ill Patients Act (SB1950), also known as "Deb's Law," was signed by Governor JB Pritzker on December 12, 2025, authorizing medical aid in dying in the state of Illinois. This made Illinois the 13th U.S. jurisdiction to affirm the rights of terminally ill adults to die peacefully on their own terms. Deb's Law goes into effect September 12, 2026.

The well-established practice of medical aid in dying also supports professionals by providing a framework for care along with regulatory guidelines and protections for both those who choose to support a patient's request as well as those who may not.

If you are reading this guide, we hope it is because you recognize the importance of patient-directed care at the end of life and are eager to learn about the practice of medical aid in dying in Illinois. This content was developed by clinical, legal, and policy experts with experience in medical aid in dying in an effort to provide our colleagues with accurate information and practical resources for supporting their patients and community.

For additional guidance or consultation, contact Compassion & Choices at 800-247-7421 or info@compassionandchoices.org.

[1] Hoffman, D., Beer, E. (2023). Have Arguments For and Against Medical Aid in Dying Stood the Test of Time? Voices in Bioethics, 9. https://doi.org/10.52214/vib.v9i.12079

Medical aid in dying

Facing the end of life can be one of the most profound and vulnerable times in a person's journey. Care during the terminal phase of an illness encompasses a range of interventions intended to relieve pain and discomfort, provide emotional and spiritual support, address practical needs, and maintain quality of life. Alongside hospice, palliative care, and comprehensive symptom management, one option for care at the end of life is medical aid in dying. While few people use this care option — less than 1% of adults who die in each jurisdiction[2] — many gain peace of mind and comfort by simply knowing it exists.

Medical aid in dying is an established clinical practice that provides eligible adults living with a terminal disease the choice to have an end-of-life experience that aligns with their beliefs and values. It is a clearly defined process with strict eligibility criteria, available only in U.S. jurisdictions where it has been authorized by legislation, ballot measure, or court decision.

Illinoisans facing a terminal diagnosis, including Deb Robertson (for whom the law is named), Andrew Flack, Lowell Sachnoff, and Miguel Carrasquillo, have been at the forefront of statewide efforts to make the full range of end-of-life care options available to Illinois residents through the addition of medical aid in dying as an option in their home state.

Eligibility

The Illinois End-of-Life Options Act, in alignment with other laws authorizing medical aid in dying in the United States, establishes strict eligibility criteria and practice requirements to ensure the highest standard of care. An individual must be[3] :

- An adult (18 years or older) resident of Illinois
- Diagnosed with a terminal (incurable and irreversible) illness
- Determined to have a prognosis of six months or less
- Able to make their own medical decisions
- Able to complete the multistep request process
- Able to self-administer medications to be absorbed by the gastrointestinal (GI) tract

An individual does not qualify for medical aid in dying solely based on age, disability, or quality of life. A mental health condition, including depression or major depressive disorder, is not a qualifying condition because it does not meet the definition of a terminal illness.

[2] *Medical Aid-in-Dying Utilization Report*, 2026. Compassion & Choices. candc.org
[3] Illinois Senate Bill 1950, 104th General Assembly, (2025-2026). ilga.gov

Request process

In Illinois, an attending physician as well as a consulting physician must independently verify the patient's request and eligibility for medical aid in dying. If the attending or consulting clinician is unsure about the patient's capacity to make their own health care decisions or has concerns about impaired judgment, a third evaluation by a licensed mental health professional is required.

The Illinois End-of-Life Options Act outlines a clear multi-step process that supports clinicians and ensures patients are aware of all end-of-life options and empowered to choose the care that is right for them.

The patient must make three clear requests for aid in dying directly to the attending physician; an initial verbal request, followed by a written request, and a second verbal request at least five days after the first. If the attending physician has determined that within their medical judgment the patient may not survive the five days between the two verbal requests, the physician can waive this waiting period and accept a second verbal request and the written request at any time.

All requests for medical aid in dying must be made by the patient. Requests through an advance directive or by a surrogate decision maker, health care agent/proxy, power of attorney, family member, or other individual acting on behalf of the patient are not permitted. Requests must be made directly to the physician, not through a member of their staff or care team.

If a patient wishes to transfer care to another physician, their medical records (including documentation of the dates of the requests for medical aid in dying), should be sent promptly. A transfer of care or medical records does not restart any waiting period.

Patients reserve the right to change their minds, and must be given the opportunity to do so. Years of practice indicate this is not an uncommon or unexpected scenario. According to utilization data from authorized jurisdictions that provide reports, approximately 38% of patients who go through the process and obtain a prescription may never take it. If this occurs, no formal notification or withdrawal process is required.

Role of the attending physician

The attending physician has primary responsibility for the care (or, in some cases, has assumed care) of the patient and treatment of their terminal disease. They must be licensed to practice in the state of Illinois and may or may not be the same physician as the attending for hospice, primary, or specialty care.

The attending physician is responsible for determining eligibility, ensuring the patient understands the care options available to them, and coordinating all steps associated with the

request process — including referrals to a consulting physician for confirmation of the patient's request and a licensed mental health professional if there are concerns about the patient's ability to make an informed decision. Once all steps of the request process are completed for a qualified patient, the attending physician can write the prescription for aid-in-dying medications.

Following a patient's request for medical aid in dying, the attending physician should complete an evaluation to confirm they meet all eligibility criteria and are making an independent and fully-informed decision. This requires meeting with the patient privately to confirm they are making the request of their own free will without any coercion or pressure. An interpreter can, and should, be present if necessary to ensure the patient is able to communicate in the language with which they are most comfortable. Illinois' law also requires the attending provider facilitate open and ongoing conversation with the patient regarding:

- Their diagnosis and prognosis
- The risks and expected result of taking the aid-in-dying medication
- All appropriate end-of-life care options and provide referrals upon request (i.e., hospice, comfort care, pain control)
- Right to rescind their request or halt the process at any time
- No obligation to fill the prescription or self-administer the medication if it is obtained
- The recommended procedure for self-administration of medications to be prescribed
- Safekeeping and proper disposal of unused medication in accordance with Illinois law
- Advise against taking the medication in a public place
- Plan for the chosen day of administration, such as what expectations the patient might have of the physician, whether the patient wishes to notify anyone of their request, and the benefit of having another person present for support at the time of self-administration

It is also recommended that the attending physician consider who will pronounce and certify the death, especially if the patient is not under the care of hospice. Unless otherwise prohibited, the attending physician may sign the death certificate.

Documentation required of the attending physician

All conversations, coordination, and care related to the patient's request for medical aid in dying must be documented in their medical record per the physician's standard procedure. Specifically, Illinois statute requires the attending physician to clearly include in the medical record:

- Eligibility for medical aid in dying, including prognosis and decision-making capacity
- The dates of the first and second verbal requests

- A copy of the written request, including date and time received
- Confirmation that all required steps of the process have been completed
- Details of all medications prescribed
- The consulting physician's written determination of eligibility
- Confirmation of the patient's decision-making capacity by a qualified licensed mental health professional, if a referral was made
- If waiving the five-day waiting period, the assessment/judgment that led to that decision

The Illinois End-of-Life Options Act also requires documentation be submitted to the Illinois Department of Public Health within the specified timeframes:

- Within 30 calendar days of providing a prescription, the attending physician must submit a copy of the Attending Physician Checklist Form
- Within 60 calendar days of notification of a patient's death from self-administration of aid in dying medications, the attending physician must submit a copy of the Attending Physician Follow-Up form

Role of the consulting physician

The consulting physician must be licensed in the state of Illinois and qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease. They are not required to have primary responsibility for the patient's health care.

The consulting physician is required to evaluate and confirm in writing to the attending physician that the patient meets all required eligibility criteria for medical aid in dying, is acting voluntarily, making an informed decision, and understands the expected result of taking the medication. If the consulting physician has doubts regarding the patient's ability to make informed decisions, they can refer to a licensed mental health professional for evaluation.

Written request

In addition to the two verbal requests, the patient must also provide a written request using the *Request for Medication to End My Life in a Peaceful Manner* form, which will be available on the Illinois Department of Health website once finalized.

This form must be signed and dated by the patient in the presence of at least two witnesses who attest that the patient has decision-making capacity, is acting voluntarily, and is not being coerced in any way. Per Illinois law, only one witness may be related to the patient by blood, marriage, or adoption; entitled to any portion of the patient's estate upon death; or an owner,

operator, or employee of an institution where the patient resides or is receiving care. Neither the attending physician nor interpreter, if needed, shall serve as a witness.

If an interpreter assists with facilitating the written request, they include documentation for the patient's medical record regarding their role and the patient's understanding of the form.

Confirming decision-making capacity

If the attending or consulting physician feels unable to confirm that the patient is capable of making an informed decision, they should refer them to a licensed mental health professional (psychiatrist, clinical psychologist, clinical social worker, or advanced practice registered nurse certified as a psychiatric mental health practitioner) for a determination of mental capability.

The focus of this additional evaluation, which is not commonly needed,[4] is to determine whether the patient has a psychiatric or psychological disorder causing impaired judgment. If an evaluation is done by a mental health professional, they shall submit a written determination of the patient's capacity to the attending or consulting physician who made the referral.

If it is determined that the patient has impaired judgment and/or decision-making capacity is lost during the request process, the patient is not eligible for medical aid in dying, as they must retain capacity up to the point of self-administration.

Summary of the Illinois request process

1. The patient makes an initial verbal request for medical aid in dying to an attending physician.
2. The patient completes a written request, signed by two qualifying witnesses.
3. The patient repeats the verbal request to the attending physician no less than five days (unless waived) after the initial verbal request, at which time the attending physician must offer the patient an opportunity to rescind their request.
4. A consulting physician meets with the patient to confirm eligibility.
5. If either physician questions capacity, refer to a mental health clinician.
6. After all steps are complete and patient eligibility confirmed, the attending physician may write the prescription and send to a compound pharmacy
7. All of the above is clearly documented in the patient's medical record.
8. Submit forms to the Department of Public Health per the required timeline.

[4] Andoh, E. *Medical aid in dying brings a compassionate close to life.* American Psychological Association, Vol 56, No 5. July 1, 2025. apa.org/monitor

Methods of self-administration

To be eligible for medical aid in dying, a patient must be able to self-administer the medication through a conscious and voluntary act of ingestion or absorption through the gastrointestinal (GI) tract. Options for self-administration will be determined by the attending physician in consultation with the patient, and may include[5]:

- **Oral ingestion** is the most common method and involves swallowing the entire mixture within a few minutes.
- **Feeding tube** administration uses an existing gastrostomy (G-tube) or jejunostomy tube (J-tube) to introduce the medication into the GI tract. A syringe attached to the tube allows the patient to push the plunger to introduce the medications, similar to how they would for feedings. Although rare, a nasogastric tube (NG) may also be used.
- **Rectal** administration allows the patient to introduce the medication into the GI tract via a syringe attached to a rectal catheter that is inserted with the assistance of a clinician.
- **Ostomy** administration allows the patient to introduce the medication by pushing the plunger of a syringe inserted into their stoma.

A patient may request an accommodation for options to self-administer medical aid-in-dying medications, just as they may for other medical services in accordance with the Americans with Disabilities Act. Appropriate assistance can include preparing and mixing the medication, bringing it to the patient, holding a cup and straw up to their mouth, and attaching it to a feeding tube or catheter. Even with assistance, the patient must control the process and take a voluntary action — such as swallowing or pushing a plunger — to introduce the entire dose of medication into their GI tract.

Administration of medications by injection, infusion, intrathecal, or other parenteral route is not permitted under any circumstances. Similarly, administration of the medication by anyone other than the patient, including a physician, clinician, or family member, is not permitted. This is generally considered euthanasia, which is not legal in the United States.

[5] Shavelson, Battin, Pope. *Medical aid in dying: Clinical Considerations.* UpToDate, updated 9/18/25.

Aid-in-dying medications

When determining medical aid-in-dying eligibility, the attending physician will determine the appropriate medication regimen based on the patient's condition and planned method of self-administration. Due to the need for this personalized approach, no medical aid-in-dying law or regulation specifies what medications should be prescribed.

Aid-in-dying medications are customized to the unique condition and needs of the patient in consideration of their preferred method of self-administration.

The pharmacology of medical aid in dying has evolved over time as drug availability has changed and understanding of the patient experience grows. Currently, the most common aid-in-dying medication is a mixture of digoxin, diazepam, morphine, amitriptyline, and phenobarbital, abbreviated as DDMAPh[6].

DDMAPh must be prepared by a compounding pharmacy within a nonsterile environment. It is typically dispensed in a powder form which is mixed with a small amount of liquid, typically 2-4 ounces of apple juice, at the time of ingestion. In compliance with compounding law, pharmacists must put a six-month expiration date on medications prepared in this manner. This should be a consideration when speaking with the patient about when they wish to receive the medications.

Clinicians familiar with aid-in-dying medicine recommend a dose of anti-nausea medication(s) approximately 30-60 minutes prior to not only reduce the risk of vomiting but to activate gastroparesis and assist in the delivery of medications to the gastrointestinal tract where they can be absorbed. Other routes of self-administration may also require other forms of pre-medication or preparation prior to self-administration.

Coordinating with the pharmacist

Pharmacists play an important role in working collaboratively with the attending physician to prepare the prescribed medications, support the patient, and confirm that all steps in the request process have been met. Pharmacists often assist with counseling the patient regarding the medications prepared for them, ensuring they understand preparation instructions as well as proper safekeeping and disposal of the medications.

Illinois allows prescriptions to be delivered personally, by mail, or through an authorized electronic transmission (such as an electronic health record) to a licensed pharmacist. The pharmacist will dispense the medication to the patient or to a person expressly designated by the qualified patient, in person or with a signature upon delivery if sent by mail or delivery service.

[6] Hoffman, Strand. *Clinical practice and pharmacology decisions of medical aid in dying providers in the United States.* BMJ Supportive & Palliative Care. Dec 2025.

Reporting and data collection

As detailed in the "Documentation required by the attending physician" section above, the following forms are required per Illinois statute and Department of Health regulations.

Form	Submitted by/to	When
Written Request for Medication to End My Life in a Humane and Dignified Manner	Attending physician completes with patient and two witnesses, uploads to medical record	After initial verbal request
Attending Physician Checklist Form	Attending physician submits to the Illinois Dept of Health	Within 30 calendar days of writing a prescription for aid-in-dying medications
Attending Physician Follow-Up Form	Attending physician submits to the Illinois Dept of Health	Within 60 calendar days of notification of patient's death from self-administration of medications prescribed

The information collected shall be confidential and handled in a manner that protects the privacy of the patient, their family, and any health care professional involved in the provision of medical aid in dying. This information will not be public record nor available through the Freedom of Information Act.

Data collected will be used to generate an annual statistical report of de-identified information, which will be available to the public on the Illinois Department of Health website.

Protection for clinicians

All medical aid-in-dying laws explicitly state that participation by both physicians, other care professionals, and health care organizations is voluntary. No provider or entity is obligated to prescribe or dispense aid-in-dying medication.

The Illinois End-of-Life Options Act provides explicit protections for care providers, ensuring those who participate or refuse to participate in the provision of aid-in-dying care are protected from criminal liability, civil liability, and professional discipline, provided they comply with legal requirements, act in good faith, and meet established medical standards of care. Similar immunities and protections are extended to health care entities and organizations.

Illinois statute specifically states that a physician who is present for the self-administration and assists the patient in preparing the medication may do so without civil or criminal liability.

Developing organizational policy

While medical aid-in-dying laws outline the specific requirements for a patient to request and obtain the prescription, health care organizations are encouraged to develop internal policies that provide clear information to patients, clinicians, and staff to address how requests for medical aid in dying will be received and managed within an interdisciplinary care team.

Broadly speaking, policies should align with the organization's mission and:

> ***Align with existing palliative care standards.*** All goals-of-care conversations should center on patient priorities, whether or not those priorities include medical aid in dying. The practice of medical aid in dying should be integrated into the organization's existing interdisciplinary model of care.
>
> ***Set clear standards for the organization's participation and serve as a reference for staff***. The policy should be explicit about the ways the organization will support patient-directed care, including medical aid in dying, and establish processes to facilitate that care.
>
> ***Support the interdisciplinary care team***. The policy should establish roles and responsibilities for all staff or volunteers who may be involved in the process. Structures for training should be established, as well as mechanisms for managing and supporting conscientious objections and moral distress.

The Compassion & Choices Medical Aid in Dying Guide to Creating Patient-Centered Policies provides in-depth guidance on developing policies that support patients as well as staff and volunteers.

If a health care organization chooses to prohibit employees and contractors from supporting medical aid in dying for patients, the Illinois End-of-Life Options Act requires them to provide written notice upon hire and on an annual basis. In addition, no health care entity can prohibit a health care professional from providing information to a patient regarding the option of medical aid in dying and how to access the care of their choice.

Frequently asked questions

Is medical aid in dying listed on the death certificate?

No. Illinois statute, in alignment with Centers for Disease Control and Prevention (CDC) guidance and established clinical practice in other situations where the cause, manner, or timing of death may have been influenced by other factors (such as ventilator withdrawal or discontinuation of dialysis), state death certificates must list the underlying terminal disease as the cause of death.

This guidance adheres to CDC Instructions for Completing the Cause of Death Section of the Death Certificate, which directs to "always enter the underlying cause of death" and states: "The immediate cause does not mean the mechanism of death or terminal event (for example, cardiac arrest). The mechanism of death should not be reported as the immediate cause of death."

In addition, clinical and evidence-based guidance for death certificates and death investigations in the United States instructs providers to "list the underlying terminal condition as the cause of death and the manner of death as natural." Any variation in this practice threatens the privacy of the patient, the confidentiality of their decision for medical aid in dying, as well as the integrity of tracking trends in disease and public health concerns.

Is organ donation an option after medical aid in dying?

Generally, no. The majority of individuals who choose medical aid in dying do not qualify for tissue, organ, or body donation due to their illness and the high-dose medications ingested. In addition, organ donation requires viable organs to be retrieved quickly, often in a hospital setting — which does not align with the majority of aid-in-dying deaths. For questions, speak with a local tissue bank or organ procurement agency to review the patient's situation.

How can a patient show proof of being a resident of Illinois ?

To qualify for medical aid in dying, an individual must show proof that they are an Illinois resident. A patient can establish residency with one of the following:

- A driver's license or other state-issued identification card
- Voter registration
- Evidence that the individual owns, rents, or leases property in Illinois
- The location of any dwelling occupied by the patient
- Motor vehicle registration

- The residence address (not a post office box) where mail is received or is shown on the previous year's income tax return
- The address (not a post office box) shown on a current hunting or fishing license
- Receipt of any public benefit that requires residency
- Or any other objective facts that indicate a patient resides in Illinois

Does medical aid in dying impact insurance or other benefits?

No. Patients who choose medical aid in dying remain entitled to existing benefits. Illinois law specifies that no health, life, or accident insurance policy can deny or alter the benefits or rates charged for a policy based on whether an individual chooses medical aid in dying or not.

Is medical aid in dying the same as euthanasia?

No. Medical aid in dying is a patient-directed clinical practice that honors patient autonomy at the end of life, whereas euthanasia is an intentional act by another person to cause a patient's death, which is illegal throughout the United States.

Is medical aid in dying in the United States the same as in Canada?

No. Just as the overall delivery of health care differs, the eligibility criteria, clinical practice, and laws defining medical aid in dying within authorized U.S. jurisdictions are fundamentally different from the Canadian "medical assistance in dying" law. A detailed breakdown is provided by Compassion & Choices at CandC.org/key-differences.

Can medical aid in dying be requested through an advance health care directive?

No. A request for medical aid in dying must come directly from the terminally ill individual, who must have decision-making capacity and meet eligibility criteria at the time of their request. No one can make a request for medical aid in dying before they are eligible, or on another person's behalf. Therefore, requests through an advance directive, conservator, or other agent or surrogate are not permitted.

Does insurance cover the cost of aid-in-dying medications?

Although most plans include benefits for end-of-life planning, coverage for medications associated with medical aid in dying is quite rare. This is largely due to the Assisted Suicide Funding Restriction Act of 1997, which prohibits the use of federal funds to assist in the death of

an individual; the fact that many compounding pharmacies operate on a cash-only basis; and the prescription being a mixture of medications, and therefore, not part of any formulary. Since benefits and coverage can vary greatly, patients are encouraged to contact their insurance provider with questions.

Are there protections for clinicians who support patients through the process of medical aid in dying?

Yes. Medical aid-in-dying laws and regulations support all members of the patient's health care team. Illinois' law specifically states that clinicians acting in good faith and in accordance with generally accepted health care standards are not subject to civil or criminal liability, or to discipline for unprofessional conduct for providing information, prescribing, or dispensing medications, or for being present when a qualified patient self-administers the prescribed medications. Participation in the medical aid-in-dying process is optional for all health care providers. Professionals have the right to refuse participation, and not be subjected to disciplinary action for such refusals.

Compassion & Choices wishes to thank the passionate advocates who worked for more than seven years to make medical aid in dying a reality in Illinois.

To the dedicated clinicians and professionals who now carry the practice of medical aid in dying forward, thank you for the tremendous compassion and skill that goes into supporting individuals facing the end of their life.